SOCIAL SECURITY AMENDMENTS OF 1971

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST AND SECOND SESSIONS

ON

H.R. 1

TO AMEND THE SOCIAL SECURITY ACT TO INCREASE BENEFITS AND IMPROVE ELIGIBILITY AND COMPUTATION METHODS UNDER THE OASDI PROGRAM, TO MAKE IMPROVEMENTS IN THE MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS WITH EMPHASIS ON IMPROVEMENTS IN THEIR OPERATING EFFECTIVENESS, TO REPLACE THE EXISTING FEDERAL-STATE PUBLIC ASSISTANCE PROGRAMS WITH A FEDERAL PROGRAM OF ADULT ASSISTANCE AND A FEDERAL PROGRAM OF BENEFITS TO LOW-INCOME FAMILIES WITH CHILDREN WITH INCENTIVES AND REQUIREMENTS FOR EMPLOYMENT AND TRAINING TO IMPROVE THE CAPACITY FOR EMPLOYMENT OF MEMBERS OF SUCH FAMILIES, AND FOR OTHER PURPOSES

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CONTENTS

Discussions Between Members of the Committee on Finance and the Witnesses—Continued

Administration Witnesses

Public Witnesses

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Public Witnesses—Continued

Communications

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Communications—Continued

Additional Information

Additional Information—Continued

Additional Information—Continued

Additional Information—Continued

Additional Information—Continued

Additional Information—Continued

Appendixes

Appendix A—Volume 1

Appendix B—Volume 1

Appendix C—Volume 1

Appendix D—Volume 1

Appendix E—Volume 1

Appendix F—Volume 2

Appendix G—Volume 4

Appendix H—Volume 4

Appendix I—Volume 4

Communications Received by the Committee Expressing an Interest in H.R. 1, the Social Security Amendments of 1971

TESTIMONY BY HON. FRANK CHURCH, A U.S. SENATOR FROM THE STATE OF IDAHO

Mr. Chairman, thank you for the opportunity to testify here this morning on H.R. 1, a bill which may be the most important domestic legislation that the Senate will consider during this session.

As Chairman of the Senate Committee on Aging, I shall direct my remarks to the sections in the bill which are of vital concern to the Nation's elderly.

Several provisions in this measure, I am pleased to say, are either identical or similar to proposals I have advanced, such as:

Major increases in minimum monthly benefits for persons with long periods of covered employment;

Cost-of-living adjustments to protect the elderly from inflation;

Full benefits for widows, instead of only 82½ percent as under present law;

Liberalization of the retirement test;

An age-62 computation point for men;

Protection against retroactive denial of payments under Medicare;

Coverage of the disabled under Medicare; and

Replacement of old age assistance with a new income supplement program to be administered by the Social Security Administration.

These welcome changes provide a solid foundation for making many crucial reforms for strengthening and improving our Social Security, Medicare and income supplement programs for the elderly. However, more comprehensive and far-reaching action is needed now—not two or three years from now—if the aged are to escape from the economic treadmill which keeps them running but going nowhere.

Make no mistake about it, the elderly are slipping further behind on a number of key fronts in terms of achieving economic security.

Today more than 4.7 million persons 65 and older fall below the poverty line, nearly 100,000 more than in 1968. Older Americans are now more than twice as likely to be poor as younger Americans. One out of every four persons 65 and older—in contrast to one in nine for younger individuals—lives in poverty.

If the marginally poor are also included, their impoverished numbers swell to more than 6.5 million. The net impact of these figures is that one out of every three aged persons is poor or near poor.

And by poverty, I mean a "rock bottom" standard. According to Census definitions, it is $1,852 for a single person and $2,328 for an elderly couple. The near poor threshold is 125 percent of these figures: $2,315 for individuals and $2,910 for couples.

Inadequate retirement income also takes its toll in many other forms: substandard housing, isolation, loneliness, malnutrition, and poorer health.

For these reasons, it is absolutely essential that the Senate make important finishing touches to perfect the House-passed Social Security-Welfare Reform proposal.

LARGER AND EARLIER BENEFIT INCREASES

Heading the list in my judgment is the need for a larger benefit increase for Social Security recipients. The House-passed bill proposes a 5 percent across-the-board raise to take effect this June.

This proposal is certainly welcome, but it simply does not go far enough to deal effectively with the retirement income crisis which now affects millions of older Americans and threatens to engulf many more. To put it bluntly adding a few dollars every one or two years is not going to solve this mounting problem.

Moreover, the rise in the cost-of-living since the last Social Security increase—which was effective in January 1971—is almost certain to outstrip the proposed 5 percent raise in H.R. 1.

With poverty on the rise for the elderly, a more substantial benefit increase is urgently needed, and not in June but to take effect January 1.

For these reasons, I am proposing—as I have in my omnibus Social Security-Welfare Reform proposal. S. 1645—that there should be an across-the-board increase which would average about 12 percent for all Social Security recipients. However, this rise would be weighted to provide for larger percentage increases for persons who need them the most, individuals with inadequate benefits because of low lifetime earnings.

For example, persons with average monthly lifetime earnings between $150 and $200 would be entitled to benefit increases averaging about 21 percent. And individuals with creditable earnings ranging from $200 to $300 would receive approximately an 18 percent raise.

A principal advantage of this approach is that it could lift large numbers of older Americans out of poverty without the necessity of resorting to welfare. Additionally, it recognizes this very basic fact: persons who now receive low Social Security benefits are less likely to have other resources than higher income beneficiaries.

And in terms of dollars and cents, this proposal would provide nearly $130 more per year than allowed under the 5 percent benefit increase in H.R. 1.

ELIMINATION OF POVERTY FOR ELDERLY

One of the major innovations in H.R. 1 is the replacement of the adult categorical assistance programs—aid to the aged, blind and disabled—with a new Federal program to be administered by the Social Security Administration.

This is certainly a step in the right direction. But the fundamental weakness is that the income standard would be too low for the elderly. The proposed $1,560 income level for fiscal 1973 for a single person is still about $300 below the 1971 poverty threshold. By the time 1973 rolls around, it is likely to be several hundred dollars below the poverty index.

For these reasons, I urge that the income standards be raised to a level to wipe out poverty once and for all for older Americans—to $160 a month for a single aged person and $200 for a couple. Moreover, I propose that these standards be adjusted annually with rises in the cost-of-living to make them inflationary proof for these low-income persons.

Certainly the wealthiest Nation in the world can make that commitment to a generation who worked so hard for the high standard of living we now enjoy.

MEDICARE REFORMS

Important as a soundly conceived income strategy is, we must not overlook the need for major improvements in Medicare. Today the rising costs of medical care and proposed cutbacks in coverage pose a very serious drain upon the limited incomes of the elderly. Medicare now covers only about 43 percent of their expenditures because gaps in coverage still exist.

One of the major gaps is coverage of out-of-hospital prescription drugs. This constitutes the largest health care cost which they must meet almost entirely from their own resources.

Today prescription expenditures for persons 65 and older average about $84 per year, nearly three times as high as for younger individuals. For aged persons with severe chronic conditions—about 15 percent of all older Americans—drug costs are six times as high as for younger persons.

Several renowned authorities—including the 1971 Social Security Advisory Council, the HEW Task Force on Prescription Drugs, and the White House Conference on Aging—have all gone on record in support of this badly needed coverage. And now, the Congress should go on record unequivocally to extend this long overdue protection for the aged.

Another major expenditure for the elderly is the $5.60 monthly premium charge for Part B of Medicare. In July, this will rise to $5.80. On an annual basis, this will mean that an elderly couple will pay nearly $140 for doctor's insurance. For persons living on fixed incomes, this can represent a very substantial expenditure.

Again, I recommend that this charge be eliminated for the aged. Instead, the Part B and Part A Hospital Insurance programs would be combined and financed by one-third contributions from employees, one-third from employers, and one-third from general revenues.

This proposal is patterned after the recommendation in the 1971 Social Securiay Advisory Council report. And for the typical retired worker, this change alone would be almost the equivalent of a 5 percent increase in benefits.

MEDICARE CUTBACKS

My earlier remarks have focused basically on positive action that the Senate can take to improve H.R. 1. Now I would like to turn to some undesirable provisions in H.R. 1 which, I believe, can limit the quality and scope of care for the aged.

Since other Members of the Committee on Aging will talk at greater length on many of these measures, I shall only concentrate on two of these proposals.

First, H.R. 1 establishes a new $7.50 copayment charge for each day in the hospital from the 31st to the 60th day. This, of course, would be in addition to the $68 deductible which the elderly would be required to pay out of their own pocket for hospitalization.

For an individual requiring 60 days in the hospital, this charge alone could add $225 to his bill. The irony of it all is that this provision is likely to hurt the very person that Medicare is supposed to help the most—the individual with a large health care bill because of a prolonged period in the hospital.

And remember this: About 9 out of every 10 persons who reach age 65 will require at least 1 stay in the hospital during their remaining years. About two out of every three will require at least two hospital stays.

Additionally, H.R. 1 would raise the deductible for Part B from $50 to $60, once again driving up the health care costs for the elderly.

These measures, I believe, should be deleted or substantially altered by the Senate.

WHITE HOUSE CONFERENCE ON AGING

At the recent White House Conference on Aging, 3,400 delegates from every State in the Union made a ringing call for action on several fronts.

Soon the Senate will consider H.R. 1, a measure that can be landmark legislation in providing genuine economic security for the aged.

Again, I reaffirm my strong support for early and favorable action on this bill, along the lines that I have outlined in my statement.

We owe this pledge to more than 20 million Americans who are now 65 and older. And we owe this pledge to the millions more nearing this age.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

I urge committee acceptance of Amendment No. 945 to HR 1. This amendment is identical to S-961, a bill I had introduced on Feburary 25, 1971, to amend the Social Security Act with respect to exclusion of certain income received by artists and composers from the sale after age 65 of works created prior to their reaching age 65.

The Social Security Act now provides that individuals 65 years and over who are receiving royalty income attributable to copyrights or patents obtained before age 65 may exclude such income from their gross income in determining their social security entitlement.

Amendment No. 945 extends the provision to artists and composers who sell uncopyrighted works, thereby placing them on an equal basis with artists and composers receiving royalty income from copyrights or patented works. The burden of proof remains upon the individual artist or composer to establish to the satisfaction of the Secretary of Health, Education, and Welfare when the art work or composition was created and when sold.

Although no precise estimates are available as to the number of individuals who would become eligible under this amendment, it should be noted that in order to be eligible, an individual author or artist must have created the work prior to age 65, and that his outside income does not exceed $1,680, the figure at which social security benefits are reduced. Estimates of the numbers of artists taking advantage of the present royalty income exclusion range in the low hundreds.

Thus, we are talking about a relatively few individuals out of almost 26.2 million social security recipients.

This proposal should be relatively easy to administer. By placing the burden of proof upon the individual we have followed the pattern of the 1965 amendments to the Social Security Act. The individual is thus required to prove his claimed

exclusion to the Secretary's satisfaction consistent with existing law. Finally, the Secretary already has general rulemaking power under the law with which to establish an orderly procedure for individuals claiming the right to exclude income under this amendment.

I urge that the Committee on Finance in its consideration of HR 1 favorably consider this proposal to correct an inequity in the law which penalizes older artists and composers at a time when they are living upon modest fixed incomes and dependent upon social security benefits.

U.S. SENATE,
Washington, D.C., February 2, 1972.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee,
Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Last year I introduced S. 918, which was designed to provide a minimum income with a floor no lower than that set for the poverty program for those on Social Security.

My schedule will preclude my appearing personally before the Committee during your hearings but I would appreciate having the attached statement appear as part of the hearings.

With best wishes,

Sincerely,

THOMAS J. MCINTYRE,
U.S. Senator.

Enclosure.

Mr. MCINTYRE. Mr. Chairman: Last year I introduced a bill to amend title II of the Social Security Act to provide supplementary payments to certain low-income recipients of monthly insurance benefits covered under the Act.

I urge the Committee's consideration of this proposal as it deals closely with questions of welfare and social security.

In view of the sharp rising costs of the past few years and the still anticipated increased consumer costs, our senior citizens must live in constant terror of poverty. Even today 25 per cent of Americans 65 or over live on a bare poverty level income or below.

Unfortunately, there are too many who are naive enough to believe that social security benefits and private pension plans adequately cover our senior citizens. This is just not so. Ironically, retired people are forced to exist on less than 20% of their preretirement income at a time when their needs are, in some cases, greater than before their retirement. Special care, housing, diets, inaccessible transportation, and other problems peculiar to the elderly are not cheap.

I would like to cite the following statistics received for the Department of Health, Education, and Welfare, based on the 1970 census, to stress the mounting degree of this problem.

First, every tenth American is 65 years of age or older. The older population (aged 65 and over) grew faster than the remaining population since the 1960 census count (21.1% vs. 12.5%).

Second, about 4.7 million older persons or almost a quarter lived in households where the total income fell below the poverty threshold.

My purpose in introducing this legislation is simple and clear: it is to assure that no one on social security will be forced to live on an income which is less than what is considered to be the minimum above poverty: namely $1,800 a year for an individual, $2,400 a year for two persons and $3,000 a year for three or more persons.

My bill has the additional feature of providing an automatic adjustment in this minimum benefit to reflect rises in the cost of living as determined by the Department of Labor; the official cost-of-living figures for the Federal Government.

I believe that the best approach—at least for the present—to guaranteeing our senior citizens a minimum income is through social security. Social security benefits remain the major source of income for most retirees. The social security system has proven to be a fast and effective way to deliver income assistance at retirement. In support of the social security approach to income maintenance, Nelson Cruikshank, president of the National Council on Senior Citizens, Inc., in testimony before Senator Williams' subcommittee said:

"Of all persons 65 or older, nine in ten now receive, or are eligible to receive, Social Security benefits. This fact, in combination with the urgent need for action documented by the findings above, clearly indicates that the fastest and most direct way of improving the income situation of the total aged population is through an increase in the benefits of the Social Security system."

My choice of the social security system as the means for providing immediate help for senior citizens is not meant to preclude careful consideration of alternative measures for income guarantee for our aged; for example, proposals for a negative income tax or a guaranteed annual income. But I feel strongly that the severity of the situation facing our elderly today demands immediate action. We cannot afford to wait until alternate approaches have been tested.

I do not see how in good conscience we can ignore this group of aged poor any longer. To me, it is unthinkable that some of our aged citizens must get along on the current social security minimum of $64 a month when the poverty line for a single person is over $150 a month.

This is why I feel so strongly about the importance of my proposal to provide a minimum income through social security of at least $150 for a single person and $225 for a couple. Nearly every responsible expert agrees that this income is on the brink of poverty in the United States. I do not see how we call in all honesty say that $1,800 is the basic minimum for the general population and then deny this amount to our senior citizens who have contributed so much to the wealth of our country.

I realize that it will be said that many senior citizens have outside sources of retirement income which would preclude the necessity of a $1,800 or $2,700 a year minimum. My bill would take this condition into account. Without causing anyone to suffer a reduction in payments, my bill would provide that the minimum payments be payable only in the absence of outside income or as a supplement to this income wherever it is less than the income considered at the poverty threshold. In this way, we will be able to reach the thousands of senior citizens who, because they have worked in low-paid or seasonal jobs, are forced to live on incomes below $150 a month. I think all would agree that this is woefully inadequate. The only way of providing them relief through social security is by assuring them a minimum benefit level.

I would like to emphasize that my proposal for increasing the minimum income of those receiving social security benefits has considerable acceptance among senior citizen groups and various task forces which have studied the problem. The President's Task Force on the Aging reported as its first recommendation raising the incomes of all older Americans above the poverty line. William C. Fitch, the Executive Director of the National Council on Aging, in his testimony before Senator William's subcommittee, stated that raising the minimum standard of benefits for the elderly under social security should be the first step taken toward meeting the economic needs of the elderly. His recommendation was endorsed by 400 representatives of public and voluntary agencies who were called together by NCOA for the purpose of establishing priorities for the 1970's.

I know that this proposal will be costly to finance, and I realize that we have a responsibility for insuring the cost of these additional benefits be borne in the most equitable and fair way. Recently, there has been a great deal of discussion about the possibility of financing any increases in minimum payments through the general revenues. Most notably, the President's Task Force on Aging, in its report "Toward a Brighter Future for the Elderly," suggested that the Federal Government bear 100 percent of the cost of bringing the incomes of the elderly up to the poverty line and that these benefits be distributed through social security.

I think there are a number of apparent advantages to this method of financing. First of all, it would eliminate the necessity of asking those who have invested a great deal in social security to finance the payments of those who have contributed very little. Second, by restricting use of general revenues to only the financing of the minimum payments differential, we would know the limits of our costs and we would not run the risk of completely open-ended appropriations for social security.

But I know that many of my colleagues would suggest alternate methods of financing, and I do not want to foreclose discussion of these alternatives. For instance, I believe it is possible to finance additional payments in an equitable fashion by increasing the wage base. The Senate Finance Committee recommended to us a raise in the wage base from $7,800 to $9,000. I believe the base could be further extended to absorb the cost of providing a minimum income level of $1,800 to all those on social security.

I must admit, very frankly, that I have considered other approaches to reaching these people but have found them to be inadequate. One alternative I considered was a proposal for removing the income limitation which would have the effect of allowing senior citizens to earn outside income without suffering any loss in their social security benefits. But, this would have the effect of granting benefits only to the working elderly, leaving less funds for the non-working elderly, whose incomes are lower.

Let us not forget that old age is not a far-out issue. It is a here-and-now issue and the solution of the problems of the elderly rests heavily upon our shoulders. Old age is as sure as tomorrow's sunrise and the only way to escape old age and its perplexities is to die young—and who of us would choose this escape?

Mr. Chairman, I appreciate the committee's consideration of my views. I sincerely hope that in the deliberations on HR 1 and related proposals that the Committee give consideration to my bill, S. 918, and the principle it sets forth of providing a minimum income for our Senior Citizens with a floor at the poverty level.

Testimony Submitted by Hon. Walter F. Mondale, a U.S. Senator From the State of Minnesota

Elimination of the Supplementary Medical Insurance (Part B) Premium

Mr. Chairman, I would like you and each of the members of this distinguished committee to know how much I appreciate this opportunity to testify on the subject of the Medicare Part B premium. The whole subject of Medicare and Social Security is enormously important, and it is a privilege to participate in the work which the Senate Finance Committee is doing in this area.

Mr. Chairman, last week on February 4, I introduced for myself and ten other Senators (several more co-sponsors have joined us since the bill was introduced) a bill to eliminate the Medicare Part B premium. This premium is now paid by more than 19 million of our elderly citizens. Ninety-six percent of all those who are eligible for Medicare hospitalization also pay the premium for Supplementary Medical Insurance.

In my home state of Minnesota, 405,000 elderly citizens were enrolled in this program in 1970. They pay about $27.2 million per year in premiums. The premium charges, therefore, were more than 4.6% of total security benefits paid in Minnesota during 1970.

Eliminating the Part B premium will be the equivalent of almost a 5% raise in the average social security benefit. This will be true in Minnesota, and it will be true in the rest of the country. And the premium payments which the elderly save will be immediately available to them for their use in meeting other urgent needs.

Mr. Chairman, the rapid increase in the cost of the Part B premium is a graphic example of the effects of inflation on the elderly. Since 1967, the premium has gone from $3.00 per individual per month to $5.60 per month per individual. In July of 1972 it is scheduled to move up to $5.80. And if nothing is done about it, the premium will continue to rise.

It is true that H.R. 1 would limit the rise to one proportional with benefit increases. But if the premium is not eliminated altogether, month by month our elderly will be forced to pick up a heavy share of rapidly rising medical costs.

$5.60 a month may not seem like much to most Americans. But to many of the elderly it is a high and cruel monthly charge. For many of them, it means the difference between being able to buy a new pair of shoes or going another year or two with the old ones.

One of my constituents has recently written to me that she has not had a new pair of shoes in ten years or a new dress in four. It is a national disgrace that we ask old people who are barely able to clothe and feed themselves adequately to pay almost $6 a month from their meager incomes for this Supplementary Medical Insurance.

The key point is that the elimination of the Part B premium is the equivalent of almost a 5% increase in social security benefits. I am in favor of raising social security benefits, not only by eliminating this premium, but by voting a larger benefit increase than is proposed in H.R. 1. But the elimination of the premium will be an important step in the right direction.

The elimination of the premium is only a step in easing the medical burdens of the aging. We should not think that its elimination would lift the entire burden of medical expenses from their shoulders. Supplementary Medical Insurance still will include a heavy deductible charge.

Medical expenses which are not covered by SMI because of its deductibles, cost the elderly more than $1 billion per year. And these charges will continue to fall on the elderly even when the premium is eliminated. In fact, H.R. 1 calls for an increase in the deductible, which is now $50, to $60, and it still includes a provision for a 20% co-insurance feature. Until 1976, the increase in the deductible proposed in H.R. 1 actually will out weigh the advantage to the elderly of the limitation on the increase in the premium also proposed in H.R. 1.

I recognize that the committee is very concerned—as we all are—with the rapid increase in medicare costs. Some people may argue that removing the premiums will lead to a wasteful increase in the use of physician services by the elderly. I think removing the premium might in fact ease any tendency which exists to "over use" Part B services. Now the fact that the elderly have already in a sense paid for services through the premium may encourage some of them to use services they do not need. Of course, the deductible and co-insurance features discourage this, but nevertheless the fact that the premium is paid may push people to unnecessarily try to get something for their payments.

This is not to say that I support the deductibles. I think deductibles should be eliminated also, but at the very least we must eliminate the premium.

Mr. Chairman, I believe that my proposal for eliminating the Part B premium is important because it will be the equivalent of about a 5% benefit increase for most social security recipients. But it is also vitally important because it maintains a provision for general revenue financing.

Many people have asked me how I intend to finance the elimination of the premium. At present, as you know, the elderly pay 50% of the costs of supplementary medical insurance through the premium. The other 50% is paid from general revenues. My bill shifts the entire costs of the supplementary medical insurance program to general revenues. This is a very important point and I want to discuss it at length.

The elderly beneficiaries of supplementary medical insurance benefits have by-and-large not paid in contributions adequate to cover this insurance. This is an insurance provision which was added after most of them had completed their payroll tax payments. We want them to have adequate medical insurance but it is unfair to ask salaried workers alone to finance these benefits which are also the responsibility of the rest of us. Congress recognized this in 1965 when it provided for a general revenue contribution to finance one-half of the cost of SMI. My bill would continue this policy.

Moreover, if the full cost of SMI is shifted to general revenues, this will bring the financing of the program into roughly the relationship which was recommended by the 1971 Advisory Council on Social Security.

Hospital insurance plus SMI cost approximately $7.47 billion in 1970–71. If the $2.03 billion cost of SMI had been borne entirely by general revenue, financing would be on the one-third general revenues, one-third employer, one-third employee basis recommended by the Advisory Council.

I was pleased by the President's announcement in his State of the Union Message that he would support the elimination of the Part B premium. However, I was disappointed to see on page 147 of his 1973 Budget that he still intends to shift the cost of eliminating the premium to the payroll tax. The President had proposed this regressive step last year, but I had hoped he would change his mind. Instead, I gather that his aim is not only to shift the cost of the premiums to the payroll tax, but to eliminate the present general revenue contribution as well. This would mean an additional charge of more than $2.5 billion on the payroll tax this year. It flies in the face of past decisions of this Committee and the recommendations of the Advisory Council.

Mr. Chairman, in my opinion, it would be grossly unfair to shift the cost of eliminating the Part B premium to the payroll tax. Our elderly citizens do not want to burden their working children unfairly by shifting the premium burden in this way.

The National Council of Senior Citizens has said that paying for the elimination of the Part B premium "through additional taxes borne by younger members of . . . families who are still working" . . . is "completely unacceptable to the members of the National Council of Senior Citizens."

Mr. Chairman, shifting the burden of the Part B premium to the payroll tax is a backward step anyway it is done. If the cost of eliminating the premium were shifted to the payroll tax by increasing the tax rate, it would require a very steep rise in that rate. Estimates are that financing elimination of the Part B premium in this way would add .25 to .3% to both the employees and the employers tax. The 1972 tax would jump from an already high 5.2% to about 5.5%. In 1973, the rates would be 5.95% for both employees and employers.

It seems, however, that President Nixon now is planning to increase the payroll tax earnings base as a means of financing the elimination of the premiums. This is fairer than increasing the tax rate but it still means that salaried workers rather than those with other forms of income—and these are our wealthy citizens—would be carrying the load.

Everyone knows that the payroll tax, unlike the income tax and the corporation tax, is regressive, falling particularly heavily on salary working people.

Capital gains, interest payments and other income sources which salaried working people rarely enjoy, are not touched by the payroll tax. We need to eliminate the Part B premium. We need to improve the situation of our elderly in many other ways also. Prescription drugs should be covered by medicare as the 1971 Advisory Council on Social Security recommended. Medicare deductibles should be reduced and eliminated. But we should not try to finance all or even most of these improvements by taxing only the American working man or woman through the payroll tax. This could generate a dangerous backlash.

So far, Mr. Chairman, we always have had the support of working men when we wished to increase social security benefits. But increases in the payroll tax have brought increasing protests from salaried workers who are being squeezed by the rapid rise of these taxes. The danger is that we will begin to have the same sort of reactions to social security benefit increases that we have had recently in the area of education. The payroll tax has many of the regressive features of the property tax and we should remember this.

The Wall Street Journal has joined many others recently in recognizing the alarming trend in our tax policy. Progressive taxes are being reduced while payroll taxes are increasing.

Mr. Chairman, I would like to insert in the Record a January 31 article from the Wall Street Journal on this point. I would also like to insert an editorial from the Washington Post dated January 29. These articles underscore the urgency of reexamining the role of the payroll tax.

Last October, I introduced with Senator Muskie a bill aimed at giving the payroll tax a degree of progressivity similar to the income tax. This proposal to cover the elimination of the Part B premium from general revenues is related to that bill. We must ask ourselves whether it is fair or even possible to keep shifting our tax burden onto regressive taxes which are not shared equitably by all Americans.

In closing, Mr. Chairman, I want to indicate that the elimination of the Part B premium is not the only change which I recommend in the social security legislation now being considered by this committee. I think several other changes should also be made.

I mentioned two of them during the course of my remarks.

I think that the 5% across-the-board benefits increase proposed in H.R. 1 is too small. It will hardly allow beneficiaries to keep up with inflation. It will do little to bring benefits up to a decent level.

In the medicare area I continue to support Senator Montoya who has long taken the lead in arguing that prescription drugs should be included in the medicare program.

I note also that H.R. 1 provides only that 6 years instead of the present 5 years may be dropped out of the calculation which is used to arrive at the computation base for social security benefits.

I introduced a bill last March to use the 10 highest years in the computation of benefits. It is clearly necessary to move in this direction. As the system works now, the period used for computation gets longer unless Congress takes specific action. This means that too many lower wage years are used in calculating benefits.

Workers who retire early under other pension plans, or who are forced out of the work force by unemployment are unfairly discriminated against.

If the ten highest years formula is not adopted, a similar formula which will prevent the computation base from lengthening should certainly be incorporated into the bill.

Last year, I also introduced a bill to increase the earnings limitation from the present $1,680 to $2,400. H.R. 1 moves a part of the way in this direction, to $2,000. I think we should move the rest of the way.

Mr. Chairman, I hope that the committee will adopt the suggestion that I have offered to eliminate the Part B premium and to finance this change from general revenues. I hope also that the other proposals which I have mentioned can be adopted.

I thank you very much for allowing me to testify.

[From the Wall Street Journal, Jan. 31, 1972]

THE OUTLOOK—APPRAISAL OF CURRENT TRENDS IN BUSINESS AND FINANCE

(By Richard F. Janssen)

On the Washington economic policy front, the waning days of January are almost as hot as was the weekend of last Aug. 15—only after seasonal adjustment, to be sure. Unlike the tense time last summer when suddenly the unthinkables of controls and dollar devaluation became reality, the period in which the budget and economic reports are bunched (along with rampant rumors, last-minute revisions, incessant press briefings and instant hearings on Capitol Hill) constitutes a quite predictable crisis.

Predictably, too, the attention centers on the government's spending plans and economic forecasts. Especially this time, with no new revenue-raising requests to make news, there's been little said about the tax half of fiscal policy.

Still, a close look at the new budget does offer insights into taxes, not the least of which is the between-the-lines implication that the subject won't stay out of the limelight long.

It is "remarkable as it is unremarked," Director George P. Shultz of the Office of Management and Budget says, the way the income tax load has been lightened lately. In the fiscal year starting next July 1, Mr. Shultz notes, "the American people will pay $22 billion less in individual income taxes than they would have been required to pay under the tax rates, bases, and structure prevailing at the time the President took office."

However cold the comfort may seem when we start matching our W-2 Form and our Form 1040 sometime between now and mid-April, this table abbreviated from the budget does show a striking lightening of the load during the last decade for typical married couples with two children:

Annual wage income	Tax 1962	Tax 1969	Tax 1971	Tax 1972
$5,000	$420	$290	$178	$98
$10,000	1,372	1,225	1,000	905
$15,000	2,486	2,268	1,996	1,820
$25,000	5,318	4,853	4,324	4,240

These cuts, Mr. Shultz says, amount to "a way of returning power to the people in the most fundamental sense." He calls them "revenue sharing with the basic unit of government, the individual and the family." Thanks also to the unexpectedly sluggish economy in the last couple of years, the Treasury expects to collect only $86.5 billion in personal income tax in the current 1972 fiscal year ending next June 30, or $270 million less than the year before and about $4 billion less than the record $90.4 billion of fiscal 1970.

Nor does the government have hope that the yield will swell enough in coming years to cover even a conservative estimate of future outlays. By fiscal 1976, Mr. Shultz glimpses only a $5 billion budget surplus, so thin a crack of light as these things go that it could disappear overnight. By fiscal 1977, he can see almsot $25 billion of prospective daylight, but this is due "almost entirely" to a scheduled—and postponable—1976 increases in Social Security tax rates.

This points up a significant trend: The individual income tax isn't nearly the budgetary mainstay it once was. Instead, less-noted increases in Social Security

and other employment-type taxes have been made these taxes increasingly important. The table below, based on original budget documents, shows how many cents of each fiscal year's budget dollar were expected from the main revenue sources:

Source	1964	1970	1971	1972	1973
Personal income tax	38	46	45	41	38
Corporation income tax	19	19	17	16	14
Employment tax	14	23	24	25	26
Excise taxes	11	8	9	8	7
Borrowing	8	0	0	5	10
Other	10	4	5	5	5

The spending bind which is related to the relatively waning role of the income tax is a very good thing, some of Mr. Nixon's advisers argue. The sheer absence of a lot of budget leeway ahead, one says, is a "philosophic cutting edge" that should help limit the size and role of the federal government. It is true, agrees a non-political Treasury aide, that the government tends to increase spending accordingly whenever some extra revenue looms ahead.

More than accordingly, the record shows. From $111.3 billion in fiscal 1963, spending has grown to President Nixon's projected $246.3 billion for fiscal 1973. And in each of those 11 years (except fiscal 1969 when Mr. Nixon and Lyndon Johnson could share honors for the slight offset of a $3.9 billion surplus) spending exceeded revenues—by a wide enough margin to add up to a deficit of about $140 billion.

So it isn't merely rhetoric in the budget which warns that unless spending increases are sliced to "a small fraction" of their past trends, "the only alternatives are higher taxes or higher prices."

Because Washington rarely makes such clear-cut choices, it is probably prudent to count on having some of all three.

After election year pressures that are likely to swell spending and the deficit even beyond the President's projections, advises private New York economist Alan Greenspan, a tax-increase bill of some sort is "seemingly inevitable in 1973."

That does raise a clear-cut question, though: What kind of tax?

Clearly, the Nixon administration is anxious to try transplanting Europe's "value-added tax" to the United States. It is based on the difference between each business' purchases and sales, and proponents assert such advantages for the VAT as rebating on exports and encouraging investment over consumer spending. It's often described as a "national sales tax" ultimately borne by the consumer, but administration men say they can avoid it being "regresssive" through special income tax rebates to lower-income consumers.

At least from a professional standpoint, though, there's still a lot of support among Democratic economists for what former Nixon budget aide Maurice Mann calls the "castrated" income tax system. "Despite the enormous erosion, contends tax expert Joseph Pechman of the Brookings Institution, "the income tax is, on balance, progressive," and he favors loophole-closing reforms or rate increases over trying an entirely new tax.

The choices aren't pleasant ones. But if the politicians face up to them early enough, the next fiscal crisis may at least be the prescheduled variety.

[From the Washington Post, Jan. 29, 1972]

Power to Which People?

The President describes the recent income-tax cuts, in his budget message, as "the return of power to people." Money is power—"economic power, real power"—and Mr. Nixon reasons that a reduction in the income-tax rates shifts more of it to the individual citizen. He believes, further, that private citizens "can use that money more productively for their own needs than government can use it for them."

A highly significant shift is overtaking the federal tax system. The proportion of the load carried by the income tax is declining. Much more is now raised by payroll taxes. This shift has been under way for a long time, under both parties, but it has been sharply accelerated during the present administration. President

Nixon cuts income taxes. and takes credit for it. Congress increases the payroll taxes to broaden Social Security benefits, and takes credit for it. The effect is to ease the load off a graduated tax system, adjusted to take account of each family's special circumstances, and to push it onto a tax that is a flat percentage of the first $7,800 that a wage earner gets each year. That flat percentage takes no account of the wage earner's other income, the size of his family, his medical bills or anything else.

The trend is clear. In 1963, payroll taxes raised only 42 per cent as much money as the personal income tax. By 1968, when Mr. Nixon was elected, the ratio had risen to 50 per cent. By last year it was 56 per cent and by next year, according to the budget estimates, it will be 68 per cent. To put it another way, in 1963 the payroll taxes accounted for only 19 per cent of federal budget receipts from all sources. By 1968, they accounted for 23 per cent. By 1971 it was 26 per cent and by 1973 it will be 29 per cent.

Under Mr. Nixon, there have been two rounds of heavy cuts in income taxes, one in 1969 and the other last month. "In 1973," Mr. Nixon said in his message, "individuals will pay $22 billion less in federal income taxes than they would if the tax rates and structures were the same as those in existence when I took office." If the economy picks up as Mr. Nixon predicts, personal income taxes next year will return $94 billion dollars, which is $25 billion more than in 1968. In contrast, over the same five years, payroll taxes will have increased $29 billion. The payroll taxes are not only rising at a faster rate. They are rising faster in absolute magnitudes.

It is a curious characteristic of American politics that the largest changes in public policy go all but unremarked, while minor matters are endlessly debated. In the case of federal taxation, this effect no doubt arises because the subject is forbiddingly technical. Perhaps it arises also because many Americans do not think of their payroll taxes as taxes. A certain public confusion has surrounded the nature of Social Security financing ever since the system was founded a generation ago with a heavy emphasis on its similarities to an insurance program. But it has never been insurance, and payroll taxes are not insurance premiums. They are general taxes to meet necessary and expanding public responsibilities. They are measured by the same standards of fairness and efficiency as any other tax. The steady movement from income to payroll taxation is, obviously, a retreat from the top bracket to the bottom one. Mr. Nixon says that he is returning power to people. Which people? The answer can be read in the tax tables.

U.S. SENATE,
Washington, D.C., February 17, 1972.

Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR CHAIRMAN LONG: I would very much appreciate the opportunity of having the enclosed statement included in the Finance Committee testimony on HR 1.

I would also ask sympathetic consideration of my proposed amendment which would increase the Social Security "outside earnings" exemption to $210 per month. Upon consideration of recent Department of Labor statistics, this figure would seem the most appropriate if we are to allow our senior citizens the opportunity to earn a moderate standard of living.

Best regards.

Sincerely,

FRANK E. MOSS, *U.S. Senator.*

STATEMENT OF HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

For this reason, I urge the Senate Finance Committee to raise the "earnings test" to $2,520 per year. I believe that this amount is a just and reasonable level. It recognizes both the economic situation and also the desires of our senior citizens for personal independence. I believe that the "outside earnings" level proposed in HR 1 continues to ignore these realities. It denies to our elderly citizens their full opportunity to maintain their hard-earned standards of living.

Section III of the bill woud permit Social Security recipients to earn only $2,000 a year without suffering the penalty of lost benefits. To the average couple

receiving Social Security, this is hardly sufficient for the maintenance of their standards of living. Today the average monthly Social Security check received by a couple comes to about $219. Adding this basic annual income of $2,628 to the $2,000 outside income permitted under HR 1, the average couple would still not have reached an amount consistent with a moderate standard of living.

According to the recent consumer price information and Bureau of Labor Statistics reports on the cost-of-living, an elderly couple living in an urban area requires approximately $4,800 to maintain an "intermediate" living standard. Even with the full $2,000, the average elderly couple cannot make ends meet.

Subject: An amendment to HR 1, liberalizing the social security "outside earnings" test

Mr. Chairman, I have long been a consistent advocate of liberalizing the "earnings test" which limits the amount of income which Social Security recipients are allowed to earn free of penalty. Two years ago, the Senate moved in this direction by raising the "retirement test" to $2,400. Unfortunately, the Social Security Amendments Act of 1970 never reached conference and recipients continue to suffer under what I consider to be an out-dated and unreasonable "outside earnings" limitation.

Today, more than ever before, I am convinced that further liberalization of the "earnings test" is the right course. As a member of the Senate Special Committee on Aging, I have had ample opportunities to sense the great desire of our senior citizens to "earn their own way" . . . to gain the maximum level of economic self-reliance which their circumstances permit. There is also a continual need on the part of Congress to allow elderly Americans to maintain their standards of living in the face of a persistent inflation.

Senior citizens should be given the opportunity to earn at least enough to guarantee themselves a moderate standard of living. I, therefore, urge that the Finance Committee reconsider their decision to limit the "earnings test" to $2,000 a year . . . what amounts to a step backward from earlier Senate decisions.

We must recognize the growing need for more liberal retirement standards. With so many Americans now beginning second careers at mid-age, it would be counter-productive to penalize couples who want to go on working after the traditional retirement ages. Congress should recognize their citizens' willingness and ability to be of productive service to our society.

Congress should also appreciate the specter of poverty that haunts even the moderately well-to-do elderly citizen. With taxes and consumer prices rising persistently, older Americans are determined not to be caught on fixed incomes which appear to offer an ever-declining purchasing power.

In 1962, for example, the average income of a family headed by a senior citizen could count on 50% of the average income of a family with a head of household less than 65. Today, the family with a senior citizen as the head of household can expect about 43% of the average income of his younger counterpart.

All the Social Security benefit increases passed by the Congress have been only stop-gap measures designed to keep the elderly "even" with the rest of the population. I urge that the committee grant those senior citizens an opportunity to earn the stronger measure of economic security which these times require.

Statement of Hon. Ted Stevens, a U.S. Senator From the State of Alaska

The Welfare Reform Family Assistance Provisions of H.R. 1 and Their Effect on Alaska

Mr. Chairman and Members of the Committee: I am in support of your efforts to reform our current welfare "system," a system which now is 50 diverse, often inequitable and highly variable approaches to the need to provide a livelihood for our Nation's poor and unemployed or unemployable citizens. The complex problem and challenge of both helping to ensure that the millions of children who are born to our poorer families will have a decent chance at the opportunity for the fuller life so many of us take for granted and also that their parent or parents will be employed whenever possible is a most urgent undertaking. The current system's tendency to break up families and too often make it more profitable not to work must be changed.

Thus, H.R. 1's proposed inclusion of the working poor and unemployed fathers

as well as its strong emphasis on registering to work and providing job training day care facilities, and public service employment is to the good. Similarly, I believe the establishment of a single national program with uniform standards and policies will help eliminate acknowledged inequities in the current "system." By providing for federal administration of the basic program, states can be saved funds currently expended for administration costs, especially if they elect to have the federal government also service their state supplement programs.

By and large, I believe most people are not on welfare by their own choosing. And, while I fully support mandatory employment for those on welfare who can and should work when a job is available, I am not at all convinced this should include the mothers who have children under age 6 at home who need their care. I would strongly recommend the age 3 limit in the House-passed bill be changed by your committee to age 6. In fact, in thinking of our welfare system, a very real tragedy to me is the children who must grow up within it. They represent over half of our Nation's 14 million welfare recipients.

In working for an improvement to our current system, I hope we may always keep them in mind. They are born to a circumstance totally beyond their control, and, I believe it is our responsibility not to make their lives become hindered with a sense of inferiority so often associated with a recipient of welfare. These children deserve decent clothes, food, shelter, and a good education as much as ours do. Hopefully, if they then grow up with a sense of confidence and integrity in their own ability, they will not spend a lifetime on welfare. They can and will move into a full life with the opportunity for jobs, travel, art, friendships, and challenges that we take as commonplace.

I am fully aware of the unique and high cost problems we are facing in Alaska by the bill's inclusion of the working poor and employable fathers provision. Accordingly, I am a co-sponsor of Senator Metcalf's amendment which will provide for full federal funding of a state's supplementary costs under H.R. 1 to American Indians, Eskimos, and Aleuts. The federal government has long had the prime responsibility for our country's Indian population. In Alaska, our welfare roles are about 80% Native. Under H.R. 1, unless the state chooses the totally inequitable approach of a dual level system whereby current recipients are paid at the full state standard of $2,700 to $4,500 for a family of four, and new working poor and unemployed father families are paid at the totally inadequate federal level of $2,400, the state stands to literally *triple* its welfare costs. It would jump from current state costs of $9 million to state supplement costs of $30 million in order to have all eligible families receive the same payment levels.

Because the preponderance of these newly eligible families are among our Native people for whom the federal government has consistently assumed program responsibility, I believe it is totally unfair to Alaska's state government to expect them to now triple their welfare costs in order to have this welfare "reform" function equitably in our state.

The working poor and unemployed father families need to be included in your bill. It is one of the most fundamental and important changes for the good which this landmark legislation provides. But, in accomplishing this, I strongly urge and request the federal government to continue its responsibility for our Indian population, or Alaska will be faced with the terrible alternative of either current costs or having a built-in and unfair tripling inequity in their welfare system family allocations. I urge you to include the Metcalf amendment in the bill which you report to the floor to avoid this unacceptable situation for my state.

May I also request that, as in numerous other federal programs, Alaska's enormously high cost of living be taken into account and our federal base payment be raised from $2,400 to at least a 25% increase up to $3,000. It is an acknowledged fact in federal programs ranging from housing to food stamps to providing federal employees a 25% increase in their salaries when they go to Alaska to work that our state is a much more costly place to live than the "Lower 48."

Our poor need this adjustment as much, if not more, than other Alaskan citizens. I believe that the state of Hawaii has similar difficulties. I hope you will take this to heart and provide for such a cost of living increase, as has been done time and time again, in other federal programs. Otherwise, Alaska's poor will, in effect, be given only a $1,800 federal payment instead of the $2,400 to which they are entitled.

One last point—in Alaska, many of our recipients of welfare live in remote villages which are difficult and costly to fly to. I understand that quarterly eligibility reviews are required of families covered by H.R. 1's welfare provisions. It

is essential that the law have enough flexibility to allow this to be done by mail and perhaps less frequently. The costs of personal visits by state or federal employees each quarter would be astronomical. We have over 200 Native villages scattered across our land, and it would take an army of bureaucrats with practically unlimited funding resources to reach each of these villages four times a year.

Thank you.

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Mr. Chairman, thank you for the opportunity to present my views on Social Security reform to the Senate Finance Committee. Although I intend to direct most of my remarks to Social Security and Medicare problems, I do want to express my approval of the new approaches being taken on the issue of welfare reforms. My views on this subject have been stated many times before, but I believe that we are finally agreeing that we must develop a new system which provides an adequate welfare payment, creates effective incentives for recipients to obtain employment, establishes workable administrative machinery, and provides a significant measure of fiscal relief to the states. I realize this is an enormous task. Perhaps it is more than can be accomplished immediately with the one bill before the Committee now. Nevertheless, a substantial beginning should be made as soon as possible. But if we must further evaluate welfare reform, we should not delay the pressing need for Social Security reforms at the same time.

OUR OBLIGATION TO OLDER AMERICANS

In speaking of improving the lot of our senior citizens, I must admit the sense of frustration which I feel because attempts to provide meaningful reforms have never been as successful as many of us keep hoping they will be. However, I am continuing my efforts for greater reforms because I am convinced that as legislators, as American citizens and as human beings we owe the greatest debts to our elderly. They are our living heritage, and we are often too concerned with other problems to remember that fact. Most of those citizens retiring today have shared the destiny of the United States for nearly one third of its entire history. They have lived through fantastic events as they nurtured this country to a prospercus maturity. They have witnessed two world wars, a severe depression, the advent of the automobile and airplane, nuclear power, wonder drugs, landing on the moon, and the increasing destruction of our environment. And, they were not only witnesses to great events and rapid changes. They were also the participants, the contributors and the builders as those events occurred. Moreover, they retain the faith that what they have accomplished will give their successors the ability to meet new challenges and to live better lives.

Yet, their society which our older citizens served so well is ignoring their basic needs at the time when they are most vulnerable to physical and financial reverses. Although they are our link to this nation's past and the builders of what we have in the present, the older citizens are often neglected or left very low in our priorities.

Indeed, it would seem to be to everyone's interest to improve the lot of the elderly. Probably, more than any other factor, aging is the common denominator of mankind. Whatever our social or economic standing, ethnic background, sex, aptitudes or beliefs, we share the fact that we all grow older. What we do to aid today's older citizens, we potentially do for everyone no matter how remote retirement may seem.

Today, 4.7 million persons 65 and older fall below the poverty line, nearly 100,000 more than in 1968. For elderly persons living alone or with nonrelatives, 60 percent would be considered poor or near poor. And for elderly Negro women living alone, more than 88 percent—or nearly nine out of every 10—live in poverty or are marginally poor.

According to the Bureau of Labor Statistics, an intermediate budget for an aged couple would be around 4,500 per year. Yet, approximately 41 percent of all aged couples have total incomes below $4,000. Having these dismal statistics available, we should now act to correct this tragic situation immediately.

The net impact of these statistics is that our Nation, as wealthy and powerful as it is, still permits one out of every four older Americans to live in abject

poverty. Moreover, these figures clearly underscore the need for bold, imaginative, and comprehensive reforms in our social security programs.

Many of the Social Security reforms H.R. 1 is trying to meet have been delayed for too long. But H.R. 1 does provide an excellent basis for improving the Social Security system. I am pleased that several of the measures in the House-passed bill are identical or similar to the recommendations I proposed in my omnibus Social Security legislation, S. 923. Both measures provide for:

An across-the-board increase in benefits;

Cost-of-living adjustments to protect the aged from inflation;

Substantial raises in minimum monthly benefits for person with long periods of covered employment;

One hundred percent benefits for widows, instead of only 82½ percent as under present law;

Liberalization of the retirement test;

More equitable treatment for couples with working wives;

An age-62 computation point for men, the same as now exists for women; and

Updating the retirement income credit for former policemen, firemen, teachers, and other government annuitants.

While I applaud these improvements, I believe some other changes must be made by the Senate to meet the needs of our Social Security beneficiaries.

SOCIAL SECURITY BENEFIT INCREASE

For some 27 million Social Security beneficiaries the most important feature of the bill is the provision for a 5 percent benefit increase that would become effective next July. This quite clearly is not an adequate increase and it does not come soon enough. As your committee print of July 14, 1971 points out, a 5 percent increase would mean an $8 increase in the average retirement benefit payable next June to retired individuals and a $12 increase in the average benefit paid to older couples. As a result, the average retirement benefit would be $141 a month and the average couple would receive $234. When we consider that Social Security has developed into the country's major retirement income program, it is obvious that these amounts are too low. Because the majority of the elderly have little or no other income to supplement their Social Security benefits, we should take steps to provide substantial increases in these benefits.

In fact, the 5 percent increase that the House has sent to us is nothing more than a cost-of-living increase based on the Committee on Ways and Means estimate of last spring as to economic changes in the period from January 1971 through June, 1972. The benefit increase that is needed should do more than keep up with the rise in the cost of living. It should provide a meaningful increase in the real income of Social Security beneficiaries. For my part, I would think that an immediate 15 percent rise in benefits effective January 1 of this year would be more in keeping with our commitment and responsiveness to the needs of older people. For a retired worker, this would provide an additional $160 above the annual benefit raise under H.R. 1. For an elderly couple, this approach would mean $265 more per year than under H.R. 1. And in my own State of New Jersey, a 15 percent increase in Social Security benefits would provide an additional $160 million in annual income to nearly 875,000 recipients.

For elderly persons struggling to make ends meet, these are compelling reasons to raise Social Security benefits to a more realistic level.

Those of us who have studied the problems of the elderly, you on this committee, and those of us on the Special Committee on Aging and the Committee on Labor and Public Welfare, have learned many times over that adequate income is the major need of the aged. It did not require the White House Conference on Aging to verify this fact. But now that the recent White House Conference is over, and the people who came to this conference have made their views known, this has become clear to the entire Nation. And the people of America are waiting to see what our response will be. I believe there is general agreement that one of our first priorities should be an adequate income for all Social Security beneficiaries.

I am happy to see that H.R. 1 would increase the benefits paid to aged widows. I have been very puzzled by that fact that when a man dies his

widow gets only 82.5 percent of his basic benefit. I know that women have been discriminated against in many ways in our history, but it has always seemed to be contrary to experience to contend that a woman can get along on a smaller income than a man.

While on the subject of discrimination, the Social Security Act also has discriminated against men. Perhaps this is designed to equalize the provision which discriminates against women. The way men's benefits are computed takes into account years up to age 65 while for a woman only years up to age 62 are used Inasmuch as this discrimination relates to determining a divisor for the purpose of arriving at an average wage, the shorter period used for women can result in a higher benefit for a woman than for a man, even though they had equal earnings. H.R. 1 contains a provision to correct this situation. However, I think that we can improve on the provisions in H.R. 1. Under the House-passed provision, as well as under the 1970 Senate-passed provision, the new computation would apply only to people who become entitled to benefits in the future and there would be a three-year transition period in which the new rules would be applied gradually. I hope that the Committee will reconsider this matter and make the provision effective not only for future benefits but also apply it immediately to all present beneficiaries.

If my understanding is correct, the 1970 decision to apply this provision prospectively was based in large measure on cost factors; the first year cost of the bill was reduced by about $900 million. Conditions have changed since then, though. The economy is lagging; unemployment is up; people are being forced to retire earlier than they had planned. This additional money along with the increase that would result from raising the basic benefits by 15 percent could be of significant assistance in providing the stimulus needed for our lagging economy. Moreover, it is needed by those who would receive it, and this would be in keeping with our traditional policy of applying benefit increases to present beneficiaries.

I would like to turn now to a discussion of the retirement income test. As you are aware this is probably the most disliked provision in the Social Security law. I recognize the arguments for keeping the test in the law. On the other hand, the present provision is dated and needs to be liberalized to take into account the economic and social changes which have occurred since 1967. Twice the Senate has acted to increase the exempt amount to $2,400 a year, $400 more than in H.R. 1. I firmly believe that we must include some substantial liberalizations in the bill passed by the Senate this year.

MEDICARE REFORMS

I am in strong agreement with the provisions in H.R. 1 to improve our Medicare system. But, again, I feel this bill is too limited and many important changes should be made to protect the health care of our elderly. I believe effective reform requires:

Including the cost of out-of-hospital drugs under Medicare;

Elimination of the monthly premium charge for supplementary medical insurance;

Rescinding of the raise in the deductible for Part B of Medicare from $50 to $60;

Disallowing the increase in the hospital deductible from $60 to $68;

Elimination of the proposed $7.50 copayment charge for hospitalization from the 31st to the 60th day of confinement; and

Repeal of the requirement for 3 days of hospitalization prior to eligibility for home health care; and

Liberalization of the 2 year waiting period for disability coverage under Medicare.

Today persons 65 and older comprise about 10 percent of our total population. Yet, they account for nearly 27 percent of all health care expenditures in the United States.

Unfortunately, gaps in Medicare coverage make it necessary for the average elderly person to pay $226 per year for medical expenses, 125 percent more than younger persons with larger incomes. A classic examples is out-of-hospital prescription drugs, which constitute an enormous expenditure for many elderly individuals. Drug expenditures for older Americans now average three times as high as for younger Americans. And for aged persons with severe chronic con-

ditions—about 15 percent of all individuals 65 and older—prescription expenditure are six times as great as for young people.

Prescription expense now account for about 20 percent of all out-of-pocket health expenditures for the aged. In fact, drugs constitute their largest personal health care cost.

For these reasons, I urge that the Senate broaden Medicare coverage to include out-of-hospital prescription drugs. Several renowned authorities, including the 1971 Social Security Advisory Council, have already recommended that this measure be enacted into law.

Another significant health expenditure for the elderly is the $5.60 monthly premium charge for supplementary Medicare insurance—Part B of Medicare. On an annual basis, this amounts to about $130 for a couple. And for the great majority of older Americans, this charge constitutes a rather heavy financial burden.

Again, I recommend—as I did in my omnibus Social Security bill, S. 923—that this premium cost be eliminated for the elderly. This change alone would amount to about a 5-percent increase for the typical retired worker. This proposal is also strongly endorsed by the Social Security Advisory Council. The premium older people must pay for supplementary medical insurance, Part B of Medicare, is steadily rising and is more than most older people can afford. On the other hand, they cannot afford to be without this insurance protection so many are forced to go without other necessities in order to pay this premium. Therefore, I am pleased to note that the Administration has adopted the position that this cost should be eliminated. Although it has not yet submitted legislation to accomplish this. I recommend such a provision be included in H.R. 1 as it was in S. 923. I would further recommend a provision to eliminate the recent increases in the deductible amount from $60 to $68. This increase occurred under the guidelines of the present law, and the present law should be amended to correct this fault. My suggestion would be to make any such increase possible only after a determination by the Secretary of Health, Education and Welfare that the increase would not impose a financial hardship on patients.

In additoin, H.R. 1 would make the elderly subject to a $7.50 daily copayment charge for each day in the hospital from the 31st to the 60th day. This would be in addition to the first $60 which the elderly would be required to meet out of their own pockets. For an elderly person in the hospital for 60 days, this could mean an additional charge of $225. Moreover, this measure would probably fall most heavily on the patient Medicare is supposed to help the most—the person who may be exposed to catastrophic health care expenditures because of a prolonged period in the hospital. Again, I believe this burden should not be forced on our hospitalized Medicare patients.

Currently, under Title 18 of the Social Security Act, essential home health care is covered only after a 3-day hospitalization. This includes visits by physicans, nurses, physical therapists, occupational therapists, speech therapists, and home health aides. I favor the extension of home health care to those covered by Medicare when prescribed by a physician. The present system not only acts as an obstacle to efficient health care for our elderly, but it also increases the expenses of Medicare hospital fees needlessly by encouraging doctors to hospitalize patients three days in order to qualify for home health care.

H.R. 1 fills a major gap in Social Security protection by providing Medicare benefits for disabled Social Security beneficiaries. The House-passed version, however, does not provide this protection at the time when the need is greatest. I would urge that this Committee modify the provision so that disabled beneficiaries would be entitled to Medicare benefits from the first month of entitlement to disability benefits rather than having to wait until 2 years after entitlement.

This provision brings out what is, in my view, a major weakness in H.R. 1. The primary problem with this provision is that it seems to be promising benefits and at the same time limiting eligibility to the extent that many needy beneficiaries will not receive them. As a result, we have a provision that is basically sound, but that will fail to achieve its full promise because the provision is too restrictive.

One of the provisions relating to medicaid, the one-third reduction in matching funds for long-term patients, seems particularly ill-advised to me. It will, I fear, reduce the availability of quality care to needy people and at the same time result in increased out-of-pocket expenditures by people who now have

far less than is needed to meet the costs of everyday living. This provision is ostensibly intended to encourage more outpatient care under medicaid, but the proposed reduction in matching funds to meet the costs of hospitalization after the 60th day in a general or TB hospital and after 90 days in a mental hospital seems unnecessary. It will only cut back on the funds available to treat the worst cases and encourage the premature discharge of people. Further, this will increase the costs to the States which are already in serious financial difficulty. Thus, the liklihood is that the provision will actually be more expensive in the long run.

GENERAL REVENUE FINANCING

As I have indicated, much more than stopgaps are needed as we consider reform of this system. For example, we have to provide for automatic cost-of-living increases and I am happy to see the provision in H.R. 1 which would provide annual cost-of-living increases whenever there is a 3 percent rise in the Consumer Price Index. However, I think it has become clear that using only Social Security tax to pay for increased benefits is becoming an ever-increasing burden on the average worker who must pay the cost of these improved benefits. Even now Social Security taxes are more than income taxes for many workers. Therefore, the time has come for a major revision in the method of financing Social Security. I suggest that we take immediate steps to provide a significant portion of the cost of the Social Security program from general revenues.

The idea of using general revenues to pay a part of the cost of the Social Security program is not new. From the very start in the 1930's, the designers of the program envisaged a time when the income from Social Security taxes would have to be supplemented from general revenues. During World War II, scheduled increases in Social Security taxes were postponed and appropriations from general revenues were authorized on an "as-needed" basis. This authority was never used and after a time it was repealed. Then, in the 1950's the long escalation of both tax rates and the tax base began.

When this escalation will end is unclear. Your committee print of July 14, 1971 projects a tax base of $26,100 for 1994 with a combined employer-employee tax payment of as much as $3,862.80. Clearly, it is time to call in a third partner and permit general revenues to pay, say, one-third of the cost of the program, with the remaining two-thirds being divided between employees and their employers. I do not believe Congress can enact this proposal now in its entirety, under present economic conditions and budgetary conditions. The President's large deficit would be unacceptably increased by immediate adoption of general revenue financing. However, we could write this principle into the law and include a schedule for the gradual assumption by the Federal government of one-third of the cost of the program.

Again, I wish to express my approval of H.R. 1 as the basis for meaningful reforms in our Social Security system. However, much more is needed if our Nation is to come to grips with the economic crisis which now affects millions of older Americans and threatens to engulf many more approaching retirement age.

I believe the recommendations I have made are essential to meet the needs I have outlined.

STATEMENT OF HON. BELLA S. ABZUG, A U.S. REPRESENTATIVE FROM THE STATE OF NEW YORK

Chairman Long, Members of the Committee, I am pleased to have the opportunity to present my views on H.R. 1. To many, this bill brings important benefits. It grants a substantial increase in social security benefit payments. It liberalizes a number of benefit eligibility requirements. It provides for future adjustments in benefit levels to reflect increases in the cost of living. Unfortunately, it does far too little for one of our more maligned groups, women, and actually worsens the lot of another, the poor.

AMENDMENTS TO OLD AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

The amendments to Title II of the Social Security Act which are proposed in this bill gives women far less than they need and far less than they deserve. There is no provision for benefits to homebound women independent of their spouses' earnings. There has been no change in the benefit structure for divorced

women except for a minor alteration removing dependency requirements. There has been no effort to give the working woman her due—benefits which are based entirely upon her own accumulated earnings and not computed together with those of her spouse. Under this computation system, called the family maximum, she receives in benefits only that percentage of her earnings and wife's benefit which is statutorily allowable depending upon what her spouse's earnings have been.

The benefit structure must be fully reformed and equalized, and I recommend to you the following steps as possible avenues for accomplishing this:

First, it is imperative that women's benefits be separated from those of their husbands, in order to erase the stigma of dependency which women have had to bear since the inception of the "wives' benefit" of the Social Security program. In its place, there should be established an independent "Woman's Basic Benefit" that would be paid in varying amounts to different classes of women: full time housewives, full time housewives with household help, working women with household help, and working women without household help. Second, women who worked would receive the full benefit depending on the amount of their earnings, regardless of the amount of their "Woman's Basic Benefit." There would be no "family maximum." Each member of a family would receive as much as he or she is legally entitled to, depending on his or her individual salary.

It is also important that women have the opportunity to get out of the house in order to earn the salaries on which their Social Security benefits are based. To that end, I recommend that a tax credit be allowed all working women to cover the cost of day care for every child in the family. Or, where this is not appropriate, direct Federal payments would be made to cover the full cost.

Another important structural change which affects both men and women is the methodology of actuarial computation, which results in women receiving different aggregate benefits because they live longer and have worked in lower paying jobs than men. The tables should reflect an average between the two sexes, and benefits should be computed in that light rather than in the present manner. Also, both men and women should receive benefits at the same time rather than women receiving benefits at age 62, and men at age 65, as is now the case.

TITLE IV

I strongly oppose Title IV of the bill, which would enact two new family programs—Opportunities For Families (OFF) and the Family Assistance Plan (FAP)—in place of the current Aid to Families with Dependent Children (AFDC) program. This portion of the bill represents a giant step backward.

It compels mothers to work without providing for adequate care for their children. It provides for a basic level of benefits which is barely one-third of the Bureau of Labor Statistics' "Lower Living Standard." It encourages the States to reduce benefit levels and discourages them from raising benefit levels, even if there are major increases in the cost of living. It contains distinctions between the family programs and the other federally assisted categories which can only have as their basis a desire to discriminate on the basis of sex and race. Under the guise of being a reform measure, it will leave many recipients of public assistance—perhaps 90 percent—worse off then under the present system.

Women are the primary victims. Under H.R. 1, they would be forced to undergo training for menial, low-paying jobs. They will be made to accept those jobs no matter how demeaning. And, most important of all, they may well be compelled to leave their children at home or on the streets, without adequate child care, in order to go to work or to attend training.

Only 16 percent of women presently receiving public assistance have completed high school, but job "training" under this bill will not even include basic adult education.

The money which H.R. 1 authorizes for child care—$700 million—would not even begin to meet the needs for children currently on welfare. When this measure was debated on the House floor, Chairman Mills assured me that no mother would be compelled to work if child care were not available, and that the amount authorized under the bill would be sufficient to meet the requirements for child care (Congressional Record, June 21, 1971, page H 5545). It is my understanding that there are presently 1,262,400 children under the age of five on welfare. The conservative, Administration estimate of the cost of child care is $1,600 per annum per child. By my calculations, the cost of child

care for the children of mothers compelled to work under this bill will exceed $2 billion. This is a far cry from the $700 million Mr. Mills says will meet the need as he has estimated it.

What this tells me is that the proponents of this bill either believe that the money will materialize, unauthorized, out of thin air, or that they are not disturbed by the fact that thousands of welfare mothers will be compelled to leave their children without adequate care while they are at work or training.

This tragedy is compounded by the fact that President Nixon vetoed S. 2007, the only piece of legislation in the last session of Congress that addressed itself to the needs of poor as well as lower middle class working mothers. If it had been signed, that bill would have initially benefitted families with incomes below the poverty level, $4320, by providing them with free child care services. From that income level to a level of $6000, there would have been a nominal fee.

This would have a wholly voluntary program; no parent would have been forced to put his or her children into day care. In fact, the only place in which we find coercion is H.R. 1, which *requires* mothers with children three years old or older to place these children in day care centers and got to work. The President's veto, taken together with the day care requirements of H.R. 1, leads to the inescapable conclusion that forced custodial day care for the poor is acceptable, but voluntary day care is not. The Child Development Act, contained in S. 2007, included provisions for substantial parent involvement and could not possibly have been as weakening to the family as is H.R. 1 in its present form.

BENEFIT LEVELS IN TITLE IV PROGRAMS

The bill provides for a basic income level of $2400 per year for a family of four, with no requirement that the States supplement this at all. In January 1970, the Bureau of Labor Statistics' "Lower Living Standard" was set at $6960 for a family of this size, and the 6.0 percent increase in the cost of living since then would bring this figure up to $7380 today. States which keep payments at the present level will be protected by the "hold harmless" clause of the bill if their total payments exceed current levels due to caseload increase, but a State which increases its level of benefits for individuals will receive no such protection. This means that for cities such as New York, where the cost of living is rising faster than in the nation as a whole, there will be an almost insurmountable disincentive to the granting of even cost-of-living increases. This leaves Congress in the rather hypocritical position of passing a bill which grants cost-of-living increases to those who receive their federal benefits under the Social Security system while effectively prohibiting the granting of such increases to those who receive their federal benefits under the two new family programs. Furthermore, it will help people in only the five or six States whose payment level is now less than $2400. It will not help the industrial States and it will not help the cities.

In addition, the bill provides for significant differences between payment levels under the family programs and those under the existing categorical programs—aid to the aged, blind and disabled. By 1974, for example, an aged, blind, or disabled couple will be receiving the same amount—$2400—as a family of *four* receiving assistance under one of the family programs. Even allowing for the fact that very young children might require less food than adults, it is inconceivable that a family of four under program requires no more money to live than a family of two which happens to be receiving its benefits under a different program.

The reason for this gross distinction is this: most of the families which presently receive benefits under the AFDC program, and which will be receiving benefits under the family programs proposed in this bill, are families which are headed by women; in addition, far more of these families are black, Puerto Rican and Mexican-American than are those in the aged, blind and disabled programs. This bill not only continues this country's pattern of discrimination against women and other oppressed groups, but actually makes it even more pronounced.

Title IV of H.R. 1 strikes out against poor people, women and children. It helps few people and harms many. It is presented as a reform bill, but its thrust is a backward one. I respectfully urge upon this committee the elimination of Title IV from the bill.

Thank you.

STATEMENT OF HON. FRANK ANNUNZIO, A U.S. REPRESENTATIVE FROM THE STATE OF ILLINOIS

THE NEED FOR PRESCRIPTION DRUGS UNDER MEDICARE

Mister Chairman, Members of the Committee—over 20 million older Americans are looking to this Committee and this Congress for relief from the financial hardships associated with high-cost prescription drugs. Ever since 1967, we have been telling our aged population that Congress is deeply concerned with the plight of those older Americans who must bear alone the full weight of expensive outpatient prescription medicines. Five years ago we directed the Department of HEW to appoint a special Task Force to study the necessity and feasibility for an outpatient prescription drug benefit under Medicare. The results of this exhaustive study conclusively showed that such a program was both desirable and economically and medically feasible.

In the time that has passed since that study and the reviews that followed, we have continued to talk about the desirability of such a program. But as we have talked, both in the halls of Congress and before this Committee, millions of older Americans have suffered severe financial and even medical harm from our needless delays. Our elderly must now spend 20 cents of their health care dollar on prescription medications. This amounts to about $1 billion a year, or about 25 percent at the Nation's total outlay for prescription drugs.

When we consider that many of these older people are living on minimal fixed incomes, that fully 25 percent of them are living at or below the poverty level, then we cannot help but realize the terrible strain which high-cost drugs must place on their limited financial resources. Furthermore, drugs for the elderly cannot be considered luxury items easily eliminated from the family budget in times of financial stress. Effective drug therapy is frequently essential to the well-being of millions of older Americans. About 80 percent of the elderly—as opposed to only about 40 percent of those under 65—suffer from one or more chronic diseases or other conditions. Arthritis and rheumatism afflict 33 percent; heart disease, 17 percent; high blood pressure, 16 percent; for those suffering from these ailments, prescription drugs are essential.

Year after year we have seen legislation introduced to eliminate or reduce this problem for our elderly. Once again we have been presented with a positive solution to the problem, a bill (H.R. 2355) which would amend the part A program under medicare to cover the cost of outpatient prescription drugs. As one of the more than one hundred house sponsors of this bill, I want to say that enactment of this legislation is clearly and urgently needed. The untiring efforts of the distinguished Senator from New Mexico, the Honorable Joseph Montoya, and my able colleague from Wisconsin, the Honorable David Obey, on behalf of this vital piece of legislation are to be especially commended.

H.R. 2355 is designed to correct one of the more serious shortcomings and defects in the existing medicare program by providing insurance protection against the costs of outpatient prescription drugs. It has been suggested by some that private health insurance, complementary to medicare, is available to the elderly and that drug insurance protection should be sought from this source. However, the facts indicate that the private sector fails to provide adequate protection at a cost that the aged can afford. Recent data shows that approximately 9½ to 10 million persons 65 or older have private protection supplementary to medicare for the cost of hospital and physician services. As for drug coverage, however, the statistics are even more alarming. Only about 3 million older people—or about 15 percent—have any protection against drug costs. Nearly 17 million have no private protection whatsoever in this area. As a result, drug outlays continue to represent the largest single out-of-pocket health expenditure among older Americans.

It is, in my judgment, absurd to underwrite—as medicare does—the costs of hospitalization and other institutional care, and not underwrite the cost of the very items which might prevent institutionalization altogether. It is also inconsistent to pay for drug costs in a hospital or extended care facility—as medicare does—but not pay for the same drugs outside the high-cost institution. Because of this gap in coverage, it is highly possible that many elderly persons are hospitalized simply because that is the only way they can get the medications they need. Thus, the extra cost of needless overutilization of hospital facilities is loaded onto the taxpayers who support this program.

There can be no question about the need for this program. The subject has been studied, restudied, and overstudied—always with the same conclusion: do it now. I urge this Committee to act promptly and favorably on H.R. 2355 and thus provide our $20 million older Americans with a well-designed, uncomplicated but effective drug insurance program. Thank you.

STATEMENT OF HON. MARIO BIAGGI A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

OUTPATIENT PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

Mr. Chairman, thank you for giving me this opportunity to express my views on providing outpatient prescription drug coverage under Medicare for our senior citizens.

Today, over 25 percent of the more than 20 million Americans over the age of 65 live below the poverty level. Moreover, more than 300 thousand citizens earn less than five thousand dollars per annum.

In light of the financial plight of our senior citizens, I have introduced a package of bills designed to relieve this burden. My proposals would provide these citizens with the opportunity to enjoy the fruits of their labors instead of merely being provided with an income which is barely adequate enough to live on. In addition, these individuals are on a fixed income and any increase in the cost of living simply magnifies the problem. One of the bills in my package of social security reforms, H.R. 9672, would include prescription drugs under Medicare.

Health care is a primary factor in the older Americans' battle with inflation. Nearly seven out of every eight Americans over the age of 65 have a heath problem which requires some type of constant care, either with medicine and doctor's visits or hospital and nursing home care. For many, however, the greatest expenditure is for the purchase of prescription drugs which can run as high as hundreds or thousands of dollars yearly for these citizens, none of which is covered by Medicare.

Is this the way we reward those citizens who have worked so long and so hard to build this country? These are the people that have transformed the United States into the technological giant that it is today. These people have contributed into the social security system for many years only to discover that the payments which they receive after they have retired are grossly inadequate.

My bill, H.R. 9672, and others like it would help solve this problem by extending medicare benefits to cover the cost of prescription drugs to medicare recipients. Also, a minimum payment of one dollar per prescription is required by the beneficiary, so that low cost items are excluded.

Mr. Chairman, at this point I would like to include for the record, a Library of Congress, Congressional Research Service report which analyzes the views of the American College of Apothecaries on my bill, H.R. 9672. The report follows:

THE LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, D.C., January 20, 1972.

To: Honorable Mario Biaggi.
From: Education and Public Welfare Division.
Subject: Views of the American College of Apothecaries on drug insurance under medicare.

This is in response to a request made some time ago by Mr. Peter K. Ilchuk of your staff for a review of a number of legislative recommendations suggested by officials of the American College of Apothecaries regarding certain features of H.R. 9672. This bill was introduced by you in July of last year. It would amend the present program of health insurance for the aged, or medicare program, by providing protection against the costs of certain prescribed and other drug products purchased on an outpatient basis by older people. Such a benefit is not now a part of the medicare program.

In his communication, Mr. Ilchuk indicated that there was no need for an immediate reply to his inquiry. We have delayed a response this long, because of a possibility that drug insurance proposals for the medicare program might have received attention in social security hearings before the Senate Committee on Finance before the end of the 1st Session of the 92nd Congress. As you know, no

hearings were held, but are now scheduled to begin later this month. This report, therefore, may be of timely interest to Mr. Ilchuk.

In a letter from the American College of Apothecaries, four specific changes to your bill were proposed. Each of these changes is discussed below. In the event that Mr. Ilchuk has any questions regarding this report, please have him give us a call.

Recommendation No. 1—Discounting of the copayment.—As it is presently drafted, H.R. 9672 would amend the hospital insurance portion of the medicare program to provide benefits toward the costs of certain prescribed and other drug products purchased by insured persons on an outpatient basis from participating vendors of pharmaceutical services (e.g., participating retail community pharmacies). Such participating pharmacies would provide the aged with drug services and, in turn, bill the Federal Government for reimbursement for the costs of such services. Under the bill, reimbursement would be based upon the lesser of (1) an amount established for each prescription drug in accordance with provisions in the legislation or (2) the actual, usual or customary charges at which the pharmacy usually sells or offers the drug to the public.

The actual amount of reimbursement to which a vendor would be entitled would be reduced by a fixed monetary amount per each prescription filled. This amount is known as a copayment and would be set at $1.00 per prescription at the beginning of the program. The copayment amount could be increased in future years to reflect any increases in the costs of drug benefits under the program. Sponsors of similar or identical drug insurance proposals have always assumed that vendors would collect the copayment amount from each beneficiary at the time of each prescription purchase. The bill would amend an existing provision in the medicare program *permitting* vendors to make such collections before dispensing prescriptions to the aged insured under the program.

The American College of Apothecaries has expressed concern, however, that some vendors might discount a portion or all of the copayment amount required by the legislation. The Apothecaries suggest that discounting could seriously compromise any utilization control value that a copayment system might bring to a drug benefit program and that such discounting would also interfere with the "delivery of complete professional pharmaceutical service." The College proposes amendments to make it clear that patients would be responsible for meeting the copayment requirement and that any discounting on the part of vendors would result in banishment from participation in the medicare program.

Although College officials are not explicit on this point, it seems clear that they are concerned about the possibility that some vendors would use discounting as a loss-leading device to attract elderly beneficiaries to their particular retail establishments. In other words, discounting could result in "unfair" competition. Most small independent pharmacies do depend upon their prescription business for a substantial portion of their sales volume and "unfair" competition from discounters could seriously affect their capacity to survive. The prescription business of discounters, on the other hand, may only account for a small portion of their total sales volume, so that discounting of the copayment could be an attractive policy to pursue. Precisely how widespread such discounting might become, however, is difficult to estimate.

The bill was not designed to resolve small business problems in the retail drug industry and, therefore, does not deal with the discounting issue insofar as the copayment features of the legislation are concerned (there are provisions in the bill which take into account the sometimes wide disparities in the prices charged by drug suppliers to different classes of retail pharmaceutical outlets). If, however, you believe that the bill should be amended to deal with a potential copayment discounting problem, there are several alternatives you might wish to examine. One approach, of course, is to incorporate the amendatory language proposed by the College of Apothecaries. A second way would involve an amendment to section 3(e) of the bill which presently authorizes a pharmacy vendor to collect the copayment. This provision could be changed to require collection of the copayment and to require, as a condition of participation, that the vendor certify that such collections have been made with respect to all bills submitted for reimbursement to the Government. Still another approach would involve an amendment to the new section 1819(a) proposed in the bill dealing with maximum allowable cost. Section 1819(a)(1)(B) could be changed to read "the actual, usual, or customary charge at which the dispenser in fact sells or offers the drug to each beneficiary." Under such a provision, discounters of the copay-

ment could lose as much as $2.00 per prescription submitted for reimbursement, a significant economic disincentive against discounting:

Example

Ingredient costs of a cover drug	$5
Reasonable fee recognized	2
Total charges	7
Reimbursement to non-discounter:	
Patient pays $1 copayment	
Government reimburses on basis of actual charges minus the $1 copayment.	
Payment to vendor equals $6.	
Reimbursement to discounter:	
Copayment discounted entirely	1
Actual charges	6
(Government reimburses on the basis of actual charges minus the copayment of $1.)	
Payment to vendor equals	5

There are a number of ways of dealing with the copayment discounting issue, if Mr. Ilchuk desires to explore this matter greater detail.

Recommendation No. 2—Drugs excluded from the formulary.—The bill adds a new section 1818 to the Social Security which would establish within the Department of Health, Eduction and Welfare a committee known as a Formulary Committee. This Committee would be assigned a number of responsibilities in connection with the drug insurance program proposed in the legislation. Among other things, this Committee would be responsible for establishing a Formulary of drugs for which reimbursements would be made under the program.

Section 1818(d) (5) of the bill authorizes the Formulary Committee to exclude from the Formulary those drugs which the Committee, in its professional judgment, does not find necessary for proper patient care. Such decisions to exclude any drugs would have to take into account the availability of alternative substances listed in the Formulary. The College of Apothecaries has proposed to amend this section of the bill to require that any decisions of the Committee to exclude drugs be supported by "the National Academy of Pharmaceutical Sciences."

The bill, as it is now drafted, contains a number of provisions that are intended to assure that full and complete drug information is available to the Formulary Committee when it considers whether to include or exclude a drug from the Formulary used for medicare reimbursement purposes. The composition of the Committee itself is also intended to assure that a variety of expert judgment is at hand during Committee deliberations. It is not clear, therefore, why the Committee's decisions to exclude certain drugs from the Formulary must coincide with the views or findings of a specific expert panel outside of the Department of Health, Education and Welfare. It could be argued that there are any number of such organizations whose views on certain drugs are important enough to limit the Committee's ability to act in this area. Should each of these groups be named in the legislation? How would the Secretary resolve differences of opinion among these different groups, or would the existence of such differences prevent the Committee from taking any action at all? It could also be argued that, if the Committee's decision to exclude a drug had to coincide with the findings of some independent panel, then why use a Committee at all to make these decisions? The recommendation of the College of Apothecaries might be evaluated in light of some of these questions.

Recommendation No. 3—Hearings pursuant to delisting of a drug.—As now drafted, the bill establishes a hearings procedure for manufacturers whose drugs might be removed from the Formulary by the Committee. The College of Apothecaries proposes that such an opportunity for a hearing be granted to all medical practitioners as well. Since the Committee would be in a position to evaluate a broad range of information about specific drugs, before proposing delisting, it is not clear what purposes would be served by permitting each and every practitioner an opportunity for a formal hearing on the Committee's proposed action. The College's proposal could, in fact, prevent the Committee from ever delisting any drug whatsoever from the Formulary.

It might also be argued that individual practitioners do not have sufficient interests regarding delisting actions to warrant granting them an opportunity for a hearing or judicial review of a Committee determination in this area. Nothing in the legislation prevents any practitioner from prescribing any drug he chooses to order for his patients.

The Formulary features of the bill are only intended to help decide whether the patient or medicare would pay for such prescription. Furthermore, unlike manufacturers, practitioners have no economic interests at stake in Committee decisions to delist specific drugs, since they are not involved in paying for the drugs they order. Before considering the College's recommendation, therefore, perhaps a rationale should be supplied for including practitioners in the hearings process.

Recommendation No. 4—Inclusion of drugs in the formulary.—The College's fourth recommendation is a variant of No. 3 above. Under the bill, a manufacturer is entitled to petition the Committee for the inclusion of a drug in the Formulary. If such a petition is denied, a hearing may be sought and judicial review if necessary. The College proposes that individual practitioners be granted the same opportunities for petition, hearing and judicial review. As before, it is suggested that a rationale be obtained, in order to evaluate the desirability of including such a change in your bill.

We hope this brief review is of some assistance to Mr. Ilchuk, and if we can be of further help in this matter, please let us know.

GLENN MARKUS.

STATEMENT OF HON. GARRY BROWN, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman and distinguished members of the Committee, I very much appreciate this opportunity to present briefly what I consider to be a few of the pertinent facts and reasons compelling amendment of the social security legislation currently being considered by this Committee to provide outpatient prescription drug coverage under Medicare.

As you know, the largest health-care cost of the elderly not presently covered by Medicare is out-of-hospital prescription drugs. While the elderly constitute approximately 10 percent of the American people, they account for well over 20 percent of all outpatient prescriptions and for 25 percent of all outpatient drug expenditures.

The nation's elderly assume these continually increasing medical-care costs, even though those over 65 years of age, on the average, live on less than half of the income of those under 65 years. The sad fact is that older persons in America are twice as likely as younger persons to be poor.

Under the resulting, often intolerable financial circumstances, older people currently live without any substantial private insurance protection. Only about three million older people—about 15 percent—have any private insurance protection covering drug costs. Nearly 17 million senior citizens have no private protection whatsoever.

Present law only covers the cost of drugs furnished to patients in hospitals and extended care facilities and drugs administered in a physician's office which cannot be self-administered.

Given these and other similar, supporting facts, I have sponsored in the House of Representatives legislation which would provide outpatient prescription drug coverage to senior citizens under Medicare. This Committee, of course, is presently considering Senate companion legislation offered to amend the Medicare portions of the Social Security Act. I urge the Committee's adoption of S. 936.

Simply put, it is unfair to force the elderly to bear the constantly increasing cost of their own medical treatment at a time in their lives when they are least prepared to afford it, living as most do on small, fixed incomes.

Aside from the inequity worked by present law, the law makes for bad public policy. Presently, the Federal Government is in the position of underwriting the costs of hospitalization, including drugs, while failing to provide an ounce of prevention by underwriting the cost of outpatient prescription drugs, an expenditure which in tending to make needed drugs more accessible to the elderly might also be expected to reduce the numbers needing institutionalization. It is a case of being penny wise and pound foolish.

There is, of course, an inconsistency in a policy which would have the Federal

Government pay for drugs taken in a hospital but not pay for the equally necessary expense of having to take many of the same drugs out of a hospital.

Of course, Mr. Chairman, I realize that equity and the demands for a coherent, reasonable public policy are not in and of themselves sufficient cause for change unless these two goals can be realized in a change capable of practical, economical and effective implementation. I am convinced that in this instance they can be, and I think facts and reason bear me out.

To emphasize the practical, economical nature of the proposed change, I briefly summarize it now, noting the rationale of some of its main provisions.

Under the proposed plan, the beneficiary would simply go to the pharmacy of his choice. If the needed drug were on a list of medically necessary drugs covered by the program, he pays the pharmacist $1 to fill the prescription. The list of "medically necessary drugs" would be annually drawn up by a committee of physicians. If the drug is not covered, he pays for it the same way he does now under Medicare—out of his own pocket.

Virtually everyone over 65 would be eligible, and thus, the administrative costs of ascertaining eligibility would be eliminated.

The need for a prescription and the listing of drugs covered by the program would provide safeguards against abuse.

The proposed amendment would have the pharmacist reimbursed by the program, providing protection to the elderly under part A of the hospital insurance portion of Medicare. By providing the benefits under part A, the program is financed through regular payroll deductions; the individual thus paying for his drug insurance during his working years when he is financially most able.

Amending part A also relieves citizens of the burden of recordkeeping and the need to file large numbers of small claims, and saves the considerable administrative expenditure that would be required to handle and process such claims. Further, it permits maximum use of automatic data processing in handling claims.

Mr. Chairman, the amendment being considered here in the Senate, and its companion legislation in the House, are the result of considerable study.

The proposed inclusion of outpatient prescription drug coverage under Medicare has been endorsed by numerous conferences—including the White House Conference on Aging, government agencies—including the Social Security Administration, and various groups in the private sector—including the American Pharmaceutical Association, to say nothing of the many other expert witnesses who have testified before this Committee.

The time has come to act. Equity, the need to establish a sound, coherent policy, and the practical efficacy of the proposed amendment along with its overwhelming support among those most aware of the problems of the aging, compel adoption of this plan to include outpatient prescription drug coverage under Medicare.

Thank you.

STATEMENT OF HON. CHARLES J. CARNEY, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, I share completely the views of many of our colleagues that there is an urgent need for immediate amendment of the medicare program to provide insurance protection against the costs of outpatient prescription drugs.

For over five years the question of drug coverage under Medicare has been under continuing study by various task forces and commissions. This data has now been compiled and analyzed; the recommendations proposed and evaluated. The results of these protracted investigations are not surprising for they confirm that the aged are burdened by drug costs. But the results are disturbing because they demonstrate the weight of that burden and the absence of possible relief from other sources.

As a group, the elderly comprise approximately 10 percent of the population. And yet they account for well over 20 percent of all outpatient prescriptions and for 25 percent of all outpatient drug expenditures. For some of the aged out of pocket expenditures for drugs reach hundreds of dollars annually. Medicare at present provides no relief from these enormous costs.

It is true, of course, that many older people have purchased additional health insurance protection on their own to complement the protection afforded by Medicare. However, this additional protection does not usually include the coverage of outpatient prescription drugs. The Social Security Administration

recently reported that only about 3 million older people, about 15% of the elderly, have managed to obtain out of hospital drug insurance.

About the time that one of the first studies on medicare coverage of outpatient prescription drugs began in 1967 the average annual expenditure by the aged for outpatient prescription drugs was $54.15. During fiscal year 1969 the private expenditures for prescription drugs and drug sundries purchased by the aged was $70.25.

In the face of the increasing burden that the costs of drugs places on the aged, it would be a grave oversight on the part of the Congress to ignore the gaping hold in Medicare coverage which now exists because of the omission of a drug insurance benefit. Therefore, Mr. Chairman, I strongly recommend that the Senate Finance Committee adopt Amendment No. 464 to the Bill, H.R. 1.

STATEMENT OF HON. SHIRLEY CHISHOLM, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

OUTPATIENT PRESCRIPTION DRUG COVERAGE

Mr. Chairman, members of the Finance Committee, I am thankful for this opportunity to testify on the outpatient prescription drug coverage amendment to H.R. 1.

As pointed out by the recent White House Conference on Aging, our senior citizens have too long been a forgotten segment of our society. The old adage "out of sight, out of mind" seems to have been applied to them. But for those who must live out their lives in a nursing home or in a lonely apartment with only an occasional visitor, life has become a burden, often complicated by the crippling effects of those ailments that appear with advanced age.

Old age is trying enough for anyone; for the elderly who are in ill health, the burdens are multiplied. The ailing senior citizen has a difficult time just getting to a doctor's clinic. Until the introduction of medicare, he had a hard, sometimes, impossible struggle to meet the costs of medical care while subsisting on a meager pension or on social security payments. Now, at least, that cost has been partially met through the advent of medicare payments to the aged who need certain types of medical care.

But in the years since the passage of medicare, the elderly have become painfully aware that there are gaps in medicare coverage. One of these—outpatient prescription drug coverage—has a large negative effect on the pocketbooks of the elderly. Some, for example, must pay more for drugs than for food. Others, who cannot afford the drugs their doctor tells them they need, must limp along without the necessary prescriptions. This, of course, renders their medical care useless.

Gentlemen, the time has come for us to include outpatient prescription drug coverage under medicare. Inclusion of drug costs in the medicare benefits of those confined to hospitals has given us a sound rationale for extending such benefits to outpatients: it shows that we have recognized that many senior citizens cannot afford to pay their drug prescription costs.

One major objection to the inclusion of outpatient drug coverage under medicare will be its cost. I say to you that a nation that could afford to pay its elderly social security benefits 35 years ago is strong enough to sustain the cost of aiding them today. A nation that in the last decade initiated medicare support on the grounds that the elderly desperately need health care support cannot turn its back today on a vital ingredient in health care—prescription drugs.

We must remember that this proposal is structured so as to get the maximum amount of prescription drug aid for each dollar. First, in determining the maximum allowance for drugs which may be available from a number of competing companies, the formulary committee, which sets such allowances, will capitalize on drug industry competition by weighting its allowances in the direction of the lowest-priced, best-quality versions of a drug. Second, we will be capitalizing on the lessons we learned from administering the pioneering medicare programs in the 60s. Third, with their one dollar per prescription contribution, the elderly will have a stake in keeping program costs down.

Gentlemen, we have a moral obligation to serve those who have served us so long and well. The health and welfare of the impoverished elderly depend on

what action you take to plug up this loophole which is so costly to the elderly so that they can live out their remaining years with a modest standard of living. I hope that when you make your decision, you make it with the interests of our senior citizens in mind.

STATEMENT OF HON. ROBERT F. DRINAN, A U.S. REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. Chairman and distinguished members of the Committee:

I am grateful for the opportunity to testify in support of Senator Montoya's proposal—originally introduced as S. 936 and now pending before your Committee as an amendment to H.R. 1—to include outpatient prescription medication coverage in a drug insurance program under Medicare.

Before I begin, I wish to commend Senator Montoya for his five years of dedicated effort in his area, and Representative David Obey, whose companion legislation in the House of Representatives (H.R. 2355) now has 113 cosponsors as a result of more than a year of diligent work. I also wish to thank the Chairman of this distinguished Committee, who since 1967 has lent his considerable prestige and support to the passage of this legislation.

Although the elderly comprise only 10 percent of our national population, they account for approximately 25 percent of all expenditures made for prescription drugs purchased outside of hospitals or other institutional facilities.

This is understandable, since 80 percent of the elderly suffer from chronic disease or other ailments, as opposed to about 40 percent of those under 65 years old who suffer from such ailments. Yet the elderly also happen to be one of the nation's poorest minorities, with per-capita earnings substantially below the national average. America's senior citizens, with limited income and limited savings, must face the heavy burden of drug costs precisely at the moment when financial resources are dwindling and the need for prescription drugs is increasing. The resulting financial squeeze can put terrible, terrible strains on the nation's elderly.

In Leominster, Massachusetts, for example, a retired man living on Social Security payments of $307 a month suffered a debilitating stroke which cost him his ability to move and his ability to speak. His wife, who suffered from diabetes and a severe kidney ailment, could manage to save enough for her husband's medication only by skimping on her own. She suffered greatly—and needlessly, I might add, had Senator Montoya's bill been passed years ago.

The elderly spend an estimated 20 percent of their private medical expenditures on prescription medication, their largest single-out-of-pocket outlay. Yet Medicare, which has been reasonably successful in reducing the cost of hospitalization and in-patient medical care, affords no relief for the long recuperative periods when prescription drugs are the major expense. Perhaps it is this fact that prompted the Department of Health, Education and Welfare's Task Force on Prescription Drugs to include in its report the following recommendation:

> We therefore find that, in order to improve the access of the elderly to high quality health care, and to protect them where possible against high drug expenses which they may be unable to meet, there is a need for an out-of-hospital drug insurance program under medicare.

These words were written three years ago. It is my belief that we should enact such a program immediately, without further delay. The legislation we are considering today is the product of almost five years of refinement and research. It has been endorse by the AFL–CIO Executive Council, the National Council of Senior Citizens, the American Pharmaceutical Association, and many other organizations.

It is the most comprehensive, most workable bill Congress has ever produced on this subject.

I would like to comment on some of the specific provisions and features of this legislation.

First, the legislation is financed under the Part A "Hospital Insurance Program" portion of Medicare, which in my opinion is one of its most commendable features. Individuals will pay for the drug insurance program during their working years, rather than later when retirement reduces income sharply. It is this provision which makes possible the one-dollar copayment feature, the keystone of the entire program.

Second, the legislation retains the "formulary" provisions included in previous

bills but refined in the bill we consider today. A "Formulary Committee" of distinguished doctors and druggists would select the drugs to be covered, place them on a master list, and distribute the list to participating pharmacies. In preparing the list, the drugs would be listed by generic name rather than brand name, and would be included under a "maximum allowable cost" provision which would lower the overall cost of drugs on the list.

And third, the legislation has as its most important feature a one-dollar co-payment provision. Medicare beneficiaries would go to a participating pharmacy and purchase any drug listed in the formularly for $1. If the prescribed drug is not on the list they would pay for it out of their own pockets, as they do now. The pharmacist would then be reimbursed by Medicare on the basis of maximum allowable cost plus a small professional fee. Thus the program would be easy to administer and would permit Medicare beneficiaries to purchase prescription drugs at a reasonable price without any bothersome paperwork at all.

I would like to say one additional word about cost. Several people have criticized this legislation on the grounds that it is prohibitively expensive. I answer: nonsense. Of course the program is expensive—most important programs are, especially those which Congress delays action on for five years. But even the most inflated cost estimate I have seen amounts to a fractional increase in total Medicare expenditures—an increase, I might add, which does not even keep pace with the increase in prescription drug costs since this legislation was first proposed.[1] Furthermore, to quote from Senator Montoya's testimony before this Committee:

> As the Committee knows, I have had very troublesome experiences with HEW on cost estimates in the past. I should like to submit that, based on those experiences, any estimate will be inflated. At no time have they taken into consideration the experiences of such programs after the initiation of a formulary. We therefore must assume that the costs will be less than we will be asked to assume.

With the increased wage base under H.R. 1 and the moderating influence of wage and price guidelines to keep Medicare costs within bounds, there is no reason in the world for claiming that the drug insurance program is prohibitively expensive.

"For many elderly people," concluded the Task Force on Prescription Drugs, "illness serves as a major cause of their poverty by reducing their incomes, while poverty serves as a major contributory cause of illness by making it difficult for them to obtain adequate health care." Could it be that by attacking the prescription drug problem we are attacking the poverty problem as well?

I think so. We have a bill which is easy to administer, reasonably priced, and visionary in scope. But most important of all, we have a bill which in some small, tentative way begins to repay our enormous debt to America's elderly citizens. With this one bill, we can make progress on two important fronts—improving medical care for the aged, while simultaneously taking a genuine step to solve the poverty problem. This legislation will go far to justify the faith that the elderly have in their government, a faith which has lasted until now but which cannot help but diminish if Congress does not justify it soon.

We have ignored the special needs of the elderly. Now, perhaps, we have an opportunity to justify their patience. Let us hope it is not our last chance.

STATEMENT OF HON. JOSHUA EILBERG, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE

Mr. Chairman, five years ago the Congress directed the Secretary of Health, Education and Welfare to study the possible coverage of outpatient prescription drugs under Medicare and to report back to us on the need for and the design

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[1] The National Journal estimates the cost of the drug prescription program at $1.7 billion—22.7% of Medicare's $7.5 billion budget for Fiscal Year 1971.

From 1967 (when Senator Montoya introduced his first legislation on this subject) until 1970 (the last year for which figures are available), the per-capita expenditure for prescription drugs for those over 65 years old increased from $40.65 to $50.94—an increase of 25.3%. (Figures from the Social Security Administration's Prescription Drug Data Summary, table 1.4).

of a workable program. The results of that study were forwarded to the Congress on February 7, 1969, over two years ago. Those results provide irrefutable evidence that the need for such a program does exist. As a group, the elderly comprise about 10 percent of the population, but they account for well over 20 percent of all outpatient prescriptions, and for 25 percent of all outpatient drug expenditures. Private insurance protection for the cost of prescription drugs is not a realistic alternative for the bulk of the elderly. The Social Security Administration recently reported that only about 3 million older people, or about 15 percent of the elderly have managed to obtain out-of-hospital drug insurance from private sources.

During the time that the question of Medicare coverage of prescription drugs has been studied and considered, the burden of drug costs on the elderly has grown progressively greater. In 1967, about the time that the HEW study of the problem began, the average expenditure by the aged for outpatient prescription drugs was $54.15; during fiscal year 1969, the private expenditures for prescription drugs purchased by the elderly was $70.25. Clearly, the cost of Congressional inaction has fallen on those of our citizens least able to bear it.

Therefore, Mr. Chairman, I am proud to join your colleague, the Honorable Joseph Montoya of New Mexico in the general effort to provide coverage of prescription drugs under Medicare and many of my colleagues in the House of Representatives in cosponsoring H.R. 2235. This bill, which embodies many of the administrative features recommended by the government study groups, would establish outpatient drug benefits as part of the Medicare hospital insurance program. Under the proposal, community pharmacies and other qualified pharmacies would enter into agreements with intermediaries or other agencies to provide a wide range of pharmaceuatical services for medicare beneficiaries. Through this "vendor" approach, the patient would be relieved of claims recording and filing responsibilities and the need for numerous exchanges of small benefit amounts would be eliminated in favor of consolidated transactions between the vendors and the intermediaries.

In addition, beneficiaries would incur a one dollar copayment for all prescriptions filled under the program so that both patient and provider would know the extent of the patient's liability at the time the services are provided. The bill also contains a provision for adjusting the amount of the copayment to reflect changes in the general level of prescription prices.

Mr. Chairman, I commend this important piece of legislation to the members of this committee for their careful consideration and for inclusion among the provisions of the Social Security Amendments-Welfare Reform Act of 1971 (H.R. 1) when reported to the full Senate.

Thank you.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 12, 1971.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
New Senate Office Building.

DEAR MR. CHAIRMAN: When H.R. 1 was before the House in June, I voted to strike Title IV because I felt that this legislation represented an inadequate response to the need for meaningful welfare reform.

If true welfare reform is to be enacted in this session of Congress, it is incumbent upon the Senate, and particularly the members of the Senate Finance Committee, to draft legislation which improves on the House passed bill in a number of areas.

I would like to urge adoption of the following provisions:

1. *States must maintain their present level of benefits.* No welfare recipients should be worse off financially under the new program than they are under the present AFDC system. President Nixon made this comment to the nation when he announced his welfare reform program in August, 1969.

In the vast majority of states, recipients are currently receiving higher benefits than the $2400 floor established in H.R. 1. The federal government must pledge to undertake a significant percentage of the cost if the states are realistically to be expected to supplement the new federal payment levels. The hold harmless provision does not provide sufficient assurance that states will maintain their current level of benefits.

2. *The $2400 benefit level for FAP-OFF recipients is inadequate and inequitable.* Administration spokesmen have admitted that such is true. We cannot establish a payment level that is woefully below the poverty level as determined by the Department of Labor. Neither can we adopt a payment standard which would result in an aged couple receiving the same stipend from the government that a poor family of four does.

3. *Payments to FAP-OFF families must be adjusted automatically to the rise in the cost-of-living.* This principle has been adopted for Social Security beneficiaries under Title I of H.R. 1. If it is not extended to FAP-OFF recipients, their status as second-class citizens will again be worsened.

4. *Mothers of children under six must not be required to seek job training.* Under current law, the mother may remain in the home until her child reaches the age of six. The Administration supports keeping the age level at this point. The change in the law under H.R. 1 is certainly not in accord with efforts to strengthen the family unit of the welfare recipients.

5. *Adequate funding must be provided for child care centers and for the job training-employment aspects of the bill.* We cannot force mothers to register for job training if the child care available for their off-spring is not in the best interests of the well being of those children. That will assuredly not be the case if we fail to increase the present allocation of $2 billion for the child care of 1¼ million children.

It is the Administration's estimate that 2.6 million families contain people who will register for employment services. Yet H.R. 1 provides for only 412,000 training and job placement slots and 200,000 public service jobs. The sum allotted for job training is only $540 million. We cannot hold out child care centers and job training as panaceas to the endless cycle of welfare dependency if we fail to fund these programs at a realistic level.

6. *Restrictions on college-level training programs for recipients must be eliminated.* H.R. 1 currently prohibits assistance payments to a family whose head of household is a full time college student. This provision, if allowed to stand, could seriously cripple useful new programs such as the one at the University of Minnesota where 400 AFDC recipients are enrolled on a full time basis.

7. *Proper working conditions must be insured for welfare recipients.* People should not be forced to accept work at $1.20 an hour, three-fourths of the federal minimum wage. The only provision in the bill limiting the types of jobs to which recipients can be assigned is a prohibition against their being used to break strikes. Further protections must be added to the bill to guarantee that employed welfare recipients will not be forced to work under substandard conditions.

8. *The rights guaranteed to welfare recipients under current law must not be tampered with.* The provisions of H.R. 1 permitting the states to reimpose residency requirements and weakening the procedural rights of welfare recipients are most glaringly in disaccord with this principle. If we expect welfare recipients to become full citizens of our society, they must be treated as such.

9. *Eligibility for assistance must be based on the current need of the applicant.* H.R. 1 would disqualify any person who had earned an amount of income over the previous nine months that, if earned regularly, would make him ineligible for assistance. This provision is highly discriminatory towards seasonal workers, such as migrant laborers. This marks a change from the present practice of eligibility being based on current need.

10. *Assistance must be provided for indigent couples without children as well as single individuals.* At present some states have undertaken such assistance programs without any federal financial assistance. Coverage should be extended to such individuals under the Family Assistance Plan.

Thank you for your consideration.

Sincerely,

DONALD M. FRASER.

STATEMENT OF HON. ROBERT N. GIAIMO A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. Chairman: May I thank you and the members of your committee for allowing me this opportunity to present a statement in favor of outpatient prescription drug coverage under Medicare.

If I had to select the most pressing social needs that should be dealt with

realistically during the current session of Congress, the need for outpatient prescription drug coverage, especially for the elderly poor, would be high on the list. There are presently 113 cosponsors of legislation to amend H.R. 1, and H.R. 6234, of which I am a cosponsor, would satisfy this pressing need. It is striking that these supporters represent a broad cross section of the nation as well as the concerned chairmanships and subcommittees of the House of Representatives.

The legislative need is obvious, most notably in the economic sphere relative to our elderly poor. At present, there are over 20 million Americans covered by Medicare. Of these, four and a half million are older Americans beneath the poverty threshold. Since the median annual earnings of the elderly poor is around $1,888, it is difficult to believe that any of this deserving group could afford outpatient prescription drugs that are required for long-term use in easing or eliminating medical problems usually confronting the elderly, specifically heart disease, high blood pressure, arthritis or kidney disorders.

As the Senate Special Committee on Aging reported, poverty for persons 60–64 years old has increased from 1968 to 1970 by almost 100,000. While these aged citizens comprise only ten percent of the population, around *one-fourth* of the 1.7 billion annual prescriptions for drugs are for the elderly. With the cost of drugs being what they are, it is inconceivable to expect that the aged poor could continue to pay for outpatient health-sustaining drugs without incurring severe economic losses.

I could not support a measure to provide outpatient prescription drug coverage under Medicare unless I believed it was economically, medically and administratively feasible. In 1967, when the Administration first studied the matter, it was concluded that a drug coverage program would have to be designed meticulously to avoid (1) a giveaway syndrome, (2) bureaucratic entanglements, and (3) arbitrary selection of the drugs to be provided. During the Nixon Administration, there have been two studies on the subject and each has emphasized the need for drug-selection management and financial control. I believe that H.R. 6243 includes decisive provisions to satisfy these requirements.

Drug selection, insuring that safe, effective and only necessary drugs are covered by the outpatient prescription program, would, as authorized by the bill, be accomplished by a Formulary Committee, a body consisting of members in the fields of medicine, pharmacology, and pharmacy. This committee would prepare an indexed listing of the favored drugs which would be delivered to all registered pharmacists. In order for a Medicare patient to take advantage of coverage, the drug he desires to purchase at a participating pharmacy of his choice must be on the list prepared by the Formulary Committee.

Financial advantages exist in the copayment system provided by the bill. The beneficiary, to receive the prescription on the formulary list, must pay $1.00 out of his own pocket. The $1.00 copayment, regardless of the type of drug prescribed, is a fixed fee. This copayment provision, by alerting the user that he is sharing in the cost of his required prescriptions, should promote cost effectiveness.

When we speak of the elderly poor, we sometimes fail to remind ourselves that it is often their illnesses and the sort of outpatient drugs that have caused their poverty. By amending H.R. 1 and delivering to the poor under Medicare an outpatient prescription drug coverage program, many unnecessary poverty conditions can be eliminated and many lives extended.

At this point, I would like to add that H.R. 6243 and identical bills have the support of the American Pharmaceutical Association, the AFL–CIO Executive Council, the Senate Special Committee on Aging, twelve members of the House of Representatives Appropriations Committee, to include two subcommittee chairmen six members of the House Ways and Means Committee, the distinguished chairman, Honorable Harley Staggers, and nine members of his House Interstate and Foreign Commerce Committee.

Considering the broad support and the pressing needs of our elderly, which were confirmed again during the recent White House Conference on Aging, it appears that the time has arrived for outpatient prescription drug coverage under Medicare. I desire continued and new support for such legislation which is contained in H.R. 6243 of which I am a cosponsor. I strongly urge that it be dignified by this committee as soon as possible reported and transformed into law. The Septembers of our aged citizens need not be cruel.

Thank you very much.

STATEMENT OF HON. ELLA T. GRASSO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

AMENDMENT 464 TO H.R. 1

Mr. Chairman, prescription drugs must be made available to older Americans under the Medicare program.

There is no reason for the elderly to continue to bear the burden of the high cost of out-of-hospital prescription drugs. It is inexcusable that many of them are forced to resolve a dilemma between two grim alternatives—either enduring pain or incurring additional expenses which overtax their incomes.

Today, one out of every ten Americans has passed his 65th birthday, and some 70 percent of this group have joined since 1961. Nearly 46,000 elderly persons live in Connecticut's Sixth District alone.

Throughout the country, millions of the elderly exist with an income below the poverty level; their median income is below $2,000. These people are cruelly punished by increases in the cost of living.

It is a cruel and unfortunate fact of life that as we grow older, we acquire more ills and longer illnesses; with these come greatly increased medical expenses. It has been estimated that the elderly incur health care expenses 275 percent higher than the costs borne by any other segment of society. Older Americans comprise only 10 percent of the population; however, their prescriptions account for 23.5 percent of all those filled in 1971. Furthermore, the average price per prescription paid by people sixty-five years old and older is 10 percent higher than the prices paid by individuals of all ages.

With food and essential services comprising such a large percentage of the elderly's income, many older people cannot bear the expenses of essential medicines. To ask that people who have contributed so much to this country be forced to choose between spending their resources on either food or medicines is a disgrace. They must have the means to buy both.

To include prescription drugs under Medicare would alleviate some of the financial burden the elderly must endure today. In 1969, the Task Force on Prescription Drugs reported that a drug insurance program under Medicare is needed by the elderly, and that such a program would be both economically and medically feasible. The recent White House Conference on Aging also recommended that the cost of prescription drugs be included under Medicare. Legislation introduced in both Houses of the Congress has proven the desirability of such a program.

This subcommittee is presently considering Amendment number 464 which would help implement these recommendations.

As a cosponsor of this measure in the House, I wholeheartedly endorse the coverage of prescription drugs under Medicare. Because of the importance and necessity of out-of-hospital prescription drugs for the well-being of our elderly, and because financial burdens have made many of these drugs luxury items—though in reality they are necessities of life—I believe that Amendment 464 should receive the strong support of this subcommittee.

No other age group in our society has been so hard pressed by the spiralling trend in our economy. Our elderly had to bear the burden of these costs far too long. It is the responsibility of all of us to provide better programs for older Americans—and surely we must provide these programs now.

TESTIMONY OF HON. LEE H. HAMILTON, A U.S. REPRESENTATIVE FROM THE STATE OF INDIANA

Mr. Chairman: I appreciate the opportunity to add my expression of support for the proposed amendment to H.R. 1 which would provide outpatient prescription drug coverage under Medicare.

One of the most frequent complaints which I receive from elderly constituents who are trying to make ends meet on a limited income is the increasing cost of health care, and particularly, prescription medicines.

The proposal by Senator Montoya, amendment No. 464, and the companion legislation which I co-sponsored in the House of Representatives (H.R. 2355),

goes to the heart of this complaint. The amendment establishes a comprehensive drug insurance program aimed at alleviating the crushing financial burden of our older, infirmed citizens whose only source of income often is a social security pension.

It is not uncommon for me to receive a letter, or to have one of my older constituents tell me, that half of a monthly benefit check was needed for doctor and medicine bills.

The elderly have inordinately high health costs. The Task Force on Prescription Drugs reported recently that for many of the elderly, the cost of recovery from an illness amounts to financial disaster. Ill health pushes many into poverty.

The central aims of the amendment are to:

1. Provide coverage, under Medicare, of prescription drugs and some non-prescription drugs of life-sustaining value.
2. Eliminate the Part B Premium of Medicare, along with the required record keeping and claim requirements, and finance the prescription drug program under Part A of Medicare.
3. Establish an appropriate committee of authorities in the health field to determine the drugs to be covered.
4. Require a $1 co-payment from the purchaser for each prescription of medication deemed to be of life-sustaining value.

This approach offers the promise, not only of easing the financial burden of our older residents, but also of providing additional health care.

It has widespread support in the Congress, as evidenced by the number of co-sponsors in the House and Senate versions of the bill.

I respectfully urge that you give favorable consideration to the legislation as an amendment to H.R. 1.

STATEMENT OF HON. WILLIAM E. MINSHALL, A U.S. REPRESENTATIVE FROM THE STATE OF OHIO

Mr. Chairman, distinguished Members of this Committee, I am grateful to you for this opportunity to testify in behalf of including prescription drugs under Medicare coverage. As a co-sponsor of H.R. 11249, I feel this amendment to present law is long overdue and is absolutely essential to ease the financial burden of our elderly citizens.

Out-patient prescription drug costs impose a significant economic drain on the often very limited incomes of the 20 million Americans under Medicare. Such drugs now represent the greatest single personal health expense these citizens must meet from their personal incomes. It has been pointed out before, but bears repeating, that annual per capita expenditures for prescription drugs for the aged is three times those for persons under 65, and annual per capita expenditure for drugs on the part of the severely disabled is six times that of the population as a whole.

I know the committee is aware that the President's Task Force on the Aging has filed a report, "Toward a Brighter Future for the Elderly", in which it recommends: "Coverage of out-of-hospital drugs at the earliest date administratively feasible".

I feel that H.R. 11249 sets forth a sound and practical program for achieving this objective, and I urge the committee to incorporate its provisions in H.R. 1.

STATEMENT BY HON. JAMES G. O'HARA, A U.S. REPRESENTATIVE FROM THE STATE OF MICHIGAN

PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

I appreciate this opportunity to present testimony to the Senate Committee on Finance in support of legislation which would provide for prescription drug coverage under Medicare.

As a sponsor of similar legislation in the House of Representatives, I am delighted that Senator Montoya and so many of his colleagues have introduced S. 936 to achieve this purpose, and I hope that the Committee will adopt this legislation as an amendment to H.R. 1.

I am convinced of the urgent need for this legislation. The prescription drugs which America's elderly require are too expensive for many of them—yet the medication is vital to sustain life.

As things stand now, many elderly people are trapped between medical need on the one hand and economic insufficiency on the other.

The concept of financing the cost of outpatient prescription drugs is consistent with the basic premise which led the Congress to enact Medicare into law to begin with. We knew that, as a person grows older, his need for medical care of all kinds increases sharply. This need reaches its maximum intensity at precisely the point in time when the individual is least able to pay for them—at the time when his income is sharply reduced due to retirement.

Medicare has made it possible—through the instrumentality of the Social Security System—for the individual to pay for his medical insurance during his working years, and to receive the benefits of that insurance during his retirement years.

From the point of view of the nation's elderly, Medicare has worked reasonably well during the first few years of its existence. It is not a perfect program—but, then, nobody expected it to be perfect. What we intended it to be was a hopeful beginning—a start along the road toward providing quality medical care for the elderly without bankrupting either the retiree or his family in the process.

We have learned some valuable lessons during these first few years of Medicare. One of the lessons we have learned is that there is a compelling need for broadening the law's provisions to include the cost of outpatient drugs and certain non-prescription drugs which are considered to have life-sustaining value.

This legislation differs from past Medicare drug coverage bills in that it would be financed under the payroll tax portion of Medicare, rather than through higher monthly premiums paid by beneficiaries. As a matter of fact, the experience that we have developed since the passage of Medicare suggest strongly that we should take another look at the question of whether or not there should be any monthly premiums charged to retirees. These premium charges may seem modest to anyone with a regular income. But they loom large, indeed, when they are laid aside the completely inadequate retirement benefits that most of our elderly citizens receive.

As in the legislation which I sponsored in the House, S. 936 would provide for a $1 payment for prescription drugs by the beneficiary, himself. This should provide a measure of assurance that there would not be any serious abuse of the program by Medicare recipients.

The balance of the cost for prescription drugs would be paid by the Federal Government, which would reimburse pharmacists directly, on the basis of a "maximum allowable cost" plus a professional fee for the service rendered. This procedure should provide reassurance against any abuse of the program—either by druggists or the pharmaceutical industry.

The direct payment to the pharmacist will have another benefit: It will mean that people over 65 will not be burdened with the task of keeping records of their drug purchases, or with the problem of filing claims and waiting for reimbursement.

The legislation now before the Committee calls for the establishment of a nine-member Formulary Committee—composed of two officials of the Department of Health, Education and Welfare and seven individuals from outside the Federal Government, the majority of whom must be physicians. Under the legislation, these are to be people of recognized professional standing and distinction in the fields of medicine, pharmacology and pharmacy.

The task of this Formulary Committee would be to select the drugs that are to be covered under this provision of the Medicare program. This would include, as I indicated earlier, both prescription drugs and certain non-prescription drugs that have special life-sustaining value. It is envisioned that all commonly used drugs would be covered, with the Formulary Committee screening out worthless or dangerous drugs.

In summary, this legislation provides the mechanism for assuring retired Americans that they will be able to obtain the medication which they require to maintain their health, and to make it possible for them to do so without courting economic hardship.

As a Member of Congress who has sponsored identical legislation in the House

of Representatives, and as a sponsor of other legislation which seeks to provide broad-range national health insurance for all Americans, I thank the Committee for this opportunity to present my views in support of S. 936 introduced by Senator Montoya. I hope that the Committee will give careful consideration and, ultimately, its full support of this legislation so that our elderly can take another step forward in their search for the dignity that accompanies physical good health and economic good health—worthy goals which they are entitled to attain after their working years are over.

STATEMENT OF HON. CLAUDE PEPPER, A U.S. REPRESENTATIVE FROM THE STATE OF FLORIDA

Mr. Chairman, along with more than 100 of my colleagues in the House, I am a co-sponsor of H.R. 2355, and its companion bills, which are the counterparts of S. 936, which is under consideration today and which is designed to correct one of the most serious shortcomings in the present program of health insurance for the aged, the absence of any outpatient prescription drug benefit. Five years ago, Congress directed the Department of Health, Education and Welfare to study the extent to which drug costs constitute a major financial burden on older persons and to report to us regarding the feasibility and design for a workable program covering the costs of prescription drugs under medicare. The Final Report of this special Task Force made it abundantly clear that older Americans sorely need assistance with their prescription drug expenditures.

Although the elderly represent somewhat less than 10 percent of the Nation's population, they account for more than 20 percent of outpatient prescriptions written in the United States and about 5 percent of total expenditures for prescribed drugs purchased on an outpatient basis. This, of course, is understandable, since about 80 percent of the elderly—as opposed to only about 40 percent of those under 65—suffer from one or more chronic diseases or other conditions for which pharmaceutical therapeutics is often used.

In recent years, prices for goods and services throughout the economy have shown the effects of marked inflation. Prices for prescription medications have been no exception. The most recent available figures for the Consumer Price Index show that the index for drugs and prescriptions moved more than twice as fast in 1970 as in 1969—2.5 percent, as compared with 1.1 percent. It has been established that by 1980, per capita annual expenditures for drugs and drug sundries will amount to as much as $56, or almost twice the per capita expenditure for 1968. This increased financial burden will fall heaviest upon the elderly, for whom the number of drug acquisitions is more than double that for the total population and nearly three times that for the under 65 age group.

The measure you are considering today, represents an effective and workable solution to the problem of covering drug costs under the Medicare program. Beneficiaries would incur initially a $1 copayment per prescription for all prescriptions filled under the program. An advantage of this system is the fact that everyone would know in advance the patient's liability at the time the services are provided. A mechanism in the bill provides for an adjustment in the amount of copay borne by the beneficiary as the general level of prescription prices rises in future years.

On behalf of myself and the other House sponsors of H.R. 2355, I commend to you the features of this proposal and convey my strong belief that positive action should be taken on this measure at the earliest possible moment. Thank you.

STATEMENT OF HON. TOM RAILSBACK, A U.S. REPRESENTATIVE FROM THE STATE OF ILLINOIS

Mr. Chairman, Approximately 80 percent of the aged population suffers from one or more chronic conditions for which drugs are required. Those persons 65 or older use twice as many drugs as do the rest of the population. Their expenses

can run into hundreds of dollars annually—expenses hardly budgetable for those living on fixed and limited cash incomes.

In Illinois, over 10% of the population is composed of persons 65 or older, and it is estimated they pay at least 25% of all outpatient drug costs.

In 1967, the Department of Health, Education, and Welfare was ordered by Congress to study the need of older Americans for prescription drugs and a design of a workable program for their distribution. Their results made it clear that older Americans sorely need assistance to meet the expense of prescription drugs, but no action was taken as a result of the study.

Unfortunately, H.R. 1, which was designed to make improvements in national health programs, passed the House of Representatives without a prescription drug program. To rectify this situation, legislation has been introduced on both the House and Senate sides to provide for prescription drug coverage under Medicare. I was pleased to join on the House effort.

Under such legislation, a Formulary Committee, composed primarily of physicians, will select drugs to be covered by the program. An elderly person may go to the participating pharmacy of his choice. He will incur initially a one dollar charge for each prescription filled under the program, and the pharmacy will be reimbursed for the remaining amount by the program. If, however, the prescription drug is not listed by the Formulary Committee, the beneficiary will do as he always has—pay out of his own pocket.

Mr. Chairman, I hope this proposal will be given an evaluation at the earliest possible time. Hopefully, you and the other Members will determine it is necessary to amend H.R. 1 to provide outpatient prescription drug coverage under Medicare. I know I am convinced we must establish a comprehensive program for the twenty million Americans covered by Medicare whose prescription drug problems have been ignored too long.

I thank you for providing me with this opportunity to present my position.

TESTIMONY OF HON. BENJAMIN S. ROSENTHAL, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I appreciate this oportunity to testify in behalf of H.R. 2355, a bill designed to provide prescription drugs to Medicare patients outside the hospital.

Health care costs have continued to skyrocket in this country while the quality of health care has not. This is particularly so for the elderly and others on fixed incomes. Unfortunately, adequate health care in this country is too often viewed as a privilege rather than as the right it should be.

A large portion of health care costs stem from the purchase of drugs. This is especially true of our elderly who must spend 20 cents of their health care dollar on medicine. While the elderly represent only 10% of our population, they account for 25% of the nation's prescription drug expenditures, or about $1 billion a year. It is essential that we make the purchase of these drugs less of a hardship.

Our elderly are faced with rising needs and costs for medicines when they can least afford it. Many are living on minimal, fixed incomes, and expenditures for drugs can have substantial impact on their often too small financial resources. Furthermore, chronic illnesses requiring continuous drug use are prevalent among the elderly and pose a tremendous burden for this age group, fully 25% of whom are living at or below the poverty level as measured by Social Security Administration indices.

Aside from financial difficulties, the elderly face additional obstacles. They frequently have transportation problems and find it difficult to shop around for the lower prices they might be better able to afford. Oftentimes, their very illnesses present impediments to their exercising full consumer power.

This measure, I believe, will have a significant side benefit. Many times, the

elderly must be admitted to hospitals in order to qualify for Medicare coverage of drug purchases that could otherwise be prescribed on an outpatient basis. The present bill will not only eliminate this unfortunate use of much needed hospital space, but will avoid the potentially tragic psychological impact that a hospital stay can have on older people. This is a price that the elderly should no longer be expected to pay.

This program would also help avoid much worry and bother for Medicare patients. They would simply pay the pharmacist $1 for each prescription and not have to worry about keeping any records, paying monthly premiums, filing claims or getting tangled up in any red tape. A person would pay for this coverage during his working years, rather than after he retires and his income is sharply reduced.

Any program has potential administrative problems, and this bill is no different. Yet, the $1 co-payment, the reimbursement directly to pharmacies, and the formulary committee proposal strike me as offering a balance between safeguards against waste, on the one hand, and protection and convenience for pharmacists, the government and, of course, the elderly, on the other.

And most programs, Mr. Chairman, are expensive. Again, this one is no different. Yet, the human costs of not enacting this bill, and thus perpetuating this hardship for our elderly, are far greater than the financial costs involved. In an age when we talk of spending over $10 billion on space shuttles and one tenth that amount on elaborate university campuses and government office complexes, surely we must find the necessary funds to provide drugs for our elderly citizens.

There is no reason why the wealthiest, most technically and scientifically advanced nation on earth cannot also be the healthiest. We can no longer permit the dire shortage of medical personnel, the lack of adequate facilities, the unequal geographical distribution of those facilities, and the soaring costs of the available services and facilities to prevent every American citizen from receiving complete and preventative health care. An integral part of this effort is making the necessary drugs available to all who need it, regardless of their ability to pay.

STATEMENT OF HON. LOUIS STOKES, A U.S. REPRESENTATIVE FROM THE STATE OF OHIO

Mr. Chairman: I appreciate this opportunity to testify in support of Senator Montoya's proposal to provide Medicare coverage for outpatient prescription drugs. I am one of the 113 co-sponsors of Congressman Obey's companion bill, H.R. 2355.

Since Senator Montoya first introduced his proposal in 1967, the subject has been studied and reviewed and reported on several times. Meanwhile, our senior citizens have had to bear their heaviest health burden, prescription drugs, with no help from the federal government. Many of them have undoubtedly been hospitalized in order to have drug costs paid by insurance or Medicare. Even more serious, many prescriptions are not refilled or never filled at all because of the high cost.

The Health Education and Welfare Department's Task Force on Prescription drugs has shown the need and the feasibility of this program. The President's Task Force on the Aging has also recommended such a program. Despite these recommendations, the first of which was nearly two and one half years ago, the Administration has not introduced a proposal to meet this critical need.

The studies indicate that the problem of costs is manageable. The formulary system and the requirement of a co-payment provided in the proposal are promising means of holding down costs. The human costs of our delay in enacting such a program are immeasurable. We must institute the program and use all of the data provided by the studies which have been to hold down the costs.

About 17 million people or 85% of those over the age of 65 have no private

insurance protection covering out-patient prescription drugs. In the Greater Cleveland area alone, the number of persons in this category is about 170,000. In my central city district, where the aged poor are concentrated, very few senior citizens are able to afford prescription drugs. For these individuals the cost of prescriptions is the largest single health item. Our senior citizens have been promised assistance with this burden for too long. It is time to deliver on the promise.

I commend Senator Montoya for offering his proposal as an amendment to H.R. 1 and urge the committee to approve the amendment.

STATEMENT OF HON. JOHN A. BURNS, GOVERNOR, STATE OF HAWAII

As the Governor of the State of Hawaii, I am privileged to be afforded the opportunity to present to the Senate Finance Committee my testimony relating to H.R. 1.

It is most encouraging that the Finance Committee considers welfare legislation to be a piece of top priority domestic legislation and is accordingly committed to a viable program of welfare reform.

With regard to the Family Programs of H.R. 1, I urge the Committee's full and favorable consideration and support of the amendments proposed by your colleague, Senator Ribicoff. The amendments represent significant improvements over the measures passed by the House and brings true welfare reform closer to reality.

The shortcomings of the current welfare program and the mounting fiscal crisis confronting states, I am sure you will concur are undisputable.

Whereas the President of the United States has recommended a deferment of the effective date for new welfare programs for a period of 18 months after enactment, I believe it is paramount that measures for immediate fiscal relief to states be enacted now and be incorporated in welfare legislation, to preclude the necessity for reduction in the current level of assistance payments. Mounting fiscal pressures have already resulted in approximately 20 states reducing its level of payment with the probability that more states would follow.

The future of 25 million Americans is in your hands; welfare reform must be now.

I submit my testimony in hopes of favorable action of my recommendations by you and your Committee.

TESTIMONY OF HON. WILLIAM T. CAHILL, GOVERNOR, STATE OF NEW JERSEY

I would like to preface my remarks by stating that I wholeheartedly endorse the basic principles of welfare reform embodied in H.R. 1.

Since January of 1969, New Jersey has supported a State-wide program of Assistance to Families of the Working Poor, which has included needy families with children, identified as "underemployed" and "never employed" as well as those federally classified as "unemployed." This is in addition to New Jersey's very progressive program of Assistance to Dependent Children. Our program of Assistance to Families of the Working Poor was recently modified and is now wholly funded by the State and its counties. Today New Jersey's welfare programs are probably closer than those of any other State in the union to the types and organization of programs recommended in H.R. 1.

Just as other states in the union have felt the severe increases in welfare costs, so has New Jersey. However we have had no choice but to accept these costs in order to provide for the needy in the state. Consequently, I strongly support the increased federal financial role that is implicit in H.R. 1 and several of the proposed amendments.

I believe that the time for experimentation has passed and now is the time for decisive federal action in this area. Nonetheless, if the Congress concludes that the new federal program of a national minimum income standard for all families should be conducted first on a trial basis, I urge that New Jersey—because of the existence of a substantially similar program—be used as a pilot state. This would not only accelerate the test period, but New Jersey's history with programs of Assistance to the Families of Working Poor will provide a valuable, historical data bank to assist in the evaluation of such a program. Statistics on the New Jersey program have been and will continue to be gathered by its Research and Evaluation Committee, established last year to analyze welfare problems and programs in our state.

There are several provisions of H.R. 1 on which I would like to comment specifically. I do not want these comments, which are intended to be in the nature of constructive criticism, to be interpreted as diminishing my enthusiasm for and support of H.R. 1.

H.R. 1 will significantly increase the number of eligible welfare recipients in New Jersey. The provisions to "hold harmless" the state for increased cash assistance payments to the 1971 level are not only very wise but imperative. However, there is no practical protection against the related increase in the cost of Medicaid. True, the state will not be mandated by statute to make Medicaid coverage available to the new welfare recipients who will be eligible under H.R. 1 but strong pressure will be exerted to make these people eligible for Medicaid; consequently, I urge the introduction of a medicaid "hold harmless" provision.

Your Committee has had extensive discussion concerning the level of the minimum income standard. In my opinion, this level should be kept reasonably low, $2,400 for a family of four would seem to be a standard acceptable to most states. I make this statement, however, with a strong qualification that the states be encouraged to supplement that minimum standard. Under H.R. 1 there is, unfortunately no provision for federal cost sharing in the state supplement. I believe that the state supplement gives the program the type of flexibility which it needs to meet the varying requirements of states as different as New Jersey, New York, Mississippi and Alabama. With no federal matching of the state supplement, the higher income states will be and have been forced to press for increases in the national minimum income standard in spite of the fact that such increases might have adverse economic effects on the lower income states. Consequently, I believe that the federal government should match the state supplement. At the same time, I recognize that the federal government should be in a position to limit supplement matching to a level which it deems appropriate.

In accord with the above, I support that portion of the Ribicoff proposal which would lead to eventual full federal funding of all public assistance costs in every state. I also believe that full federal funding need not and should not result in the identical dollar standard for every state. The possibility of identifying and administering varying regional standards, related to regional "poverty levels," should be explored.

Under existing regulations the earned income disregards, except for expenses of employment, are not taken into account in determining initial eligibility for welfare. Under H.R. 1 a modified income disregard is taken into account in determining eligibility. This will result in making a large number of people who are earning incomes in excess of the poverty level eligible for income supplements through welfare. I cannot support that concept. I believe that H.R. 1 must be modified so that the income disregards, other than the $60.00 per month provision for expenses of employment, will not be applied in determining eligibility. I recognize that this will continue the present inequitable situation which makes some families ineligible for assistance though their earned income is less than the combined earned income plus benefits of other families receiving welfare assistance. The existing inequity is, however, less destructive than the proposed application of the income disregards to eligibility because the application of the

diregards will introduce many thousands of persons presently earning an income in excess of the poverty level to welfare. To introduce these people to welfare cannot possibly provide them with work incentive; in fact it would seem to provide them with exactly the opposite.

Under H.R. 1 computable earned income is credited 100% to the Federal contribution. Just as I believe that there should be federal matching for the state's supplement, I also strongly urge you to consider amending the bill so that computable earned income can be applied pro rata to the state share as well as the federal share of the assistance grant.

In New Jersey, as in many other states, assistance to the single adult and to the childless couple is financed largely at the municipal level. Municipalities have felt the pinch of increased welfare costs to the same extent as have state governments. Without proposing a specific amendment to the bill, I ask that you give consideration to including assistance to single adults and to childless couples in H.R. 1, if only on a modified basis. While the original concept of the federal welfare program was focused on the aged, blind, disabled and certain families with children, it is clear that today our concept is one of aid to the poor. Equity requires that this program be extended to single adults and to childless couples. The favorable financial impact this will have on our already financially distraught cities needs no further comment here.

As I said in the beginning of my remarks, welfare is a national as well as a local problem. H.R. 1 economically mandates a complete federal takeover of administration of the income-maintenance aspects of welfare programs. I believe that so long as there is any state or local money involved in the payment of welfare assistance the states must be given the option *without financial penalty* to administer the program themselves. Consideration should also be given to the possibility of local administration through private agencies on a contract basis.

I support the provisions of H.R. 1 that strengthen the validation procedures in determining and reviewing eligibility. There is strong evidence that the "simplified method" heretofore prescribed is not now working. I support the implicit provision in H.R. 1 that welfare grants to individual families vary only by family size and income; in July of 1971, in keeping with this theory, New Jersey modified its grant procedures to establish a program of so-called "flat grants" that are at the core of the simplified and efficiently manageable system of income maintenance for individuals and families which true welfare reform requires. I also support the provisions in the bill that strengthen the effort to make the deserting father financially responsible.

The bill calls for wide-ranging changes in the administration and scope of Day Care Services and Worker Training Programs. In theory, I support these provisions, but I strongly urge your Committee to give careful consideration to legislated provisions in order to insure adequate standards of accountability and performance measurement as well as standards of quality and quantity. For example, I do not believe that it is socially or economically desirable to provide Day Care at a cost of $2,000 to $5,000 per year per child for a family of four or five children for the purpose of enabling a mother to get a job paying $5,000 or $6,000 a year. Similarly, I cannot support expensive Worker Training Programs which train people for menial jobs which have neither financial nor psychological benefit to the worker. I am pleased to see that the already enacted Talmadge Amendment provides a clear beginning emphasis on monitoring and evaluation which is result oriented.

I support the provisions for making available expanded public service jobs to welfare recipents. However, I think that federal support for those jobs would be more effective if it were decreased to half the rate now contemplated in the program but over a longer period of time.

I appreciate this opportunity to testify before your Committee and I am hopeful that you will be able to give full consideration to my recommendation.

STATEMENT OF HON. DAVID HALL, GOVERNOR OF THE STATE OF OKLAHOMA

Mr. Chairman, I thank you for giving me the opportunity of presenting my views on legislation pending before the Senate Committee on Finance, on H.R. 1. First, let me say, that I wish to go on record as favoring the principles of welfare reform, as adopted by the Governors' Conference in Puerto Rico, which I understand have been filed with the Committee. In general, I support the principles which appear in H.R. 1, and which principles I think should be enacted into law.

While our current system of providing for the welfare of the people was adequate in its day and served well, as did the Model-T Ford, changes in our society, both economically and socially, have necessitated an up-dating of our system of caring for people in need.

The very immensity of our federal government and its spending or lack of spending in different areas has such an economic impact on a community and industry that a given state cannot adequately meet the economic and employment needs of its citizens during such periods, even with federal matching under current programs.

It is with this in mind that I believe the time has come to finance the care of the needy from federal funds entirely, or with a very limited state supplementation, with some percentage of federal matching of the supplement. Much discussion has been given to the method of administration of H.R. 1 when enacted. The concensus of those in discussions I have heard favor state administration, with federal financing, similar to the relationship between the Department of Labor and the unemployment compensation programs. I am advised that the Chairman has stated his own inclination relative to this type of administration, using federal guidelines and supervision to assure compliance, with virtually all federal financing, and the basic administration being done at state and local levels. I heartily endorse what I understand to be the Chairman's views.

In the event that there are some states which, for reasons peculiar to that specific state, feel they cannot adequately administer the provisions of H.R. 1, the legislation should contain other provisions for making the administration optional with the state.

Time will not permit me to deal with the specifics of H.R. 1, as passed by the House, and now pending before this Committee. However, we in Oklahoma are much concerned relative to the administration of a welfare reform law, when enacted by Congress. Permit me to quote from the resolutions of the Governors' Conference on this subject:

C-2—WELFARE REFORM

> F. Allow for state administration without financial penalties if the state chooses to administer the program. (Policy Positions of National Governors' Conference 1971)

While I endorse the principle of the option, and consider it to be a "must" that the states be given the sole responsibility of the decision to opt or not to opt for state administration, I would like to state our thinking on the question of administration. As far as the State of Oklahoma is concerned, we feel very strongly that it is far better for the State to administer the program, than for the federal government to attempt to set up a new system. This is also the opinion of the nine-member Constitutional Board, the Oklahoma Public Welfare Commission, and its Director, L. E. Rader, who is authorized by me, as Chief Executive, and by his Commission, in addition to my statement, to advise the Committee of his and our great concern relative to this question of administration. I would like to point out what I consider to be some of the rationale of this position:

If states administer the program, through their welfare boards or commissions and the state administration, they will be better able to recognize the needs of their particular state. The state will have more input into the program, which

should provide a stabilizing effect and a more objective evaluation of the program, on a day to day basis.

States currently have trained staffs which can put a new program into effect immediately.

States currently have offices leased or owned by the state which could continue to be used under the new program. This would prevent a tremendous problem in setting up a new program and would be much less costly administratively to the nation's taxpayers.

States currently have office equipment, desks, typewriters, and electronic data processing equipment which could continue to be used. With a change to federal administration, millions of additional tax dollars would have to be expended just to purchase equipment to begin the program. The logistics of this alone would bottle-neck the program, no doubt, for years following passage of the bill.

Mr. Rader advises me that it is his understanding that the Chairman has requested the Committee staff to prepare an amendment for a take-over of the bulk of state and local share of the medical care program for indigents, again using the states to handle eligibility and certification with the Social Security Administration making payments direct to hospitals and other providers and practitioners. This approach has my endorsement in principle.

I appreciate having the opportunity to share my views with the Committee and applaud your leadership in attempting to solve this very complex problem.

TESTIMONY OF HON. PATRICK J. LUCEY, GOVERNOR, STATE OF WISCONSIN

I wish to thank the members of the Senate Finance Committee for the opportunity to present written testimony on H.R. 1 as passed by the House of Representatives. I regret that I was unable to appear before the Committee during the January hearings as I had originally hoped. The critical importance of the subject matter of this legislation has so considerable an impact on state government that I am pleased to have this opportunity to present my evaluation of H.R. 1 for the Committee's consideration.

At the outset, I think it is important to identify the specific objectives that a welfare reform bill must include:

a. Immediate substantial fiscal relief to the states, with a commitment towards eventual complete federal assumption of the costs;

b. Increased financial assistance to our poor, particularly those now receiving the least financial assistance;

c. Equal financial assistance standards for all families of a similar size in a geographic area regardless of the existence of a male head or the employment status of each head;

d. An administrative structure that is simple, efficient and that respects the dignity of recipients;

e. Adequate employment opportunities and related supportive services;

f. Meaningful incentives for employment.

The income maintenance system contained in H.R. 1 fails to meet these objectives. It would appear, however, that H.R. 1 does not contain any substantial fiscal relief for the State of Wisconsin except at the expense of the recipient. Advocates of H.R. 1 estimated that the bill would mean savings of $33 million for Wisconsin. The analysis in the attached tables, however, suggests that Wisconsin will have to spend from $10.7 million to $18.3 more than is budgeted for 1972–73 to insure that all recipients receive the level of assistance presently provided.

The major reason for this discrepancy is that H.R. 1 requires that the "hold harmless provisions' be applied to state programs as they applied in January, 1971. Under the provisions of H.R. 1, the state would presumably save the differences between the proposed benefit levels. Wisconsin, however, has raised 1972–73 assistance standards by more than $12 million and re-established AFDC-

U. In order for Wisconsin to realize substantial fiscal relief, recipients would lose between $25.9 million and $33.8 million in benefits.

Furthermore, the state could lose anywhere from $10 to $30 million annually in funds for social and rehabilitative services, depending on how the Department of Health, Education and Welfare interprets the provisions governing social services.

Just as H.R. 1 does not provide fiscal relief for the states, it does not provide equal financial assistance for families. A family of four, headed by an underemployed father, will receive substantially less than an equivalent size family headed by a working mother. For instance, a family of four with $1,500 income is eligible for $1,854 under the proposed national standard; however, if that family is headed by a female, the family would receive approximately $3,370, including state supplements at the existing levels and food stamps. The result is that two families of the same size and with the same earned income, would receive a difference of $1,500 in the amount of income support.

H.R. 1 actually places the states in the role of perpetuating the growing inequities in the welfare system. If the states do not give equal supplements, the objective of keeping families together will be defeated. Only at a cost of $15 million annually could Wisconsin provide benefits for the working poor equal to those received by unemployed families supplemented by the state.

The administrative structure proposed in this bill creates problems rather than solves them. Although basic grants will be simplified, federal agencies will have to keep two separate records—one for determining federal benefits and another for those cases eligible for state supplements. However, this extensive bureaucracy does not relieve the state of the need for record keeping. States will want to review these records thoroughly to insure that they are not billed for cases that would be federally funded or for state supplements in excess of established benefits.

Since administrative costs are relatively small in comparison to total assistance payments, most states will want to keep administrative control over their supplemental program to insure that the savings are realized. However, the bill is structured in such a way that states are in effect precluded from retaining administrative control of the supplements even though the state supplements may still approximate 50 percent of the total cost of benefits.

The size and complexity of the administrative structure created by the bill is not a model of government efficiency. But we must look beyond the question of efficiency to the actual impact this administrative structure will have on state and local governments and recipients. The method of eligibility determination and the amount of benefits paid will actually shift costs back to local general relief programs. The time needed to obtain data on an applicant's earnings for the past three quarters, verification of birth-dates and number of dependents claimed will delay substantially the granting of benefits.

For example, the Social Securtiy Administration, which must obtain comparable information, often requires three months to determine eligibility for OASDHI benefits. While some procedure may be desirable to prevent gross abuses, it is clear that families applying for relief will need immediate income—more than the $100 proposed in H.R. 1—and state and local governments will have to pay the cost.

It is also important to point out that counting income earned in the past three quarters to arrive at the amount granted means that in most cases recipients will receive less than they receive under the present system which is based on current need. In many cases, the difference between the federal benefit—including the state supplement—and the actual income needs of the family will be great. State and local agencies will have to make up the difference. This aspect of the benefit determination will be extremely severe on rural families who face seasonal underemployment, and who are often not covered by unemployment compensation. They ordinarily earn lower wages than male-headed families.

Another defect of the bill is that the administrative structure provided does not guarantee recipients adequate legal protection. Under the present system,

welfare recipients can obtain hearings and make use of federal district courts. Under H.R. 1 the Secretary's decision would be final. In addition, the Secretary can ban certain people from entering Family Assistance offices. This could mean the exclusion of people who help recipients obtain their legal rights.

H.R. 1 does not accomplish welfare reform. It does not provide fiscal relief for Wisconsin; it does not simplify administration of the program; and overall, it does not provide added assistance for most recipients. In fact, the basic philosophy of the bill implies that individuals who are poor, seek to avoid employment. It also suggests that income support should be fixed below the poverty level because it is hypothesized that initiative is destroyed if the income support level is raised. Such concepts are seemingly based on the assumption that economic motives are the principal influence of human initiative. H.R. 1 gives new life to the outworn myths of the past and perpetuates them through this proposed law.

The mandatory work provisions of this bill will not remove many people from the welfare rolls. Similar provisions have been incorporated by Congressional amendment with other federal public assistance programs and there is no evidence to suggest that these provisions have significantly reduced caseloads. While registration for employment services or information about the latest training and employment opportunities may be helpful, all too often such requirements result in the harassment of the recipient.

Unfortunately, the mandatory work requirement in H.R. 1 places employment counselors in the untenable position of determining whether or not a recipient is entitled to public assistance. Such action will foster an aura of suspicion and replace confidence with distrust.

These provisions included in H.R. 1 create second-class citizenship. They also point to a contradiction in administration policy. President Nixon vetoed the Economic Opportunity Act which contained a new comprehensive child development program. This program would have provided substantial sums to create community child care and develop centers, but contained no requirement for a parent to place a child in such a center. In his veto message, the President expressed concern that this program might supplant the essential responsibility of parents in raising their children. Yet H.R. 1 proposes to remove from mothers who have not outside means of financial support the responsibility and the right to choose how to raise their children. Mothers who receive social security or workmens compensation are not required to participate in employment programs; neither should mothers who are public assistance recipients.

H.R. 1 can be amended to make it more acceptable to state and local governments. However, I think the time has come to design a public assistance program which contains a timetable for complete federal financing of an income maintenance program, establishes a schedule of federal standards for financial assistance and income exclusions, provides sufficient income to families to raise them above poverty and assures equal coverage to all families and individuals. Such a program is largely a proposal contained in the amount to H.R. 1 authored by Senator Ribicoff of Connecticut. I wholeheartedly support this amendment as a point of departure for welfare reform.

The three key provisions of this amendment which are likely to generate the greatest concern are 1) the federalization of the costs of the program, 2) the move towards uniform standards for benefits by 1976 and 3) the eligibility of all individuals for benefits.

These reforms are absolutely essential because, under the present system, the federal government can shift the consequences of economic policies that encourage unemployment to the state and local governments. The impact of unemployment on federal governmental operations is limited. Revenues may decline slightly, but deficits need not be made up through increased taxes.

The increased cost to the federal government of public assistance is as low as one-tenth of one percent of the federal government's final outlays. However, at the state and local level, every dollar of a deficit must be made up immediately; and a substantial share of a state or local government's deficit during a recession is larger welfare expenditures. So while the federal government is passing

tax cuts to stimulate the economy, state and local governments are completely offsetting the federal tax cuts with tax increases to make up the deficits created by national economic policies.

Furthermore, under the present welfare system, the burden of "deflationary" economic policies falls heaviest on the poor, unemployed and underemployed. The Ribicoff amendment will guarantee that these families no longer bear the cost of such policies. The increased income provided to families who have pressing consumer needs would probably do more to stimulate the economy than corporate tax cuts.

The Ribicoff amendment also provides Congress with the opportunity to pass on to the states substantial fiscal relief and will remove them from a program over which they have no control. Also of importance is the fact that the amendment provides for an equitable distribution of relief because it is based on present burdens for state and local governments.

I also hope that the Committee will incorporate additional reforms to the Ribicoff amendment. I believe the issue of medical assistance must be dealt with at the same time that income maintenance aspects of the program are reformed. The added financial incentives to states for establishing programs with health maintenance organizations will probably accomplish little without establishment of a program to provide all medical services to all individuals in a community. Moreover, the single largest cost component of the medical assistance program is nursing care. Prepaid health insurance would have no impact on such care.

I am convinced that H.R. 1, as it now stands, will not be of substantial benefit to Wisconsin. Furthermore, I believe the bill is essentially the expression of a regressive philosophy which does not deal adequately with the problems of the current public assistance system. I strongly urge this Committee to act favorably on the Ribicoff amendment to remedy the present defects in H.R. 1. In this manner you can make a significant advance toward meaningful welfare reform.

Respectfully submitted,

PATRICK J. LUCEY,
Governor of Wisconsin.

TABLE.—FISCAL IMPACT OF H.R. 1 ON WISCONSIN UNDER DIFFERENT ASSUMPTIONS

	Total	Federal	State
A. Estimated cost of financial grants under present program for adult and family categories in fiscal 1972-73	$161,497,000	$100,420,000	$61,077,000
B. Costs under H.R. 1 affected by hold harmless provision (1971 State costs $45,585,000):			
1. State supplement up to 1971 State standards and Federal benefits	102,293,000	73,030,000	24,263,000
2. Food stamps	21,092,000	0	21,092,00
3. Adjustment to 1971 standards to set them at maximum	8,148,000	0	8,148,000
Subtotal	131,533,000	78,030,000	53,5003,003
C. Adjustment to State share if B.3 adjustment is accepted as part of hold harmless provision: Subtract $45,585,000 from State share	0	+7,918,000	−7,918,000
Subtotal	131,533,000	85,948,000	45,585,000
D. Costs not affected by hold harmless:			
1. Transfer of money payments for intermediate care facility patients to medical assistance	16,489,000	9,316,000	7,173,000
2. Cost of increased state standards above 1971 levels	12,468,000	0	12,468,000
3. Cost of aid to unmarried pregnant women	853,000	0	853,000
4. Cost of aid to step children and children living with nonlegal relatives	4,546,000	0	4,546,000
5. Cost of providing aid under AFDC-U (not in January 1971 plan)	3,256,000	2,866,000	890,000
Subtotal	38,112,000	12,182,000	25,930,000
E. Financial grants costs of H.R. 1:			
1. Based on adjustment made in item C	169,645,000	98,130,000	71,515,000
2. Based on adjustment made in item B.3. but not subject to hold harmless provisions (B. & D.)	169,645,000	90,212,000	79,433,000
F. Net change to present financial grants program:			
1. E. 1—A	+8,148,000	−2,290,000	+10,438,000
2. E. 2—A	+8,148,000	−10,208,000	+18,356,000
G. Other H.R. 1 cost implications:			
1. Changes to the medical assistance program			+3,098,000
2. Income maintenance administration (county and State)			−4,605,000

TABLE.—CONSTRUCTION OF WISCONSIN 1972-73 FINANCIAL GRANTS TO INDIVIDUALS UNDER PRESENT PROGRAM

	Total	Federal	State and county
1. Cost of financial grants at 1971 level of benefits	$124,181,000	$70,162,000	$54,019,000
2. Cost of increased standards	12,468,000	7,044,000	5,424,000
3. Cost of AFDC-U	3,756,000	2,122,000	1,634,000
Subtotal	140,405,000	79,328,000	61,077,000
Value of food stamps	21,092,000	21,092,000	0
Total	161,497,000	100,420,000	61,077,000

COMMONWEALTH OF PENNSYLVANIA,
OFFICE OF THE GOVERNOR,
Harrisburg, Pa., January 20, 1972.

Hon. RUSSELL B. LONG,
U.S. Senate, Washington, D.C.

DEAR SENATOR: I am writing to express my views on H.R. 1 which is before your committee.

I continue to support the basic principles in H.R. 1 of a federal floor under income as I did when the bill was in the House Ways and Means Committee. However, the bill in its present form is faulty in a number of respects.

As you know, I have joined with more than 20 governors to support Senator Ribicoff's proposed Amendments to H.R. 1 in which he is joined by a number of Senators.

These amendments go part of the way to meet the objectives I have in mind. I consider that the Ribicoff package is an irreducible minimum. I hope they will be improved in your Committee.

More specifically I urge that your Committee amend H.R. 1 so that it conforms fully with the following principles:

(1) A comprehensive Federal income maintenance program with adequate national minimum standards.

(2) Assistance given on the basis of need to all individuals and families, including the working poor. There should be a Federally established, regionally adjusted, poverty level. Work by the able bodied should be encouraged by a work incentive. An adequately financed public employment program for those unable to secure a job in the private sector is vital to this objective.

Those able to work should work. Training for work is needed by many and should be provided. Women with school age children should be allowed to volunteer for work. Many AFDC recipients are working, many more go in and out of the job market constantly. The American work force contains a substantial percentage of all women of childbearing age. Adequate day care should be afforded to all women who work.

State supplements to a Federal base should require that states maintain benefit levels.

(3) State financial participation should be phased out gradually. The Federal tax system is capable of dealing soundly and equitably with the problem of poverty; State tax systems are not. Income maintenance is a national, not a local problem.

(4) H.R. 1 should include immediate fiscal relief for States. Pressures are difficult now and states should not have to wait until fiscal 1973 for relief.

(5) As State governments are phased out of income maintenance programs, their role in social services should be strengthened. Each state should be required to have a comprehensive social services program dedicated to promoting opportunities for self-support, to improve individual functioning, facilitate independent living, and strengthen family lives. Making family planning information and

service available to all women should be a major part of this program as should protection of children and adults who need protection. The State should have a major role in day care planning and funding.

Public Law 92-223 (H.R. 10604) establishes a more clear social service role for states than does H.R. 1. Its provisions, plus others which my staff will submit to your staff, can serve to establish a sound service program.

All social services, including day care and child development services, should be available to all citizens. The non-poor should be able to purchase these services with participation in costs through use of a fee schedule. The law should provide a limitation on the amount of Federal funding available for those above the poverty line, as well as priorities for use of services funds.

In addition, H.R. 1 proposes a method of eligibility accounting which will deny benefits to many now eligible, including migrant and seasonal workers. This should be amended so that eligibility is based on need.

H.R. 1 calls for Federal administration but does not make provision for ensuring the rights of State employees who may be Federalized. Such provisions are essential.

H.R. 1 contains a number of Medicaid (Title XIX) provisions which disadvantage some states financially. I recognize that the entire range of medical assistance, health insurance, and health care programs are under review; also that the health delivery system is, at best, a collection of uncoordinated, efforts. Nevertheless, I urge that in the course of seeking solutions your Committee take cognizance of the fiscal plight of the states. One approach, until sounder solutions are forth coming, is for the Federal government to assist the states by freezing their expenditures at 1971 levels.

I hope that these suggestions may be useful to you and to your Committee. Please call on me or on members of my staff if we can be of further service in your most important efforts.

Sincerely,

MILTON J. SHAPP, *Governor.*

STATEMENT OF THE NATIONAL LEAGUE OF CITIES AND THE UNITED STATES CONFERENCE OF MAYORS

(Submitted by Patrick Healy, Executive Vice President, National League of Cities and John Gunther, Executive Director, U.S. Conference of Mayors)

Both the National League of Cities and the United States Conference of Mayors support welfare reform.

As the Kerner Commission pointed out almost four years ago, "The failures of the (welfare) system alienate the taxpayers who support it, the social workers who administer it, and the poor who depend on it." To this list of the disenchanted, our organizations would add the cities that have to pick up the pieces dropped by other levels of government that have failed to deal adequately with the problems of dependency.

So much has been written and said about the need for welfare reform and the possible solutions that we do not need here to repeat information that we are sure is thoroughly familiar to the members of the Senate Finance Committee. We are, however, appending for the record the positions the National League of Cities and the United States Conference of Mayors on welfare reform adopted by delegates representing 15,000 local governments at their last annual national meetings.

To get to the heart of the matters under current active consideration, both organizations support:

Federal take-over of the welfare system, with due regard for the status of employees of local governments, who should be absorbed by the federal system if they wish.

Mandated state supplements.

Eventual assumption of all welfare costs by the federal government.

Meanwhile, federal matching funds above the $1,600 floor in the first year.

An initial minimum payment level of $3.000 to a family of four.

Coverage of the working poor, single individuals, and childless couples.

A sufficient number of public service jobs to cover those willing and able to work but unable to find employment in the private sector.

Expansion of child care facilities to provide for the needs of mothers covered

by the program who are working or would be able to work if such facilities were provided.

The National League of Cities and United States Conference of Mayors wishes to thank the Senate Finance Committee for this opportunity to express their views.

FEBRUARY 18, 1972.

NATIONAL MUNICIPAL POLICY ADOPTED DECEMBER 1, 1971, BY NATIONAL LEAGUE OF CITIES 48TH ANNUAL CONGRESS OF CITIES

PUBLIC ASSISTANCE

2.400 Public Asistance and Welfare Goals

Welfare in the United States has become a national problem requiring solutions. Our present system of public assistance has been found to contribute materially to the tensions and social disorganization which permeate many areas of our cities. As one critic has stated, "The welfare system is designed to save money instead of people and tragically ends up doing neither."

The welfare program should be altered, expanded *and coordinated with the medicare and social security programs* to encompass *all of* those in genuine need, *to remove from the walfare rolls all of those able to work by providing adequate employment opportunities and day care facilities, to* provide a national minimum standard of assistance and eliminate demeaning restrictions, and thus help recapture the rich human resources presently wasted by a system that creates and perpetuates dependency.

2.401 Funding

A. Require assumption by the federal government of full responsibility for the administration and financing of the income maintenance program; the social service aspects should be *federally-mandated and federally-financed with open-ended appropriations*, but administered locally with cities having the option of prime sponsorship of such programs.

B. Establish open-ended appropriations for the day care of children, including capital funds for the construction and/or renovation of facilities.

C. Provide for federal matching of supplementary state benefits to assist states currently maintaining higher levels, *and prevent states from curtailing such supplementary benefits.*

2.402 Coverage

A. Transfer all aged, blind and disabled persons—the latter two categories at any age—to the Social Security System to be financed by general appropriations at benefit levels sufficient to maintain a minimally decent standard of living.

B. Eliminate the categorical assistance system by including individuals, couples and families whose resources fall below the established benefit levels.

C. Include individuals, couples and families who are employed but whose incomes fall below established benefit levels.

D. Provide for retention of a significant share of earnings.

2.403 Operation

A. Require the use of a declaration form of application for assistance by all types of cases, including families and the working poor.

B. Expand opportunities for job training and day care to enable women in female-headed families to work if they wish to, being careful to avoid any elements of coercion.

Resolution adopted June 16, 1971 at annual meeting of the United States Conference of Mayors:

46. WELFARE REFORM

Whereas, public assistance rolls have increased dramatically over the last decade: and

Whereas, the poverty population for the first time in ten years increased in 1970 by 1.2 million American people over 1969; and

Whereas, the present tax burden for financing welfare is now inequitably distributed throughout the nation and is in part financed by regressive taxes, such as sales and real property, which unfairly burden low and middle income families; and

Whereas, the U.S. Conference of Mayors has repeatedly called for a total reform of the welfare system and the establishment of basic income supplement payments for all people unable to work and whose income falls below the officially recognized level of poverty; and

Whereas, the House Ways and Means Committee has reported out a welfare reform bill with an income maintenance payment of $2400 a year for a family of four; and

Whereas, the underlying principle of eligibility for public assistance should be the need of the recipient rather than his category of disability, employment status, age, sex, or place of residence; and

Whereas, mayors and local governments have demonstrated a commitment to assume greater leadership and responsibmility for manpower and social services at the local level but cannot raise the funds needed to meet long-delayed health, welfare, education and social services and to train and employ participants in the Opportunities for Families Program; and

Whereas, Title XX of last year's welfare reform proposal provided the large cities the opportunity to be the prime sponsor of the delivery of social services; and

Whereas, the city itself is in the best position to determine the needs of its citizens, evaluate its economic and social resources, organize and operate manpower programs, and deliver social services effectively; and

Whereas, state and local governments need immediate relief from spiraling welfare costs this year; and

Whereas, the proposed funding formula would provide inadequate, uneven, and disproportionate relief for state and local governments that provide welfare costs this year; Now, therefore, be it

Resolved, That the United States Conference of Mayors again affirm its support for welfare reform with these features, among others:

1. An adequate basic supplement for the working poor and payments to other American citizens who are unable to work and whose income falls below the officially recognized poverty level;

2. Eligibility based on need, rather than category;

3. A federally funded, comprehensive social services delivery system that governments of lacalities—regardless of their population—may have an opportunity to coordinate and administer, if they choose to do so;

4. Immediate federalization of the funding of public assistance programs this year;

5. Federal matching of supplementary state benefits to assist jurisdictions that provide benefits at a higher level than will be supported by full federal funding;

6. One hundred percent funding of the public service jobs to be created under the Opportunities for Families Program and provision for integrating activities into planning, coordinating, and operating of ongoing manpower programs at the city level,

7. Provision of vendor payments on recurring items, as well as nonrecurring items, at the option of the recipient, and exploration of this concept through demonstration projects and studies.

ANTHONY C. BEILENSON,
CALIFORNIA STATE SENATE,
February 17, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee, Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: As Chairman of the California Senate Health and Welfare Committee, and as author of our state's Welfare Reform Act of 1971, I have closely followed news accounts of your Committee's recent hearings on federal welfare reform legislation, H.R. 1.

I am prompted to write you and your fellow Committee members at this time because of my concern that misleading testimony given on February 1 by Governor Reagan not go unchallenged. At the time, the Governor recommended numerous amendments to H.R. 1 based on what he termed "the product of our experience with an actual reform program that is succeeding in California."

Unfortunately, the Governor's description of our experience with reform bears little resemblance to what has actually transpired. Accordingly, I find it necessary to set the record straight.

As you will recall, the Governor presented 25 specific reforms for the consideration of your Committee contending that the California reform experience constituted proof of the efficacy of his proposals.

Upon close examination, however, only 10 of the 25 recommendations resemble measures adopted by the California Legislature in 1971. Further, of these 10 items only three had been implemented by December 31,[1] 1971 and two of the three had been stayed by the courts.[2]

In other words, only one of the Governor's total 25 proposals can accurately be said to have been an unimpeded part of applied reform in our state.

The single operative item is a fiscal incentive to county government to work harder at securing support contributions from absent fathers of AFDC children. However, county welfare officials inform me that support contributions are presently being collected from fewer absent fathers than before the Welfare Reform Act of 1971 became operative on October 1, 1971.

These same county sources advise me that the California State Department of Social Welfare has completed a survey of welfare reform implementation which bears out this statement.

Governor Reagan emphasized before this Committee that California welfare rolls dropped significantly during 1971. Yet the Governor did not tell this Committee that he has requested a welfare budget increase of $118 million for the fiscal year commencing July 1, 1972. Moreover, this $118 million increase was made assuming 100 percent implementation of our 1971 reforms, and it fails to take into account a major court decision that will mean an estimated added cost of $70 million for AFDC grants.

In short, welfare costs in California are rising at a yearly rate of approximately $190 million.

That fact alone makes it clear that caseload reduction figures merit close analysis.

Of the 176,000 net reduction cited by the Governor, 108,000 were in the AFDC–U (Aid to Families with Dependent Children—Unemployed Parent) category. This reduction occurred over a period of a time during which the unemployment rate dropped in California from a peak of 8.1 percent to slightly over 6 percent.

The fact that nearly two percent of California's labor force left the ranks of the unemployed obviously had a great impact on a welfare program for which eligibility is based on unemployment as AFDC–U is.

Thus, the improved job situation would seem a much more likely explanation for the reduction in numbers of persons receiving AFDC–U benefits than any welfare reform efforts.

Second, of the remaining 68,000 decrease, 47,548 were recipients of County General Relief—a program totally unaffected by our Reform Act. Hence, 88% of the 176,000 decline was directly attributable to improved employment conditions and a decrease in County Relief cases, neither of which can be properly ascribed to the reforms.

Third, the Governor did not tell this Committee that more than 20,000 of the caseload drop was accomplished by a change in accounting procedures by Los Angeles County. Previously, many persons on County General Relief were counted twice because they also received AFDC benefits during the same month.

Fourth, a significant portion of the overall caseload decrease stems from a major decrease in average size of welfare families. In the AFDC-FG (Family Group) program, for example, cases *increased* by more than 3,000 during the March-December 1971 period cited by the Governor although the total number of persons on the program declined by more than 12,000.

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[1] Welfare reforms relating to the list presented to the Committee which were actually implemented in 1971 in California were:

5. *Work-related expenses.*
10. *Increased federal reimbursement for child support activities.*
22. *Marital and community property resources.*

[2] Reforms which were implemented and then stayed by court order before the end of 1971 were:

5. *Work-related expenses.*
22. *Marital and community property resources.*—A Superior Court ruling ordered the State Department of Social Welfare to cease and desist from presuming the availability of income from a stepfather, basing the decision on 45 CFR 233.90, and HEW regulation specifically prohibiting such a presumption where there is no legal support liability under a law of general applicability. (Stepfathers are not generally liable for the support of non-adoptive stepchildren under California law.)

Finally, it should be noted that the California welfare system is presently under court order to reinstate 7,000 families whose aid was terminated last June under regulations subsequently found invalid by the State Supreme Court.

So while there was a decline in the total number of Californians receiving welfare, the causal effect of welfare reform in that decline seems minimal. In the least, it certainly is not the kind of hard evidence on which to base long-term legislation.

Nonetheless, any decrease in welfare caseloads is a good sign. My relief at the downturn is considerable. Were I self-seeking, I should be capitalizing on such good news, since the Welfare Reform Act of 1971 bears my name as lead author.

My concern here, however, is not with credit but with *credibility*. I share your devotion to making public policy strictly on the basis of the *facts*. The Congress is now in its third year of debate on welfare reform. That is evidence that Congress has a deep concern for the possible effects of proposed welfare reforms on the poor people who are so vulnerable to public policy decisions in these matters. For that reason, I see it as my duty to warn you against drawing prematurely any general conclusions on the relationship between California "welfare reform" and California caseload declines.

In this connection, the State Department of Social Welfare late last year sent auditors into every California county to examine case records in an effort to determine how welfare reform is working.

This information has not been provided to the Legislature nor to the public. However, in view of the Governor's claims before your Committee, this factual report would seem most appropriate for your consideration. If the facts bear out the Govenor's claim, there should be no hesitancy in making this report available to you.

Permit me at this point to offer a few comments on H.R. 1 from my viewpoint as a state legislator who has been actively involved in the complexities and intricacies of welfare reform.

The overriding objective in welfare reform, in my view, should be to reduce poverty. Welfare costs have risen dramatically over the past decade largely because we have failed to defeat poverty by reforming some of our more basic social institutions.

Ironically, there are fewer poor people in the United States than ever before, just as there are more poor Americans on welfare than at any time since the Great Depression. The explanation for this is simple. As affluent America rediscovered poverty, poor Americans rediscovered welfare.

In 1960, no more than one in seven or eight poor people received welfare benefits. The vast majority of the poor simply suffered on tragically substandard incomes. Today, about half the poor people in America receive welfare benefits. Although those who subsist on welfare still do so for the most part at substandard income levels, they are relatively less destitute than they were a decade ago.

I submit that in a limited sense we should take pride in our ability to assist the less fortunate to the degree we do. If we have something to worry about, it is that the size of our welfare population represents our failure to provide better alternatives to the disadvantaged.

The adoption of a program of assistance to working poor families, regardless of the sex of the head of household or the parental deprivation status of the children will be a major step forward toward equitable treatment of the poor. It will only haunt us if we do not follow up with what is *true* welfare reform—namely the elimination of economic dependency for employable people by pursuing every means at our command to insure a decent job at a living wage to every American who can work. It was done during World War II—it can be done *without* war.

Likewise the adoption of a federal floor on income is commendable. Unfortunately, the level of the income floor being considered is totally inadequate to meet the minimum needs of families without other resources. I will not belabor this point in view of the massive testimony you have already received on it. I do, however, urge that in the event Congress chooses to establish a floor without regard to adequacy, it does so in conjunction with absolute guarantees that existing benefit levels in states with higher minimums be maintained.

Finally on the matter of substantive programs, I urge the Committee to eliminate the forced labor provisions of HR 1, especially those which require acceptance of a job paying substandard wages. There is absolutely no justification

for such a corruption of our work ethic. The vast majority of welfare recipients who can be defined as "employable" have not been able to support themselves in the labor market for reasons other than those implied by the forced labor rule. Many are victims of systematic exclusion from opportunities to be self-supporting as members of racial minorities, but even more to the point vis-a-vis welfare, because they are women.

Even with the inclusion of the working poor, the large majority of heads of poor families will continue to be women. They are victims of restricted educational opportunities and generally can find employment, when it is available, only in a very narrow range of jobs. Despite the increasing participation of women in the labor force, the average woman earns only slightly more than half what men earn. In addition, AFDC mothers generally have young children who need care, and until the expansion of child care programs proposed by HR 1 becomes a reality and those programs have been able to demonstrate their quality and effectiveness, it will be improper to force such services on a woman simply to push her into a dubious work situation.

Associated with this problem is HR 1's prohibition on aid to families headed by a full-time student. If we are truly concerned with promoting economic independence of families who now need public help, it seems to me that we would encourage in every way possible an expansion of educational opportunities.

Generally I support the approach of HR 1 to aid programs for the aged, blind and disabled. A uniform federal floor on such aid would be a giant step toward eventual integration of welfare with Social Security. The establishment of a livable minimum income for all persons covered is long overdue.

Although the minimum standards for aid to adults is a great improvement over what is being proposed for families with children, the federal minimum is still below existing benefit levels in many states, including my own. I therefore urge Congress to require the states to guarantee maintenance of current benefit levels to the aged, blind and disabled where they are above the proposed federal floor.

Further, as to aid to the aged, I strongly recommend that the Congress allow the states to give our senior citizens rebates on their property taxes without having such rebates considered as income for welfare purposes.

In California, we have a Senior Citizens Property Tax Assistance law that provides for refunds to aged homeowners based on their income and the assessed valuation of their home. Yet aged welfare recipients are not eligible because such refunds would, under federal law, be considered as "income" and hence deducted from their subsequent Old Age Security grants.

As a result of this present federal requirement, the elderly homeowners who most need this help are ineligible for it. I urge that this inequity be corrected.

Any comprehensive discussion of welfare reform must deal with suggestions as to the federal administration of welfare programs.

Experience has shown that poverty is a national problem that has not proved amenable to elimination or substantial reduction by state and local efforts.

Further, the degree of federal participation has continually increased over the years due to the growing inability of state and local governments to raise the necessary revenues. The problem largely relates to the ability to finance such programs on a deficit basis.

Welfare dollar needs are most pressing when there is an economic slump. This is the time when state and local governments suffer from reduced general revenues, which they cannot deal with through accumulation of debt to be reduced when the economy improves. The federal government, on the other hand, is able to adjust its finances on a countercyclical basis. For this reason, it makes sense for the federal government to assume the major share of expense, and, as HR 1 proposes, to hold the states harmless against unanticipated cost increases.

I firmly believe that the federal government is entirely capable of operating a national welfare system efficiently and humanely, if the genuine commitment to do so is made by the Executive branch and if Congress maintains a careful watch over implementation.

The experience of the last several years in California has clearly shown that a State Government which sets out to defy the Federal Government on a program for which it accepts Federal funds can do a great amount of mischief before Washington clamps down. The politics of such a situation is understandable, but no less deplorable for its understandability. The courts have had to bear a great burden in forcing States like California to obey Federal law. I believe it is time that Congress relieve that burden on the courts, and to a

great extent relieve the same kind of pressure that surely must be felt here by assuming the responsibility for welfare under a program of fair, uniform, and lawful Federal administration.

From my own involvement in welfare legislation, I have come to the conclusion that the most useful efforts to improve the overall welfare situation are focused in three areas—job training and career development, easily available voluntary family planning services, and widespread and effective child care facilities. These three factors, I submit, offer the best hope for enabling people to become self sufficient and to end their welfare dependency.

A number of attachments are included for the purpose of providing the factual basis for the statements I have made in the foregoing.

Your inclusion of this statement in your Committee's hearing record with respect to HR 1 would be genuinely appreciated.

Sincerely,

ANTHONY C. BEILENSON.

Attachments.

SUMMARY OF SB 796 (BEILENSON)
THE WELFARE REFORM ACT OF 1971

I. GRANT PAYMENTS AND TREATMENT OF INCOME

a. Section 17.5.—Amount of aid

Existing law directs those administering aid to secure the "maximum amount of aid" for the recipient. This amendment deletes "maximum" so that the direction would be to secure the amount of aid to which the recipient is entitled.

b. Section 20.5.—Earned income exemptions

Modifies the requirement that a recipient's earned income shall be disregarded to the maximum extent *permitted* by Federal law, and instead provides that earned income shall be disregarded to the extent *required* by Federal law: provided that any exemption permitted by Federal law on August 1, 1971 and applied in California shall continue until Federal law is changed ("grandfather" clause for existing exemptions).

c. Section 21.—Scholarship exemption

Provides that certain loans or grants to undergraduates from the State Scholarship and Loan Commission or accredited colleges shall no longer be considered in determining eligibility or the amount of the grant.

d. Section 21.5.—Interest on savings accounts

Repeals the provision excluding interest on savings accounts from income in determining eligibility.

e. Section 22.—Treatment of casual income

Provides that casual income to the extent of $60 per quarter shall be excluded in determining aid.

f. Sections 24.3, 24.4, 24.14, 32.9, 34.2.—Treatment of lump sum income

Provides that all non-recurring lump sum income received by applicants and recipients shall be regarded as income in the month received except for certain social insurance such as social security income and workmen's compensation benefits.

g. Section 25.1.—Immediate need

Requires the counties to pay an applicant up to $100 for immediate assistance, and requires that verification of the applicant's eligibility within five days must be made, or the county bears the cost of such payment.

h. Sections 28, 28.5, 29, 29.1.—Revised AFDC grant system—flat grants, cost-of-living adjustment, increased aid to truly needy

A standard AFDC payment level is provided which will allow maximum administrative efficiency. All recipients with no other income (50% of cases) will receive increases ranging from 8% to 20%. About 1 out of 5 cases, those with highest outside income and highest aggregate needs, will receive great decreases.

AFDC recipients will receive an automatic annual cost-of-living increase in grants, based on federal indices, beginning in July 1973.

In addition to the basic grant, all recipients will be entitled to a special needs allowance when genuine need exists.

i. Section 28.1.—Work-related expenses

Restricts work-related expenses to $50 per month, plus reasonable and necessary costs of child care. Currently state law places no dollar limitation on work-related expenses.

j. Section 28, 29.2.—Food stamp cash-out

Anticipates federal welfare reform proposals by converting food stamp bonuses to cash benefits for AFDC recipients. This will protect recipient food purchasing power at no additional cost to state.

k. Section 29.5.—AFDC grant mismanagement

Requires, rather than permits, counties to pay aid in the form of goods or services (in kind) to recipients where there is mismanagement of aid payments by recipients themselves.

II. ELIGIBILITY CONTROL

a. Sections 115, 12, 13, 14 and 19.—Confidentiality

Permits inspection of state income tax records, unemployment insurance records, and county records by the SDSW for purposes directly related to the administration of welfare.

b. Section 23.2.—Verification of eligibility

Provides that eligibility must be verified by the County Welfare Department before an applicant receives assistance. Currently, aid is granted on the basis of an applicant's simple declaration or affirmation of need. (See section 23.1, Immediate Need, for exception)

c. Sections 24.1, 24.2, 24.12, 24.13.—Exempt personal property

Permits an applicant or recipient to retain items of nonliquid personal property up to a market value of $1,000 plus the entire value of wedding and engagement rings, heirlooms, and clothing, the reasonable value of household furnishings, other household equipment up to a market value of $300 for each item, reasonable value of equipment and material needed for employment, and certain other property rights. Liquid asset exemptions remain.

d. Section 24.5.—Annual income averaging

Provides that the income of any person who has a contract of employment on an annual basis, but who works and receives income in fewer than 12 but more than 8 months shall be averaged over a 12-month basis for the purpose of determining eligibility.

e. Section 24.7.—Eligibility of college students

Limits AFDC eligibility of college students up to age 21 to those achieving passing grades.

f. Section 25.—Redetermination of eligibility to be under penalty of perjury

Requires that the certificate of eligibility in connection with an annual redetermination of eligibility shall contain a written declaration by the recipient that it is executed under penalty of perjury.

g. Section 25.2—156% of need limit

To extent permitted by federal law, limits AFDC eligibility to families with gross incomes of or less than 150% of the applicable standard of need.

III. EMPLOYMENT AND TRAINING

a. Section 15.—Job development program

Provides that the State Personnel Board shall develop jobs leading to permanent employment for welfare recipients, to be contracted for by the State Department of Human Resources Development under WIN (Work Incentive Program). All jobs developed shall pay the prevailing wage.

b. Section 15.1.—Career opportunities development program

Provides that State Personnel Board shall carry a career opportunities development program in state employment and provide technical assistance and direct

grants to cities and counties and other units of state and local government. Appropriation: $5 million

c. Section 25.3.—Public assistance work force

Establishes demonstration program, when federal law permits, to develop and implement a plan for community work experience programs so that welfare applicants and recipients may receive work experience that will assist them to move into regular employment. If the adult recipient refuses to accept work, training or participate in a public assistance work force, his portion of the family's welfare grant will be terminated. Administered by HRD.

IV. ABSENT FATHERS

a. Section 3.3.—Award of attorney fees to county

Provides that attorney fees may be awarded by the court to a county in actions to enforce a support obligation.

b. Sections 8.8 and 31.5.—Attachment of earnings

Provides for the enforcement of the support obligation of the absent parent of an AFDC child by attachment of earnings after judgment.

Allows attachment of absent parent earnings in court actions to enforce support obligations to children receiving welfare aid.

c. Sections 10, 25, and 27.—Social security numbers

Requires the social security numbers of the parents on birth certificates, on the redetermination of eligibility and absent parent statements, as well as certain other information—all designed to assist in locating absent parents.

d. Section 18.—Grand jury review of support activities

Revises the provision requiring review of county child support activities and would require annual review by an auditor appointed by the county grand jury. A report would be made to the County Board of Supervisors and to the State Department of Social Welfare annually.

e. Sections 25.4 and 25.5.—Absent parent obligation

A parent whose absence from the family results in the family's eligibility for aid shall be obligated to repay the amount of aid so paid. The District Attorney of the county administering such aid is required to enforce this obligation.

f. Section 30.—Enforcement of support

Shortens the time for referral to the District Attorney of absent parent cases; provides for use of liens where appropriate, and would give the District Attorney the authority to request immediate referral to his office of any absent parent case for prosecution.

g. Section 31.—Support recoveries

Provides counties with a greater share of repaid or recovered monies as an inducement for county recovery efforts in the area of parental support liability.

h. Section 3302.—Support enforcement incentive fund

Appropriates state funds to the counties to offset county welfare costs to the extent of 75 percent of the amounts received or collected from absent parents. This is an incentive to the counties to retrieve absent parent payments. (The 75 percent applies to non-federal share).

i. Sections 8.6 and 26.1.—Support by remarried mothers

Provides that the wife's interest in the community property, including earnings of her husband, is liable for support of her children with certain deductions. This would allow a remarried woman to use her community property interest in her husband's earnings, as well as her own, to support her children to the extent the natural father was not meeting his support obligation. However, all direct obligations of stepfathers are eliminated.

V. OAS RELATIVE'S RESPONSIBILITY

a. Section 3.—Duty to support aged parents

Requires the children of a person receiving aid to the aged (OAS) to support such person to the extent of their ability.

b. Section 33.—OAS relatives' responsibility

Permits SDSW Director to increase the amount of support an adult child must contribute toward the support of a parent receiving OAS, depending on the adult child's ability to pay.

c. Section 34.—Contributions paid to county

Requires adult children's contribution toward the support of parents receiving OAS to be paid directly to the county.

d. Section 34.1.—Discretion of SDSW director

States that OAS Relatives' Responsibility Program is operative at discretion of Director of State Department of Social Welfare.

VI. RESIDENCE

a. Section 23.5.—Out-of-state recipients

Provides that the continued absence from the state of a recipient of public assistance will constitute prima facie evidence of his intent to establish residence elsewhere after a period of 60 days as opposed to the present period of one year. *Requires* the counties to make the necessary inquiries of such recipients.

b. Section 24.65.—Emergency residence requirement

Establishes a one-year residence requirement for needy relatives under the AFDC program when the unemployment rate in the county of residence exceeds 6 percent.

c. Sections 23.6, 24.01, 24.6, 32.5, 38 and 39.5.—Durational residence requirements

Eliminates all existing (durational) residence requirements, but makes clear that aid may be granted only to state residents.

d. Section 24.—Illegal aliens

Permits an alien to receive welfare if he certifies under penalty of perjury that he is in the country legally and entitled to remain indefinitely, or that he is not under order for deportation, or that his spouse is not under order for deportation. Upon such certification aid shall be paid pending verification by the U.S. Immigration Service.

If alien can prove he has been in U.S. continuously for past 5 years, further verification of legal residence is not mandatory on county.

VII. OVERPAYMENTS

a. Section 9.5.—Duplicate warrant

Provides that where a welfare check is lost or destroyed, and only a portion of the original amount is still due, the county auditor shall, upon the filing of an affidavit, issue and deliver to the legal owner or custodian a duplicate welfare check for the amount still due.

b. Section 20.3.—Restitution for underpayments, overpayments, fraud

This amendment would reduce the period for a recipient to claim underpayment from 4 years to one year; would extend from two to six months the period of time a county has to seek an adjustment for an overpayment; and would allow a county one year following discovery of fraud to adjust grants, instead of the present two months.

c. Section 22.5.—Repayment of aid by ineligible recipient

Requires the repayment of aid received by a recipient in good faith but when he was in fact ineligible because he owned excess property.

VIII. SOCIAL SERVICES

a. Sections 61 and 17.—Family planning

Requires counties to contract with the State Department of Public Health to provide family planning services for recipients of childbearing age desiring such services.

Appropriation: $1 million

b. Sections 18.3 and 18.4.--Child care

Requires counties to provide child care services for former, current, and potential recipients of public assistants who certify that they would otherwise be unable to accept or maintain employment or training and that they would, therefore, remain eligible for aid. The counties would be authorized to charge a fee for these services based on the ability of a person to pay.

A child care training program would be initiated giving priority to the training and employment of public assistance recipients.

Appropriation: $2 million.

c. Section 18.5.—Social services

Enables counties, if they wish, to provide any public social services permitted by federal law and for which federal participation is available.

d. Section 39.01.—Health care for minors

Parents of emancipated minors cannot be held financially responsible for health care services.

IX. STATE/COUNTY RESPONSIBILITIES

a. Sections 18.1, 18.2 and 23.—Simplified administration

Provides for contracts between the State Department of Social Welfare and the counties to enable the Department to simplify and tighten eligibility and grant determinations.

Also authorizes SDSW to enter into agreements with the federal government for purposes of meeting possible requirements of federal welfare reform, with view to saving state and county funds.

b. Sections 42.5 and 43.—State share in administrative costs

The state will assume 50 percent of the non-federal share of county administrative costs, beginning in 1972, in eligibity and grant determination, unless federal government assumes administrative costs (see c. below).

c. Sections 39.1, 39.2, 39.3, 39.4 and 43.--State funding of the aged, blind and disabled programs

Provides for the stae to pay 100 percent of non-federal grant payments in the aged and blind programs and 50 percent in the disabled program, beginning in 1972, unless the federal government assumes administrative costs (see b. above).

X. APPROPRIATIONS—SECTION 39.7

a. Family planning (see social services)	$1,000,000
b. Child care (see social services)	2,000,000
c. Job development (see employment and training)	5,000,000
d. Career opportunities development (see employment and training)	5,000,000
e. Hearing officers—Office of Administrative Procedure (to cancel welfare fair hearing backlog)	600,000
Total	13,000,000

f. Open-end apropriation—Restores county property taxpayer protection language vetoed out of budget.

XI. EFFECTIVE DATE.—URGENCY

October 1, 1971 or sooner at discretion of SDSW, except state/county sharing shifts begin June 1, 1972.

COPY OF THE REPORT OF THE LEGISLATIVE ANALYST, THE CALIFORNIA LEGISLATURE'S NON-PARTISAN ECONOMIC AND FISCAL EXPERT, WHOSE OFFICE STUDIED WELFARE REFORM IMPLEMENTATION IN NOVEMBER, 1971

MAJOR LEGISLATION

Major legislation affecting the administration of welfare in California was enacted during the 1971–72 fiscal year. Chapter 578, Statutes of 1971 (Senate Bill 796), requires the implementation of very significant program modifications relating to eligibility and grant determinations, the administrative and funding relationship between the counties and the state, OAS responsible relative liability,

confidentiality, family planning services, day care services, and employability programs. Among the more significant changes required to be effected by the statute are the following:

(1) 150 percent of gross income limitation—Section 25.2 of the chaptered bill renders ineligible for aid, to the extent permitted by federal law, and AFDC recipient whose total gross income, exclusive of grant payment and prior to any deductions, exceeds 150 percent of the need standards for such recipient. (Section 11267 of the Welfare and Institutions [W. and I.] Code.)

(2) Work Related Expenses—Section 28.1 provides that exemptions related to expenses incurred by employed AFDC recipients shall be limited to $50 plus reasonable and necessary costs associated with child care. (Section 11451.6 of the W. and I. Code.)

(3) AFDC Flat Grant Schedule—Sections 28, 28.5, and 29.1 (a) eliminate the maximum participating base (MPB) and (b) provide for the establishment of a flat grant schedule adjusted to reflect only the differing dollar requirements related to various family sizes. Grants paid to AFDC recipients are required to equal the amount specified by the schedule when added to all other income available to the family after deduction from the gross income of the family of the exemptions required by federal and state law. The schedule is required to be adjusted annually, commencing during the 1973–74 fiscal year, to reflect changes in the cost of living. (Sections 11450, 11452, and 11453 of the W. and I. Code.)

(4) Special Needs—Section 28 eliminates state participation in the funding of allowances in the AFDC program for special needs which are not common to the majority of needy persons. Recurring special needs not common to the majority of needy persons and nonrecurring special needs caused by sudden and unusual circumstancee beyond the control of the needy family are to be funded by the counties. The state continues to participate in the funding of recurring special needs which are common to the majority of recipients. (Section 11450 of the W. and I. Code.)

(5) Verification of Eligibility—Sections 23.2 and 25.1 provide that verification of applications of recipients requiring immediate assistance must occur within five working days. If eligibility is not verified within five working days, the county must bear the entire cost of the cash payment made to the applicant. (Sections 11056 and 11266 of the W. and I. Code.)

(6) Exempt Property—Sections 24.1, 24.2, 24.12 and 24.13 repeal those sections of the Welfare and Institutions Code which provide for the exemption of certain personal property in determining eligibility for assistance under the provisions of the various aid programs. These sections establish maximum value limits relating to such personal property. (Sections 11155, 11258, and 11261 of the W. and I. Code.)

(7) Changed Sharing Ratios: Administrative Costs—Section 23 requires that the State Department of Social Welfare, rather than the counties, assume all responsibility relating to the control of the eligibility and grant level determinations which underlie the various aid programs. It further requires that the state fund 50 percent of the administrative costs related thereto. The State Department of Social Welfare is permitted, however, to contract with the counties for the discharge of its responsibilities relating to the determination of eligibility and grant amounts. This section of the chaptered bill is not to be implemented until July 1, 1972. (Section 11050 of the W. and I. Code.)

(8) Changed Sharing Ratios: Grant Costs—Sections 39.1 through 39.4 provide (a) that the state and the counties shall share equally the nonfederal costs for support of ATD cash grant payments and (b) that the state shall assume the full funding of the nonfederal costs for support of cash grant payments made to recipients of the three other adult aid programs, AB, APSB and OAS. This section of the chaptered bill is not to be implemented until July 1, 1972. (Sections 15201, 15202, 15203, and 15204 of the W. and I. Code.)

(9) Lump Sum Income and Casual and Inconsequential Income—Sections 22, 24.3, 24.4, 24.14 and 32.9 of the bill very significantly reduce the exemptions which can be claimed on the basis of the lump-sum income and casual and inconsequential income provisions of the Welfare and Institutions Code. (Sections 11018, 11157, 11262, and 12052 of the W. and I. Code.)

(10) Absent Parents and Stepfather Restrictions—Various sections provide for the implementation of administrative machinery needed to facilitate the collection of absent parent payments. In addition, Section 8.6 requires that a wife's community property interest in a stepfather's income be used for support of her chil-

dren by a previous marriage. The section further provides, however, that in determining the wife's interest in her husband's community property, all prior support liability of her husband as well as $300 of his gross monthly income shall first be excluded. (Section 512.75 of the Civil Code.)

(11) OAS Responsible Relative Liability—Section 33 authorizes a very significant increase in the relatives' contribution scale. In addition, the bill requires that relatives' contributions be paid directly to county welfare departments rather than the recipient. (Section 12101 of the W. and I. Code.)

(12) Confidentiality—Sections 11.5, 12, 13 and 14 permit the release of information by the State Franchise Tax Board and the Department of Human Resources Development to the Director of the State Department of Social Welfare for the purpose of determining entitlement to public social services. In addition, Section 19 permits county welfare departments to release lists of applicants for, or recipients of, public social services to any other county welfare department, the State Department of Social Welfare, or any other public agency to the extent required to verify eligibility. (Section 19286.5 of the Revenue and Taxation Code, and Sections 1094, 1095 and 2714 of the Unemployment Insurance Code.)

(13) Work Programs—The statute appropriated $7 million to the State Personnel Board for support of special work projects and career opportunities development programs and $2 million to HRD and SDSW for the work incentive program (Sections 11300–11308 of the Welfare and Institutions Code, Sections 5000–5403 and 12000 of the Unemployment Insurance Code.)

(14) Day Care Services—The statute appropriated $3 million for support of an expansion of day care services throughout the state. Specifically, it requires each county to establish a day care program in cooperation with the Departments of Human Resources Development and Education. (Sections 10811 and 10811–5 of the Welfare and Institutions Code.)

(15) Family Planning Services—Sections 16 and 17 provide that family planning services shall be offered to all former, current, or potential recipients of child-bearing age. These services are to be provided on the basis of contracts between county welfare departments and the State Department of Public Health, subject to the approval of the State Department of Social Welfare. Section 39.7 (a) appropriated $1 million to the Department of Public Health, to be used in conjunction with $3 million in federal matching funds, for provision of the family planning services. (Sections 10053.2 and 10053.3 of the W. and I. Code.)

CHAPTER 578: FULL-YEAR SAVINGS ESTIMATE

The Department of Social Welfare estimated that passage of the act would generate, on a full fiscal year basis, a General Fund savings of approximately $59.5 million during 1971–72. Table 2 depicts the estimated full-year savings associated with the various provisions incorporated into Chapter 578.

TABLE 2.—*SDSW estimated savings associated with implementation of chapter 578*

Provision:	*Savings (millions)*
1. 150 percent of gross income limitation	$4.6
2. Work-related expense exemption limitation	12.0
3. AFDC flat grant schedule	.0
4. Stricter eligibility standards including reform of (a) special needs, (b) verification of eligibility, (c) exempt personal property	15.0
5. Standardized eligibility operations including (a) changed sharing ratios relating to grant and administrative costs and (b) contracting with counties to achieve enhanced administrative efficiency (not to be fully implemented until July 1, 1972)	5.0
6. Lump sum income and casual and inconsequential income restrictions	.5
7. Absent parents and stepfather restrictions	6.8
8. OAS responsible relative liability scale	17.6
9. Confidentiality	11.3
10. Work programs including day care services (cost)	12.0
11. Family planning (cost)	1.0
12. Others (cost)	.3
Total savings	59.5

DELAYED IMPLEMENTATION OF CHAPTER 578

With the exception of the provisions relating to (1) state assumption of the responsibilities underlying eligibility and grant determinations and (2) changed administrative and grant cost sharing ratios, which are to become effective July 1, 1972, implementation of Chapter 578 was scheduled for October 1, 1971. Since the implementation date was three months subsequent to the start of the fiscal year, the savings estimates associated with passage of the act had to be adjusted to reflect a maximum potential savings accrual period of only three-quarters of 1971–72 fiscal year. The adjustment reduced the maximum savings estimate for 1971–72 from $59.5 million to $44.6 million.

SURVEY OF IMPLEMENTATION OF CHAPTER 578

In early November, one month after the chaptered bill was scheduled to be implemented, we undertook a county survey in order to determine the extent to which the bill had been implemented and, in addition, the effectiveness of the administrative procedures developed by the department to effectuate the implementation. The survey was signed to serve as a monitoring device which could be used to determine the impact of the act throughout the course of the entire fiscal year. The survey will be updated in February and May of 1972. Sixteen counties, representing approximately 85 percent of the AFDC caseload and approximately 80 percent of the adult caseload, have been selected to participate in the survey.

SURVEY FINDINGS FOR OCTOBER 1971

The November survey indicated that the October implementation of Chapter 578 was undertaken amidst considerable administrative confusion. Of the 13 major provisions of Chapter 578 which we reviewed in our survey, only three—the work-related expense limitation, the casual and inconsequential income restriction, and the stepfather restriction—were fully implemented in all 16 of the survey counties. However, of these three provisions, only two were securing savings of any significance, the work-related expense limitation and the stepfather restriction.

Five of the provisions, the 150 percent of gross income limitation, the AFDC flat grant schedule, the family planning provision, the confidentiality provision, and the employability program including day care services, had not been implemented in any of the 16 survey counties.

The remaining four provisions, the five-day verification of eligibility restriction, the special needs restriction, the lump-sum income restriction, and the OAS responsible relatives' liability scale, had been partially implemented in several but not all of the survey counties. However, the counties which reported having implemented these four provisions indicated that significant savings related thereto had not yet materialized.

Table 3 summarizes the extent of implementation achieved during October.

TABLE 3.—IMPLEMENTATION OF MAJOR PROVISIONS OF CHAPTER 578, NOVEMBER 1971

Fully implemented	Not implemented	Partially implemented
$50 work-related expense limitation	150-percent gross income limitation [1]	5-day verification of eligibility (no saving accruing).
Casual and inconsequential income restriction (but no savings accruing).	AFDC flat grant schedule [2]	Special needs restrictions (no savings accruing).
Stepfather restriction	Family planning [3]	Lump sum income restrictions (no savings accruing).
	Confidentiality [3]	OAS responsible relatives liability scale (no savings have materialized).
	Employability programs including day care services [3].	

[1] Counties instructed not to implement by the Department of Social Welfare.
[2] Invalidated by the California Supreme Court.
[3] Counties had received no implementing regulations from the State Department of Social Welfare.

SURVEY FINDINGS FOR OCTOBER 1971: SAVINGS REESTIMATE

The extent of implementation revealed by our November survey caused us to further recalculate our estimate of savings associated with passage of the act.

The reestimate was not intended to reflect the maximum potential savings which we expected to accrue as a result of passage of the act. Rather, it was intended only to indicate the amount of savings which would accrue unless the act were more effectively and extensively implemented during the ensuing months. Table 4 summarizes the calculations underlying our November reestimate.

TABLE 4.—CHAPTER 578 SAVINGS ESTIMATES ADJUSTED TO REFLECT NOVEMBER SURVEY FINDINGS OF OCTOBER IMPLEMENTATION

[In millions]

Provision	Estimated full year 1971-72 savings depicted in table 0	Adjusted to reflect delayed implementation on Oct. 1, 1971	Further adjusted to reflect actual October implementation per county survey
1. 150 percent of gross income limitation	$4.6	$3.4	.....
2. Work-related expense limitation	12.0	9.0	$9.0
3. AFDC flat grant schedule	.....	.....	.....
4. Stricter eligibility standards including reform of (a) special needs, (b) verification of eligibility, and (c) exempt personal property	15.0	11.1	.....
5. Standardized eligibility operations including (a) changed sharing ratios relating to grant and administrative costs, and (b) contracting with counties to achieve enhanced administrative efficiency	5.0	3.7	.....
6. Lump sum income and casual and inconsequential income restrictions	.5	.4	.4
7. Absent parent and stepfather restrictions	6.8	5.1	.8
8. OAS responsible relative scale	17.6	13.2	(1)
9. Confidentiality	11.3	8.6	.....
10. Work programs including day care services	[2] 12.0	[2] 9.0	.....
11. Family planning services	[2] 1.0	[2] .8	.....
12. Others	[2] 3	[2] .1	[2] .1
Total savings	59.5	44.6	10.1

[1] Survey indicated that counties, because of court challenge, are placing contributions collected from relatives in trust rather than using them as abatements to offset grant costs. Therefore no savings have yet materialized.
[2] Cost.

COUNTY-STATE PROBLEMS CONTRIBUTING TO CONFUSION UNDERLYING IMPLEMENTATION OF CHAPTER 578

In addition to revealing the confusion which characterized implementation of Chapter 578 during October, the November survey also highlighted many of the specific factors which gave rise to the confusion.

(A) Department Reorganization—Throughout the course of the current fiscal year, the Department of Social Welfare has been undergoing a major reorganization. The reorganization reflects a reordering of priorities on the part of departmental management. Specifically, the fiscal responsibilities of the department are being emphasized much more than in the past, and, correspondingly, the service responsibilities of the department are being less emphasized. We do not find fault with some shift of emphasis based upon a more realistic assessment on the part of departmental management of the relative importance of its service and fiscal functions. Nevertheless, we do question the wisdom of attempting to undertake a major departmental reorganization while at the same time attempting to implement the most complex, massive, and significant welfare act in the state's history.

The effective implementation of any major program change requires an administrative apparatus which is stable. Firmly established relationships between organizational units and management personnel within a department and between the department and other governmental agencies are indispensable preconditions for undertaking an efficient program implementation effort. Consequently, it would appear that a departmental reorganization, which disturbs such relationships, should not have been attempted while the department was engaged in an effort to implement major program modifications. The Department of Social Welfare, we believe, by attempting to undertake reorganization while at the

same time implementing Chapter 578, made administrative confusion almost inevitable.

(B) Elimination of the Field Representatives and the Erosion of the State-County Relationship—A serious administrative failing arising from the department's reorganization efforts was, we believe, the elimination of the department's field representatives and the resultant weakening of the state-county relationship. The SDSW field representatives have in the past helped to coordinate and supervise on a day-to-day basis the activities of the 58 county welfare departments—the specific governmental units charged with the responsibility of directly administering the state's welfare programs.

"DSW departmental management was not unaware of the communication and supervisorial difficulties which were generated because of the elimination of the field representatives. It did attempt to establish new points of liaison with the counties. Nevertheless, almost without exception, the various counties included in our November survey indicated that the termination of the field representative function resulted in a critical communications and supervisorial breakdown between the counties and SDSW at a time when such a breakdown could have been least afforded.

In short, rather than exerting every effort to reinforce the relationship between the state and the counties in order to expedite implementation of Chapter 578, the SDSW management chose to delete from the department's organizational structure a key administrative link with the counties—a link which county welfare officials have relied upon heavily in the past. The ad hoc, interim points of contact which the state department established as substitutes for the field representative positions proved to be incapable of providing the level of communications and supervisorial efficiency necessary to assure a smooth implementation of Chapter 578.

(C) Circumvention of County Welfare Directors' Association (CWDA) by SDSW—The elimination of the field representative function is, while important in itself, also symptomatic, we believe, of a deeper, more general deterioration of the relationship between the State Department of Social Welfare and the various county welfare departments throughout the state. Testifying to this deeper, more general deterioration is the manner in which state welfare officials largely circumvented the County Welfare Directors' Association (CWDA), the primary organizational entity representing and reflecting the interests and concerns of county welfare officials, during the initial drafting stages of the implementing welfare reform regulations. Recourse to CWDA by the State Department of Social Welfare is not required by statute. However, in the past CWDA has provided important input to the department relating to (a) how properly to draft regulations, (b) the clarity and completeness of proposed regulations, (c) the administrative workability of proposed regulations, (d) potential legal problems associated with proposed regulations, (e) the consistency of proposed regulations with those already implemented and (f) the need for new regulations. CWDA has, in addition, played an important role in identifying problem areas associated with the state's welfare programs and has suggested workable solutions. Its publication of *Time for Change* constituted the basis for many of the reform provisions incorporated into Chapter 578. Finally, the organizational structure of CWDA provides for a quick assignment of important program and fiscal matters to appropriate informed personnel, permitting it thereby to function as a ready information resource. Valuable information relating to the program and fiscal impact of the department's proposed regulations implementing Chapter 578 could have been provided to SDSW by CWDA had the relationship between the two organizational entities been more firmly established and more rigorously exploited. Instead, an inadequate level of county input characterized implementation of Chapter 578 resulting, we believe, in a considerable loss of administrative efficiency as well as additional costs to the taxpayer. Further discussion of the frayed relationship between state and county welfare officials is discussed in Item 255 of the Analysis.

The following recommendations have been made in order to (a) reinforce the state-county relationship by grounding it in formalized, institutional procedures; (b) provide for a routine county check of the clarity, completeness, workability and consistency of proposed departmental regulations; and (c) afford counties adequate lead time to prepare for implementation.

(1) We recommend that the Legislature require the State Department of Social Welfare to submit all new proposed regulations to the executive committee of the County Welfare Directors Association for its advice.

(2) We recommend that the Legislature require the State Department of Social Welfare to submit the proposed regulations to the executive committee no later than 30 days prior to the date of filing with the Secretary of State unless a regulation is to be adopted on an emergency basis in which case it shall be submitted to the executive committee no later than 15 days prior to the date of filing.

(3) We recommend that the County Welfare Directors Association and the Director of the State Department of Social Welfare be required to jointly develop specific criteria establishing the basis for the issuance of emergency regulations. The association and the director should be further required to submit no later than the 30th day of the 1973 legislative session a listing of such criteria to the Legislature.

(4) We recommend that in all cases in which the Director does not abide by the advice of the association, he be required to submit to it within 15 days a report specifying in detail the reasons for his refusal.

(D) Internal Departmental Weakness—In addition to eliminating critical points of contact with the counties and, in general, damaging the relationship between state and county welfare officials, the department's reorganization efforts tended, we believe, to seriously weaken the relationship between the services and program staff of the department on the one hand and the fiscal, regulations, and executive staff of the department on the other. The counties which we surveyed indicated that many of the difficulties associated with the regulations developed and promulgated by the department to implement Chapter 578 could have avoided or at least alleviated if departmental management had vigorously required an adequate level of input on the part of its own program and services experts.

(E) Inadequate Lead Time—without exception, the counties included in our November survey reported that the administrative difficulties associated with the lack of adequate lead time were, in many cases, insurmountable. Senate Bill 796, Chapter 578, was signed by the Governor on August 13, 1971. The bill was scheduled to become effective on October 1, 1971. The amount of lead time, therefore, afforded to the State Department of Social Welfare and the 58 county welfare departments throughout the state amounted to only 33 working days. In comparison to the amount of lead time provided by other major reform bills enacted by the California Legislature during recent years, a lead time of only 33 working days is indeed very short. The Lanterman-Petris-Short Act, which revamped the provision of mental health services, was passed by the Legislature during 1967 with an effective date of July 1, 1969, a lead time of approximately two years. The Lanterman Mental Retardation Services Act, which established wholly new procedures for the care and treatment of mentally retarded persons, was enacted during the 1969 Legislative Session with an effective date of July 1, 1971, a lead time of again approximately two years. The State Aid for Probation Services Act, which reorganized the probation system in California, was passed during 1965 with an operative date of July 1, 1966, a lead time of approximately one year.

Furthermore, although Chapter 578 was signed by the Governor on August 13, 1971, the initial guidelines for implementation were not provided to the counties until September 2, 1971. The guidelines, however, were not regulatory in effect, nor could it have been reasonably expected that the guidelines would be effectively used by the counties as a basis for planning implementation. At the most, the guidelines issued on September 2 amounted to little more than a summary description of the act itself. On September 14, supplementary guidelines were issued to the counties via telegram. These guidelines, like those issued on September 2, amounted to little more than a summary description of Chapter 578 and did not, therefore, furnish an adequate planning basis for implementation of the act. Further guidelines, similar to those issued on September 2 and 14, were provided to the counties on September 16 and 20. Finally, on September 23 through 29, advance and filed copies of the regulations began to arrive at county welfare departments. The actual amount of lead time, therefore, provided to county welfare departments to gear-up for implementation of Chapter 578 totaled little more than six working days.

The lack of adequate lead time cannot be attributed to the State Department of Social Welfare nor to the 58 county welfare departments throughout the state. It was inherent in the act itself. However, county welfare officials have indicated that the absence of lead time has been an endemic problem during recent years. There can be no doubt that unless it is satisfactorily remedied an efficient imple-

mentation of departmental regulations will not be possible. We believe that the adoption of recommendations No. 2 and No. 3 (page 719 of the analysis) should help not only to reinforce the relationship between state and county welfare officials but, in addition, produce the lead time required by the counties.

(F) Inadequate Training—Many of the difficulties associated with the department's implementation of Chapter 578 during October 1971 can be attributed to an inadequate training effort on the part of the department. One of the most effective means of assuring an efficient implementation of any major program change is to furnish adequate training to the administration personnel responsible for effecting the change. Regardless of the amount of lead time provided and the adequacy of the implementing regulations, it is not reasonable to expect an effective implementation of a major program change in the absence of an intelligently devised and efficiently executed training effort. The organizational structure of the Department of Social Welfare appears to reflect an understanding of this administrative principle. Specifically, a county training bureau is included in the administrative branch of the department. Ostensibly, it is charged with the responsibility of developing and implementing for county use training programs related to eligibility and grant determinations as well as the provision of social services.

However, notwithstanding the department's establishment of a county training bureau, county welfare officials indicated during our November survey that departmental training related to the implementation of Chapter 578 was totally inadequate. The department did provide for one statewide training conference to which key county personnel were invited. However, the county welfare officials interviewed indicated that the training provided at the conference was not very useful. They further noted that because the conference was not held until September 29, 1971, only two days prior to the scheduled implementation of the act, the training, even if it had been adequate, could not have been brought back to the counties and put into effect in time to have lessened the administrative difficulties which developed during the first two weeks of October 1971.

Again, the absence of adequate training cannot be fully attributed to the State Department of Social Welfare. The department was not provided sufficient lead time to permit the development of an effective training program. Nevertheless, the counties which we surveyed reported that the county training bureau of the State Department of Social Welfare has not furnished adequate training services to county welfare personnel even when sufficient lead time was available. County welfare officials further complained that in the past the bureau (a) did not sufficiently stress training for eligibility workers and (b) employed classroom instruction techniques rather than on-the-job training.

The department's failure to provide effective training to county welfare departments reflects, we believe, an inadequate estimation of the crucial administrative role of the training function. Effective training of county personnel by a centralized state training agency could, more than any other single undertaking, help to accomplish a uniform, efficient implementation of welfare regulations. Furthermore, the department's past stress upon the training of social workers rather than eligibility technicians is difficult to understand. The eligibility and grant administration of county welfare departments is far larger, more costly, more complex, and much more vulnerable to administrative weaknesses than the administration of the social service function. The vast organizational network of county welfare departments relates almost entirely to the determination of eligibility and the payment of grants. In comparison, the social services program is merely an adjunctive function. The adoption of the following recommendations will, we believe, help to establish an appropriate role for the department's bureau of county training.

(1) We recommend that the Department of Social Welfare be required to develop specific, measurable goals as well as potential outputs for its bureau of county training and that these goals and outputs be included in the department's program budget statement for fiscal year 1973–74. The goals developed by the department should (a) assure a uniform application of welfare regulations throughout the state, (b) reflect a much heavier emphasis upon the training eligibility technicians than social workers, and (c) stress the use of on-the-job training in preference to classroom instruction. A listing of the goals developed by the department should be provided to the Joint Legislative Budget Committee no later than June 30, 1972.

(2) We recommend that because of the altered training needs of county welfare departments, the Chief of the Bureau of County Training, State Department

of Social Welfare, not be required to possess a master's degree in social work, which is the case under current departmental regulations.

COURT CHALLENGES: CHAPTER 578

Compounding the administrative difficulties generated by departmental reorganization, inadequate lead time and poor training was a series of court challenges directed at various provisions of Chapter 578 during the last three months of 1971. Specifically, suits were initiated against (a) the $50 work-related expense limitation, (b) the AFDC flat grant schedule, (c) the stepfather restrictions, (d) the OAS liability scale, and (e) the alleged inadequacy of notices of terminations and grant reductions sent by county welfare departments to affected recipients.

(1) The $50 Work-Related Expense Limitation—On September 22, before the counties had received even the first packet of implementing regulations, the Sacramento Superior Court issued a temporary restraining order enjoining implementation of the $50 work-related expense limitation. On September 28, however, the Court of Appeals, Third Appellate District, stayed execution of the restraining order.

Ten days later, on October 8, the Sacramento Superior Court issued a preliminary injunction enjoining any further implementation of the provision. The State Department of Social Welfare appealed the injunction to the Court of Appeal, Third Appellate District. Five days later, the State Attorney General advised the department that its appeal of the preliminary injunction had resulted in a stay of its execution. Consequently, the department directed the counties, pursuant to the advice of the Attorney General, to continue to implement the provision. However, on October 27, the Sacramento Superior Court issued another order stating that its October 8 preliminary injunction had not been stayed by the appeal and that full compliance should be immediately effected.

On November 1, the department filed an appeal from the October 27 superior court order. On the same day, the Attorney General advised the department that (1) the Sacramento Superior Court had no jurisdiction to issue its October 27 order and (2) the order was, in any case, stayed by the November 1 appeal. However, on November 4, the Court of Appeals, Third Appellate District, declined to stay execution of the October 27 Sacramento Superior Court order.

Approximately one month later, on December 8, the California Supreme Court refused to transfer the case from the Third Appellate District and declined to halt further proceedings in the superior court. The following da , the department notified the counties to cease implementing the provision.

Administrative costs: The counties included in our November survey reported that a significant portion of the excessive administrative costs incurred during October was attributable to the confusion generated by this court challenge. They expressed the further concern—a concern which proved later to be well-founded—that eventually the court challenge would result in a stay of implementation which would entail additional administrative costs to the counties by requiring expensive retroactive grant adjustments.

(2) The AFDC Flat Grant Schedule—On September 29, the California Supreme Court issued an order staying operation of Section 28, the section of the act relating to the AFDC flat grant schedule, pending a final determination of the proceedings. Enforcement of the entire section was stayed.

The State Department of Social Welfare, claiming that the September 29 order precluded issuance of the October 1 AFDC grant payments, sought a clarification from the court on September 30. As a result, the California Supreme Court modified its September 29 order staying operation of Section 28 only as it affected subsection A of Section 11450 of the Welfare and Institutions Code. Procedurally, this required (1) reversion to the old MPB, including the 21.4 percent increase required by departmental regulations issued in April, and (2) the use of the new minimum standard of adequate care, Section 11452, instead of the old coded cost schedules. Nonexempt income was to be deducted from the minimum standard of adequate care rather than the flat grant schedule as required by the invalidated portion of Section 28.

This procedural change required county welfare departments to recompute all of the October 1 AFDC grant payments. Such a recomputation was, of course, administratively impossible given a lead time of only one day. Consequently, the State Department of Social Welfare filed an emergency regulation with the Secretary of State to permit AFDC monthly grants to be paid in two unequal installments. This revision allowed counties to release the miscalculated October 1 AFDC checks, which had been computed on the basis of subsection A, and correct

for overpayments or underpayments in the balance of the monthly grants included in the midmonth October 15 payments. Nevertheless, several counties, notwithstanding the emergency regulations issued by the department, failed to mail the October 1 AFDC checks. Apparently, the confusion generated by a failure to anticipate the September 29 and 30 California Supreme Court orders in conjunction with the breakdown of the communication and supervisorial relationship between state and county welfare officials proved simply too overwhelming to permit an orderly release of the first October grant payments as scheduled.

On December 6, the California Supreme Court invalidated subsection A of Section 11450 of the Welfare and Institutions Code. The court ruled that nonexempt income must be deducted from the minimum standard of adequate care (Section 11452) not from the grant schedule. In addition, the court decision implied a return to the computation of AFDC payments on the basis of the flat grant schedule. (The September 30 California Supreme Court order had required that the computation of AFDC grant payments be made on the basis of the old MPB plus the 21.4 percent increase required by departmental regulations issued in April.)

The effect of the December 8 California Supreme Court order was to generate increased costs to the state. As originally designed, Section 28 would have entailed no additional costs. Specifically, the savings resulting from grant decreases to families with nonexempt outside income would have approximately balanced out the costs resulting from grant increases to families with no nonexempt outside income. However, as a result of having invalidated the deduction of nonexempt income from the AFDC flat grant schedule and requiring instead that the deduction be made from the need standard, the court decision has, in effect, eliminated the savings aspect of the provision while at the same time approving the cost aspect. We estimate that additional state funds of approximately $12 million will be required as a result.

Administrative Costs: Between October 1 and October 15, the date the second payment of the October grant was scheduled to be mailed to recipients, all of the counties included in our November survey were able to secure sufficient clarification from the State Department of Social Welfare to permit a recalculation of the October grant and to adjust the October 15 payment accordingly. Thus, by the end of October, county welfare officials had largely overcome the initial confusion resulting from not planning for the two California Supreme Court orders. However, the administrative costs generated by that confusion were excessive. Many county welfare departments, especially those which have not developed automated procedures for determining grant amounts, were compelled to spend large amounts of county funds for support of overtime payments to staff.

(3) The Stepfather Restrictions—On October 6, the Sacramento Superior Court issued a temporary restraining order enjoining implementation of the stepfather restrictions. The case was, however, limited to three named recipients. On October 19, the court broadened the case to a class action and issued a preliminary injunction. The department immediately appealed the injunction to the Appellate Court, Third Appellate District, and eight days later, pursuant to advice provided by the Attorney General, notified the counties that its appeal of the October 19 injunction had resulted in a stay of its execution. Accordingly, the department directed the counties to continue to implement the provision.

On November 19, the Court of Appeal, Third Appellate District, declined to halt further proceedings in the Sacramento Superior Court. Accordingly, three days later the State Department of Social Welfare directed the counties to cease implementing the provision. On December 2, the department issued new regulations which required evidence that a stepfather's income is actually available, rather than merely assumed to be available, to the wife for support of her children by a previous marriage.

Administrative Costs: The November survey did indicate that implementation of the stepfather restrictions had been inefficient and excessively costly. However, the survey produced evidence revealing that the confusion which resulted was more attributable to inadequately developed regulations than to the October 6 court challenge.

(4) The OAS Liability Scale—On October 20, the Sacramento Superior Court issued a temporary restraining order enjoining enforcement of the OAS liability scale. However, nine days later the Court of Appeal, third Appellate District, vacated the temporary restraining order and halted all further action of the Sacramento Superior Court, pending final determination of the proceedings scheduled for January 19, 1972.

Many of the counties, because of the uncertainty generated by the court chal-

lenge, are placing the contributions secured from relatives into trust funds rather than using the contributions as abatements to offset the cost of the OAS program

(5) The Inadequacy of the 15-Day Notices of Termination and Grant Reduction—On September 28, the United States District Court for the Northern District of California issued a temporary restraining order enjoining implementation of the scheduled October 1 AFDC grant terminations, suspensions and reductions. The issuance of the temporary restraining order was based upon the alleged inadequacy of the SDSW designed 15-day notice of grant changes sent by county welfare departments to affected recipients. The court order further required that prior to October 8 supplemental payments be sent to recipients whose October 1 checks could not be corrected due to insufficient lead time.

Administrative Costs—Because the court order required supplemental checks to be issued prior to October 8, county welfare departments were precluded from correcting for October 1 payment errors through a simple adjustment of the mid-month check. The counties reported that this resulted in very significant increased administrative costs in addition to further delaying implementation of Chapter 578.

COURT CHALLENGES: SAVINGS REESTIMATE

The court action which occurred during October, November and December required us to again recalculate our estimate of savings associated with implementation of Chapter 578. Table 5 depicts the amount of savings (cost) which can

TABLE 5.—CHAPTER 578 COST-SAVINGS ESTIMATES ADJUSTED TO REFLECT DELAYED IMPLEMENTATION AND COURT ACTIONS

[In millions]

Provision	Estimated full year 1971-72 savings depicted in table 0	Adjusted to reflect delayed implementation on Oct. 1, 1971	Further adjusted to reflect both the results of the county survey for October and the November and December court action
1. 150 percent of gross income limitation	$4.6	$3.4	(1)
2. Work-related expenses limitation	12.0	9.0	
3. AFDC flat grant schedule			[2] −12.0
4. Stricter eligibility standards including reform of (a) special needs, (b) verification of eligibility, and (c) exempt personal property	15.0	11.1	(3)
5. Standardized eligibility operations including (a) changed sharing ratios relating to grant and administrative costs, and (b) contracting with counties to achieve enhanced administrative efficiency	5.0	3.7	(4)
6. Lump sum income and casual and inconsequential income restrictions	.5	.4	+.4
7. Absent parent and stepfather restrictions	6.8	5.1	
8. OAS responsible relative scale	17.6	13.2	(5)
9. Confidentiality	11.3	8.6	
10. Work programs including day care services	[2] 12.0	[2] 9.0	(6)
11. Family planning services	[2] 1.0	[2] .8	(6)
12. Others	.3	.1	.1
Total savings	59.5	44.6	[2] 11.6

[1] Not implemented by order of State Department of Social Welfare.
[2] Cost.
[3] County survey conducted during November indicates no savings are accruing. Currently, staff of our office is planning to undertake an additional survey during February. That survey should provide further information as to savings potential of this provision.
[4] Unknown.
[5] County survey conducted during November indicated that counties, because of the court challenge, are placing contributions collected from relatives in trust funds rather than using them as abatements to offset cost of OAS program. Effect of this provision must remain unknown pending final determination of court proceedings.
[6] County survey conducted during November indicated than no implementing regulations had been issued. Currently staff of our office is planning to undertake an additional survey during February.

be anticipated if the current (December 1971) state of implementation is not improved during ensuing months. It is to be noted that should the current state of implementation continue to prevail during the remainder of 1971–72, a cost to the state of approximately $11.6 million may result.

In short, rather than more extensively implementing the provisions of Chapter 578 during the two months following October, state and county welfare officials have actually lost considerable ground because of successful court challenges.

COURT CHALLENGES: ADMINISTRATIVE REGULATIONS

Implementation of Chapter 578 did not constitute the sole basis underlying the department's attempt to reform California's welfare system. The department proposed additionally to achieve reform and savings by recourse to unilateral administrative action. Specifically, the department developed and promulgated the following four major regulations for which no change in state or federal statute was thought to be necessary: (a) the elimination of AFDC-U families receiving Unemployment Insurance Benefits (UIB); (b) the redefinition of unemployment to require that eligibility for payments under the provisions of the AFDC-U program not become effective until after 30 days of unemployment have expired; (c) the redefinition of unemployment to require the elimination of AFDC-U families with heads of households employed for more than 25 hours per week (100 hours per month); and (d) the redetermination of eligibility every four months.

(1) Unemployment Insurance Benefits—The regulation requiring the elimination of AFDC-U families receiving unemployment insurance benefits was to become effective January 1, 1972. The regulation had been filed with the Secretary of State and issued to the various county welfare departments. However, the Department of Social Welfare notified the counties by telegram on December 27 and 28 and by letter on December 29 not to implement the regulation.

Fiscal Effect: The department estimates that approximately 15 percent of AFDC-U families are securing unemployment insurance benefits and, in addition, are entitled to an average grant of approximately $154 per month. Therefore, based upon the department's own caseload estimates, the failure to implement the UIB regulation will result in a loss of savings to the state of approximately $4.9 million during the current fiscal year.

(2) 30-Day Waiting Period—The regulation rendering ineligible families with heads of households unemployed for less than 30 days became effective July 1, 1971. However, in December, the Sacramento Superior Court invalidated the regulation.

Fiscal Effects: It is estimated by the department that approximately three percent of the AFDC-U cases were affected by implementation of this regulation. The average grant is estimated to be approximately $200 per month. Therefore, based upon the department's own caseload estimates, the invalidation of the regulation will result in a loss of savings to the state of approximately $2.6 million during the current fiscal year.

(3) 25-Hour Per Week Redefinition of Unemployment—On March 17, 1971, the department adopted regulations which required the termination of AFDC-U families with heads of households employed in excess of 25 hours per week (100 hours per month). The regulation became effective July 1, 1971. Currently, the regulation remains in effect.

Fiscal Effect: The department estimates that approximately seven percent of the AFDC-U cases were affected by implementation of this regulation. The average grant of the families affected is estimated to be $180 per month. Consequently, based upon the department's estimated caseload, savings to the state of approximately $2.0 million should result during the current fiscal year.

(4) The Four-Month Rule—In April 1971, the department adopted regulations requiring a redetermination of eligibility every four months. The regulation became effective on June 1, 1971. It was designed to eliminate AFDC fam-

ilies with outside earned income which cannot be exempted on any basis other than the work-related expense exclusions.

On May 25, the Sacramento Superior Court issued a temporary restraining order enjoining implementation of the regulation. However, the Department of Social Welfare, claiming that it was bound by an earlier Alameda Superior Court decision, continued to implement the regulation. Finally, on September 22, the California Supreme Court invalidated the regulation and, in addition, ordered retroactive grants to be paid to all of the families eliminated as a result of its implementation. The court further directed all county welfare departments to submit to the Director of the Department of Social Welfare a report identifying the administrative procedures and actions adopted to assure compliance with the order.

Fiscal Effect: We estimate that the loss of state savings associated with the invalidation of the regulation totals approximately $9.0 million for the current fiscal year.

Table 6 indicates the amount of savings which can be anticipated as a result of unilateral departmental action if the current (December 1971) state of implementation is not improved during the ensuing months.

TABLE 6.—ESTIMATED SAVINGS FROM UNILATERAL DEPARTMENTAL REFORMS ADJUSTED TO REFLECT COURT ACTIONS

Regulation	Estimated full year savings, 1971–72 (millions)	Adjusted to reflect effect of court action, 1971–72
1. UIB regulation	$4.9	0
2. 30-day regulation	2.6	0
3. 25-hour/week regulation	2.0	2.0
4. 4-month rule	9.0	0
Total	18.5	2.0

SUMMARY OF CURRENT STATE OF IMPLEMENTATION OF WELFARE REFORM MEASURES

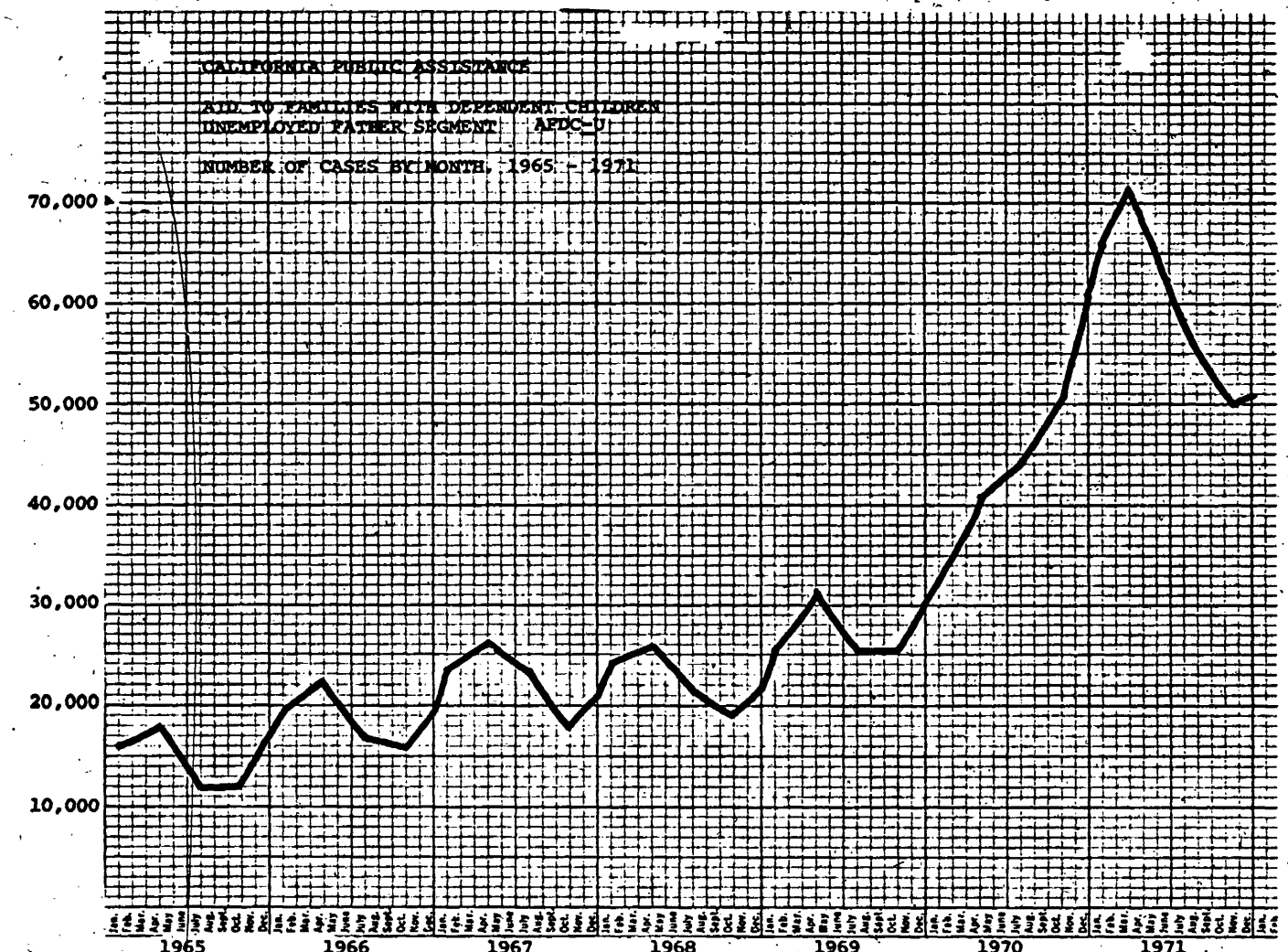
Table 7 depicts the current state of implementation of each of the major welfare reform measures undertaken by the State Department of Social Welfare during the current fiscal year. In addition, the table compares the estimated full-year savings related to each of the measures with the adjusted savings estimates which are based upon (1) our county survey for October and (2) court actions which occurred during October, November and December. It should be noted that if the current state of implementation prevails throughout the remainder of the 1971–72 fiscal year, the department's reform efforts, both Chapter 578 and its unilateral administrative changes, may cost the state approximately $9.6 million.

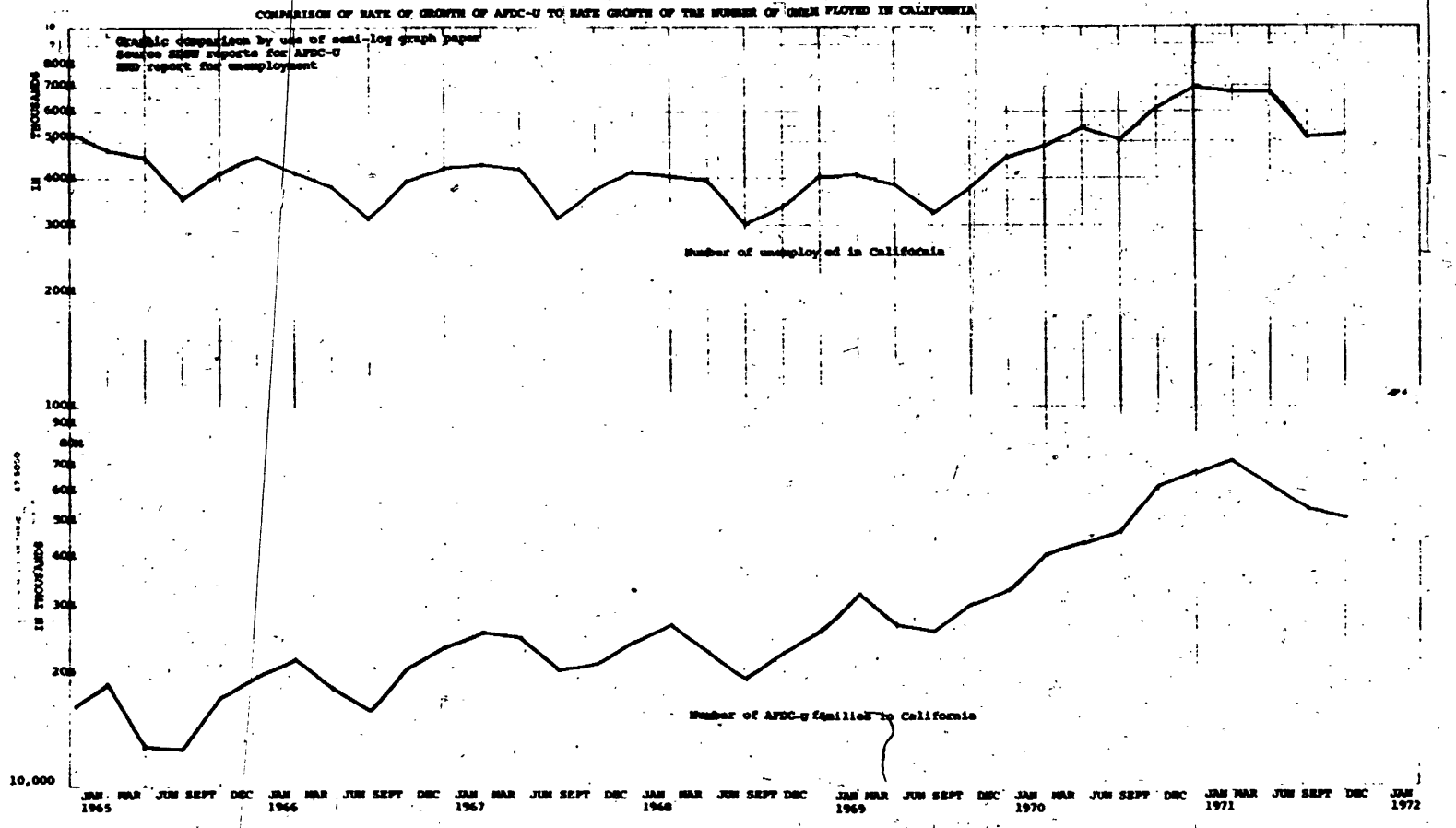
TABLE 7.—STATUS OF WELFARE REFORM MEASURES, JANUARY 1972

[Dollars in millions]

Reform measure	Estimated full-year savings	State of implementation	Adjusted savings estimate	Difference between estimated full-year savings and adjusted savings estimate
Chapter 578:				
1. 150 percent of gross income limitation.	$4.6	Not implemented by order of the department prior to October 1, 1971.	.....	−$4.6
2. Work-related expense exemption limitation.	12.0	Implementation enjoined by preliminary injunction. Retroactive grant adjustments required. (Superior court.)	.....	−12.0
3. AFDC flat grant schedule	.....	Implementation of subsection A, requiring deduction of nonexempt income from flat grant schedule enjoined (California Supreme Court.)	[1] $12.0	−12.0
4. Stricter eligibility standards including reform of (a) special needs, (b) verification of eligibility, (c) exempt personal property.	15.0	Review of counties indicated a partial implementation but little savings accrual.	[2]	−15.0
5. Standardized eligibility operations including (a) changed sharing ratios relative to grant administrative costs, and (b) contracting with counties to achieve enhanced administrative efficiency.	5.0	Not to be fully implemented until July 1, 1972. Review of counties indicates negligible savings.	[3]	[4]
6. Lump sum income and causal and inconsequential income restrictions.	.5	Review of counties indicated a partial implementation but negligible savings accrual.	[5] .5	.....
7. Absent parent and stepfather restrictions.	6.8	Stepfather restrictions enjoined from being implemented by preliminary injunction. Retroactive grant adjustments. (Superior court.) Absent parent provisions not implemented due to administrative difficulties.	.....	−6.8
8. OAS responsible relative scale.	17.6	Not fully implemented. Savings accrual potential unknown. Currently, counties not using collected contributions as abatements against the cost of the program.	[3]	[4]
9. Confidentiality	11.3	Review of counties indicated no implementation. No regulations adopted by SDSW.	[3]	−11.3
10. Work programs including day care services.	[1] 12.0	Survey for October indicated no implementation. No regulations adopted by SDSW.	[3]	+12.0
11. Family planning services	[1] 1.0	....do	[3]	+1.0
12. Others	.3	.....	[1] .1	+.2
Total for chapter 578	59.5	.....	[6] 11.6	−48.5
Unilateral administrative reform:				
13. UIB regulation	4.9	Implementation enjoined	.....	−4.9
14. 30-day regulation	2.6	Implementation enjoined. Retroactive grant adjustments required.	.....	−2.6
15. 25-week regulation	2.0	Currently in effect	2.0	.....
16. 4-month rule	9.0	Invalidated by California Supreme Court. Retroactive grant adjustments required.	.....	−9.0
Total for unilateral administrative reform.	18.5	.....	2.0	−16.5
Grand total	78.0	.....	[1] 9.6	−65.0

[1] Cost.
[2] Negligible (October).
[3] Unknown (October).
[4] Unknown.
[5] October.


CALIFORNIA PUBLIC ASSISTANCE
AID TO FAMILIES WITH DEPENDENT CHILDREN
UNEMPLOYED FATHER SEGMENT AFDC-U
NUMBER OF CASES BY MONTH, 1965 - 1971
70,000
60,000
50,000
40,000
30,000
20,000
10,000
1965
1966
1967
1968
1969
1970
1971


COMPARISON OF RATE OF GROWTH OF AFDC-U TO RATE GROWTH OF THE NUMBER OF OMEN FLOYED IN CALIFORNIA
Graphic comparison by use of semi-log graph paper
Source HSSM reports for AFDC-U
EDD report for unemployment
IN THOUSANDS
800
700
600
500
400
300
200
100
90
80
70
60
50
40
30
20
10,000
Number of unemployed in California
Number of AFDC-U families in California
JAN MAR JUN SEPT DEC
1965
1966
1967
1968
1969
1970
1971
1972

The attached tables are taken from the monthly reports of the California State Department of Social Welfare, Public Welfare in California. The Los Angeles County reports on General Home Relief caseloads are appropriately marked.

The virtual elimination of the GR family caseload in Los Angeles has been explained by county welfare officials as the result of an accounting procedure which eliminated duplicate counting of cases that received both GR and AFDC payments in the same month. The change was made possible by legislation which enabled Los Angeles County to meet emergent needs of AFDC applicants by checks issued from district welfare offices. Prior to beginning implementation of the legislation in March 1971, Los Angeles granted emergency GR to AFDC applicants in immediate need and prepared an AFDC warrant at a central location, a process which took several days. As a result, such cases were counted twice in the month of intake - once as GR, once as AFDC.

TABLE 11b. GENERAL HOME RELIEF1/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

December 1970

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	14,495	51,055	49,872	$5,243,536	$1,027,464	70 88	$4,216,072	84.54	$3,429,814	$1,813,722
Alameda	154	309	2,966	232,986	13,114	85.16	219,872	74.13	214,354	18,632
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	0	0	3	81	0	--	81	27.00	24	57
Butte	7	14	42	2,621	476	68.00	2,145	51.07	1,916	705
Calaveras	3	6	4	325	220	73.33	105	26.25	15	310
Colusa	1	4	0	14	14	14.00	0	--	0	14
Contra Costa	245	610	1,341	104,267	19,286	78.72	84,981	63.37	99,668	4,599
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	38	97	78	5,064	1,828	48.11	3,236	41.49	0	5,064
Fresno	78	360	114	8,001	2,307	29.58	5,694	49.95	0	3,001
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	69	237	112	12,295	4,200	60.87	8,095	72.28	7,753	4,542
Imperial	13	45	48	2,943	709	54.54	2,234	46.54	109	2,834
Inyo	10	24	27	1,307	258	25.80	1,049	38.85	0	1,307
Kern	6	12	131	7,792	491	81.83	7,301	55.73	7,457	335
Kings	2	4	27	1,256	130	65.00	1,126	41.70	40	1,216
Lake	3	12	6	133	50	16.67	83	13.83	0	133
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	11,324	41,016	27,686	3,191,589	806,966	71.23	2,385,023	86.15	2,038,627	1,152,962
Madera	20	78	13	537	230	11.50	307	23.62	26	511
Marin	10	27	103	8,597	725	72.50	7,872	76.43	8,333	264
Mariposa	0	0	1	15	0	--	15	15.00	15	0
Mendocino	35	108	31	2,622	909	25.97	1,713	55.26	230	2,392
Merced	19	58	74	5,623	863	45.42	4,760	64.32	0	5,623
Modoc	12	57	8	314	238	19.83	76	9.50	283	31
Mono	0	0	1	83	0	--	83	83.00	83	0
Monterey	255	1,166	129	13,938	9,478	37.17	4,460	34.57	86	13,852
Napa	13	43	45	2,653	588	45.23	2,065	45.89	0	2,653
Nevada	5	16	1	51	24	4.80	27	27.00	0	51
Orange	772	3,080	736	98,904	38,577	49.97	60,327	81.97	48,828	50,076
Placer	59	210	12	1,008	670	11.36	338	28.17	0	1,008
Plumas	1	4	7	538	53	53.00	485	69.29	0	538
Riverside	55	162	265	18,558	3,053	55.51	15,505	58.51	644	17,914
Sacramento	340	780	3,008	257,089	22,900	67.35	234,189	77.86	131,809	125,280
San Benito	0	0	0	0	0	--	0	--	0	0
San Bernardino	46	116	270	30,753	2,292	49.83	28,461	105.41	5,218	25,535
San Diego	133	342	1,329	142,555	16,689	125.48	125,866	94.71	132,468	10,087
San Francisco	265	580	7,218	689,628	39,887	150.52	649,741	90.02	451,787	237,841
San Joaquin	15	31	83	3,827	967	64.47	2,860	34.46	0	3,827
San Luis Obispo	58	176	135	12,832	4,025	69.40	8,807	65.24	10,905	1,927
San Mateo	50	131	657	83,017	7,929	158.58	75,088	114.29	82,826	191
Santa Barbara	5	10	186	12,290	764	152 80	11,526	61.97	5,162	7,128
Santa Clara	116	364	2,044	233,004	17,889	154.22	215,115	105.24	171,330	61,674
Santa Cruz	8	24	123	7,282	490	61.25	6,792	55.22	0	7,282
Shasta	38	106	65	3,525	1,045	27.50	2,480	38.15	2,700	825
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	9	19	10	659	54	10.80	605	60.50	259	400
Solano	7	17	72	7,012	791	113.00	6,221	86.40	5,704	1,308
Sonoma	99	358	173	8,541	2,181	22.03	6,360	36.76	25	8,516
Stanislaus	66	164	266	15,686	3,295	49.92	12,391	46.58	0	15,686
Sutter	7	18	9	189	89	12.71	100	11.11	0	189
Tehama	1	2	2	66	10	10.00	56	28.00	66	0
Trinity	2	12	3	174	12	6.00	162	54.00	0	174
Tulare	1	2	34	2,532	139	139.00	2,393	70.38	512	2,020
Tuolumne	1	2	6	556	4	4.00	552	92.00	552	4
Ventura	8	15	19	1,603	353	70.60	1,250	65.79	0	1,603
Yolo	17	45	112	4,852	575	33.82	4,277	38.19	0	4,852
Yuba	1	2	37	1,749	27	27.00	1,722	46.54	0	1,749

1/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

January 1971

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	15,608	50,477	52,668	85,556,420	61,135,242	72.73	24,421,178	83.94	83,620,948	81,935,472
Alameda	173	349	3,065	234,261	14,495	83.79	219,766	71.70	217,976	16,285
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	2	7	2	166	118	59.00	48	24.00	60	106
Butte	8	16	48	2,776	350	43.75	2,426	50.54	2,329	447
Calaveras	3	6	5	382	259	86.33	123	24.60	15	367
Colusa	2	13	5	85	35	17.50	50	10.00	0	85
Contra Costa	246	615	1,410	106,169	19,924	80.99	86,245	61.17	101,335	4,834
Del Norte	2	13	0	111	111	55.50	0	--	0	111
El Dorado	19	44	91	5,503	1,387	73.00	4,116	45.23	0	5,503
Fresno	87	400	122	9,833	2,515	28.91	7,018	57.52	0	9,533
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	79	250	119	13,694	5,174	65.49	8,520	71.60	10,245	3,449
Imperial	19	48	53	3,163	716	37.68	2,447	46.17	109	3,054
Inyo	27	92	27	1,740	793	29.37	947	35.07	0	1,740
Kern	8	16	140	8,147	683	85.38	7,464	53.31	7,900	247
Kings	1	2	24	1,122	64	64.00	1,058	44.08	47	1,075
Lake	3	16	5	244	45	15.00	199	39.80	0	244
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	12,907	42,487	29,832	3,503,230	925,266	71.69	2,577,964	86.42	2,237,513	1,265,717
Madera	14	50	7	120	94	6.71	26	3.71	19	101
Marin	3	6	100	8,114	312	104.00	7,802	78.02	7,883	231
Mariposa	0	0	0	0	0	--	0	--	0	0
Mendocino	25	72	29	2,212	813	32.52	1,399	48.24	182	2,030
Merced	16	41	78	5,266	748	46.75	4,518	57.92	0	5,266
Modoc	8	38	3	395	265	33.12	130	43.33	160	235
Mono	1	4	1	133	50	50.00	83	83.00	83	50
Monterey	275	1,231	313	17,646	10,860	39.49	6,786	21.68	86	17,560
Napa	5	12	39	2,270	252	50.40	2,018	51.74	0	2,270
Nevada	4	13	2	195	26	6.50	169	84.50	0	195
Orange	379	1,466	599	65,574	16,847	44.45	48,727	81.35	40,791	24,783
Placer	40	128	14	1,556	774	19.35	782	55.86	0	1,556
Plumas	1	2	10	609	55	55.00	554	55.40	0	609
Riverside	49	133	257	17,652	2,786	56.86	14,866	57.84	197	17,455
Sacramento	313	702	2,982	259,312	20,193	64.51	239,119	80.19	138,420	120,892
San Benito	0	0	3	94	0	--	94	31.33	0	94
San Bernardino	45	118	284	29,092	2,645	58.78	26,447	93.12	4,816	24,276
San Diego	157	389	1,375	145,321	18,071	115.10	127,250	92.55	135,051	10,270
San Francisco	264	509	7,567	732,011	51,241	194.09	680,770	89.97	438,127	293,884
San Joaquin	11	23	78	3,588	764	69.45	2,824	36.21	0	3,588
San Luis Obispo	88	176	135	12,832	4,025	69.40	8,807	65.24	10,905	1,927
San Mateo	90	122	622	81,276	8,523	170.46	72,753	116.97	81,108	168
Santa Barbara	9	18	196	14,373	910	101.11	13,463	68.69	5,849	8,524
Santa Clara	106	334	2,062	212,716	15,828	149.32	196,888	95.48	170,711	42,005
Santa Cruz	13	28	162	6,403	450	34.62	5,953	36.75	0	6,403
Shasta	18	62	84	2,748	621	34.50	2,127	39.39	2,218	530
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	4	16	15	726	54	13.50	672	44.80	205	521
Solano	3	6	79	6,547	393	131.00	6,154	77.90	4,732	1,815
Sonoma	59	171	181	8,124	1,726	29.25	6,398	35.35	25	8,099
Stanislaus	82	118	257	16,106	2,570	49.42	13,536	52.67	0	16,106
Sutter	4	12	0	48	48	12.00	0	--	0	48
Tehama	4	12	2	154	52	13.00	102	51.00	154	0
Trinity	2	4	1	94	25	12.50	69	69.00	0	94
Tulare	2	4	44	2,695	144	72.00	2,551	57.98	431	2,264
Tuolumne	1	2	6	556	4	4.00	552	92.00	552	4
Ventura	5	11	28	2,579	394	78.80	2,185	78.04	714	1,865
Yolo	21	58	105	5,359	681	32.43	4,678	44.55	0	5,359
Yuba	1	2	30	1,598	63	63.00	1,535	51.17	0	1,598

a/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

February 1971

County	Recipients			Expenditures						
	Family cases		One person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	16,105	50,292	54,126	$5,655,155	$1,139,754	$70.77	$4,515,401	$83.42	$3,741,662	$1,913,49[illegible]
Alameda	173	347	3,023	231,661	14,748	85.25	216,913	71.75	216,682	14,979
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	0	0	1	28	0	--	28	28.00	0	28
Butte	7	14	50	3,069	387	55.29	2,682	53.64	2,449	620
Calaveras	1	2	5	209	74	74.00	135	27.00	15	194
Colusa	1	3	1	33	22	22.00	11	11.00	0	33
Contra Costa	253	632	1,432	106,985	20,020	79.13	86,965	60.73	100,543	6,442
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	31	72	82	5,029	1,330	42.90	3,699	45.11	0	5,029
Fresno	55	221	97	6,642	1,640	29.82	5,002	51.57	0	6,642
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	69	195	139	14,525	5,127	74.30	9,398	78.97	11,545	2,980
Imperial	7	14	52	2,521	416	59.43	2,105	40.48	109	2,412
Inyo	14	48	18	859	415	29.64	444	24.67	0	859
Kern	10	20	150	9,217	888	88.80	8,329	55.53	8,882	335
Kings	1	2	22	964	83	83.00	881	40.05	42	922
Lake	0	0	7	318	0	--	318	45.43	0	318
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	13,723	43,604	31,716	3,610,332	953,489	69.48	2,656,843	83.77	2,305,919	1,304,413
Madera	17	62	18	592	132	7.76	460	25.56	27	565
Marin	23	58	101	9,038	631	27.43	8,407	83.24	8,505	533
Mariposa	1	2	2	174	50	50.00	124	62.00	65	109
Mendocino	19	58	32	2,073	690	36.32	1,383	43.22	1,935	138
Merced	12	32	74	5,693	833	69.42	4,860	65.68	0	5,693
Modoc	10	40	10	434	188	18.80	246	24.60	94	340
Mono	0	0	1	83	0	--	83	83.00	83	0
Monterey	210	783	470	16,545	7,562	36.01	8,983	19.11	86	18,459
Napa	5	10	35	2,440	324	64.80	2,116	60.46	0	2,440
Nevada	4	11	0	42	42	10.50	0	--	0	42
Orange	247	932	473	46,038	9,838	39.83	36,200	76.53	30,570	15,468
Placer	47	179	13	1,846	924	19.66	922	70.92	0	1,846
Plumas	0	0	10	594	0	--	594	59.40	-	594
Riverside	35	102	238	14,711	2,104	60.11	12,607	52.97	1,349	13,362
Sacramento	286	709	2,838	254,972	18,524	64.77	236,448	83.32	138,061	116,911
San Benito	0	0	0	0	0	--	0	--	0	0
San Bernardino	55	121	260	27,438	2,192	39.85	25,246	97.10	4,196	23,242
San Diego	124	322	1,278	134,449	14,282	115.18	120,167	94.03	126,613	7,836
San Francisco*	280	630	7,520	744,227	44,915	160.41	699,312	92.99	505,800	238,427
San Joaquin	14	29	82	3,491	848	60.57	2,643	32.23	0	3,491
San Luis Obispo	33	104	104	9,723	2,297	69.61	7,426	71.40	8,565	1,158
San Mateo	55	153	612	80,580	8,739	158.89	71,841	117.39	80,412	168
Santa Barbara	9	18	219	14,601	1,183	131.44	13,418	61.27	6,306	8,295
Santa Clara	107	325	2,070	238,494	17,381	162.44	221,113	106.82	172,401	66,093
Santa Cruz	12	24	145	7,984	813	67.75	7,171	49.46	0	7,984
Shasta	17	58	44	2,241	397	23.35	1,844	41.91	1,872	369
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	4	16	12	962	91	22.75	871	72.58	307	655
Solano	6	12	90	8,394	719	119.83	7,675	85.28	6,431	1,963
Sonoma	52	155	168	8,225	1,563	30.06	6,662	33.65	25	8,200
Stanislaus	54	120	233	13,967	2,600	48.15	11,367	48.79	0	13,967
Sutter	1	2	4	91	27	27.00	64	16.00	91	0
Tehama	0	0	2	76	0	--	76	38.00	76	0
Trinity	1	2	1	150	25	25.00	25	25.00	0	150
Tulare	3	6	36	2,725	285	95.00	2,440	67.78	431	2,294
Tuolumne	2	6	6	600	20	10.00	580	96.67	555	45
Ventura	4	9	24	2,647	325	81.25	2,322	80.07	620	2,027
Yolo	10	21	103	5,742	436	43.60	5,306	51.51	0	5,742
Yuba	1	2	18	711	65	65.00	646	35.89	0	711

1/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated.

TABLE 11b. GENERAL HOME RELIEF/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

March 1971

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	15,326	50,167	52,982	$5,109,033	$941,533	$61.43	$4,167,500	$78.66	$3,377,542	$1,731,491
Alameda	175	369	3,170	249,157	16,244	92.82	232,913	73.47	231,091	18,066
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	1	4	1	78	50	50.00	28	28.00	0	78
Butte	9	18	52	3,680	509	56.56	3,151	60.60	3,111	569
Calaveras	2	4	6	260	81	40.50	179	29.83	15	245
Colusa	1	9	0	37	37	37.00	0	--	0	37
Contra Costa	258	626	1,392	107,089	20,000	77.52	87,089	62.56	104,339	2,750
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	26	65	80	5,052	1,284	49.38	3,768	47.10	0	5,052
Fresno	70	298	148	10,072	2,303	32.90	7,769	52.49	0	10,072
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	62	204	123	15,216	4,615	74.44	10,601	86.19	13,344	1,872
Imperial	21	94	44	1,920	413	19.67	1,507	34.25	0	1,920
Inyo	85	184	41	4,994	3,060	55.64	1,934	47.17	0	4,994
Kern	10	27	164	10,372	917	91.70	9,455	57.65	10,050	322
Kings	1	2	26	1,357	38	38.00	1,319	50.73	46	1,311
Lake	0	0	9	324	0	--	324	36.00	0	324
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	13,047	43,706	30,154	3,008,514	760,251	58.27	2,248,263	74.56	1,921,538	1,086,976
Madera	9	23	16	493	39	4.33	454	28.38	14	479
Marin	14	39	104	8,823	309	22.07	8,514	81.87	8,389	434
Mariposa	0	0	3	158	0	--	158	52.67	65	93
Mendocino	25	72	52	3,241	907	36.28	2,334	44.88	184	3,057
Merced	10	24	63	4,781	543	54.30	4,238	67.27	0	4,781
Modoc	16	80	7	752	465	29.06	287	41.00	195	557
Mono	0	0	1	83	0	--	83	83.00	83	0
Monterey	118	455	123	9,066	4,160	35.25	4,906	39.89	86	8,980
Napa	4	8	32	1,931	213	53.25	1,718	53.69	0	1,931
Nevada	3	11	0	24	24	8.00	0	--	0	24
Orange	204	784	444	44,778	9,051	44.37	35,727	80.47	29,703	15,075
Placer	33	111	18	1,842	612	18.55	1,230	68.33	0	1,842
Plumas	2	4	10	578	108	54.00	470	47.00	0	578
Riverside	38	122	245	18,800	2,219	58.39	16,581	67.68	1,232	17,568
Sacramento	316	766	2,980	279,664	19,969	63.19	259,695	87.15	135,474	144,190
San Benito	0	0	2	135	0	--	135	67.50	0	135
San Bernardino	18	70	193	29,853	2,153	119.61	27,700	143.62	4,392	25,461
San Diego	131	378	1,372	146,802	16,015	122.25	130,787	95.33	136,843	10,959
San Francisco	272	592	7,823	712,728	38,980	143.31	673,748	86.12	485,897	226,831
San Joaquin	14	29	89	3,946	913	65.21	3,033	34.08	0	3,946
San Luis Obispo	43	137	102	10,678	2,973	69.14	7,705	75.54	9,405	1,273
San Mateo	48	115	635	81,565	8,342	173.79	73,223	115.31	81,512	53
Santa Barbara	10	20	228	15,719	829	82.90	14,890	65.31	6,828	8,891
Santa Clara	88	310	2,053	259,225	16,417	167.52	242,808	118.27	174,053	85,172
Santa Cruz	10	20	150	7,593	571	57.10	7,022	46.81	0	7,593
Shasta	27	78	50	2,289	453	16.78	1,836	36.72	1,849	440
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	5	13	10	776	99	19.80	677	67.70	251	525
Solano	6	12	95	8,927	575	95.83	8,352	87.92	6,758	2,169
Sonoma	47	144	194	9,056	1,476	31.40	7,576	39.05	25	9,007
Stanislaus	47	96	250	13,219	2,301	48.96	10,918	43.67	0	13,219
Sutter	2	4	3	73	45	22.50	28	9.33	0	73
Tehama	1	2	2	8	3	3.00	5	2.50	0	4
Trinity	0	0	2	25	0	--	25	12.50	0	25
Tulare	3	6	36	2,597	167	55.67	2,430	67.50	431	2,166
Tuolumne	0	0	7	586	0	--	586	83.71	556	30
Ventura	3	6	36	3,173	376	125.33	2,797	77.69	774	2,399
Yolo	10	22	127	6,328	359	35.90	5,969	47.00	0	6,328
Yuba	1	2	15	620	65	65.00	555	37.00	0	620

/ Includes miscellaneous general relief and supplemental aid to categorical aid recipients.

Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.

* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF a/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

April 1971

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	11,513	36,921	50,665	$4,424,575	$693,167	$60.21	$3,731,408	$73.65	$3,257,928	$1,166,647
Alameda	175	352	3,234	250,409	15,504	88.59	234,905	72.64	233,072	17,337
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	0	0	2	46	0	--	46	23.00	18	28
Butte	8	16	50	2,838	390	48.75	2,448	48.96	2,252	586
Calaveras	2	4	5	329	194	97.00	135	27.00	15	314
Colusa	1	9	1	15	7	7.00	8	8.00	0	15
Contra Costa	179	439	1,300	98,482	16,029	89.55	82,453	63.43	96,075	2,407
Del Norte	0	0	6	0	0	--	0	--	0	0
El Dorado	21	59	78	4,388	1,057	50.33	3,331	42.71	0	4,388
Fresno	114	487	129	8,680	2,481	21.76	6,199	48.05	0	8,680
Glenn	0	0	1	35	0	--	35	35.00	0	35
Humboldt	39	115	93	10,734	2,982	76.46	7,752	83.35	9,527	1,207
Imperial	16	41	33	1,766	346	21.62	1,420	43.03	0	1,766
Inyo	31	109	32	2,110	844	27.23	1,266	39.56	0	2,110
Kern	9	28	145	9,718	1,123	124.78	8,595	59.28	8,983	735
Kings	2	9	19	788	69	34.50	719	37.84	37	751
Lake	0	0	10	276	0	--	276	27.60	0	276
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	9,500	31,149	28,580	2,471,040	524,431	55.20	1,946,609	68.11	1,894,439	576,601
Madera	8	21	14	251	53	6.62	198	14.14	13	238
Marin	6	11	90	8,167	639	106.50	7,528	83.64	7,976	191
Mariposa	1	3	1	125	50	50.00	75	75.00	65	60
Mendocino	18	45	35	2,500	676	37.56	1,824	52.11	304	2,196
Merced	12	29	67	5,226	617	51.42	4,609	68.79	0	5,226
Modoc	12	43	4	676	437	36.42	239	59.75	326	350
Mono*	0	0	1	83	0	--	83	83.00	83	0
Monterey	114	435	115	10,191	4,857	42.61	5,334	46.38	86	10,105
Napa	3	8	26	1,793	212	70.67	1,581	60.81	0	1,793
Nevada	0	0	1	7	0	--	7	7.00	0	7
Orange*	204	784	444	44,778	9,051	44.37	35,727	80.47	29,703	15,075
Placer	34	121	16	1,818	775	22.79	1,043	65.19	0	1,818
Plumas	2	4	8	475	145	72.50	330	41.25	0	475
Riverside	46	147	274	19,067	2,331	50.67	16,736	61.08	1,454	17,613
Sacramento	255	643	2,592	246,989	15,864	62.21	231,125	89.17	130,461	116,528
San Benito*	0	0	2	135	0	--	135	67.50	0	135
San Bernardino	12	34	207	19,843	1,126	93.83	18,717	90.42	3,941	15,902
San Diego	109	303	1,360	144,364	13,259	121.64	131,105	96.40	134,636	9,728
San Francisco	259	565	7,853	672,601	47,443	183.18	625,158	79.61	430,792	241,809
San Joaquin	18	44	85	4,314	1,168	64.89	3,146	37.01	0	4,314
San Luis Obispo	45	142	89	8,187	2,602	57.82	5,585	62.75	6,777	1,410
San Mateo	40	97	654	82,032	6,743	168.58	75,289	115.12	81,871	161
Santa Barbara	7	14	213	14,227	989	141.29	13,238	62.15	6,318	7,909
Santa Clara	81	263	1,889	222,350	13,283	163.99	209,067	110.68	168,222	54,128
Santa Cruz	9	18	154	7,880	360	40.00	7,520	48.83	0	7,880
Shasta	19	61	43	2,231	469	24.68	1,762	40.98	1,800	431
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	3	15	15	607	41	13.67	566	37.73	282	325
Solano	6	12	89	8,638	500	83.33	8,138	91.44	6,727	1,911
Sonoma	28	75	178	7,548	811	28.96	6,737	37.85	25	7,523
Stanislaus	49	109	226	13,295	2,412	49.22	10,883	48.15	0	13,295
Sutter	1	2	2	30	9	9.00	21	10.50	0	30
Tehama	0	0	1	1	0	--	1	1.00	1	0
Trinity	0	0	1	25	0	--	26	25.00	0	25
Tulare	8	20	51	2,790	266	33.25	2,524	49.49	903	2,287
Tuolumne	1	3	6	641	50	50.00	591	98.50	566	75
Ventura	2	4	49	4,110	266	133.00	3,844	78.45	578	3,532
Yolo	4	9	88	4,528	206	51.50	4,322	49.11	0	4,528
Yuba	0	0	10	298	0	--	298	29.80	0	298

a/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF[1]/ RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

May 1971

County	Recipients			Expenditures						
	Family cases		One person cases	Total *	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	11,506	36,299	50,655	$4,368,768	$670,296	$58.26	$3,698,472	$73.01	$3,278,515	$1,090,253
Alameda	192	386	3,241	251,994	15,971	83.18	236,023	72.82	235,575	16,419
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	0	0	1	28	0	--	28	28.00	0	28
Butte	8	16	36	2,242	368	46.00	1,874	52.06	306	1,936
Calaveras	1	2	4	165	60	60.00	105	26.25	15	150
Colusa	1	9	4	118	20	20.00	98	24.50	0	118
Contra Costa	159	404	1,276	93,142	13,885	87.33	79,257	62.11	90,393	2,749
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	29	94	91	5,796	1,502	51.79	4,294	47.19	0	5,796
Fresno	67	275	142	8,411	1,804	26.93	6,607	46.53	0	8,411
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	35	101	81	8,665	2,095	59.86	6,570	81.11	7,454	1,211
Imperial	25	99	57	2,346	508	20.32	1,838	32.25	0	2,346
Inyo	9	25	17	740	287	31.89	453	26.65	0	740
Kern	10	20	141	9,524	1,080	108.00	8,444	59.89	9,192	332
Kings	2	4	17	789	74	37.00	715	42.06	37	752
Lake	0	0	8	347	0	--	347	43.38	0	347
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	9,731	31,493	29,277	2,521,762	535,196	55.00	1,986,566	67.85	1,933,325	588,437
Madera	12	40	13	172	42	3.50	130	10.00	18	154
Marin	6	16	87	7,912	413	68.83	7,499	86.20	7,737	175
Mariposa	1	3	2	140	50	50.00	90	45.00	80	60
Mendocino	15	47	28	1,417	525	35.00	892	31.86	210	1,207
Merced	13	34	61	5,154	718	55.23	4,436	72.72	0	5,154
Modoc	9	29	11	808	449	49.89	359	32.64	302	506
Mono *	0	0	1	83	0	--	83	83.00	83	0
Monterey	89	304	105	6,699	2,826	31.75	3,873	36.89	86	6,613
Napa	2	4	21	1,585	193	96.50	1,392	66.29	0	1,585
Nevada	0	0	2	13	0	--	13	6.50	0	13
Orange	101	353	373	31,295	3,160	31.29	28,136	75.43	21,202	10,093
Placer	29	93	10	1,744	550	18.97	1,194	119.40	0	1,744
Plumas	2	4	7	347	115	57.50	232	33.14	0	347
Riverside	42	116	265	19,571	2,695	64.17	16,876	63.68	1,257	18,314
Sacramento	240	605	2,458	224,699	15,316	63.82	209,383	85.18	125,205	99,494
San Benito	0	0	0	0	0	--	0	--	0	0
San Bernardino	7	14	158	13,702	609	87.00	13,093	82.87	3,959	9,743
San Diego	124	326	1,487	141,480	14,806	119.40	126,674	85.19	132,638	8,842
San Francisco	241	536	7,548	635,968	24,069	99.87	611,899	81.07	441,053	194,915
San Joaquin	19	47	93	4,779	1,327	69.84	3,452	37.12	0	4,779
San Luis Obispo	33	104	68	6,030	2,393	72.52	4,537	66.72	5,869	1,061
San Mateo	47	110	623	85,611	8,166	173.74	77,445	124.31	85,454	157
Santa Barbara	7	14	208	15,052	947	135.29	14,105	67.81	6,839	8,213
Santa Clara	87	288	1,772	203,440	12,643	145.32	190,797	107.67	159,606	43,834
Santa Cruz	11	22	168	9,069	593	53.91	8,476	50.45	0	9,069
Shasta	12	44	42	1,568	203	16.92	1,365	32.50	1,280	288
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	2	12	10	420	33	16.50	387	38.70	229	191
Solano *	6	12	89	8,638	500	83.33	8,138	91.44	6,727	1,911
Sonoma	23	69	180	7,570	892	38.78	6,678	37.10	25	7,545
Stanislaus	42	89	180	13,166	2,167	51.60	10,999	61.11	0	13,166
Sutter	2	8	2	45	17	8.50	28	14.00	0	45
Tehama	1	2	2	159	105	105.00	54	27.00	159	0
Trinity	1	4	0	35	35	35.00	0	--	0	35
Tulare	5	10	44	3,096	322	64.40	2,774	63.05	738	2,358
Tuolumne	0	0	7	627	0	--	627	89.57	592	35
Ventura	2	4	59	5,704	415	207.50	5,289	89.64	819	4,885
Yolo	3	6	66	3,416	124	41.33	3,292	49.88	0	3,416
Yuba	1	2	12	584	28	28.00	556	46.33	50	534

1/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note. Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF1/ RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

June 1971

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	11,458	35,448	50,976	$4,380,818	$675,276	$58.93	$3,705,542	$72.69	$3,381,011	$999,807
Alameda	170	346	3,222	213,763	14,478	85.16	239,285	74.27	237,056	16,707
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	3	15	1	195	185	61.67	10	10.00	160	35
Butte	7	14	40	2,304	404	57.71	1,900	47.50	1,790	514
Calaveras	1	2	5	183	60	60.00	123	24.60	15	168
Colusa	0	0	0	0	0	--	0	--	0	0
Contra Costa	245	610	1,341	104,267	19,286	78.72	84,981	63.37	99,668	4,599
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	30	99	105	5,909	1,567	52.23	4,342	41.35	0	5,909
Fresno	59	228	115	6,364	1,374	23.29	4,990	43.39	0	6,364
Glenn	0	0	1	22	0	--	22	22.00	0	22
Humboldt	43	159	88	9,845	2,962	68.88	6,883	78.22	7,761	2,084
Imperial	42	163	53	3,265	941	22.40	2,324	43.85	0	3,265
Inyo	27	86	39	1,680	701	25.96	979	25.10	0	1,680
Kern	6	12	139	8,843	631	105.17	8,212	59.08	8,492	351
Kings	4	8	15	843	173	43.25	670	44.67	37	806
Lake	3	11	7	387	45	15.00	342	48.86	0	387
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	9,467	29,967	28,483	2,485,335	527,463	55.72	1,957,872	68.74	1,905,397	579,938
Madera	6	21	11	175	29	4.83	96	8.73	10	115
Marin	3	10	89	8,690	609	203.00	8,081	90.80	8,528	162
Mariposa	1	3	1	135	75	75.00	60	60.00	75	60
Mendocino	7	17	16	1,114	315	45.00	799	49.94	343	771
Merced	17	45	48	4,182	619	36.41	3,563	74.23	0	4,182
Modoc	17	79	12	935	614	36.12	321	26.75	585	350
Mono *	0	0	1	83	0	--	83	83.00	83	0
Monterey	102	408	127	8,297	3,267	32.03	5,030	39.61	0	8,297
Napa	0	0	13	504	0	--	504	38.77	504	0
Nevada	4	13	1	61	37	9.25	24	24.00	0	61
Orange	90	299	332	30,559	3,508	38.98	27,051	81.48	22,184	8,375
Placer	20	73	9	1,205	437	21.85	768	85.33	0	1,205
Plumas *	2	4	7	347	115	57.50	232	33.14	0	347
Riverside	43	121	267	19,801	2,996	69.67	16,805	62.94	749	19,052
Sacramento	267	629	2,584	236,631	14,934	55.93	221,697	85.80	124,738	111,893
San Benito	0	0	2	97	0	--	97	48.50	0	97
San Bernardino	3	15	132	13,252	422	140.67	12,830	97.20	4,312	8,940
San Diego	140	385	1,749	163,248	14,822	105.87	148,426	84.86	152,337	10,911
San Francisco	250	550	7,700	597,916	24,163	96.65	573,753	74.51	488,607	109,309
San Joaquin	10	22	100	4,688	815	81.50	3,873	38.73	0	4,688
San Luis Obispo	45	159	90	8,578	2,221	49.36	6,357	70.63	8,815	1,763
San Mateo	61	147	959	104,619	10,597	173.72	94,022	98.04	104,376	243
Santa Barbara	8	18	215	16,362	1,089	136.12	15,273	71.04	7,824	8,538
Santa Clara	115	338	1,976	222,780	16,724	145.43	206,056	104.28	187,392	35,388
Santa Cruz	7	18	151	7,781	570	81.43	7,211	47.75	0	7,781
Shasta	26	83	49	1,921	521	20.04	1,400	28.57	1,676	245
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	1	3	10	702	10	10.00	692	69.20	466	236
Solano	7	14	79	7,997	846	120.86	7,151	90.52	6,801	1,196
Sonoma	44	134	161	7,669	1,177	26.75	6,492	35.87	25	7,644
Stanislaus	37	75	187	13,280	2,659	71.86	10,621	56.80	0	13,280
Sutter	1	2	3	46	9	9.00	37	12.33	0	46
Tehama	1	4	1	28	3	3.00	25	25.00	28	0
Trinity	0	0	0	0	0	--	0	--	0	0
Tulare	4	9	36	2,536	253	63.25	2,283	63.42	715	1,821
Tuolumne	1	4	5	543	60	60.00	483	96.60	458	85
Ventura	4	11	79	6,696	345	86.25	6,351	80.39	954	5,742
Yolo	6	18	85	3,577	96	16.00	3,481	40.95	0	3,577
Yuba	1	2	15	628	49	49.00	579	38.60	50	578

1/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF[1]
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

July 1971

County	Recipients			Expenditures						
	Family cases		One person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	10,683	33,187	49,265	$4,204,443	$636,013	$59.54	$3,568,430	$72.43	$3,172,118	$1,032,325
Alameda	98	303	3,165	231,076	8,226	83.94	222,850	70.41	213,931	17,145
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	0	0	0	0	0	--	0	--	0	0
Butte	3	6	41	2,687	144	48.00	2,543	62.02	2,517	170
Calaveras	1	2	5	195	60	60.00	135	27.00	15	180
Colusa	0	0	0	0	0	--	0	--	0	0
Contra Costa	168	426	1,314	99,723	16,296	99.98	83,427	63.49	95,050	4,673
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	30	99	105	5,909	1,567	52.23	4,342	41.35	0	5,909
Fresno	61	241	153	8,502	1,829	29.98	6,673	43.61	0	8,502
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	65	197	97	10,937	4,029	61.98	6,908	71.22	7,918	3,019
Imperial	29	135	45	3,193	898	30.97	2,295	51.00	90	3,103
Inyo	12	35	14	661	157	13.08	504	36.00	0	661
Kern	17	40	148	10,425	1,698	99.88	8,727	58.97	10,091	334
Kings	4	8	21	1,129	180	45.00	949	45.19	37	1,092
Lake	2	6	10	305	25	12.50	280	28.00	6	305
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	8,644	27,274	26,006	2,204,225	467,296	54.06	1,736,929	66.79	1,690,641	513,584
Madera	3	6	12	131	52	17.33	79	6.58	6	125
Marin	12	30	93	7,727	876	73.00	6,851	73.67	7,362	365
Mariposa	2	9	0	15	15	7.50	0	--	7	8
Mendocino	10	34	15	1,063	390	39.00	673	42.06	126	937
Merced	27	95	58	3,751	753	27.89	2,998	51.69	0	3,751
Modoc	27	114	4	974	885	32.78	89	22.25	764	210
Mono	0	0	1	83	0	--	83	83.00	83	0
Monterey	149	606	129	10,783	5,012	33.64	5,771	44.74	0	10,781
Napa	1	2	7	350	10	10.00	340	48.57	0	350
Nevada	1	7	1	2	1	1.00	1	1.00	0	2
Orange	118	385	375	35,690	4,715	39.96	30,975	82.60	23,596	12,094
Placer	18	55	10	1,294	456	25.33	838	83.80	0	1,294
Plumas	2	4	7	347	115	57.50	232	33.14	0	347
Riverside	45	123	257	19,508	3,610	80.22	15,898	61.86	1,236	18,272
Sacramento	265	691	2,951	257,357	15,827	59.72	241,530	81.85	130,462	126,895
San Benito	0	0	6	314	0	--	314	52.33	0	314
San Bernardino	10	28	124	12,383	558	55.80	11,825	95.36	4,098	8,285
San Diego	129	486	2,015	179,264	15,547	120.52	163,717	81.25	163,932	15,332
San Francisco	2008/	3008/	7,4008/	606,161	33,127	165.64	573,034	77.44	430,395	175,766
San Joaquin	13	29	109	3,993	717	55.15	3,276	30.06	0	3,993
San Luis Obispo	59	194	83	8,579	3,240	54.92	5,339	64.33	6,122	2,457
San Mateo	85	196	1,021	126,028	12,911	151.89	113,117	110.79	125,965	63
Santa Barbara	13	26	246	16,999	1,180	90.77	15,819	64.30	7,594	9,405
Santa Clara	169	522	2,281	269,554	24,333	143.98	245,221	107.51	236,275	33,279
Santa Cruz	7	15	131	6,953	531	75.86	6,422	49.02	0	6,953
Shasta	33	133	54	2,174	536	16.24	1,638	30.33	1,835	339
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	1	4	14	775	15	15.00	760	54.29	682	93
Solano	6	12	86	8,700	946	157.67	7,754	90.16	7,144	1,556
Sonoma	67	201	203	8,661	1,610	24.03	7,051	34.73	25	8,636
Stanislaus	49	110	201	15,222	3,662	74.73	11,560	57.51	0	15,222
Sutter	4	16	4	100	57	14.25	43	10.75	0	100
Tehama	0	0	1	30	0	--	30	30.00	30	0
Trinity	2	9	0	35	35	17.50	0	--	0	35
Tulare	12	25	35	3,298	847	70.58	2,451	70.03	946	2,352
Tuolumne	0	0	4	458	0	--	458	114.50	458	0
Ventura	7	24	115	12,032	768	109.71	11,264	97.95	2,635	9,397
Yolo	7	22	75	4,171	230	32.86	3,941	52.55	0	4,171
Yuba	1	2	12	517	41	41.00	476	39.67	50	467

1/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
2/ Data estimated by San Francisco County.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF[a]/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

August 1971

County	Recipients			Expenditures						
	Family Cases		One-person cases	Total	Family cases		One person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	10,909	35,252	49,663	$4,438,115	$677,906	$62.14	$3,760,209	$75.71	$3,358,714	$1,079,401
Alameda	81	198	2,885	214,634	6,045	74.63	208,589	72.30	199,859	14,775
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	1	6	0	28	28	28.00	0	--	0	28
Butte	4	8	56	3,669	224	56.0	3,245	57.95	3,369	100
Calaveras	1	2	5	145	80	60.00	135	27.00	15	180
Colusa	1	6	0	52	52	52.00	0	--	0	52
Contra Costa	165	420	1,426	110,448	15,513	94.02	94,935	66.57	104,612	5,836
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	31	96	110	5,153	3,978	128.-2	1,175	10.68	0	5,153
Fresno	50	219	151	8,841	1,307	26.14	7,534	49.89	0	8,841
Glenn	0	0	0	0	0	--	0	--	0	0
Humboldt	71	224	106	12,315	4,045	56.97	8,270	78.02	8,541	3,774
Imperial	29	94	42	3,203	1,009	34.79	2,194	52.24	386	2,817
Inyo	28	97	41	2,529	811	28.96	1,718	41.90	0	2,529
Kern	101	412	248	17,241	6,205	61.44	11,036	44.50	15,274	1,967
Kings	1	2	27	1,299	14	14.00	1,285	47.59	37	1,262
Lake	1	2	7	246	10	10.00	236	33.71	0	246
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	8,751	28,621	26,329	2,358,831	500,072	57.14	1,858,759	70.60	1,809,223	549,608
Madera	3	10	14	140	5	1.67	135	9.64	25	115
Marin	9	23	99	10,025	707	78.56	9,318	94.12	9,671	354
Mariposa	0	0	0	0	0	--	0	--	0	0
Mendocino	12	36	28	1,095	249	20.75	846	30.21	192	903
Merced	29	90	56	4,831	1,477	50.93	3,354	59.89	1,617	3,214
Modoc	17	74	7	829	534	31.41	295	42.14	365	464
Mono	0	0	0	0	0	--	0	--	0	0
Monterey	139	503	125	10,482	4,359	31.36	6,123	48.98	0	10,482
Napa	0	0	5	119	0	--	119	23.80	0	119
Nevada	2	12	0	3	3	1.50	0	--	0	3
Orange	108	329	346	34,107	4,908	45.44	29,199	84.39	24,300	9,807
Placer	6	18	7	724	201	33.50	523	74.71	0	724
Plumas*	2	6	10	599	138	69.00	461	46.10	0	599
Riverside	48	149	273	21,838	3,378	70.38	18,460	67.67	1,120	20,718
Sacramento	275	760	3,149	271,107	14,821	53.89	256,286	81.49	140,252	130,855
San Benito	0	0	3	183	0	--	183	61.00	0	183
San Bernardino	11	37	105	13,473	662	60.18	12,813	122.01	4,997	8,476
San Diego	145	544	2,085	193,022	17,517	120.81	175,505	84.18	173,545	19,477
San Francisco	200	500	6,800	582,369	29,650	148.25	552,719	81.28	416,485	165,884
San Joaquin	17	39	116	4,799	932	54.82	3,867	33.34	0	4,799
San Luis Obispo	74	280	79	7,771	3,323	44.91	4,448	56.36	2,995	4,776
San Mateo	80	214	1,166	140,000	13,924	174.05	126,076	108.13	139,580	420
Santa Barbara	19	40	283	20,574	1,888	99.37	18,686	66.03	8,742	11,832
Santa Clara	209	552	2,554	320,144	31,661	151.49	288,483	112.95	278,143	42,001
Santa Cruz	7	15	106	6,382	586	83.71	5,796	54.68	0	6,382
Shasta*	33	133	54	2,174	536	16.24	1,638	30.33	1,835	339
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	4	15	20	999	91	22.75	908	45.40	782	217
Solano	7	14	84	8,920	815	116 43	8,105	96.49	7,228	1,692
Sonoma	59	241	183	9,192	1,542	26.14	7,650	41.80	25	9,167
Stanislaus	53	139	228	14,841	2,787	52.58	12,054	52.87	0	14,841
Sutter	0	0	1	22	0	--	22	22.00	0	22
Tehama	0	0	0	0	0	--	0	--	0	0
Trinity	2	5	0	87	87	43.50	0	--	0	87
Tulare	7	23	42	3,366	580	82.86	2,786	166.33	1,192	2,174
Tuolumne	2	7	6	746	20	10.00	726	121.00	726	20
Ventura	9	31	116	10,415	1,000	111.11	9,415	81.16	3,581	6,834
Yolo	5	11	71	3,793	152	30.40	3,641	51.28	0	3,793
Yuba	0	0	13	460	0	--	460	35.38	0	460

a/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

September 1971

County	Recipients			Expenditures						
	Family cases		One person cases	Total	Family cases		One person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	2,193	6,561	52,049	$4,075,924	$186,646	$85.11	$3,889,278	$ 74.92	$3,076,991	$998,933
Alameda	86	188	2,926	211,246	7,327	85.20	203,919	69.69	193,727	17,519
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	2	8	1	117	89	44.50	28	28.00	60	57
Butte	4	8	61	5,614	432	108.00	5,182	84.95	3,151	2,463
Calaveras	0	0	8	225	0	--	225	28.12	15	210
Colusa	1	4	0	15	15	15.00	0	--	0	15
Contra Costa	190	505	1,423	110,163	17,888	94.15	92,275	64.85	105,416	4,747
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	37	120	78	5,055	1,790	48.38	3,265	41.86	0	5,055
Fresno	54	236	137	7,649	1,568	29.04	6,081	44.39	0	7,649
Glenn	1	2	0	21	21	21.00	0	--	0	21
Humboldt	78	272	97	12,065	6,441	82.58	5,624	57.98	9,013	3,052
Imperial	33	116	57	3,035	833	25.24	2,202	38.63	0	3,035
Inyo	9	28	13	665	104	11.56	561	43.15	0	665
Kern	7	13	168	10,291	565	80.71	9,726	57.80	9,910	381
Kings	1	2	25	1,313	50	50.00	1,263	50.52	37	1,276
Lake	1	5	7	249	15	15.00	234	33.43	0	249
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	110	306	28,500	2,009,706	9,030	82.09	2,000,676	70.20	1,541,444	468,262
Madera	5	14	6	28	7	1.40	21	3.50	9	19
Marin	2	13	79	8,069	751	107.29	7,318	92.63	7,919	150
Mariposa	1	0	1	110	0	--	110	110.00	0	110
Mendocino	2	13	31	1,597	196	39.20	1,401	45.19	186	1,411
Merced	32	126	70	4,011	887	27.72	3,124	44.63	1,931	2,080
Modoc	9	50	5	485	220	24.44	265	53.00	236	249
Mono*	0	0	0	0	0	--	0	--	0	0
Monterey	94	352	114	9,043	3,224	34.30	5,819	51.04	0	9,043
Napa	0	0	2	166	0	--	166	83.00	0	166
Nevada	1	4	1	13	5	5.00	8	8.00	0	13
Orange	137	473	332	33,408	5,670	41.39	27,738	83.55	22,627	10,781
Placer	9	36	14	1,113	213	23.67	900	64.29	0	1,113
Plumas	2	4	12	756	105	52.50	651	54.25	0	756
Riverside	43	131	281	18,729	2,866	66.65	15,863	56.45	1,538	17,191
Sacramento	243	664	3,274	284,919	15,200	62.55	269,719	82.38	140,598	144,321
San Benito	0	0	5	334	0	--	334	66.80	0	334
San Bernardino	6	19	134	13,145	576	96.00	12,569	93.80	4,897	8,248
San Diego	140	490	2,037	193,820	15,904	113.60	177,616	87.34	174,605	19,215
San Francisco	250 b/	600 b/	6,900 b/	560,140	27,817	111.27	532,323	77.15	392,286	167,854
San Joaquin	18	50	110	3,633	977	54.28	2,656	24.15	0	3,633
San Luis Obispo	53	193	72	7,817	2,927	55.23	4,990	69.31	5,176	2,741
San Mateo	81	192	1,260	146,390	13,531	167.05	132,859	105.44	146,255	135
Santa Barbara	23	53	281	20,843	2,292	99.65	18,551	66.02	8,173	12,670
Santa Clara	231	678	2,634	329,269	38,077	164.84	291,192	110.55	292,629	36,640
Santa Cruz	8	16	99	5,300	501	62.62	4,799	48.47	0	5,300
Shasta*	32	134	54	2,103	509	15.91	1,594	29.52	1,775	328
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	2	5	18	991	30	15.00	961	53.39	620	371
Solano	7	14	84	9,102	917	131.00	8,185	97.44	6,760	2,342
Sonoma	63	202	179	9,198	1,712	27.17	7,486	41.82	25	9,173
Stanislaus	53	137	205	14,515	3,506	66.15	11,009	53.70	0	14,515
Sutter	1	2	0	9	9	9.00	0	--	0	9
Tehama	3	7	0	21	21	7.00	0	--	21	0
Trinity	2	10	0	157	157	78.50	0	--	0	157
Tulare	3	6	48	3,315	369	123.00	2,946	61.38	1,211	2,104
Tuolumne	1	2	5	617	25	25.00	592	118.40	592	25
Ventura	14	36	117	11,344	1,215	86.79	10,129	86.57	4,149	7,195
Yolo	1	2	72	3,369	62	62.00	3,307	45.93	0	3,369
Yuba	0	0	12	516	0	--	516	43.00	0	516

a/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
b/ Data estimated by San Francisco County.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE IID. GENERAL HOME RELIEF[a]
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

October 1971

County	Recipients			Expenditures						
	Family cases		One-person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	2,008	5,881	50,486	$3,943,136	$175,217	$87.26	$3,767,919	$74.63	$3,090,742	$852,394
Alameda	77	190	2,967	213,440	6,988	90.75	206,452	69.58	199,815	13,625
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	2	5	2	202	168	84.00	34	17.00	65	137
Butte	4	8	52	4,733	454	113.50	4,279	82.29	2,930	1,803
Calaveras	0	0	8	225	0	--	225	28.12	15	210
Colusa	0	0	0	0	0	--	0	--	0	0
Contra Costa	169	447	1,451	116,099	18,078	106.97	98,021	67.55	111,482	4,617
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	30	80	73	4,389	1,662	55.40	2,727	37.36	0	4,389
Fresno	50	177	152	8,148	1,426	28.52	6,722	44.22	0	8,148
Glenn	1	2	1	49	2	2.00	47	47.00	0	49
Humboldt	59	191	97	10,723	3,403	57.68	7,320	75.46	7,712	3,011
Imperial	16	51	53	2,798	624	39.00	2,174	41.02	384	2,414
Inyo	2	10	1	141	52	26.00	89	89.00	0	141
Kern	8	27	170	9,976	718	89.75	9,258	54.46	9,730	246
Kings	1	2	28	1,499	60	60.00	1,439	51.39	37	1,462
Lake	1	5	4	188	10	10.00	178	44.50	0	188
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	28	90	27,617	1,953,882	3,074	109.79	1,950,808	70.64	1,570,097	383,785
Madera	0	0	4	47	0	--	47	11.75	0	47
Marin	8	19	100	8,590	564	70.50	8,026	80.26	8,213	377
Mariposa	0	0	1	20	0	--	20	20.00	20	0
Mendocino	15	40	25	1,890	523	34.87	1,367	54.68	186	1,704
Merced	24	72	70	5,590	1,419	59.12	4,171	59.59	4,450	1,140
Modoc	7	33	2	361	203	29.00	158	79.00	114	247
Mono*	0	0	0	0	0	--	0	--	0	0
Monterey	110	425	130	10,167	3,949	35.90	6,218	47.83	0	10,167
Napa	0	0	3	147	0	--	147	49.00	0	147
Nevada	1	7	1	7	4	4.00	3	3.00	0	7
Orange	129	451	301	30,893	4,806	37.26	26,087	86.67	20,579	10,314
Placer	10	31	10	963	167	16.70	796	79.60	0	963
Plumas*	2	4	12	756	105	52.50	651	54.25	0	756
Riverside	59	202	297	24,502	3,827	64.86	20,675	69.61	1,643	22,859
Sacramento	287	772	3,275	282,891	17,045	59.39	265,846	81.17	140,078	142,813
San Benito	0	0	1	87	0	--	87	87.00	0	87
San Bernardino	7	30	125	12,980	269	38.43	12,711	101.69	4,633	8,347
San Diego	128	423	1,996	180,675	14,524	113.47	166,151	83.24	166,080	14,595
San Francisco	2000/	4500/	5,950	483,278	29,548	147.74	453,730	76.26	364,964	118,314
San Joaquin	23	75	97	4,556	1,333	57.96	3,223	33.23	0	4,556
San Luis Obispo	63	244	60	5,823	2,786	44.22	3,037	50.62	3,285	2,538
San Mateo	79	180	1,457	146,563	12,562	159.01	133,981	91.96	146,408	155
Santa Barbara	20	49	311	20,706	2,426	121.30	18,280	58.78	10,666	10,040
Santa Clara	227	629	2,709	335,845	33,656	148.26	302,189	111.55	299,043	36,802
Santa Cruz	6	16	89	5,429	553	69.12	4,876	54.79	0	5,429
Shasta	15	59	51	2,553	619	41.27	1,934	37.92	2,145	408
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	4	11	11	457	34	8.50	423	38.45	375	82
Solano	7	14	87	8,494	853	121.86	7,641	87.83	6,708	1,786
Sonoma	30	147	176	8,246	1,162	23.24	7,084	40.25	35	8,211
Stanislaus	45	115	199	14,046	2,981	66.24	11,065	55.60	0	14,046
Sutter	2	6	0	18	18	9.00	0	--	0	18
Tehama	1	6	3	115	3	3.00	112	37.33	115	0
Trinity	2	10	0	80	80	40.00	0	--	0	80
Tulare	6	13	60	4,411	568	94.67	3,843	64.05	2,711	1,700
Tuolumne	0	0	5	440	0	--	440	88.00	415	25
Ventura	18	52	113	11,435	1,843	102.39	9,592	84.88	5,619	5,816
Yolo	3	11	65	3,039	68	22.67	2,971	45.71	0	3,039
Yuba	0	0	14	564	0	--	564	40.29	0	564

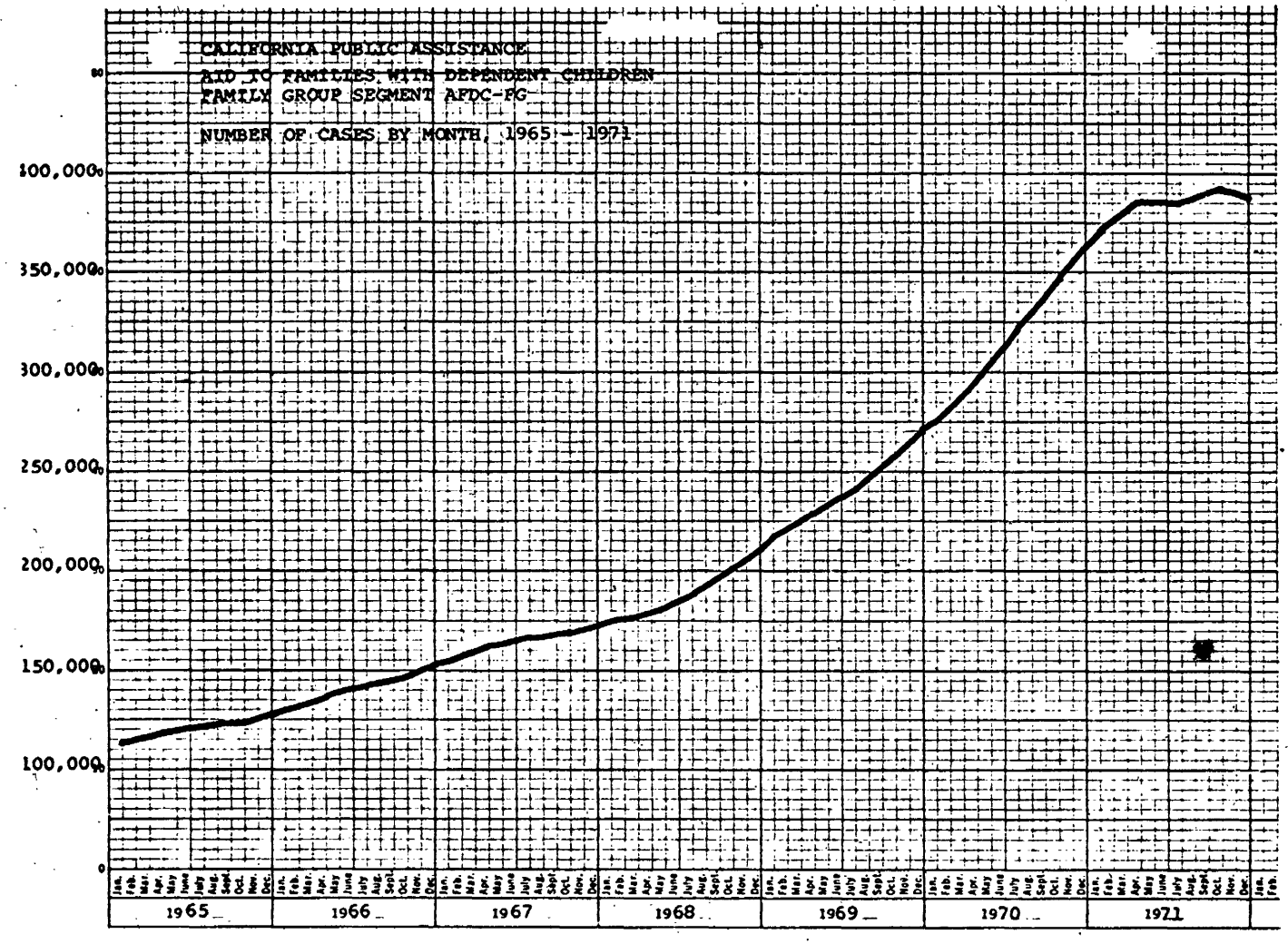
a/ Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
b/ Data estimated by San Francisco County.
Note: Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
* Data estimated, report(s) not received.

TABLE 11b. GENERAL HOME RELIEF/
RECIPIENTS AND EXPENDITURES BY TYPE OF CASE

November 1971

County	Recipients			Expenditures						
	Family cases		One person cases	Total	Family cases		One-person cases		Aid in cash	Aid in kind
	Cases	Persons			Total	Average	Total	Average		
All counties	2,935	7,351	50,535	$3,795,233	$188,392	$80.68	$3,606,841	$71.37	$2,904,589	$890,644
Alameda	82	181	2,997	216,193	7,635	93.11	208,558	69.59	202,492	13,701
Alpine	0	0	0	0	0	--	0	--	0	0
Amador	3	7	1	155	140	46.67	15	15.00	60	95
Butte	5	17	94	4,276	467	93.40	3,809	70.54	3,447	829
Calaveras*	0	0	8	225	0	--	225	28.12	15	210
Colusa	1	8	0	20	20	20.00	0	--	0	20
Contra Costa	226	665	1,562	125,344	18,734	82.89	106,610	68.25	116,950	8,194
Del Norte	0	0	0	0	0	--	0	--	0	0
El Dorado	32	92	90	5,697	1,936	60.50	3,761	41.79	0	5,697
Fresno	66	257	154	8,676	2,150	32.58	6,526	42.38	0	8,676
Glenn	0	0	1	50	0	-	50	50.00	0	50
Humboldt	48	133	91	9,578	3,103	64.65	6,475	71.15	7,304	2,274
Imperial	37	157	58	3,121	646	17.46	2,475	42.67	0	3,121
Inyo	20	73	40	2,760	544	27.20	2,216	55.40	0	2,760
Kern	12	39	166	11,412	1,069	89.08	10,343	62.31	11,132	280
Kings	2	4	55	2,058	128	64.00	1,930	35.14	42	2,016
Lake	4	11	6	295	57	14.25	238	39.67	0	295
Lassen	0	0	0	0	0	--	0	--	0	0
Los Angeles	20	65	26,660	1,774,894	2,195	109 75	1,772,699	66.49	1,426,269	348,625
Madera	7	17	10	46	14	2.00	32	3.20	11	35
Marin	6	12	118	9,821	782	130 33	9,039	76.60	9,491	330
Mariposa	1	2	1	45	25	25 00	20	20.00	20	25
Mendocino	15	45	27	1,613	369	24.60	1,244	46 07	221	1,392
Merced	44	180	81	8,034	3,179	72.25	4,855	59.94	6,494	1,540
Modoc	12	81	6	532	260	21.67	272	45.33	390	142
Mono*	0	0	0	0	0	--	0	--	0	0
Monterey	182	808	147	16,874	7,550	41.48	7,324	49.82	0	14,874
Napa	0	0	4	145	0	-	145	36.25	0	145
Nevada	0	0	0	0	0	--	0	--	0	0
Orange	104	359	299	28,461	4,006	38.52	24,455	81.79	20,919	7,542
Placer	9	16	12	1,040	48	5.60	992	82.67	0	1,040
Plumas	3	6	13	519	62	20 67	457	35.15	0	519
Riverside	43	113	289	19,050	2,941	68.40	16,109	55.74	1,441	17,609
Sacramento	331	889	3,756	323,917	21,578	65.04	302,389	80.51	141,974	181,943
San Benito	0	0	1	211	0	--	211	211.00	0	211
San Bernardino	7	15	127	13,498	276	39.43	13,222	104.11	5,422	8,076
San Diego	148	573	2,187	190,721	16,212	109.68	174,489	79.78	172,079	18,642
San Francisco	209	469	5,882	393,031	19,743	94.46	373,288	63.40	267,548	125,483
San Joaquin	15	52	102	4,120	929	61.93	3,191	31.28	0	4,120
San Luis Obispo	77	273	67	8,603	3,802	49.38	4,801	71.66	5,198	3,405
San Mateo	81	183	1,374	155,634	13,911	171.74	141,723	103.15	155,557	77
Santa Barbara	30	87	299	19,206	2,465	82.17	16,741	55.99	7,909	11,297
Santa Clara	249	869	2,676	364,975	40,128	161.16	324,847	121.39	322,162	42,813
Santa Cruz	6	12	120	6,908	351	58.50	6,557	54.64	0	6,908
Shasta	20	62	51	2,356	518	25.90	1,838	36.04	2,148	208
Sierra	0	0	0	0	0	--	0	--	0	0
Siskiyou	2	16	9	417	38	19.00	379	42.11	331	86
Solano	8	16	98	9,446	974	121.75	8,472	86.45	7,120	2,326
Sonoma	68	209	205	10,981	2,532	37.24	8,449	41.21	25	10,956
Stanislaus	74	210	256	19,375	4,985	67.36	14,390	56.21	0	19,375
Sutter	1	2	0	18	18	18.00	0	-	0	18
Tehama	2	8	0	24	24	12.00	0	--	21	0
Trinity	1	3	0	20	20	20 00	0	--	0	20
Tulare	8	19	71	3,786	411	68.50	3,375	47.54	3,299	487
Tuolumne	0	0	4	460	0	--	460	115.00	460	0
Ventura	14	30	145	14,434	1,206	86.14	13,228	91.23	6,634	7,800
Yolo	6	13	61	3,447	241	40.17	3,206	52.56	0	3,447
Yuba	0	0	14	711	0	--	711	50.79	0	711

Excludes miscellaneous general relief and supplemental aid to categorical aid recipients.
(a): Because of differences among counties in general relief program and policy, data in this table are not strictly comparable.
Data estimated, report(s) not received.


CALIFORNIA PUBLIC ASSISTANCE
AID TO FAMILIES WITH DEPENDENT CHILDREN
FAMILY GROUP SEGMENT AFDC-FG
NUMBER OF CASES BY MONTH, 1965 - 1971
400,000
350,000
300,000
250,000
200,000
150,000
100,000
0
1965
1966
1967
1968
1969
1970
1971

Average Number of Persons Per AFDC-FG (Family Group) Case
December of Each Year, 1965 Through 1971

	Average No. Persons Per Case	Persons	Cases
December 1965	3.88	497,511	128,105
1966	3.84	585,707	152,409
1967	3.75	646,543	172,478
1968	3.66	774,788	211,527
1969	3.55	964,593	273,878
1970	3.40	1,238,422	363,989
1971	3.29	1,273,241	386,465

Source: State Department of Social Welfare
Management Information Systems
Public Assistance Caseloads and Expenditures
(Monthly Report)

STATEMENT OF HON. HERBERT FINEMAN, SPEAKER, HOUSE OF REPRESENTATIVES, COMMONWEALTH OF PENNSYLVANIA

Approximately a year ago, I submitted a statement to this Honorable Committee when it was then considering the President's Family Assistance Program. At that time, I endeavored to indicate the measure of the impact on the states of the proposed Federal legislation concerning welfare. Because of this impact upon the states, I firmly believe any Federal legislation should be approached on a reasonably reciprocative basis betwen the states and Federal Government. I think it is incumbent upon state officials to make known what affect your proposals will have on their respective state governments. I am grateful to you, therefore, for this opportunity to state the views herein contained.

May I initially state that although I am solely responsible for this statement, the views expressed are in essence the views of officials of the Commonwealth of Pennsylvania. After HR-1 passed the House of Representatives, representatives of the Pennsylvania House and Senate, the Governor's Office and the Pennsylvania Departments of Public Welfare and Labor and Industry reviewed the provisions of the bill and developed a consensus position on recommendations to be made for amending the proposed legislation in the U.S. Senate. Therefore, while the following comments are mine, they also represent the thinking of the top government officials of the Commonwealth of Pennsylvania.

Although there are a total of fourteen suggested revisions to the House bill that I would like to offer, I will address myself at this time to only several of the proposals which are of more important consequence to Pennsylvania and its citizens.

HR-1, as it passed the House, makes state supplementation of welfare payments optional. I can't help but believe that this is a grievous mistake. Knowing my fellow legislative leaders and the Governor of the Commonwealth, I can

assure you that the idea of reducing payments to public welfare recipients would be most repugnant to them. Despite this, however, I would have to state that legislative leaders and the Governor of the Commonwealth, during periods of extreme financial duress, could be forced into a position of seriously contemplating welfare reductions. I would much prefer that the Federal law not make such a potential consequence possible.

I assure you this is not an idle or unfounded apprehension. This can become a reality and in fact came close to being a reality in the State of Pennsylvania. A little over a year ago a former Governor of the Commonwealth, in an effort to balance the State's budget without a tax increase, recommended to the General Assembly that the general assistance payments in the State be reduced by 75%. Along this line, recently the State of New York announced a 10% across-the-board reduction in welfare payments. Again, this was brought on by severe financial problems in the State of New York. I do not believe that the law should be so constructed, either state of Federal, that the poor people of our society can become the pawns in political hassles during a severe financial crisis.

HR-1, also calls for a Federal base payment for a family of four of $2,400 a year. It is our recommendation that this sum be increased, at the very least, to $3,000 a year. The establishment of such a low floor on the Federal payment would be a conscious penalty to those states, like Pennsylvania, who have made an effort in the past to have a reasonably decent public welfare program. With a Federal base of $2,400, the benefits to the State of Pennsylvania would be significantly and practically non-existent. There is just no motivation for Pennsylvania to support such a rate.

If one of the purposes of this Bill is to give financial relief to the states, it fails dismally in this goal in the Commonwealth of Pennsylvania. Figuring the benefits at the very possible maximum and giving the proposal the benefit of the doubt, the most Pennsylvania could hope to realize would be a $30 million dollar saving. This is compared against approximately $1,000,000 that the State expects to spend this year on public welfare. This simply cannot be viewed as significant or meaningful fiscal relief.

I would like to endorse at this time, as a basic goal of this Bill, the phased, full Federal take-over of welfare costs for all categories. I am sure there are different processes by which this could happen, and I express no strong views as to the mechanics to be employed in implementing this takeover. However, I do find Senator Ribicoff's proposal on this matter to be highly acceptable. You are aware, I am sure, that the Senator recommended an increasing percentage of Federal assumption of welfare costs over a four or five year period until which time the Federal Government had assumed 100% of the financial responsibility. I further endorse the Senator's recommendation that this Federal assumption be based on the federally established poverty level.

The restrictions in HR-1, on the Medical Assistance Program, are completely unacceptable to the Commonwealth of Pennsylvania. Whereas, the purpose of HR-1 is to give financial relief to the states, the title on medical assistance would cost the State of Pennsylvania approximately 12,000,000 additional dollars the first year and approximately 20,000,000 dollars the second year of the program. These limitations on skilled nursing care, mental hospital care and intermediate care would have an injurious effect not only on the State but on the citizens who would be put under a time limitation as to how many days they were permitted to be ill.

HR-1, as it passed the House, has a rather unusual administrative mechanism for carrying out the purposes of welfare reform. The Departments of Labor and HEW are assigned similar responsibilities and would be required to perform the same services for welfare recipients depending on whether a family has an employable person. In other words, a family without an employable person would receive their social welfare assistance and services from the Department of HEW or its state counterpart. If a family has an employable person, that family would receive its public welfare assistance and services from the Department of Labor or its state counterpart. This would result in having two parallel governmental agencies performing the same function. It just simply cannot be justified for our Pennsylvania Department of Labor & Industry to set up the same bureaucratic mechanism and hire a staff of social workers to perform the same functions which Pennsylvania Department of Public Welfare is already properly equipped to handle.

I see nothing wrong with the Bill requiring that employable persons be referred

to the Department of Labor & Industry for training and employment, but I can see no advantage whatsoever for that Department to provide for welfare assistance and services. Even if the Labor Department would sign an agreement for the Welfare Department to perform this function, no advantages accrue in placing the legal responsibility on the Labor Department.

One of the very big deficiencies in the present Bill is its silence on childless couples and single persons. They are excluded from any coverage in HR-1. It would be my recommendation that this oversight be corrected and a category, which is known as General Assistance in our State, be made part of the Federal Welfare Program. In addition to the above suggestions, I would like to list some other proposals that the Commonwealth of Pennsylvania is most desirous of having incorporated in the legislation in question.

The poverty level, which would be used to determine assistance level, should be redetermined annually to reflect changes in the cost of living. The provety level should not be frozen at an amount that is specified by law. Updating should require amendment of the law.

Reality would require that if we are going to have national standards on public welfare, we must also recognize that the cost of living varies between different regions in the nation and that there should be adjustments in payments between those regions.

H.R.-1 presently provides that recipients could be required to accept employment, at a pay level which is no more than three-quarters of the Federal minimum wage. This is completely unacceptable and is inconsistent with other Federal laws. The Bill should not require employment below the minimum wage.

The provisions in this Bill to establish 200,000 public service jobs is insignificant, and this provision should be expanded considerably, to a more realistic level.

The day care provisions are also extremely unrealistic and the provisions in the Bill for 875,000 day care slots should be increased by at least three fold.

There is no provision in the Bill to protect a potential recipient in the event that there are no day care facilities, training or employment opportunities available. No one should be denied benefits because of the lack of such facilities for which the recipient cannot be faulted.

Federal courts have already stated that residency requirements for welfare recipients are unconstitutional and such requirements in HR-1 should be eliminated.

Regarding the goal for full Federal assumption of public welfare, we would like to see the Bill provide protection for the rights of all employees who are presently employed in state and local welfare programs.

I cannot stress strongly enough the importance of welfare reform to the states of this nation. I would like to urge with all vigor that it is a critical need for the states to have help in public welfare just as quickly as possible. We, in state government, have been under the gun to take a more responsible position in solving our domestic problems such as education, housing, transportation, pollution, etc. I want to assure this Committee that the legislative leaders of the State of Pennsylvania accept that responsibility, but we must have your help to fulfill it. If the U.S. Government will move toward a complete welfare reform which will include full Federal assumption of the welfare program, the states will be able to do much more toward the above-mentioned problem areas and to provide heavier financial assistance to their cities and municipalities, which, in like turn, should relieve considerably the pressures upon the Congress from the cities for urban aid. If you will help us help ourselves, you hopefully will be relieving yourselves of considerable pressures for Federal assistance in the future.

Thank you. I appreciate this opportunity to have submitted this statement.

STATEMENT OF HON. K. LEROY IRVIS, MAJORITY LEADER, PENNSYLVANIA HOUSE OF REPRESENTATIVES

Mr. Chairman and members of the Senate Finance Committee, I am both pleased and honored to be able to present to you the following statement.

I know this committee of senators has heard all types and kinds of testimony concerning the effect of HR-1 upon the various states. To a good bit of this testimony I will subscribe and a large part of it I can endorse; and I will speak about some of it later. However, my immediate concern is not the government of the Commonwealth of Pennsylvania but rather its citizens.

I would also like to preface my comments in an effort to put my statement into context. We have made an effort in the Commonwealth of Pennsylvania to analize HR–1 in terms of the effect the bill would have on the Commonwealth and its citizens. A committee of people representing the Pennsylvania House and Senate, the Governor and two executive departments, Welfare and Labor and Industry analyzed HR–1 with the purpose in mind that concrete and specific suggestions would be made for amending the bill in the United States Senate. The comments I will make will be consistent with this concensus position, which has been agreed to by the top elected and appointed officials in the State of Pennsylvania.

HR–1 presently freezes welfare benefits for the next five years. This is terribly inconsistent with reality. It completely eliminates consideration of the condition of life some of our more unfortunate citizens must live. Even if the President's anti-inflation program should be successful, there is bound to be an inflationary process taking place, at the rate of at least 2 to 3 percent a year. I believe the President has indicated that he will consider his program successful if he can hold the inflationary spiral to 3 percent a year. Therefore, in actuality HR–1 would call for at least a 3 percent annual decrease in benefits to welfare recipients. Of course, at this point those who are critically suspicious of the whole public welfare program could charge that there are too many ineligible people on the welfare rolls. Even if this were true, which I seriously dispute, I ask you, do you want to penalize those unfortunate citizens who are legitimately on the welfare rolls by reducing their benefits because of a statutory freeze.

It is my recommendation, therefore, that all such assistance benefits should be subject to cost-of-living increases to be implemented at least on an annual basis.

One of the concepts that we in Pennsylvania have endorsed wholeheartedly both in the President's proposal and in the language of HR–1, are national standards for both eligibility and benefits. Although we do endorse national standards, I think this can only be effective if we recognize the fact that there are different cost-of-living levels in different regions within the United States. I think it is rather obvious to most of us that a family is probably a little less economically deprived on $2,400 or $3,000 a year in a rural parish in Louisiana if compared to a $2,400 or $3,000 income in the cities of either Pittsburgh or Philadelphia. Having regional differences of benefits will not be an insurmountable administrative problem. I think the United States Government has more than ample data available to it to support such differences.

I am sure that most of you are very much aware that HR–1 presently allows employment at three-fourths the federal minimum wage. In fact, it not only allows for sub-minimum pay but would require a welfare recipient to be willing to accept sub-minimum pay with threat of losing benefits if refused. It is inconceivable to me that the United States Government could on the one hand establish an absolute minimum value for human labor and on the other hand ignore it. I can tell you precisely the psychological effect that such an inconsistency will have upon a wefare recipient. A large number of welfare recipients have problems concerning their own self-esteem and self-value, and with a policy such as this, this will only emphasize their feeling of being some kind of inferior human being. I believe it is the consensus of opinion of almost everyone that the present welfare system has been self-defeating. This has come about because the system has forced recipients to consider themselves inferior and therefore destroyed their ability to become self-sufficient citizens. The provision in HR–1 requiring recipients to work for sub-minimal pay will cause the new welfare program to be self-defeating in the same manner as the present program. I can only state with all the vigor at my command that this is the worst possible method to reduce the welfare rolls. Our job is to give these people some self-esteem and feeling of self-value—not take it away—so that they will believe that it is within their power to elevate themselves. If there is any one thing in HR–1, as it is presently written, that I have to say is totally and completely repugnant to any sense of decency or propriety, it is this requirement that welfare recipients would have to be willing to work at a sub-minimum level of compensation.

I, therefore, recommend as firmly as I can, that HR–1 be amended to state that no one would be required to accept work below the federal minimum wage as a condition for receiving benefits.

HR–1's provision to provide approximately two-hundred-thousand public service employment jobs is begging the issue at best. I am in no way implying that I oppose public employment as a step in the process of making everyone self-sup-

porting, but two-hundred thousand, is meaningless. If this is not increased at least to approximately one-half million jobs, it will not be of any particular significance. On public service employment, there is an aspect of this that worries me considerably and has worried me since the passage of the Emergency Employment Act of 1971. How much the public employment provision in HR–1 worries me depends on how similar it is to the Emergency Employment Act provision. Under the Emergency Employment Act a state or a locality will receive federal funds to hire and train unemployed people. Under the Emergency Employment Act, after a certain period of lower unemployment the federal funds for the program can be withdrawn from the state or locality, which means that those people who have been holding jobs underwritten by the federal funds will again possibly find themselves unemployed. This process that we have been following in the last years of starting to help poor or under-privileged people and then suddenly dropping them has led to a horrible cynicism on the part of the under privileged. This cynicism makes it extremely difficult to motivate and lead these people to more positive attitudes toward life. I would ask you to review the provisions of HR–1 on public employment both from the standpoint of expanding its provisions and to assure that it is intended to help and not damage.

As we are all well aware, the very core of any welfare reform program should center around the children who are caught in the welfare trap. The self defeating aspects of the present welfare program are no more evident than they are with the children of mothers who find it necessary to receive welfare. It is not difficult at all to obtain supporters for a day care program, which would permit mothers who are receiving welfare to obtain employment and leave the welfare rolls. However, what is much more important than just providing custodial care for children so the mothers can work, is the providing of developmental programs for the children. A comprehensive child welfare program, providing education, health and medical care, nutrition and positive social outlets in order that the children will have a fighting chance to develop into self confident and productive human beings is an absolute necessity. In lieu of the provisions of HR–1, I would recommend the program that was included in the OEO extension bill which the President vetoed. At the very least, I would recommend that Senator Ribicoff's proposal be accepted whereby the money provision of HR–1 for child care be increased from $700 million to $1.5 billion.

The big issue that has provided the motivation for welfare reform has been a mythological issue whereby the average taxpayer feels that the average welfare recipient is a lazy bum, and will remain a lazy bum and on welfare unless he is provided with some pretty hard-nosed incentive, to get off his duff and get working. For those who believe this myth as being gospel and accept it as an absolute truth in our society, I will make no attempt to convince otherwise. I am sure they have heard every argument which I am capable of mustering. They have heard all of the data; they have been told all of the realities; and they choose to believe that the average welfare recipient is still what they thought in the first place—a lazy bum. Accepting the fact that a large number of our population and also a large number of our elected public officials accept this myth, I am prepared to agree, especially in light of the recent passage of the Talmadge amendments to the Social Security Act, that HR–1 will have to include some provision requiring a welfare recipient to register for work and/or training. I find this requirement repugnant among other reasons because it was built upon a myth that fact cannot seem to destroy. As I am prepared to endorse the consequence of this myth, I would like to ask you to consider the administrative reality of what this requirement calls for. This means that there will have to be many, many more social workers, job counselors, education counselors and day care attendants. This is fine. I don't disagree with the concept that the public should provide technicians to assist low income people, but what I am saying is that I doubt very much that either the Congress of the United States or the legislatures of the various states are going to be willing to appropriate any where near the necessary funds to provide all of these necessary employees. Considering that this is probably a better than even possibility that all of the necessary functions will not be financed, we will have to admit that a lot of welfare recipients will not be placed in training and will not be placed in jobs. It is my recommendation that these people be protected in the bill from a loss of beenfits because of the absence of training or employment in their local area. I am requesting that language be written into the bill that would prohibit any state or locality from denying benefits to any indi-

vidual who is unable to participate in either training or employment through no fault of his own. No fault would be interpreted as the lack of suitable and available training or employment within a reasonable distance from his home. Availability of transportation should be a consideration in making this judgment. The lack of day care facilities should not be used to deny a recipient benefits.

I would like to follow through on the requirement in HR–1 that would eventually require the mothers of pre-school age children to register for work or training. As a human being, I find this repugnant beyond belief that we can be so unrealistic as to separate a mother and a baby during one of the most critical periods of time in a child's growth. The Talmadge amendments to the Social Security Act recognizes this and does not place mothers of children under six in a forced work situation. Psychiatrists are now telling us that the emotional patterns of later life are fairly well established in the first few years of one's existence. They further tell us that these emotional patterns to a large degree depend on how much physical coddling and physical attention based on love the child received in its first few years of life. My friends of this committee, it is not my intention to wave a flag of motherhood before you, but I am citing to you what to my understanding is scientific fact. I would like to see the bill amended so as not to require any mother with pre-school age children to register for work or training.

I would like to take this opportunity to endorse a couple of recommendations that were recently made by Governor Sargent of Massachusetts, Governor Shapp of Pennsylvania and a number of other Governors. I wholeheartedly endorse their suggestion that HR–1 have a basic floor of $3,000 a year for a family of four. I also endorse their recommendation that no recipient should receive less than he would have received under a combined program of food stamps and welfare payments under the existing programs.

Following, I would like to leave with this committee a very brief outline of suggestions for amendment to the bill that would improve its administration from the viewpoint of the State.

HR 1 should be amended to make State supplementation of welfare payments mandatory at least up to the level of their present benefits. To permit a state to lower its benefit level would both be disastrous for the welfare recipient and to the political process in the states.

I wholeheartedly endorse the concept of full federal assumption of all welfare categories including state general assistance programs. I can endorse the proposal made by Senator Ribicoff to have a phased federal takeover in a 4 to 5 year period. This federal assumption of federal welfare benefits should be based upon the federal government's poverty level criteria.

I am very much opposed to the restrictions in HR–1 on the medical assistance program. The limitations this bill would place on skilled nursing care, mental hospital care and intermediate care would be fiscally injurious to the State and inconsistent with one of the purposes of this bill to give the State fiscal relief.

Under HR–1, as it is presently written, welfare services and assistance will be provided both by the departments of Labor and Health, Education and Welfare and their state counterparts. I think this would be very bad law and I think the responsibility for public welfare should be lodged with a single government department.

I have submitted this statement with the expressed purpose of addressing myself to the human aspects of HR–1. I am not unaware that when one addresses himself to the human aspects he runs the risk of the charge of "do-gooder" or a "bleeding heart". This risk I have taken wilfully and knowingly. I have taken this risk and I am willing to be called a "do-gooder" or a "bleeding heart", but what is more important is to get these people off the welfare rolls if it is possible. To this goal I will stand shoulder to shoulder with the most conservative person in the United States whose ambition it is to remove all people from the welfare rolls. I can think of nothing I would sooner do. I can think of nothing I would rather see happen. That is why I have spoken on this matter. I see some aspects of HR–1 that would be self-defeating and I with everyone else would like to see welfare reform be successful. I would like to see all of our citizens self-supporting and off the welfare rolls; and I can sincerely say that everything I have commented on has that goal in mind.

Are there any among us who are not concerned about the poor? Of course not. Is there anyone who doesn't care? I doubt it very much. My only desire is to

challenge all of us to direct that concern and care into a welfare reform program that will not be self-defeating. Let us help people get off welfare—not trap them into an eternal hell of welfare.

WISCONSIN LEGISLATURE,
SENATE CHAMBER,
January 31, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Committee on Finance,
U.S. Congress,
Senate Office Building,

DEAR SENATOR LONG: Upon direction of the Wisconsin Legislature we are transmitting a copy of Senate Joint Resolution 19, memorializing Congress to enact federal legislation authorizing state public assistance programs to use vendor and voucher payments in certain circumstances.

This Joint Resolution was adopted by both Houses of the Wisconsin Legislature and expresses its feelings.

Sincerely yours,

WILLIAM P. NUGENT,
Senate Chief Clerk.

Enclosure.

THE STATE OF WISCONSIN—1971 SENATE JOINT RESOLUTION

ENROLLED JOINT RESOLUTION

Memorializing congress to enact federal legislation authorizing state public assistance programs to use vendor and voucher payments in certain circumstances.

Whereas, state administration of a public assistance program should recognize two basic objectives, first, the desirability of delegating some measure of moderate control to the local governments dispensing such assistance, and second, the necessity of taking into account the real difficulties encountered in administering assistance cases where there is a demonstrated mismanagement or misuse of funds; and

Whereas, in an attempt to meet the latter objective congress has heretofore enacted sections 603 (a) (5) and 606 (b) (2) of the federal social security act, which provide in part that aid to families with dependent children may include payments in behalf of any such children made either to another individual concerned with the welfare of those children or to a person furnishing food, shelter, or other goods, services or items to or for them, provided that the number of said individuals or persons (who are commonly referred to as "protective payees") do not exceed 10 per centum of the number of other recipients of aid to families with dependent children in the state for any particular month; and

Whereas, other sections of the social security act relating to the administration of public assistance require an unrestricted money payment unless the assistance agency has first provided the opportunity for a hearing to determine that the public assistance recipient is incapable of handling his funds, and only then may the agency appoint a protective payee; and

Whereas, the protective payee system has proven completely unworkable because local welfare directors find it difficult if not impossible to find persons willing to serve as protective payees; and

Whereas, as of January 1, 1971, Milwaukee county alone had 1,259 active cases in which there had been a demonstrated mismanagement of funds primarily because of failure to pay rent or utilities; and

Whereas, in certain cases under the federally subsidized program of aid to families with dependent children (AFDC) where there has been demonstrated mismanagement of funds, the local welfare department often finds it necessary to authorize a double payment for rent and utilities after the first payment made from AFDC funds has been misspent, with the second payment coming from strictly county funds; and

Whereas, failure to authorize federal funds for vendor and voucher payments made to AFDC recipients forces the state to assume an unfair burden in financ-

ing public assistance cases where mismanagement of funds has been demonstrated; and

Whereas, the unrestricted money payment requirement causes problems for both the public and private assistance agencies because some AFDC recipients presently misuse the public funds given them for special needs, such as furniture and then proceed to obtain these special needs items from private agencies; and

Whereas, this situation results in a waste of public funds and depletion of the resources of private agencies; and

Whereas, the practice of prohibiting voucher and vendor payments to AFDC recipients is neither economical nor equitable for state and local agencies administering federal assistance programs; and

Whereas, as stated in the second paragraph hereof, the congress of the United States has already established the legislative precedent for a 10 per centum formula of restricted payments in AFDC cases; now, therefore, be it

Resolved, By the senate, the assembly concurring, That the legislature of the state of Wisconsin urges federal legislation to permit a county government or its welfare agency administering federal assistance programs to authorize the following two-fold limited voucher and vendor plan in granting aid to families with dependent children, without the loss of reimbursement of the federal share of such aid: 1st, to dispense grants of aid to all new AFDC recipients in the form of vendor payments and vouchers for commodities for an initial period of up to 120 days wherever it is feasible to do so, provided that the number of new recipients getting restricted payments do not exceed 10 per centum of the number of other AFDC recipients getting assistance from the same county government or agency for any particular month; and 2nd, to give aid to families with dependent children, as provided in section 49.19(5) of the Wisconsin statutes, in the form of supplies or commodities or vouchers for the same, in lieu of money, as a type of remedial care whenever the giving of aid in such form is deemed advisable by the county welfare director dispensing such aid as a means either of attempting to rehabilitate a particular person having the care and custody of any such children or of preventing the misuse or mismanagement by such person of aid in the form of money payments, provided that the number of such persons getting restricted payments do not exceed 10 per centum of the number of other AFDC recipients getting assistance from the same county government or agency for any particular month; and, be it further

Resolved, That duly attested copies of this adopted resolution be immediately transmitted to the secretary of the federal department of health, education and welfare, the chairman of the finance committee and the secretary of the senate of the United States, the chairman of the ways and means committee and the clerk of the house of representatives of the United States, and to each of the 12 members of congress from this state.

WILLIAM P. NUGENT,
Chief Clerk of the Senate.
THOMAS P. FOX,
Chief Clerk of the Assembly.

STATEMENT PREPARED BY STATE REPRESENTATIVE ARTHUR L. BUCK, WYOMING, NATIONAL LEGISLATIVE CONFERENCE TASK FORCE ON HUMAN RESOURCES

ENACTMENT OF H.R. 1

It is the consensus that it might be better to defer enactment until pilot programs in a few states, both sparsely and heavily populated, to determine merits of the program before adoption nationally.

There was general concurrence with the statement of objectives for true welfare reform outlined by Chairman Russell Long:

1. It must discourage family breakup and foster family unity;
2. It must prevent cheating and dishonesty and when this fails, detect it and deal firmly with it;
3. It must reward efforts at self-help rather than rewarding idleness among the employable; and
4. It must provide adequate child care services for children of low-income working mothers and mothers on welfare.

Since there is considerable variation among the states in welfare volume and extent of services, some latitude should be left to the several states in adminis-

tration of the program. (Only 3% of Wyoming's population, approximately 8,000 persons, are on welfare.)

National minimum income standards

In view of inflationary developments, there is an obvious need for upward adjustment, at least to the level of that proposed in H.R. 1. (Wyoming presently allows $104 monthly for individuals and $178 for couples.)

Fiscal relief or fiscal protection for States

States should have federal relief in the proposed program of national coverage in deference to the new residence requirement as determined by the courts. At least the states should have no additional liability.

Financial incentives to work, or income disregards

Incentives should be retained. (The first $30 and one-third of additional income are permitted in Wyoming.)

Work requirements and suitability of work

Should be determined by the individual state, depending on nature of relief rolls and availability of opportunity. (In Wyoming, opportunity is limited, both in the private and public sector. Retraining, also expensive, is essential in many cases.)

Federal-State administrative responsibilities and options

Federal Regulations as a rule are not flexible enough to meet requirements of individual states. (Wyoming has no large urban areas which may be eligible for impact programs.)

Day care and child development services

Is needed at low income level when pay of parent does not compensate for cost of child's day care which in many cases is inadequate and not socially to best interest of the child. (Child care centers in Wyoming at present are inadequately regulated.)

Welfare administrative procedures

Procedures should be implemented by, in addition to interview, validation of statements involving checking with various federal social security and tax information sources.

In addition, a deserting parent would be obligated to the United States for the amount of any federal payment made to his family less any amount that he actually contributes by court order or otherwise to his family.

State role in administering manpower, child care and supportive services in the opportunities for families program for employable recipients

Administration should be left to the states without the involvement of the Labor Department. Local agencies are more familiar with recipient needs in relation to actual working conditions and pay scales. (Employment is frequently limited to a short work week so that the employee does not qualify under existing statutes.)

State administered social services

The concept of an "open-ended" appropriation should be restored, eliminating the ceilings as provided in H.R. 1.

SOUTH JERSEY CHAMBER OF COMMERCE,
Pennsauken, N.J., December 1, 1971.

Re Social Security Tax—Provision of H.R. 1.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: On August 5, 1970 the South Jersey Chamber of Commerce wrote you to express its views on H.R. 17550, a Social Security bill then under consideration by the Senate Finance Committee. We favored Social Security benefit increases but opposed automatic benefit increases and the method of financing the automatic increases.

Fortunately H.R. 17550 was laid to rest and indeed we are grateful for the sound judgment that prevailed in the 91st Congress which prevented its passage.

Congress did, however, increase Social Security Benefits and in fact over the past two years benefits have increased some 25%.

We are back again, Senator, to solicit your support for the defeat of the Social Security Provision of H.R. 1 which passed the House of Representatives June 22, 1971.

Our organization opposes the Social Security Provision of H.R. 1 which provides for automatic benefit increases because of the alarming additional taxes to individuals and their employers.

President Nixon's Tax Reform Program proposes an increase in the individual income tax exemptions for 1972 and the enactment of the reference tax would off-set net tax relief for the middle class citizen.

It would burden American Business with additional costs making it difficult to compete with foreign competition.

If the measure is enacted it would establish a dangerous precedent and those on welfare, unemployment compensation and State and local pensions would also demand automatic benefit increases. Again this would require substantial amounts of taxpayers funds whether from the State or local source.

The South Jersey Chamber of Commerce represents over 600 businesses who employ in excess of 100,000 and we urge you to work for the defeat of the Social Security Provision of H.R. 1.

Thank you for the opportunity of expressing our views to you on this vitally important matter.

Sincerely yours,

S. NATHAN LEV, *President.*

AMERICAN BAR ASSOCIATION,
SECTION OF ADMINISTRATIVE LAW,
Chicago, Ill., January 17, 1972.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The Committee on Hearing Examiners of our Section has brought to my attention Section 2031(d)(2) and 2171(d)(2) of H.R. 1, presently pending before the Senate, proposing amendments to the Social Security Act. These are not consonant with the intent and policy of a resolution adopted by the Council of the Section of Administrative Law.

The particular aspects of the bill which concern us are those that provide that the Secretary of the Department of Health, Education and Welfare would be authorized in his sole discretion to appoint persons to act as Hearing Examiners in Family Assistance Hearings and others, without requiring such persons to qualify as Hearing Examiners under the Administrative Procedure Act, 5 U.S.C. 551 et seq.

In view of our Council position, it is the policy of the Section of Administrative Law of the American Bar Association that the appointment of such Hearing Officers by the Secretary would not promote the purpose of the Administrative Procedure Act, and consequently, Congress should grant such authority to make appointments of qualified persons only on condition that the Civil Service Commission is unable to provide the Social Security Administration with a large enough number of persons qualfied for, and willing to accept, appointments by the Social Security Administration as Hearing Examiners under 5 U.S.C. Sec. 3105.

Very truly yours,

MILTON M. CARROW,
Chairman, Section of Administrative Law.

JOINT STATEMENT OF AMERICAN CHIROPRACTIC ASSOCIATION AND INTERNATIONAL CHIROPRACTORS ASSOCIATION

(Jointly submitted by: Dr. John L. Simons, President, American Chiropractic Association; and Dr. William S. Day, President, International Chiropractors Association)

SUMMARY OF CHIROPRACTIC POSITION

1. H.R. 1 should be amended to include chiropractic benefits for Medicare beneficiaries. This can be accomplished by deleting Section 273 of H.R. 1 and sub-

stituting Section 205 of H.R. 17550 (91st Cong., 2d Session) as passed by the Senate in 1970.

2. No further study of chiropractic (as proposed by the House bill) is necessary, since the existing data among the States medicaid programs fully justifies chiropractic inclusion in Medicare.

3. The States are requiring the inclusion of chiropractic services in commercial health and accident insurance policies.

4. Industry is providing chiropractic benefits in health programs for its employees and retirees.

INCLUSION OF CHIROPRACTIC BENEFITS IN MEDICARE

Chiropractic urges this Committee to delete § 273 of H.R. 1 (pp. 280–1) which provides only for another study, and substitute in its place the language which this Committee previously adopted in 1970, under identical circumstances. Specifically, we urge you to adopt the language of Section 205 of H.R. 17550, 91st Congress, 2nd Session, which would directly include chiropractic services, as follows:

"(a) Section 1861(r) 'or (4)' of the Social Security Act . . . is further amended by—

"(1) striking out 'or (4)' and inserting in lieu thereof '(4)', and

"(2) inserting before the period at the end thereof the following 'or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services) and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided."

(b) The amendments made by this section shall be effective with respect to services furnished after June 30, 1972."

(N.B.—We have changed this date from the 1971 which appeared previously.)

NEW INFORMATION

In the interest of saving the Committee's time, we shall not repeat the arguments presented to you when chiropractic testified on September 17, 1970, and request that you consider those earlier statements as part of this present one.

Instead, we should like to call your attention to certain important developments that have taken place since we testified almost one and one-half years ago.

1. A further study is unnecessary

There is no need for any study of chiropractic in medicaid, as would be required by the House bill. The pertinent data is already available and it proves the wisdom of the Senate's previous action in including chiropractic.

At present, some 18 States authorize chiropractic services in their medicaid programs. They are: California, Connecticut, Idaho, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Texas, and Washington State.

Take California, for example. The official data from the California State Department of Health Care Services shows that in 1970 there were 469,915 visits to doctors of chiropractic and a total payment of $2,340,416 for these visits at an average cost of $4.94 per visit. (In addition, some $384,286 was paid for other services). The official data gives the "average monthly payment per eligible" to all providers of health care in 1969 and shows that the average monthly payment to chiropractic doctors was the lowest, by far, of any of the providers: 8¢ for chiropractic doctors, $7.70 for other doctors, $3.24 for pharmacists, $2.03 for dentists, 44¢ for optometrists, 13¢ for podiatrists, somewhere between $6.62 and $7.85 for hospitals, and $9.47 for nursing homes. The total "average monthly payment per eligible" in 1969 was $39.56, of which the 8¢ paid to doctors of chiropractic represents only 0.002% of the total, or the infinitesimal amount of 2/1000ths of the average monthly payment for California's medicaid beneficiary.

The extremely small financial impact of chiropractic on the total cost of State

medicaid programs throughout the country is illustrated also by the North Carolina program. In 1970, there were 2295 cases, and doctors of chiropractic were paid $114,361.06 out of the State's total expenditure of some $69 and one-quarter million, or ½ of 1% of the 1970 total. A similar pattern appeared in Nebraska where the cost of the chiropractic program represented only 0.029% of the total medical assistance program for 1970.

Let us turn to New York City's medicaid program. A survey made by the City Health Department for 1970 showed 27,737 cases under chiropractic care primarily for the treatment of neuromuscular skeletal disorders and that more than 50% of the cases treated required fewer than 9 visits for completion of care.

The data is already available without further study, and it is even more true now than it was in 1970 when the Committee's report stated:

"The Committee on Finance believes, however, that further study of chiropractic services under other plans is not required to support coverage of the services of chiropractors under the supplementary medical insurance program."—(Sen. Report 91–1431, pp. 142–3).

2. States Insist Upon Chiropractic Benefits in Insurance Policies

During the 1971 State legislative sessions, seven States adopted what have been called "insurance equality" laws. These statutes *require* that all insurance contracts written or renewed in the state thereafter which include physicians' services must also *mandatorily* include chiropractic services under the policy. These seven states are: Arkansas, Nevada, New York, Oklahoma, Pennsylvania, Washington, Wyoming.

With these seven States, there are now 26 States that have enacted such "insurance equality" laws. And there is reason to believe that this number will be increased. *These 26 States include 64% of the entire American population.* Thus, some 64% of all of our population *must* be offered the opportunity, in their free choice, to select chiropractic services under their commercial insurance policies.

In addition, I should point out that there are other States which have the same kind of mandatory provisions about the inclusion of chiropractic services under Blue Cross-Blue Shield plans. For example, since the first day of 1971, Michigan's six million Blue Cross-Blue Shield beneficiaries have the statutory freedom of choice to select chiropractic care is they want it.

The "insurance equality" laws represent a relatively new development. Of the 26 States that have enacted such statutes, 16 passed or amended their laws only since 1969. This is obviously the wave of the future, Mr. Chairman, and it completely justifies the action previously taken by this Committee in proposing immediate inclusion of chiropractic services in Medicare. There is nothing so strong as an idea whose time has come. These legislative developments alone illustrate clearly that the time has come for chiropractic inclusion in Medicare.

Would it not be odd if *every* insurance company in the States had to provide their beneficiaries with the option to choose chiropractic services—every one, that is, except that sponsored by the Federal Government? We do not believe that the Congress wants the Federal health care program to be out of step with the clearly expressed desires of the American people for chiropractic benefits in *all* of their health care programs. We respectfully submit that there is no valid reason for Medicare to deny to the American people the same right they have to obtain chiropractic services in commercial insurance.

3. Industry provides chiropractic coverage

Another significant development that took place last year is that large industry has decided to include chiropractic services in its own employee health plan. For example, General Motors changed its employee health benefit plan specifically in order to include chiropractic for all of its employees in the United States *and for its retirees.* Another example: Monsanto Company, a leading American chemical producer, defines the term "physician" so as to cover the services of a chiropractic doctor which he is legally qualified and licensed to perform at the time and place where such health service is rendered. And similar actions are taking place in ever-increasing numbers.

CONCLUSION

In terms of major current developments among the States and in industry, it is wholly anomalous for Medicare to exclude chiropractic services. It is contrary

to the best interests, as well as the clearly expressed desires, of the American people in their health care services.

Therefore, we urgently suggest that once again this Committee take the leadership which you have already exhibited and that you amend H.R. 1 to include chiropractic health care services in Medicare. Specifically, we urge that you delete Section 273 of H.R. 1 and substitute in its place the provisions of Section 205 of H.R. 17550 reported by this Committee in 1970. Only in this way would Medicare beneficiaries have Freedom of Choice of their health care providers.

STATEMENT OF THE AMERICAN COLLEGE OF NURSING HOME ADMINISTRATORS, SUBMITTED BY DONOVAN J. PERKINS, D.P.A., PRESIDENT

The American College of Nursing Home Administrators, the professional society of individual administrators with a proved record of accomplishments and dedication to high standards of professional administration, is deeply concerned over proposed sections 269 and 270 of H.R. 1, the Social Security Amendments 1971, which would permit states to grant permanent waiver licenses to administrators who had been working as nursing home administrators for more than three years before the basic provision became effective in July, 1970 and which would terminate the National Advisory Council on Nursing Home Administration prematurely.

The provision permitting the granting of permanent waiver licenses would almost certainly throw into total chaos the carefully constructed and implemented licensing programs of the states participating in the Title XIX (Medicaid) program. The approach designed by the 1967 amendments establishing the initial requirements for licensure of nursing home administrators did not provide for such "grandfathering." The states, in order to comply with the original and subsequent requirements, have made great efforts to establish licensure programs based largely on the extremely valuable guidance of the National Advisory Council.

At this time the states already have licensed thousands of administrators, many of these provisionally. Section 1908 of PL 90–248 permits states to grant provisional licenses to administrators who have served as nursing home administrators during all of the calendar year immediately preceding the calendar year in which state licensure legislation is enacted. This "provisional" license must expire no later than two years after issuance or on June 30, 1972, whichever is earlier. The salient stipulation of this waiver provision is the attendant educational requirement which provisional licensees seeking a permanent license must satisfy prior to acceptance to the licensure examination. The obvious purpose of this educational requirement is to upgrade the professional competence of "waivered" administrators to satisfy the federally established minimum standards.

As a direct effect of the provisional waiver, numerous preparatory training programs have been designed across the nation. Most of these programs are based in higher education institutions. The development of these preparatory programs along with state levied requirements for future education levels necessary for entry into the profession and an increasing awareness among the nation's educators of the need for formal academic degree programs have stimulated the growth and proliferation of adult continuing education programs and associate, baccalaureate and masters degree programs. The continuing education requirement for license reregistration alone is responsible for the development of hundreds of workshops, institutes and seminars sponsored by higher education institutions, professional societies, trade associations and private organizations. The continuing education requirement as a condition of licensure reregistration adopted by most states is a unique development in established patterns of occupational licensing. All of these programs have been designed to upgrade the administrator's understanding and abilities as well as to advance his professional competence to levels hitherto unknown. The ultimate impact of these programs is the improvement of the patient care services provided to the nation's chronically ill and aged infirm.

The American College of Nursing Home Administrators strongly shares the concern of other leaders and organizations in the long-term health care field that to deliver such a debilitating blow, as is constituted by the "waiver pro-

vision," to a nascent licensing system that has transformed a difficult and disorganized situation into a relatively orderly process under severe time pressures, would not be in the interest of either the public or the profession. Passage of this provision would seriously reverse or undermine the strong movements in most states to develop essential education programs which until now have been virtually nonexistent. It must be emphasized that an individual's exposure to an administrative position alone is an insufficient measure of his ability to provide proper patient care. Education and demonstrated ability in addition to the successful passing of a specifically designed examination process also must be required.

The College also must express its disappointment over the proposed termination of the National Advisory Council. As it now stands the National Advisory Council is inactive and by law is due to terminate on December 31, 1971. To eliminate such an outstanding advisory body only a few months or weeks prior to its legally established termination date would appear to be without real meaning and would only serve to cast doubt on the Council's past efforts and achievements in laying the proper model groundwork upon which the states could construct their licensure programs. In fact, the relative ease with which the states have implemented their licensure programs is due in large part to the intense and successful efforts of the Council.

In light of the increased public security and the President's recent announcement of more stringent regulation of the nation's nursing homes with the attendant requirement for greater numbers of nursing home inspectors it would seem singularly appropriate to give serious consideration to commending, recognizing and continuing the National Advisory Council. The Council by making available the expert opinions of recognized national authorities could provide greatly needed assistance by formulating guidelines for the development and implementation of a variety of appropriate programs and by monitoring existing programs to insure that these were being properly administered. It may be recalled that the Council provided excellent guidance from its beginning despite the total lack of experience or precedent upon which to base its efforts, and now that established expertise can once again be put to proper use.

THE AMERICAN PARENTS COMMITTEE, INC.,
New York, N.Y., February 1, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

POSITION STATEMENT ON H.R. 1

DEAR SENATOR LONG: Please include the following statement in the record of the hearing on H.R. 1.

The American Parents Committee, Inc. is concerned about inadequate income and services to meet the needs of poor children and their families. We would support a sound federal floor for income to poor families.

The so-called welfare "reform" bill, H.R. 1, however, seems to us to be inadequate, inequitable and even more retrogressive than the present law as far as families and children are concerned. We, therefore, oppose Title IV of that bill, now before the Senate, even though it includes help for the "working poor," and provides more federal welfare funds to the states. Major problems in Title IV are:

1. The inadequacy of federal payment levels, with no required state supplement and the likelihood that 90 percent of the grants of present recipients will be lower than they now are. Eligibility is not based on current need.
2. The mandatory work requirements for mothers of children over three.
3. The provisions for inadequate and damaging child care with no guarantee of child care before a mother is required to work.
4. The discriminatory provisions limiting the rights of needy children and families as compared to other families. Examples include what we believe to be unconstitutional residency requirements, excessive penalties for failure to register or accept work, inadequate work protection, third party payments, complex reporting procedures with excessive penalties for failure to file on time, renewal of applications "de novo" every 24 months, required support by

step-parents (not legal in 49 states), double standard for child support—federal liens and federal criminal sanctions against deserting fathers, etc.

5. The complex dual administration of programs for families by the Departments of Labor and HEW with eligibility determined by the employability status of family members. The creation of more costly administration and more "red tape" for families.

We are aware of good proposals to improve H.R. 1, such as the Ribicoff Amendment, now before the Senate. Since we do not believe it possible for such improvements to survive the legislative process, we recommend that Title IV should be eliminated from the Senate bill.

As an alternative, however, we believe that states should be required to maintain welfare payments at least at the 1971 levels and given federal fiscal relief for rising welfare costs. Such proposals are also now before the Senate. These measures are necessary until such time as a more equitable welfare reform bill can be achieved.

Title V—Part of B of H.R. 1 establishes "New Social Services Provisions." We recommend that financing for all social services required for assistance related individuals remain on an open ended basis. We oppose the "closed end" provision in Title V for all but family planning and child care services.

We also urge maintenance of state fiscal effort for these programs so that federal funds will not merely substitute for present state funds.

We believe that the "statewideness" requirement for services should be maintained rather than eliminated if people are to be equitably served.

We endorse Senator Griffin's Amendment No. 411 which would provide for a National Adoption Information Exchange System. We also support the additional federal funding for foster care and adoption services proposed under the Child Welfare Services section of Title IV of the Social Security Act.

Respectfully yours,

GEORGE J. HECHT, *Chairman.*

AMERICAN SPEECH AND HEARING ASSOCIATION,
Washington, D.C., August 6, 1971.

Senator RUSSELL LONG,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The purpose of this letter is to express the viewpoints of the American Speech and Hearing Association to the Committee relative to H.R. 1 Social Security Amendments of 1971. In particular, we wish to address our comments to Title II, Part C, Section 251 of the bill entitled "Physical Therapy Services and Other Therapy Services Under Medicare", as relevant to the services provided by speech pathologists and audiologists.

As the Committee is fully aware, deliberations on the House version of H.R. 17550 in 1970 resulted in the Senate Finance Committee modifying the limitation on reimbursement for institutional health related services by changing the limitation from a "salary equivalent" to a "salary related" basis for physical therapy services, *and* also extending the limitations to apply to other health related services provided in an institutional setting. We recognize that this limitation was deemed necessary by the Committee to control program expenditures for therapy services and services of other health related personnel. We commend the Committee on its recognition that health related services rendered on a "salary related" basis will provide the needed services to patients in the most efficient and economical way.

The House version of H.R. 1 would provide Medicare reimbursement to the provider of physical therapy and other health related services on a "reasonable salary payment basis" for the services. In essence, payment for the reasonable cost of speech pathology and audiology services may not exceed an amount equal to the salary which would have been payable if the services had been performed in an employment relationship, *plus* the cost of such other expenses an individual not working as an employee might have, such as maintaining an office, travel time and expense, and similar costs.

In the interest of providing services to the speech and hearing impaired citizens of our country, the American Speech and Hearing Association strongly urges the Committee to maintain the provision that health related services be reimbursed on a reasonable cost basis as specified in the House version.

We believe that reimbursement for services must be sufficient to cover costs in order to achieve effective delivery of speech and hearing services. There are many patients in extended care facilities and home health care programs who have hearing or speech problems (such as loss of speech after a stroke). However, a particular extended care facility or home health care program may be too small to justify the employment of a full-time speech pathologist or full-time audiologist to deliver services to a relatively small percentage of patients. It is, therefore, necessary for these smaller institutions to contract for the services of a speech pathologist and/or audiologist on a part-time basis. Reimbursement to the provider must be at a level sufficient to meet the costs in providing the service. Under contractural arrangements, overhead costs (e.g., travel-time expenses, office maintenance, etc.) must be taken into account when determining costs of services.

The American Speech and Hearing Association would be glad to present these views to the Finance Committee when hearings are held on H.R. 1, and we request that in addition to any such testimony, this letter be inserted as part of the report on the hearings. We know that you will give careful consideration to our concerns relative to Title II, Part C, Section 251 of the Social Security Amendments of 1971. We commend you on your diligent efforts to improve health care in our country.

Sincerely,

KENNETH O. JOHNSON, PH. D.
Executive Secretary.

STATEMENT BY ALLAN J. WINICK, PARTNER, ARTHUR ANDERSEN & CO.

In general, I believe the Medicare Program has functioned very effectively since its inception in 1966. However, there are five problems in the administration of the Program that, hopefully, will be cured by Congress through H.R. 1.

The first problem relates to the failure of the past legislation to provide for judicial review of Intermediary determinations of reimbursable cost. Although H.R. 1 has given further rights of appeal to providers of service in this area, it still does not allow full review by the courts. I believe H.R. 1 should be amended to provide that reimbursable cost determinations involving controversies in the amount of $10,000 or more be appealable through the judicial process, in the same manner that Federal income tax controversies are handled.

The second problem relates to unwarranted financial risks which providers of services must bear. Under present administrative procedures, a provider of service must receive a "report of eligibility" from the Social Security Administration through its Intermediary before it can bill the Intremediary for services performed for a Medicare patient. In a great many cases, these reports are not received until after the patient has been discharged, and it is not unusual for a provider to receive the reports several months, or several years, after the patient has been discharged.

From what I understand of the problem, there is very little more that either the Social Security Administration or the Intermediaries can do toward speeding up the issuance of the eligibility reports because of the technical processing problems involved. However, I do not believe that the provider of services should bear the financial risk of this delay and hope that a provision will be included in H.R. 1 to the effect that, if an Intermediary does not confirm eligibility of benefits to the provider within ten days after a request has been furnished for such information from the Intermediary, then the provider, where it acted in good faith, should be allowed to bill and receive payment from the Program for the services rendered immediately. Further, where the Intermediary later informs the provider that benefits were not available, the provider should be required to refund the payments only in situations where the provider is able to collect for such services from the patient or other third party.

Although there has been a simplification in this regard since the inception of the Medicare Program, providers of services are still required to bill certain services where a physician is involved partly under Part A of the Program and partly under Part B. This expensive administrative procedure should be removed and all provider services should be allowed to be billed under Part A.

Another problem relates to the complexity of the required cost reports under the Program. As the Program has progressed, the cost report requirements have become more and more complex, to a point that even the most sophisticated

accountant has difficulty in preparing them. It might be helpful to the Committee if they were furnished samples of the required reports to give them a first-hand impression of their complexity. Although the objective of this reporting is to insure that the Medicare Program only pays for the costs attributable to Program beneficiaries, I think this end can be accomplished with a simplified reimbursement formula and reporting format which would reduce not only the cost of administering the Program to the provider, but also to the Intermediary and Federal government. As a step in solving this problem, I suggest that the Social Security Administration be instructed to develop a reimbursement formula which would be based on a per diem cost discounted to recognize the lower utilization of ancillary services by beneficiaries of the Program. Although there would be considerable debate as to how large the discount should be, I believe a realistic rate could be set based on an analysis of the thousands of Medicare reports filed during the initial years of the Program.

The last problem I wish to comment about relates to the inadequate reimbursement to providers for capital facilities. As you know, the present law and regulations limit reimbursement to historical cost depreciation and even the option to claim accelerated depreciation, which was allowed in the original regulations, has been eliminated. Because of the significant effects of inflation, reimbursement for depreciation computed on an historical cost basis does not provide sufficient funds to replace the health care institutions' facilities and, just as importantly, results in a confiscation of the provider's capital since the Program is not paying for the fair value of the assets consumed in rendering service to Medicare patients. To assure the financial viability of our health care institutions, H.R. 1 should include a provision to require that providers be reimbursed for depreciation adjusted to recognize the increase in price levels since the related assets were acquired.

BARONESS ERLANGER HOSPITAL,
T. C. THOMPSON CHILDRENS HOSPITAL,
Chattanooga, Tenn., August 19, 1971.

Re H.R. 1, The Social Security Amendments of 1971.

Mr. TOM VALE,
Chief Counsel for the Committee on Finance,
Senate Office Building, Washington, D.C.

DEAR MR. VAIL: We note in Commerce Clearing House Medicare/Medicaid Guide of August 13 that the Senate Finance Committee plans to resume hearings on H.R. 1 beginning Tuesday, September 21. We believe it is essential the appeals mechanism permits providers of health care, hospital, et al, to have access to the judicial system and we wish to make this a matter of record.

Sincerely,

E. B. CRAIG, *Controller.*

STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES, SUBMITTED BY WILLIAM P. MCHENRY, JR., ECONOMIC SECURITY MANAGER

The National Chamber appreciates this opportunity to express its views on the Social Security and Medicare provisions of H.R. 1. We intend to testify separately on the welfare provisions contained in the House-approved bill.

Our overall appraisal of the House bill is that it is an extraordinarily expensive "package." As Table I shows, long-range average annual costs would be increased by $13.4 billion. The cumulative tax increase, over the next six years, amounts to $57 billion. Workers and employers would have to bear an oppressive tax burden.

After carefully studying the many provisions of this bill, we urge the Committee to:

(1) Reject the 5 percent benefit increase. The benefit level currently is well ahead of the rise in living costs.

(2) Reject those provisions in the bill calling for *automatic* increases in benefits, *automatic* increases in the taxable wage base, and *automatic* increases in the amount of "exempt" earnings under the retirement test.

(3) Reject the special minimum benefit based on *presumed* "years of coverage."

(4) Reject the annual increment for delayed retirement.

The record shows that Congress has maintained benefits well ahead of the rise in living costs. For this reason, the National Chamber sees no economic need for another benefit increase at this time, and we recommend that Section 101 be deleted from the bill.

TABLE II.—RISE IN THE COST OF LIVING COMPARED WITH BENEFIT INCREASES APPROVED BY CONGRESS, DECEMBER 1950–JANUARY 1971

Month and year	Consumer Price Index [1] (1957–59 equals 100)	Cumulative price increase (percent)	Average monthly benefit workers who retired in 1950 [2]	Cumulative benefit increase (percent)
December 1950	87.1		$49.50	
September 1952	92.0	6.8	55.70	12.5
September 1954	93.5	7.3	60.70	22.6
January 1959	100.0	15.8	65.00	31.3
January 1965	108.9	25.0	69.60	40.6
February 1968	118.6	36.2	78.70	59.0
January 1970	131.8	51.3	90.60	83.0
January 1971	138.6	59.1	[3] 99.70	101.3

[1] Data from Bureau of Labor Statistics.
[2] Data for 1950–68 from Social Security Bulletin, Annual Statistical Supplement, 1969, table 13, p. 31. Data for 1970 from House Ways and Means Committee, Social Security Amendments of 1969, Report 91–700, 91st Cong., 1st sess., p. 16.
[3] Estimate; based on 10 percent increased enacted under 1971 Social Security Amendments.

Note. Since 1950, Congress has enacted 7 general benefit increases: 12.5 percent under the 1952 amendments (effective September 1952); 9 percent under the 1954 amendments (effective September 1954); 7.1 percent under the 1958 amendments (effective January 1959); 7.1 percent under the 1965 amendments (effective January 1965); 13.1 percent under the 1967 amendments (effective February 1968); 15.1 percent under the 1969 amendments (effective January 1970); and 10 percent under the 1971 amendments (effective January 1971).

AUTOMATIC BENEFIT ESCALATOR

Section 102 provides for future automatic increases in benefits and in the amount of "exempt" annual earnings under the retirement test. Benefit payments would be increased whenever the cost of living, as measured by the Consumer Price Index, increased by at least 3 percent in a year (or, if earlier, since the last previous benefit change). Any increase would be effective in January of the following year.

However, the benefit escalator would not operate if a general benefit increase had become effective or had been enacted by Congress in the preceding year. This means, for example, that the proposed 5 percent benefit increase (effective in June 1972) would preclude an automatic increase until January 1974.

The bill does not include a provision to reduce benefits if the cost of living decreases in the future.

The advocates of an automatic benefit escalator contend that this provision is needed because:

(1) It is uncertain that Congress will act to increase benefits when such action is needed because of a rise in the cost of living;

(2) A benefit escalator will "depoliticize" this aspect of the Social Security program.

Evaluating Congressional Performance

The record shows that Congress will act with regularly on Social Security. Over the past 20 years, the Senate Finance and House Ways and Means Committees have held public hearings on Social Security no less than 15 times. As a result, benefit protection has been extended to most jobs; benefits have been increased and made easier to get; new kinds of benefits, such as payments for total disability and Medicare protection, have been added; and payroll taxes on workers and employers have been substantially increased to pay for the many changes.

Moreover, the facts demonstrate that benefit improvements, enacted by Congress, have surpassed the rise in living costs by a wide margin. Since 1950, the seven benefit increases, on a cumulative basis, have amounted to 101 percent as compared with a 59 percent rise in the price level. Thus, benefits have risen about 70 percent more than the cost of living.

It should be noted that the rise in benefit levels does not take into account the

(5) Increase the amount of "exempt" earnings under the retirement test from $1,680 to $2,000 a year as a means of encouraging part-time employment by elderly persons.

(6) Reject the provision calling for additional "drop-out" years in the computation of benefits.

(7) Retain the present 6 month "waiting period" for disability benefits.

(8) Defer any extension of Medicare to the long-term disabled until the costs of the present program are under control.

(9) Maintain the taxable wage base at $9,000 in 1972.

If these modifications are made, benefit costs can be pared by a long-range average of $8.5 billion a year, with consequent reductions in tax rates on workers and employers in all future years. Furthermore, we believe it would be highly desirable to schedule future tax rate increases over the next 16 years—rather than 6 years—to avoid an unnecessary build-up in trust fund balances.

The underlying reasons for the Chamber's recommendations are analyzed in subsequent sections.

Table I.—Long-range average annual costs for social security and medicare provisions in H.R. 1 [1]

[In billions]

Provision	*Average annual cost* [2]
5 percent benefit increase	$3.4
Additional drop-out years (prospective)	1.2
Age 62 point for men (prospective)	0.5
Earnings test changes	1.0
Widows benefits—100 percent of PIA at 65	1.3
Special minimum benefit	0.8
Election of actuarial reduction changes	0.8
Combined earnings (prospective)	1.1
Delayed retirement increment (prospective)	0.5
5-month disability waiting period	0.1
Miscellaneous changes	0.2
Medicare (HI) benefits for disabled	2.5
Total	13.4

[1] These estimates were developed by Robert J. Myers, Professor of Actuarial Science, Temple University, and a member of the National Chamber's Social Security Committee. From 1947 to 1970, Mr. Myers was the Chief Actuary, Social Security Administration, U.S. Department of H.E.W.

[2] The "level-equivalent" annual costs are based on an estimated average $650 billion taxable payroll for Social Security (OASDI) and $540 billion for Medicare (HI). With a $10,200 tax base, taxable payroll is estimated to be about $490 billion currently.

ACROSS-THE-BOARD BENEFIT INCREASE

For many years, the National Chamber has supported the concept of periodic Congressional examination of all aspects of Social Security, including benefit levels, to determine whether adjustments in the program are needed.

It is apparent that, from time to time, changes in benefit amounts are required to assure that the great majority of elderly beneficiaries are not compelled to seek Old-Age Assistance for their ordinary expenses of living, and are not hurt by the effects of price inflation.

Section 101 of H.R. 1 provides for a 5 percent across-the-board increase in benefits, effective in June 1972. Under the bill, about 27 million people would get higher benefits, and approximately $2.1 billion in additional payments would be made during fiscal year 1973.

On a long-range basis, the average annual cost of this change is estimated to be $3.4 billion.

In the past 21 months, Congress has increased benefits twice—by over 25 percent in the aggregate. The 1969 Amendments, effective in January 1970, raised benefits by 15 percent. This year's Amendments increased benefits by 10 percent, effective January 1971.

These two increases, plus five earlier ones, have more than offset the effects of price inflation in the past 20 years. As Table II shows, cumulative benefit increases enacted by Congress have exceeded 100 percent. During this period of time, the cumulative increase in prices amounted to 59 percent.

value of the many other changes made in the Social Security program by Congress during that 20-year interval. One of the most important changes, when measured by the dollar value to the elderly, was the enactment of Medicare. The Department of Health, Education, and Welfare has estimated that the value of the non-cash benefits available under the Medicare program is about $36 a month to each beneficiary. When this benefit value is added to the cash benefit amounts, as it certainly should be, it is evident that Congress has done much more than merely prevent aged beneficiaries from incurring any real loss in their aggregate benefit entitlement.

Perhaps even more significant than the action of Congress over the last 20 years is its performance since 1964. In the last 6 years, Congress has raised benefits on four occasions—in 1965, 1968, 1970 and 1971. These increases exceeded 45 percent.

Whatever may have been the case in the comparatively distant past, recent Congresses have been prompt to act to assure that benefits were not watered down as a consequence of the inflation to which the entire nation has been subjected. There is no valid basis for concluding that future Congresses will be less responsive to upward movement in the cost of living.

Removing Social Security From Politics

It has been asserted that substituting mechanical devices (i.e. benefit and wage base escalators) for the considered judgment of Congress would remove the issue of benefit increases designed to offset the effects of inflation from politics. This assertion gives rise to two questions:

(1) Would such "depoliticization" actually occur?

(2) Would "depoliticization" be desirable?

The House and Senate debates on the Social Security Amendments of 1970 (H.R. 17750) clearly indicate that the broad issue of benefit adequacy would not be "depoliticized." Those who supported the benefit escalator stated unequivocally that the benefit escalator would not, and should not, preclude the need for further Congressional review of benefit levels. At most, the "depoliticization" would be of a limited nature.

The desirability of even limited "depoliticization" is open to serious question. Would it be in the best interests of Social Security beneficiaries and the taxpayers who support the program? In a program as significant as Social Security, it is essential that the judgment of Congress be brought into play whenever changes are contemplated. In the final analysis, neither Social Security nor any other major governmental program which affects virtually the entire population, can be, or should be, removed from "politics," since to do so would remove it from any influence or control by the electorate.

Inflationary Potential

An automatic benefit escalator could, and almost certainly would, have wide ramifications. If this principle is established in Social Security, it inevitably will spread to many other public programs such as public assistance, unemployment compensation, workmen's compensation, state and local retirement systems; to private pension plans; to negotiated wage settlements; and, conceivably, to the entire wage structure.

The potential adverse consequences of a cost-of-living benefit escalator were recognized by several members of the 1971 Advisory Council on Social Security. Mr. Gabriel Hauge, Chairman of the Board, Manufacturers Hanover Trust Company, stated:

"The Council's recommendation that Social Security cash benefit levels be automatically adjusted upward to keep pace with the cost of living, leaves me with deep concern, because such automatic adjustment would make the control of price inflation even more difficult than it already is.

"One-eighth of the total population of the Nation, and fully 21 percent of the voting age population, receive retirement, survivors, or disability insurance benefits. To insulate so large a group from the cost of inflation with respect to their Social Security benefits would surely undermine the public's willingness to support the self-restraint and sometimes painful policies that are necessary to curb inflation. Of even more importance is the virtual certainty that the adoption of an 'escalator clause' for Social Security benefit payments would give additional support to the already insistent demands for inflation protection through escalation in a whole range of other private contracts. I do not see how we, as a

Nation, can wage a successful battle against inflation by automatically adjusting to it." [1]

In passing, it is interesting to note that the labor members of the Advisory Council did not place a high priority on an automatic benefit escalator. In fact, they conditioned their support for this provision on even further "substantial" benefit increases.[2]

We urge this Committee to reject an automatic benefit escalator for Social Security because it is unnecessary and unsound, and because it would have widespread adverse effects on other governmental and private programs.

A cost of living escalator seems especially inappropriate at a time when the federal government is engaged in an unprecedented peace-time program to halt inflation through wage and price controls.

AUTOMATIC WAGE BASE ESCALATOR

The automatic benefit escalator would be financed by automatic increases in the taxable wage base. Unlike last year's bill (H.R. 17550), an automatic increase in the tax base would take place *only* if there had been an automatic increase in benefits.

In the future, the taxable wage base would be raised in proportion to the increase in the level of average wages of workers covered by Social Security. Under the automatic adjustment procedure, the Social Security Administration estimates that the taxable wage base would be $10,800 in 1974, $11,700 in 1976, $12,900 in 1978, $14,100 in 1980, and ultimately rise to $26,100 in the early 1990's.

We are opposed to an automatic wage base escalator for several reasons. First, the proposed financing is uncertain and inequitable. Second, Congressional taxing authority would be weakened. Finally, it would have an adverse effect on private pension plans integrated with Social Security.

Uncertain Financing

The wage base escalator is intended to fully finance any benefit costs that result from future increases of the cost-of-living benefit provision. However, in order to be self-financing, it is necessary for the rate of increase in the earnings level to be about twice the rise in the price level—in other words, if prices rise 3 percent a year, earnings will increase 6 percent a year.

An examination of recent trends in earnings and prices leads us to the conclusion that the automatic provision may be underfinanced. As Table III shows, between 1966 and 1970, the average increase in covered wages has been about 6 percent a year. During the same period of time, the cost of living has risen an average of 4.2 percent a year. Obviously, the earnings level has not risen twice as fast as prices.

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[1] Mr. Hauge's statement was concurred in by three other Council members: Charles A. Siegfried, Vice Chairman of the Board and Chairman of the Executive Committee, Metropolitan Life Insurance Company; Robert C. Tyson, Director, former Chairman of the Finance Committee, United States Steel Corporation; and Dwight L. Wilbur, M.D., Past President, American Medical Association. See, *Reports of the 1971 Advisory Council on Social Security*, 1971, p. 135.

[2] See, statement of Walter J. Burke, Secretary-Treasurer, United Steelworkers of America; Burt Seidman, Director, Department of Social-Security, AFL-CIO; and Joseph P. Tonelli, President-Secretary, International Brotherhood of Pulp, Sulphite and Paper Mill Workers of the United States and Canada, *Reports of the 1971 Advisory Council on Social Security*, 1971, pp. 128–29.

TABLE III.—COMPARISON OF INCREASES IN AVERAGE WAGES AND COST OF LIVING

[In percent]

Year	Increase over previous year	
	Average wages in covered employment	Cost of living
1966	4.4	2.8
1967	6.3	2.9
1968	7.0	4.2
1969	6.0	5.4
1970	6.2	5.9
Average: 1966–70	6.0	4.2

Continuation of present trends in wages and prices indicates that Congress almost certainly would have to step in and raise taxes further because the wage base escalator would not produce the required revenue over the long run.

Weakens Congressional Taxing Authority

Under the bill, the Secretary of Health, Education, and Welfare would be authorized to increase the taxable wage base—and hence the amount of taxes payable—to finance the automatic benefit escalator. These automatic increases would be based on the Secretary's determination of the extent to which average taxable wages of workers covered by Social Security have risen since 1972. The

While these reporting procedures are intended to preserve some Congressional Secretary would be required to report (not later than August 15) each year to the House Ways and Means and Senate Finance Committees on the likelihood of "imminent action" under the automatic escalator provisions.

responsibility and control over taxes, the Chamber is still opposed to such a provision. Much of the public support for the Social Security program is based on the knowledge that the Congress carefully considers in *public hearings and executive sessions* any proposals to revise or increase taxes on workers and employers. If future tax increases are effected without this kind of responsible review, the confidence of both workers and employers in the program may be adversely affected. Whether taxpayers agree in every instance with the decisions of Congress is less significant than the fact that they have much more confidence in the judgment of responsible men than in decisions based on mechanical contrivances.

Inequitable Financing

If the wage base escalator were to be adopted, it would mean that the added cost resulting from automatic increases in the amount of earnings taxed would not be shared by all workers and their employers. Rather, it would be financed by loading the added tax burden mainly on those workers who earn more than $10,200 a year—and their employers.

This would be the first time in the history of Social Security that Congress financed a benefit change entirely through a wage base increase. On previous occasions, when Congress has raised benefits or made other program changes, the added costs were financed either by an increase in tax rates on all workers and their employers or by a combination of tax rate and wage base increases.

We believe it is inequitable to finance such benefit increases solely through increases in the taxable wage base.

Impact on Private Pensions

Congress has not considered the potential impact of the automatic benefit and wage base escalator provisions on private pension plans which mesh their benefits with Social Security payments.

Pension experts believe that the automatic provisions will create very serious problems for employers who integrate their pension plan benefits with the Social Security program. According to Edwin F. Boynton, Actuary, The Wyatt Company, a nationally-known employee benefits consulting firm:

". . . the automatic wage base adjustment and cost-of-living increases will create completely chaotic conditions when it comes to designing integrated pension plans. If one stays with the present plan design, there will be a great deal of duplication of benefits on wage base earnings, which would result in higher and higher pension costs for the duplicate coverage."[3]

We recommend that this provision be deleted from the bill. However, if Congress decides to include an automatic benefit escalator in H.R. 1, then it should be financed by:

(1) Using the "actuarial surplus" generated by future increases in the level of taxable earnings, and

(2) Obtaining any remaining funds, on a 50/50 basis, from increases in tax rates *and* the taxable wage base.

SPECIAL MINIMUM BENEFIT PAYMENT

Section 103 of the bill provides for a special minimum payment for individuals who have ostensibly worked in covered employment at least 15 years. The

[3] *Social Security vs. Private Pensions*, an address presented to the 24th Annual Conference of the Council on Employee Benefits, New York Hilton Hotel, October 8, 1970, p. 15.

benefit would be equal to $5 multiplied by the number of "years of coverage," not in excess of 30 years. Thus, a person with 20 "years of coverage" would be eligible for $100 a month, while a person with 30 or more "years of coverage" would receive $150.

Approximately $30 million in additional benefits would be paid out during fiscal year 1973. However, the long-range average annual cost of this provision is substantial—an estimated $800 million.

This proposal is in direct conflict with one of the basic principles insisted upon by past Congresses, approved by the National Chamber, endorsed by the AFL-CIO, and previously supported by the Department of Health, Education, and Welfare—that is, benefits should be wage-related. The principle of wage-relationship of benefits means that workers who earn more—and hence experience greater job income loss—stand to get a larger benefit.

The National Chamber opposes the special minimum benefit because it would seriously weaken this fundamental principle.

As this Committee knows, from 1939 to 1950, there was a provision in the Social Security Act under which each worker's primary insurance amount was increased by 1 percent for each year of covered employment credited the worker. The purpose was to raise the level of benefits for long-term workers. Congress decided that this was not an appropriate method of providing retired workers with higher benefits. Accordingly, the provision was removed from the law in 1950, and a new formula for computing benefits was adopted.

The special minimum payment would not benefit all workers. Instead, it would apply initially to only a select group of individuals—some 300,000 workers.

The Chamber's opposition to this proposal can best be summarized by reference to the 1939 Report of this Committee on pending Social Security Amendments (H.R. 6635). In that Report, the Committee pointed out:

"Since the objective of social insurance is to compensate for wage loss, it is imperative that benefits be reasonably related to the wages of the individual. This insures that the cost of the benefits will stay within reasonable limits and that the system will be flexible enough to meet the wide variations in earnings which exist." [4]

We believe the following examples illustrate that Section 103 of H.R. 1 would, if enacted, seriously weaken the principle of wage-related benefits. Exemple 1 shows that it is not necessary for a worker to actually have extremely long service under Social Security to qualify for a high benefit payment. Example 2 shows that Section 103 would discard the principle of payment of larger benefits to those workers who experience a greater job-income loss.

Example 1: Worker A—21 years of employment: average monthly earnings of $108. Retired at end 1966, at age 65, on a benefit of $68.50 a month.

Section 103 provides that to obtain 14 "years of coverage" during 1037 to 1950, a worker only needs total wage credits of $12,600. Thus, worker A with annual earnings of $2,600 in *any* five years between 1937 through 1950 would be credited with 14 years of coverage. Worker A goes to work for the Federal government in 1951, but works part-time in covered employment at $1,300 a year until the end of 1966 when he retires. Today, as a result of benefit increases enacted by Congres, this worker is getting $98.20 a month—91 percent of his pre-retirement earnings. Under Section 103, his benefit would be raised to $150 a month—39 percent more than he made on the job—despite the fact that he only had 21 years of regular employment.

Example 2: Worker A—30 years of employment; average monthly earnings of $100. Worker B—17 years of employment; average monthly earnings of $200. Both workers retired at the end of 1966, at age 65. Worker A's benefit was $63.20 a month; Worker B's benefit was $89.90 per month because his average monthly earnings were 100 percent higher than Worker A's.

Under present law, as a result of benefit increases enacted by Congress, Worker A is receiving $90.60 a month. Worker A had total wage credits of $18,600 during the 14-year period from 1937 through 1950, and his earnings were not less than 25 percent of the wage base in each year from 1951 through

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[4] *Social Security Act Amendments of 1939*, Senate Report No. 734, 76th Congress, 1st Sess., p. 10.

1966.[5] Under Section 103, Worker A's benefit would be raised 65 percent to $150 a month since he had 30 "years of coverage."

Under present law, Worker B receives $128.60 a month. Under H.R. 1, his benefit would be raised 5.1 percent, to $135.10 a month. Thus, despite the fact that Worker B's earnings loss was twice as great as Worker A's, he would receive a much smaller benefit. This example shows how this proposal would undermine Social Security as a job-income loss program based on wage-related benefits.

We recommend that Section 103 be deleted from this bill.

ANNUAL INCREASE FOR DELAYED RETIREMENT

Section 106 provides for an annual increase in benefits for those aged who continue working. The primary benefit would be increased one percent for each year of employment after age 65 and up to age 72. This provision would be effective in 1972, on a prospective basis.

An estimated $11 million in benefits would be paid out during the first year. On a long-range basis, the average annual cost of this provision is much higher—about $500 million.

This proposal raises several issues for consideration:

(1) Would an annual increment be a useful device in slowing down early retirement?

(2) Would it serve as an incentive to attract elderly persons back into the employment market?

(3) Is a delayed retirement increment needed?

Early Retirement Trends

Under existing law, a worker can retire at age 65 on a full benefit, or as early as age 62, on a permanently reduced benefit. At age 62, the actuarial reduction is 20 percent. The early retirement provisions were enacted in 1956 for women, and in 1961 for men.

Presently, a very substantial number of retired-worker beneficiaries are receiving reduced benefits. In March 1971, for example, about 46 percent of the 13.5 million retired-worker beneficiaries had their benefits reduced because they chose to retire early. This compares with 2.2 percent and 16.3 percent of the beneficiaries who were receiving reduced benefits in December 1956 and December 1961.[6]

A study of new benefit awards for July–December 1968 indicates that these are a variety of reasons why male beneficiaries retire before age 65.[7] As Table IV shows, 54 percent of the men retired because of health—either a specific illness or disability, an accident or injury, or poor health in general. This is closely followed by job-related reasons—that is, such things as job discontinuation or layoffs; 20 percent of the beneficiaries fell into this category. Finally, 17 percent of the men wanted to retire before age 65.

Table IV.—Reasons cited by male beneficiaries, aged 62–64, explaining early retirement

Reason:	Percent
Total	100
Health	54
Job-Related	20
Wanted to Retire	17
General Retirement Age	5
Miscellaneous	4

Statistics on new retirement benefit awards indicate that a majority of workers retire before age 65. For example, the proportion of reduced benefits awarded (as a percentage of all awards moving to payment status) has been about 60–62 percent in recent years.[8]

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[5] The maximum taxable base from 1951–66 was: $3,600, 1951–54; $4,200, 1955–58; $4,800, 1959–65; 1966, $6,600. The worker would receive credit for a year of coverage based on the following annual earnings during this 16 year period: $900, 1951–54; $1,050, 1955–58; $1,200, 1959–65; and $1,650, 1966.

[6] U.S. Department of H.E.W., *Social Security Bulletin*, September 1971, Table Q–5, p. 58.

[7] See, Virginia Reno, "Why Men Stop Working at or Before Age 65: Findings from the Survey of New Beneficiaries," *Social Security Bulletin*, June 1971, Table A, p. 5.

[8] U.S. Department of H.E.W., *The Same*, Septemebr 1971, Table Q–6, p. 59.

These facts indicate that an annual increment for delayed retirement will probably have little, if any, appreciable effect on slowing down the large number of beneficiaries who retire at age 65 or earlier.

Employment Incentive

Most elderly persons are not working. In May 1970, the U.S. Department of Labor reported that about 16.1 million men and women, 65 years of age and over, were *not* in the labor force. Of the estimated 3.2 million elderly who were in the labor force, about 3.1 million were employed and 97,000 unemployed. Most of the employed group (86 percent) had jobs in non-agricultural industries.[9]

Would an increased benefit serve as an incentive to encourage more persons 65 and over to postpone retirement and continue working?

There is no information in the House Ways and Means Committee report to indicate whether the 400,000 persons who are expected to qualify for higher benefits under this provision in the first year of operation are *not* now in the labor force. However, we doubt that a benefit increase of 1 percent per year is a strong enough inducement to persuade persons 65 and over to return to the labor force or to continue working.

Data on the number of persons expected to qualify for benefits under the retirement test strongly suggests that most, if not all, of the 400,000 are already employed. The delayed retirement increment will not be an employment incentive, but just a device to raise benefits for people who are already working. Obviously, when these persons do retire, they will have no social need for larger benefits because they worked longer.

Is It Needed?

Existing law already contains two provisions which serve to encourage employment among the elderly.

The first is an automatic recomputation of benefits for those persons who continue to work after age 65. If the person's earnings then exceed his previous pay, then the retirement benefit will be increased. Naturally, a recomputation never decreases the retirement benefit.

The annual amount of "exempt" earnings under the retirement test also serves as a device to encourage employment by elderly persons. A 1963 study of the Social Security Administration indicates that quite often the key factor in determining how much work a "retired" beneficiary undertakes is the annual amount of "exempt" earnings—whether it is $1,200 as in 1963, or $1,680 as at present, or $2,000 as proposed in H.R. 1.[10]

More recent information from the 1968 Survey of New Beneficiaries confirms the earlier findings. According to the Social Security Administration:

"The high concentration for all beneficiaries with payable awards (reduced and full) at earnings of $1,680 or less is further evidence that some recent awardees make a conscious effort to control the amount of their earnings to continue to receive all or part of their social security benefits . . . those who are self-employed can more easily control the amount of their work. Many who work in highly seasonal occupations or industries may have actually earned as much as they could.

"To the extent that earnings are controllable, workers could be expected to respond to an increase in the maximum amount of earnings allowed under the retirement test by earnings higher amounts with which to supplement their social security benefits." [11]

We recommend that the delayed retirement increment be deleted from the bill. The increase in the amount of "exempt" earnings to $2,000 a year and the elimination of the dollar-for-dollar benefit withholding provisions are far more likely to encourage beneficiaries to do additional work or take a job at higher pay.

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[9] U.S. Department of Labor, *Employment and Earnings*, June 1971, Table A–3, A–17, and A–25, pp. 21–22, 31, 37–38.

[10] See Kenneth G. Sander, "The Retirement Test: Its Effect on Older Workers' Earnings," *Social Security Bulletin*, June 1968.

[11] See Patience Lauriat and William Rabin, "Men Who Claim Benefits Before Age 65: Findings from the Survey of New Beneficiaries, 1968," *Social Security Bulletin*, November 1970, p. 16.

MODIFICATIONS IN THE RETIREMENT TEST

Social Security benefits are intended to provide regular cash payments to a worker when he has withdrawn from the labor force because of age or total and permanent disability.

The so-called retirement test is the basis for determining whether a beneficiary has substantially retired from the labor force or is continuing to support himself by working.

Under present law, a beneficiary can earn $1,680 a year and still receive all his benefits; these are called "exempt earnings." For earnings between $1,680 and $2,880, one dollar in benefits is withheld for every two dollars of earnings. If a worker makes more than $2,880, one dollar in benefits is withheld for every dollar of earnings.

H.R. 1 would make three changes in present law:

(1) The annual amount of "exempt" earnings would be increased from $1,680 to $2,000 in 1972;

(2) For earnings in excess of $2,000 a year, one dollar of benefits would be withheld for every two dollars of job earnings;

(3) The annual amount of "exempt" earnings would be *automatically* raised in the future as average taxable wages rise.

We endorse the increase in the annual amount of "exempt" earnings from $1,680 to $2,000, and the elimination of the dollar-for-dollar withholding provision. These changes should help encourage part-time work among the relatively few elderly persons who are able to do so.

On the other hand, we are opposed to the automatic upward adjustment of the "exempt" earnings amount under the escalator provisions set forth in Section 102. Revision of any element of the Social Security program should be made only after Congress has evaluated the advisability of such a change, at the time the change is being considered, and in the light of then existing conditions.

ADDITIONAL DROP-OUT YEARS

Under present law, benefits payable to a worker, his dependents or survivors, are based on his average monthly earnings record in covered employment. The time span used in determining average monthly earnings is from 1951 up to the year in which the worker reaches age 65 (age 62 for women), becomes disabled, or dies. Five years of low or no earnings are eliminated in determining the worker's earnings record. This "drop-out" raises the average and produces a higher benefit.

Section 108 of H.R. 1 would provide an additional "drop-out" year for each 15 "years of coverage", starting in 1972. A "year of coverage" would be defined as it would be under the so-called special minimum benefit—namely, on a *presumptive* basis for the 14 year period from 1937 to 1950 and on a year-by-year basis from 1951 on.

The Social Security Administration estimates that approximately $17 million in benefits would be paid out in the first year. On a long-range basis, however, the average annual cost would be substantial—about $1.2 billion.

We are opposed to this provision because it represents a "back-door" approach to increasing benefits. Furthermore, there is no need for another increase, back-door or otherwise, because benefits are substantially ahead of the rise in the cost of living. We recommend that Section 108 be deleted from the bill.

DISABILITY WAITING PERIOD

Under present law, monthly benefits are payable to disabled workers under age 65 with long-term total disabilities. There is a six-month "waiting period" for benefits.

Section 122 would reduce the "waiting period" from 6 months to 5 months, effective January 1, 1972. There would be no change in the definition of disability.

An estimated $105 million in benefits would be paid out in the first year. On a long-range basis, the average annual cost would be approximately $100 million.

We recommend that the present 6 month "waiting period" be retained. The facts show that the Social Security Administration needs a substantial amount of time to process claims and to make a medical determination of disability. For March 1971, the median processing time for disability insurance awards was 98

days. Since June 30, 1968, median processing time, in calendar days, has risen 26 percent.[12]

Furthermore, reduction in the "waiting period" tends to move the Social Security program in the direction of covering short-term disability—an area now served by private enterprise. In 1969, about 63 percent of all workers in private industry were protected against short-term disability under either voluntary or compulsory income maintenance programs. Another 10 million employees in federal, state and local government had protection against this risk through formal sick leave arrangements. Overall, about 66 percent of all wage and salary workers had coveage against short-term disability in 1969.[13]

MEDICARE AMENDMENTS

H.R. 1 proposes sharp increases in Medicare (Hospital Insurance) payroll taxes to correct the deficit in the present program, and to finance an expansion to cover the long-term disabled under age 65. Combined employer-employee payroll taxes would be increased from 1.2 percent in 1971 to 2.4 percent in 1972, and to 2.6 percent in 1977. Taxable wage base would be increased from $9,000 to $10,200 in 1972. In the future, additional tax money would probably be channeled into the program on a continuing basis via *automatic* increases in the taxable wage base beginning in 1974.

Rising Costs of Medicare

The latest cost estimates for Medicare (Hospital Insurance) show that the program is still in serious financial difficulty. Information submitted to the Finance Committee by the Social Security Administration actuaries shows that the Hospital Insurance Trust Fund will be exhausted in 1973. On a long-range basis (over the next 25 years), the "level-cost" of benefits, on a $9,000 wage base, is estimated to be 2.89 percent of taxable payroll. The "level-equivalent" of taxes works out to 1.54 percent—leaving a deficit of 1.35 percent. Thus, "tax take" will need to be increased by 88 percent to put the program on a self-sustaining basis over the next 25 years.[14]

Extension to the Disabled

Section 201 would extend Medicare protection (Hospital Insurance and Supplementary Medical Insurance) to 1.5 million disabled Social Security and Railroad Retirement beneficiaries. The covered group would include disabled workers under age 65, disabled widows and widowers between the ages of 50 and 65, and people 18 and over who became disabled before age 22.

Under the House bill, only the long-term disabled would be eligible for benefits; in order to qualify, a person would have to be on the disability rolls for 25 consecutive months.

About $1.8 billion in benefits would be paid during the first full year of operation. On a "long-range" basis, the average annual cost of this expansion is estimated to be $2.5 billion.

Recommendations

The first five years' experience with Medicare confirms our earlier conviction that it is virtually impossible to develop reliable long-range cost estimates for a program that pays for services. However, the facts show that the Medicare (Hospital Insurance) program must have more tax revenues immediately if it is going to meet its commitments. We are opposed to an increase in the taxable wage base, automatic or otherwise, to accomplish this objective. Instead, we recommend that Congress raise Hospital Insurance tax rates to provide an immediate solution to the revenue problem. A proposed schedule of tax rates for both the Hospital Insurance program and Social Security cash benefits program is discussed in the section on Financing.

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[12] Hearings, *Departments of Labor and Health, Education, and Welfare Appropriations for 1972*, House Subcommittee on Appropriations, Part IV, 92nd Cong., 1st Sess., p. 852.

[13] See Daniel N. Price, "Cash Benefits for Short-term Sickness, 1948–69," *Social Security Bulletin*, January 1971, p. 22.

[14] The Social Security Administration submitted two cost estimates to the Finance Committee. Under the first, which assumes a $9,000 taxable wage base, the deficit is 1.35 percent of taxable payroll. The second estimate, which assumes that the tax base will be automatically increased to keep up to the general earnings level, shows a deficit of 0.62 percent of taxable payroll.

On the other hand, the continuing difficulties with the present program argue against any proposed expansion at this time. No one knows whether the current actuarial cost estimates are any more reliable than earlier projections. For this reason, we recommend that Congress defer any expansion until taxpayers can be assured that the costs of the present program are under control.

FINANCING SOCIAL SECURITY AND MEDICARE

H.R. 1 would be financed by increasing *both* the taxable wage base and tax rates. The tax base would be increased from $9,000 to $10,200 in 1972. Combined tax rates on employers and employees would rise from 10.4 percent this year to 10.8 percent in 1972, with steep increases over the next several years to a combined rate of 14.8 percent in 1977. Under present law, the combined employer-employee rate is scheduled to 12.1 percent in 1987 and after.

Table V compares Social Security and Medicare taxes for both employees and employers, under present law with those proposed in H.R. 1. Maximum combined taxes are scheduled to rise, under present law, from $811 in 1971 to $936 in 1972, and eventually to $1,089. Under H.R. 1, on the other hand, the maximum combined tax will rise to $1,102 in 1972 and to significantly higher amounts later on as a result of the automatic wage base escalator. It is estimated that the maximum combined tax will be $1,339 in 1975, $2,087 in 1980, $2,486 in 1985, and will eventually rise to $3,863.

Taxable Wage Base

The Social Security Amendments enacted last March provided for an increase in the taxable wage base from $7,800 in 1971 to $9,000, effective in 1972. When Congress raised the taxable wage base to $7,800 in 1968, it was about $1,000 above the median earnings of regularly employed male workers. Today, it is estimated that the $7,800 wage base is about $250 below median earnings of regularly employed male workers.

Median earnings of regularly employed male workers is a reasonable yardstick to use in considering whether or not a wage base change is necessary. This guideline will ensure that half of all regularly employed male workers have their total earnings protected under the program. At the same time, it will allow the other half of the workers, who have some earnings not taxed, to use a greater proportion of their pay to save or spend, as they choose.

As Table VI shows, the $9,000 wage base under present law appears adequate for the next several years. Congress should not consider any change in the wage base for tax or benefit purposes until 1974. We recommend that the taxable wage base be maintained at $9,000.

TABLE V.—SOCIAL SECURITY AND MEDICARE TAXES—PRESENT LAW COMPARED WITH HOUSE-PASSED SOCIAL SECURITY BILL (H.R. 1)

Year	Employee-employer tax rate [1] (percent)		Taxable wage base		Maximum combined taxes [2]	
	Present law	H.R. 1	Present law	H.R. 1 [3]	Present law.	H.R. 1 [3]
1971	10.4	10.4	$7,800	$7,800	$811.20	$811.20
1972	10.4	10.4	9 000	10,200	936.00	1,101.60
1973	11.3	10.4	9,000	10,200	1,017.00	1,101.60
1974	11.3	10.4	9,000	10,800	1,017.00	1,166.40
1975	11.3	12.4	9,000	10,800	1,017.00	1,339.20
1976	11.4	12.4	9,000	11,700	1,053.00	1,450.80
1977	11.4	14.8	9,000	11,700	1,053.00	1,731.60
1978-79	11.4	14.8	9,000	12,900	1,053.00	1,909.20
1980	11.9	14.8	9,000	14,100	1,071.00	2,086.80
1985	11.9	14.8	9,000	16,800	1,071.00	2,486.40
1990	12.1	14.8	9,000	21,900	1,089.00	3,241.20
1995	12.1	14.8	9,000	26,100	1,089.00	3,682,80

[1] Combined employer-employee tax rates for social security and medicare (hospital insurance).
[2] Maximum combined taxes for both employer and employee.
[3] H.R. 1 calls for initial increase in the taxable wage base from $9,000 to $10,200 in 1972. All subsequent increases, beginning with 1974, will be made in accordance with a formula based on estimated increases in average taxable wages. The Secretary of HEW, not the Congress, will determine how much to raise the taxable wage base. Estimated figures for taxable wage base from 1974 on, obtained from Office of the Actuary, Social Security Administration.

TABLE VI. COMPARISON OF SOCIAL SECURITY TAXABLE WAGE BASE WITH MEDIAN ANNUAL EARNINGS OF "REGULARLY EMPLOYED WORKERS," 1960-75 [1]

Year	Taxable wage base [2]	Median annual earnings [3]		Year	Taxable wage base [2]	Median annual earnings [3]	
		Men	Women			Men	Women
1960	$4,800	$4,837	$2,706	1968	$7,800	$6,820	$3,770
1961	4,800	4,950	2,776	1969	7,800	7,340	4,010
1962	4,800	5,139	2,876	1970	7,800	7,689	4,190
1963	4,800	5,298	2,956	1971	7,800	8,055	4,378
1964	4,880	5,629	3,063	1972	10,200	8,438	4,524
1965	4,800	5,739	3,168	1973	10,200	8,840	4,779
1966	6,600	6,124	3,338	1974	10,800	9,261	4,993
1967	6,600	6,360	3,510	1975	10,800	9,702	5,217

[1] Data for 1960-69 obtained from U.S. Department of Health, Education, and Welfare, Social Security Bulletin, annual statistical supplement, 1969, table 36, p. 51, "Regularly Employed Workers" refers to 4-quarter wage and salary workers covered by social security.

[2] H.R. 1 calls for an initial increase in the taxable wage base from $9,000 to $10,200 effective in 1972. All subsequent increases, beginning in 1974, will be made in accordance with estimated increases, as determined by the Secretary of HEW, in average taxable wages of workers covered by social security; 1974-75 base estimated.

[3] Growth in median annual earnings estimated from 1970 through 1975. Projection based on average annual increase in earnings from 1960 through 1969.

Tax Rate Increases

As this Committee knows, the National Chamber has consistently supported maintaining the Social Security and Hospital Insurance programs on a self-sustaining basis solely from payroll taxes on covered workers and employers. We continue to support that fundamental principle.

We think, however, that H.R. 1 is an extraordinarily expensive "package" because it proposes to add $13.4 billion in average long-range annual costs to the present program. It proposes an oppressive tax burden on workers and employers.

In 1972, taxes on workers and employers would be increased $4.2 billion. As Table VII shows, the cumulative tax increase over the next six years would amount to $57 billion.

The Finance Committee should substantially reduce the costs of H.R. 1 by eliminating the 5 percent benefit increase and the other provisions which we have noted. If these modifications are made, long-range average annual benefit costs can be pared by $8.5 billion, with consequent reductions in tax rates. Furthermore, future tax rate increases should be scheduled over the next 10 years, rather than 6 years, to avoid an unnecessary build-up in the trust funds.

Table VIII below, compares combined employer-employee Social Security and Medicare (HI) tax rates in H.R. 1 with the schedule recommended by the National Chamber. Our recommendations would result in much lower taxes on workers and business in all future years.

If the Finance Committee does not decide to reduce the costs of H.R. 1 in accordance with our recommendations, it is still possible to ease the tax burden on workers and employers over the next several years. Future tax rate increases should be scheduled to maintain trust fund balances about equal to one-year's benefit payments. This would result in lower taxes on business and workers over the next 12 years.

TABLE VII.—SOCIAL SECURITY AND MEDICARE TAX TAKE—PRESENT LAW COMPARED WITH H.R. 1, 1971-77 [1]

[In billions of dollars]

Year	Present law	H.R. 1	Increase
1971	45.0	45.0	
1972	51.3	55.6	4.2
1973	59.1	59.5	.4
1974	62.5	63.7	1.2
1975	65.6	76.2	10.6
1976	70.8	82.7	11.9
1977	72.4	102.9	28.7
Cumulative increase			57.0

[1] House Ways and Means Committee, Social Security Amendments of 1971, Rpt. 92-231, 92d Cong., 1st sess., pp. 132 and 143; and Social Security Administration, Office of the Actuary.

TABLE VIII.—SCHEDULE OF SOCIAL SECURITY AND MEDICARE (HI) TAX RATES FOR H.R. 1 AND MODIFICATIONS THEREOF[1] (COMBINED EMPLOYER-EMPLOYEE RATES)

[In percent]

Year	H.R. 1 benefits and modifications of H.R. 1		
	H.R. 1 tax base of $10,200	Modification of H.R. 1—tax base of $9,000[2]	Difference
1971	10.4	10.4	
1972-74	10.8	10.4	+0.4
1975-76	12.4	11.0	+1.4
1977	14.8	11.0	+3.8
1978-80	14.8	11.8	+3.0
1981-83	14.8	12.6	+2.2
1984-86	14.8	13.4	+1.4
1987 and after	14.8	14.2	+.6

[1] These tax schedules were developed by Robert J. Myers, professor of actuarial science, Temple University, and a member of the national chamber's social security committee. From 1947 to 1970, Mr. Myers was the chief actuary, Social Security Administration, U.S. Department of HEW.

[2] Modification of H.R. 1 eliminates $10,200 tax base, 5-percent benefit increase, 5 month "waiting period" for disability benefits, special minimum benefit based on "years of coverage," additional dropout years, delayed retirement increment, and extension of hospital insurance benefits to disabled persons under age 65.

Table IX compares the combined employer-employee Social Security and Medicare (HI) tax rates in H.R. 1 with an equivalent alternative schedule designed to finance the provisions of H.R. 1 as passed by the House.

TABLE IX.—SCHEDULE OF SOCIAL SECURITY AND MEDICARE (HI) TAX RATES FOR H.R. 1 AND EQUIVALENT ALTERNATIVE[1]

[Combined employer-employee rates]

Period	H.R. 1 benefits—Tax base of $10,200		
	H.R. 1 (percent)	Equivalent alternative (percent)	Difference
1971	10.4	10.4	
1972 to 1974	10.8	10.8	
1975 to 1976	12.4	11.6	+0.8
1977	14.8	11.6	+3.2
1978 to 1980	14.8	12.6	+2.2
1981 to 1983	14.8	13.6	+1.2
1984 to 1986	14.8	14.6	+.2
1987 and after	14.8	15.4	−.6

[1] These tax schedules were developed by Robert J. Myers, professor of actuarial science, Temple University, Philadelphia, Pa.

CONCLUSION

The record shows that Congress has acted regularly on Social Security over the years and treated beneficiaries very fairly. Benefits are well ahead of the rise in living costs. There is no economic need for another increase today.

Moreover, the facts clearly indicate that there is no real justification for automatic cost-of-living provisions, financed by automatic escalation in the taxable wage base. We think it would be particularly inappropriate to initiate such a provision at a time when the government is engaged in an unprecedented effort to halt inflation through wage and price controls.

In conclusion, we believe that the House bill is an extraordinarily expensive package which proposes an oppressive tax burden on workers and employers. The Finance Committee should make every effort to reduce the long-range costs of H.R. 1 in order to lower Social Security taxes to a reasonable level.

CHILD CARE AND PRESCHOOL PROGRAMS COMMISSION, OFFICE OF EDUCATION, SANTA CRUZ COUNTY, RICHARD R. FICKEL, SUPERINTENDENT

H.R. 1 COMMENTS ON ITS CHILD CARE PROVISIONS

CONTENTS

I. *Summary of principal points*

A. H.R. 1 is oriented almost entirely to requiring AFDC recipients to register for work or training.

B. Its provisions for child care are ill-defined and provide no guarantee of quality.

C. The Ribicoff Amendment would considerably ameliorate the harsh effects of H.R. 1's work requirement on family life.

D. It is critically important that child care programs should spring from the community, with full family and community participation, and we urge that there be legislation to enable and assure this.

E. Without full child development services, we will pay dearly in children grown into unproductive adults, broken homes, and the huge future cost of delinquency, drug dependence, and mental illness.

II. *Introduction*

In September 1970, the Board of Supervisors of Santa Cruz County established an advisory Child Care and Preschool Programs Commission. The Commission works with the County Office of Education and has representation from 18 agencies, teachers and parent groups. It grew out of the concentrated efforts of many people in the community, both lay and professional, for the overall welfare of young children. Its original concerns were to coordinate the scattered programs for young children, to avoid waste and duplication, to provide common resources, and in general, to make the wisest use of public funds.

As the Commission accumulated information on existing programs and on the unmet needs, it became clear that duplication was not the problem. The unmet need in our small county alone may be inferred from the fact that not more than 900 places are available in the entire county in licensed day care, while the number of children of working mothers is estimated from census figures to be not less than 8,000, and perhaps a great deal higher.

The Commission is deluged with requests for assistance in finding such care. We receive daily inquiries from groups and individuals anxious to start day care centers, from teachers willing and anxious to do the job, from students eager to begin a career with children.

We have been increasingly frustrated because the funds to put these elements together have not been available. Many local centers exist only by the devoted work of underpaid teachers and volunteers. Several valuable programs have gone under in spite of local concern and support.

Santa Cruz County has made valiant efforts to serve the child care needs of its working families. Local matching funds have been stretched to the utmost. All available State funds for children's centers, and also for compensatory preschools, and parent education are utilized by its school districts. Virtually the only open-ended funds for children that our Commission has found available are Title IV-A Social Security funds, already being utilized by the County Department of Social Welfare. The use of these funds is of course limited by the eligibility requirements, so that in practice, they serve mainly single-parent AFDC families in very low paying work or in training programs in limited fields. The great majority of working parents, including many intact families struggling to maintain a decent standard of living, are not served at all. Even those able to pay the high cost of good child care cannot find acceptable substitutes for a mother's care.

III. Statement of Position

A. *Purpose of H.R. 1.*—Mr. Nixon states that ". . . day care centers to provide for the children of the poor so that their parents can leave the welfare rolls to go on the payrolls of the Nation, are already provided in H.R. 1." He goes on to say that ". . . child development centers are a duplication of these efforts."[1]

Clearly, the mothers now in need of day care services are not the same group as the welfare recipients, not now working, which the bill proposes to serve. By its own statement of purpose (Title XXI) H.R. 1 is to provide:

> ". . . for members of needy families with children the manpower services, training, employment, child care, family planning, and related services which are necessary to train them, prepare them for employment, and otherwise assist them in securing and retaining regular employment and having the opportunity for advancement in employment, to the end that such families will be restored to self-supporting, independent, and useful roles in their communities . . ." (Sec. 2101, page 326)

It goes on to require that:

> "(a) Every individual who is determined by the Secretary of Health, Education, and Welfare to be a member of an eligible family and to be available for employment shall register with the Secretary of Labor for manpower services, training, and employment." (Sec. 2111, page 328)

Exemptions are provided only for illness, incapacity, age, for children under 16, and for mothers of children under three (or until 1974, under six).

The stipulations for wages and working conditions (Sec. 2111) offer little protection and no guarantee that the job will suit the individual. Wages as low as three-quarters of the minimum wage would be permitted.

Under this act, mothers who prefer to stay home and care for their young children will be required in many cases to leave them for unfulfilling, low-paid work. In what way would this strengthen family life and break the cycle of neglect and poverty?

We take the stand that:

> H.R. 1 is oriented almost entirely to requiring AFDC recipients to register for work or training.

B. *Standards For Day Care.*—H.R. 1 spells out few requirements as to the quality of the day care to be provided. (Pages 347–9) It states (Sec. 2133a) that the Secretary ". . . shall arrange for and purchase, *from whatever sources may be available,* all such necessary child care services . . ." (our emphasis) Facilities developed through the act are given preference for funding, and for school-age children local educational agencies are given preference. In sec. 2134(a) it states that the Secretary shall establish ". . . standards assuring the quality of child care provided . . .", *but these standards are nowhere spelled out.* Nor are there provisions for local control, parent representation, or health and social services to children and families.

We take the stand that:

> Its provisions for child care are ill-defined and provide no guarantee of quality.

C. *The Ribicoff Amendment.*—An amendment has been proposed which would improve H.R. 1 in several vital respects:

1. Raising the family allowances (Sec. 2151, page 35).
2. Eliminating the work requirement for mothers of children under 6 (Sec. 2111, page 4).
3. Establishing more reasonable and suitable working conditions and wages (Sec. 2111, pages 5–7).
4. Protecting the standards of the child care to be provided (Sec. 2134, pages 30–31).

We take the stand that:

> The Ribicoff Amendment would considerably ameliorate the harsh effects of H.R. 1's work requirement on family life.

D. *Need for Community and Parental Involvement.*—In its day-to-day work in the community, the Child Care and Preschool Programs Commission functions very much as a local Child Development Council, as envisioned in the national 4C Program (Community Coordinated Child Care). It fosters active parental involvement in the planning of all programs for children.

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[1] Economic Opportunity Amendments of 1971—Veto Message (H. Doc. No. 92–48).

We take the stand that:

It is critically important that child care programs should spring from the community, with full family and community participation, and we urge that there be legislation to enable and assure this.

E. *Need for Comprehensive Services to Children.*—From the experience in surveying local needs, it is our conviction that no one type of program can best serve all children. Families need a choice of programs from which to pick those which are most congenial and helpful.

Day care homes can provide a home-like environment for some children, particularly for the very young.

Children's centers can provide convenience and continuity for many children of school age.

For some families, corporate day care at the work site can help to keep a mother close to her child.

For others, a private nursery proves most congenial.

Compensatory preschool programs help children, regardless of the work status of their families, by providing experiences often lacking in an environment of poverty.

Cooperative nursery schools offer a valuable educational supplement to a home of any income level, and assist all parents to gain in skills they need to help children grow into happy, productive adults.

All settings can provide an integrated, humane, stimulating atmosphere, helping each child to grow into his own best self.

Our own State Superintendent of Schools, Wilson Riles, has declared that a year of preschool education would be beneficial to all children and is an important goal for school districts to work toward.[2]

Comprehensive legislation on child development is needed to implement this Administration's "national commitment to providing all American children an opportunity for a healthful and stimulating development during the first five years of life".[3]

We take the stand that:

Without full child development services, we will pay dearly in children grown into unproductive adults, broken homes, and the huge future cost of delinquency, drug dependence, and mental illness.

STATEMENT OF COLLEGE OF AMERICAN PATHOLOGISTS, SUBMITTED BY C. A. MCWHORTER, M.D.

Mr. Chairman and Members of the Committee:

The College of American Pathologists appreciates this opportunity to submit a statement to the Senate Finance Committee on H.R. 1, the Social Security Amendments of 1971.

The College of American Pathologists is a national society with a membership of more than 5,500 physicians certified by the American Board of Pathology. The membership of the College is composed entirely of physicians.

This statement will generally concern itself with those sections of the legislation which would affect the manner and method in which pathology is practiced, regardless of the setting, i.e., hospital laboratory, independent laboratory, teaching institution, or the private practice of pathology by an individual pathologist. This approach is being taken because CAP membership is representative of all these areas.

SECTION 207—ESTABLISHMENT OF INCENTIVES FOR STATES TO EMPHASIZE COMPREHENSIVE HEALTH CARE UNDER MEDICAID

The College of American Pathologists can see the need for new approaches by the states to reduce the continuing increase in the cost of the Title XIX program. We agree generally with the portions of this section aimed at improving utilization of services and reducing the length of stay in inpatient facilities.

Many Health Mantenance Organizations (HMOs) are currently being funded on an experimental basis by the Medical Service Administration of the Depart-

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[2] Task Force Report on Early Child Education, Wilson Riles, November 1971.
[3] Economic Opportunity Amendments of 1971—Veto Message (H. Doc. No. 92-48).

ment of HEW. HSMHA is also funding on an experimental basis many HMO and community-oriented group practice programs.

The portion of the section which concerns us is the significant incentive of increased federal matching funds by 25%, up to a maximum of 95%, for states which contract with HMOs or similar organizations to provide services.

The HMO concept, though not new in the country, is new in its wide availability to the general public. The majority of these programs has been designed to meet the needs of a specific group of people, usually with similar employment or other common bond. To make available this benefit on a mixed population basis could, in our opinion, cause more harm than benefit. The reasons for our concern in this are:

1. The ability of HMOs to produce the desired quality and quantity of medical care when applied to a heterogeneous group on a widespread basis has not yet been demonstrated.

2. An immediate effort by state agencies either to organize, or cause to be organized, HMOs or similar organizations without the proper administrative detail being developed for delivery.

3. A rush by groups to organize such services without the depth and the expertise of people knowledgeable in the administration of such programs.

4. The possibility of the total health field not being able to produce the personnel, equipment, and expertise to meet the demand.

5. The possibility of creating for Title XIX recipients another promise that cannot be delivered by state agencies.

We hope that Congress would delay action on this portion of Section 207 until such time as measurable results have been carefully reviewed by both Congress and the Department of HEW to ascertain the benefits derived from, and problems created by, the experiments currently being conducted.

SECTION 222—REPORT ON PLAN FOR PROSPECTIVE REIMBURSEMENT; EXPERIMENTS AND DEMONSTRATION PROJECTS TO DEVELOP INCENTIVES FOR ECONOMY IN THE PROVISION OF HEALTH SERVICES

The recognition by Congress that the existing cost reimbursement mechanism has created some serious financing problems is to be applauded. For this forward look we agree with the intent of this section.

We believe that the experimental approach to finding a more equitable and reasonable method of financing institutional care under Titles V, XVIII, and XIX is appropriate and logical.

The experiments dealing with prospective reimbursement must be well-controlled and monitored to be of value. The Department of HEW should be required to place these experimental programs within institutions that are involved in delivering inpatient services. In the past, the Department too often has assigned "experimental programs" to large universities and research-oriented firms. The results obtained have had little practical application. The concept of prospective reimbursement and other forms of payment must be well-tested before they are put into effect.

The pathologist in the hospital setting is primarily providing services ordered for patients by the admitting physician and/or consultants on these patients. In such a role, the pathologists in effect has little immediate control over the quantity of laboratory tests ordered for the patient. In a payment system in which all laboratory services provided to the patient would be included in the per diem or all-inclusive rate, inequities would be created for the laboratory department. These inequities could arise, for example, if a patient were required to have certain tests performed on a daily basis over an extended period of time. (Electrolyte studies or blood gas tests on critically ill patients, which must be performed on at least a daily basis, would be an example of such tests.) The hospital administration and/or the pathologist could not limit the performance of these tests, which are ordered by the attending physician and are medically necessary. These tests might well use up a substantial portion of the institution's per diem rate. One result would be deficit payment to the institution for this type patient. Another result might be the concern expressed in the House Ways and Means Report, that institutions might reduce the quality, scope, and depth of certain necessary patient services to stay within a set per diem payment.

The College of American Pathologists would like to re-emphasize that these

experiments (1) must be well-controlled and monitored; (2) must be placed in institutions representative of present providers; and (3) must be of sufficient duration to be valid in their findings.

SECTION 224—LIMITS ON PREVAILING CHARGE LEVELS

The College of American Pathologists strongly objects to this further reduction in the percentile figure for determination of the reasonable charge for physician services.

The proposed intent of P.L. 89-97 was to assist the elderly patient in the payment of his health care expenses. The original percentile figure used was 90; this was reduced by the 1967 Amendments to the 83rd percentile. This further reduction to the 75th percentile in federal liability increases again the payment that must be made from the limited means of the beneficiary.

The College also questions the use of data compiled from IRS sources as a common denominator for determining allowable aggregate increases.

The 40-60 ratio used in the example in the Ways and Means Report is not realistic when applied to a medical specialty medical field such as pathology.

The expenses involved for a pathologist in the operation of his practice are considerably higher than for most other physicians. The differential in operating expenses is caused by many factors, some of which are:

1. Higher costs of necessary complex and sophisticated laboratory equipment.
2. Higher percentage of labor costs by virtue of a large number of professional personnel in good income brackets.
3. Pathologists, regardless of their laboratory setting, must have, either physically on duty or available on a 24-hour basis, necessary trained personnel for the conduct of emergency procedures.
4. Federal and state requirements for licensed and/or professional personnel.
5. Federal and state requirements for quality testing of tests performed under the direction and supervision of the pathologist. (Clinical Laboratory Improvement Act and Title XVIII).

For these reasons, the College believes that if some formula were to be used in determining aggregate allowable increases, all factors (such as those mentioned above) must be considered when dealing with allowable increases in pathologists' charges.

The College of American Pathologists also must question the portion of this section dealing with reasonable charge levels for medical supplies, equipment, and services. If this section is intended to include services of laboratories, then we must object to including such medical services in this grouping.

To assume that the quality of laboratory services cannot vary is erroneous. In the area of laboratory services, variation in cost is brought about by several factors, many of which are not immediately evident to the nonprofessional. These are:

1. Volume of work done by a particular laboratory in a testing area.
2. Sophistication and variation of equipment to do the testing.
3. Level and number of professional personnel employed in the laboratory.
4. Quality control methods used by the laboratory and frequency of checking on employee performance.

There are laboratories today that are doing a high volume of work in specialty areas of testing. This type of laboratory rarely does emergency testing, and its workload is scheduled by the receipt of specimens forwarded to it by mail and/or messenger. These laboratories usually can offer a lower fee for their services. However, they do not provide the wide scope of tests and services which are necessary for proper diagnosis and treatment of the total patient. The hospital laboratory or the general service independent laboratory must be staffed and operated to provide immediate services in emergency cases. This emergency service causes delays in the performance of routine tests and requires a higher personnel load, which relates to an increase in the cost of providing services to the patient.

Some of the high-volume laboratories may not exercise the quality control system, nor do they employ the necessary qualified personnel beyond minimums needed to meet standards.

As an example of this, HEW has recently taken steps to withdraw, under the Clinical Laboratory Improvement Act, federal licensure of one portion of one

such high-volume specialty laboratory. Medicare certification in this area is also being removed.

The concern for cost reduction in the Medicare and Medicaid programs should not be the factor used to possibly create a lower level of quality.

SECTION 226—PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

As mentioned earlier, the College is interested in the effect of HMOs on the health care delivery system.

However, HMOs serving various mixes of people have not been in existence long enough to meet the test of adequacy. We support the proposal that experimentation in this area should be undertaken to determine the proper role and function of this vehicle in the system.

HMOs cannot be looked upon as the panacea for all the health delivery problems of the nation. Rather, they should be looked upon as a part of a multifaceted system which allows freedom of choice for both the government and the public.

SECTION 227—PAYMENT UNDER MEDICARE FOR SERVICES OF PHYSICIANS RENDERED AT A TEACHING HOSPITAL

The College recognizes the problems that exist in administering the section of the present Title XVIII with regard to payment for teaching physicians.

We also recognize the wide variation that exists in teaching arrangements in this country.

The College must register opposition to the language of HR 1 which would place the reimbursement of teaching physicians under Part A hospital reimbursement, if the patient is a non-private Medicare patient and the hospital does not meet the requirements outlined in the section.

The education of the future physicians of this nation for the care of the patient under both Titles XVIII and XIX is essential for the continuation of these programs. The concept of a "salary equivalency" for supervisory physicians would make for an inequitable double standard for reimbursement of physicians for patient services in teaching institutions.

Inasmuch as the attending physician, including the pathologist, is equally responsible for patient care in this setting, as in all other medical institutions, there should be no artificial differential for this group. The end result of care provided to the patient is the same, in that the patient has received the benefit of equal professional activities.

Under the present proposal, hospital teaching staffs would be required to subsidize patient care under Titles XVIII and XIX by this difference in reimbursement. In addition, in the opinion of CAP, the administrative problems involved in determining the "salary equivalency" and the distillation of this into an hourly rate would create a sea of chaos that would leave this area of reimbursement in a morass of paperwork from which it could never recover.

The proposed distinction between a non-private Medicare patient and a private Medicare patient also must be questioned. Are we reverting to the very situation which proponents of Medicare claimed existed prior to the passage of P.L. 89-97—namely, two levels of service: one for paying patients and one for non-paying patients? The Ways and Means Committee in its report is aware of this problem (p. 96, ¶2) when it states that appropriate safeguards should be established to preclude fee-for-service payment on the basis of performance or token compliance with these private patient criteria.

Are these administrative safeguards to be in the law? Are they to be in the form of Rules and Regulations promulgated by the Social Security Administration? If we can assume that SSA will prepare these procedures, the administrative nightmare that will follow will be beyond comprehension. The separation of patients into fee-for-service or cost-reimbursement classes is compounded further by the part of this section dealing with continuation of fee-for-service only for those institutions which, prior to 1966, billed all patients and collected from a majority of them for professional services.

Where does this leave the large teaching, charity, and municipal hospitals, which had legal barriers preventing such billings? Many of these teaching hospitals have been able to improve the quality of their teaching staff with the advent of Medicare. The fee-for-service concept for the Medicare patient generated addi-

tional income for these institutions. This income was utilized to expand the budget portion for teaching salaries. By this means, the institution could attract highly qualified physicians to its staff. This practice in reality has benefited the patient to a great extent.

Are they now to revert to their fiscal binds that existed prior to 1966?

In conclusion, we must object to what we consider a backward step for health services.

SECTION 229—AUTHORITY OF SECRETARY TO TERMINATE PAYMENTS TO SUPPLIERS OF SERVICES

The College is in agreement with the intent of this section. The problem of dealing with the provider who flagrantly violates the law must be met. These violators must be found and punished so that the public will not suffer from their acts.

However, the College does have some concern over certain portions of the section.

1. Furnish excessive services to patients—The role of the pathologist is one of providing service to a patient who has been admitted by another physician. The admitting physician alone, or in consultation with other physicians, determines the course of action to be followed in treating the patient. The pathologist cannot reasonably refuse to provide services ordered unless he can show that the service ordered would be medically harmful to the patient. If the program review team determines that there is excessive utilization of laboratory services in a particular case, would the liability be placed on the physician ordering services, or on the pathologist providing the services? In light of the heavy incidence of malpractice suits today, many physicians are reluctant not to order certain services.

We agree with the concept that physicians only should review the work of physicians embodied in the program review approach.

2. Public disclosure of violators—We do not object to the disclosure aspect; however, we do have reservations regarding the timing of the disclosure. The language contained in HR 1, in our opinion, is not clear as to whether this public disclosure would take place before or after a hearing by SSA, following action or recommendation by the appropriate program review team. Our opinion is that such public disclosure should take place only after all administrative and review proceedings have been exhausted. To accuse a provider publicly, prior to proper hearings, could do irreparable harm to the individual or institution involved.

SECTION 232—ELIMINATION OF REASONABLE COSTS OF INPATIENT HOSPITAL SERVICES UNDER MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAM

This section again brings to public attention the problem of state agencies in the payment of Title XIX benefits.

The College cannot agree with the language of HR 1 in permitting states to develop a reimbursement formula for inpatient care which differs from the Medicare reimbursement formula. We believe that such an option will lead states into an area of program cost reduction that will create a two-level health system within an institution. It is reasonable to assume that the state will develop formulas which reduce its obligation to meet the costs of care rendered to Title XIX recipients. Who then will pick up the deficit? Certainly not Title XVIII, which can only pay for those costs which it deems reasonable for meeting the needs of their beneficiaries. The only group left then is the non-government-supported segment of the public. Through their third-party programs of their own funds, they will have to pick up the deficit.

Where the states have been able to exercise options under Title XIX in the area of payment for services, they usually have cut payment to the point so that costs could not be met by the provider. We believe that the states again would react to the next option by reducing payment to a point well below the reasonable and allowable level of Title XVIII.

SECTION 236—PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS

The College of American Pathologists is generally in agreement with the intent of this section. However, our concern is with the effect that implementation of this section might have on professional corporations, partnerships, and as-

sociations, especially as it applies to independent laboratories. Implementation of this section should not interfere with existing legal and medically ethical mechanisms of payment.

SECTION 241—PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

The College is in agreement with this forward step in bringing into the health system those persons who now are unable to lend their effort to meeting the health manpower shortage. We believe that the development of proficiency testing and equivalency factors will create career and job opportunities for persons whose only fault has been not having the necessary formal training and education to meet licensure requirements.

The College again wishes to thank the Committee for the opportunity to submit this written statement. We would request that this statement be made a part of the record of the Senate Finance Committee in its consideration of HR 1.

If the Committee, or the staff of the Committee have questions concerning the statement, the College will make every effort to provide answers.

COLLEGE OF AMERICAN PATHOLOGISTS,
Washington, D.C., November 10, 1971.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: Enclosed is a statement of the College of American Pathologists indicating the attitude of the College toward peer review.

The statement is not meant to support any one piece of legislation, but rather it points out the areas of concern to the College that we feel must be considered in any peer review legislation to be enacted by the Congress.

The College requests that this statement be made a part of any hearings or record developed by your Committee in the consideration of HR 1, the Social Security Amendments of 1971.

For your information, I am enclosing brochures explaining the programs mentioned in the statement. It is not intended that these be included in the record of any hearing.

A copy of the statement and the brochures are being forwarded to each member of the Finance Committee. In addition, we are providing to the staff of the Committee a supply of the statement and brochures.

Sincerely,

WILLIAM J. REALS, M.D.,
President.

STATEMENT OF COLLEGE OF AMERICAN PATHOLOGISTS

Mr. Chairman and Members of the Committee:

The College of American Pathologists appreciates this opportunity to submit a statement to the Senate Finance Committee on the subject of Peer Review Programs.

The College of American Pathologists is a national society with a membership of more than 5,500 physicians certified by the American Board of Pathology. The membership of the College is composed entirely of physicians.

The College has a history for pioneering peer review programs in the field of laboratory medicine dating back to 1949. From the beginning, the aim of the College has been to establish, through these programs, peer review as an ongoing evaluation process. From those pioneer efforts, there has evolved a multiplicity of peer evaluation programs that has established CAP as a dominant national and worldwide force in quality evaluation in the field of laboratory medicine.

Today there is a variety of quality programs offered through the College.

1. Quality Evaluation Programs (QEP)—CAP Quality Evaluation Programs are proficiency testing systems designed to monitor a participant's laboratory results by comparing his results to the national mean, reference laboratories, and/or selected referee laboratories. The programs are designed to define the "state of the art" in laboratory medicine and to correct problems within the laboratory through generally accepted evaluation criteria.

Today there are approximately 7,100 hospital and independent laboratories

participating in the CAP Quality Evaluation Programs. The program has also been accepted in many foreign countries, including Japan, Australia, New Zealand, and a majority of the nations in Western Europe.

In addition to those areas mentioned above, the College's QEP is used by the Veterans' Administration in all of its hospitals. The College is also providing this service to Air Force hospitals. State health departments have contracted with the College for the provision of materials to be used in their testing programs. The Center for Disease Control, the Federal Governmental agency which has the responsibility for regulating laboratories in interstate commerce under the Clinical Laboratory Improvement Act of 1967, has also approved the QEP in lieu of a laboratory's participating in their programs. Finally, the program has been approved by state agencies in forty-two states for proficiency testing under Medicare regulations and for some state licensure programs.

2. Quality Assurance Service (QAS)—QAS has been designed specifically to assist laboratory personnel in solving the many problems arising from the challenge of total quality control. QAS not only uses a convenient and sophisticated computer program, but also provides a flexible personalized system for the medical laboratory and its director. The laboratory's director generates the input data on the basis of the specific constituent being analyzed, the method used for the assay, and the particular lot of quality control material utilized. This quality control input data is mailed on a weekly basis to the College's national computer center. Centralized data processing then applies standardized and specialized statistical procedures to all QAS participants for more meaningful comparisons of controlled data. Thus, the laboratory is provided vital information to make significant comparisons within the laboratory on a month-to-month basis. The laboratory also is provided statistical information to compare its performance with other QAS subscribers on a state, regional, or a national basis.

This program was initiated early in 1971 and already has more than 250 laboratories participating.

3. Physicians Evaluation Program (PEP)—This program was created approximately two years ago by the College. The program already has more than 400 physician office laboratories participating. For some time the College has been working with other medical groups in an effort to gain widespread acceptance of the PEP concept. These efforts recently resulted in the formation of a joint venture into this field by the CAP and the American Society of Internal Medicine (ASIM). The College believes that this approach will bring recognition and acceptance by physicians who are concerned with offering quality office laboratory services.

This program is similar in concept to the Quality Evaluation Program conducted for clinical and hospital laboratories, but is designed specifically to meet the needs of physician office laboratories. It offers to the physician with an office laboratory an inexpensive system for monitoring the capabilities of his office laboratory. It allows the physician to evaluate specific tests, reagents, and instruments for accuracy and precision. The program also provides confidential data which compares the performance of the physician office laboratory to a peer group of participating physician office laboratories. The program provides facts which can assist the physician in the management of laboratory technicians and personnel in his office laboratory and will help him to attain and maintain high standards of patient care.

4. Inspection and Accreditation Program (I & A)—This program reviews the total performance and function of both hospital and independent laboratories throughout the country. Almost 1,000 laboratories have been accredited and 200 are in the process of accreditation through this program. In this number, are approximately 180 laboratories involved in interstate commerce. In these laboratories, accreditation serves in lieu of federal licensure under the Clinical Laboratory Improvement Act. The Veterans' Administration also uses our I & A program in all of its hospitals.

The two essential factors in all of these programs are voluntary participation, and pathologists reviewing the professional competence of pathologists and other professionals in the field of laboratory medicine.

This background is provided to help establish for the Committee the concern of the College for quality performance, not only in the hospital-based and independent laboratories, but also in the physician "office laboratories."

1. SCOPE OF PEER REVIEW

The thrust of peer review must not be limited to inpatient hospital services received by recipients. Medical services know no boundary and the delivery and evaluation of the quality and necessity of these services should not be limited to any one setting. A major portion of the medical services provided to patients is offered in settings, other than hospitals, on an outpatient basis, which at times have little to offer in the way of quality assurance.

2. NATIONAL ADVISORY BODIES

The creation of a national advisory council to the Secretary in this area is essential to the success of the program. Proposed legislation calls for the establishment of such a council to be composed entirely of physicians. The College is in agreement with this intent. However, we must strongly urge that these physicians must be physicians in active practice. In addition, we also strongly recommend that there must be adequate representation of the medical specialty disciplines, i.e., radiologists, pathologists, etc. on this council.

3. NATIONAL ADVISORY PANELS

Many times the efforts of national advisory bodies are in vain because of the lack of consultation from specialties within the fields that the council is attempting to serve. For this reason, the College strongly urges that national advisory panels representative of national medical specialty societies be established to advise and assist the national advisory council. The purpose of these panels would be to aid the council in the preparation of criteria of care and treatment as may be within their area of expertise.

4. STATE AND LOCAL PARTICIPATION

Any program that is national in scope must have the benefit of lines of communication to the local level. The College therefore agrees with proposed legislation that there must be state and local advisory groups to assist in the carrying out of the intent of peer review programming. The concept of specialty advisory panels should also be carried out at the state and local level to assist these local groups in their deliberations.

5. PHYSICIAN OFFICE LABORATORY SERVICES

Special attention in any peer review program must be given to the provision of laboratory services in the physician's office. The "office laboratory's" performance, equipment, proficiency testing, and quality control procedures must be monitored and evaluated. The "office laboratory" should meet standards of performance of quality control established for hospitals and/or independent laboratories, on a voluntary basis, such as the PEP program of CAP/ASIM (see P. 3, or its equivalent).

6. THE ROLE OF PEER REVIEW

Peer rerview must be allowed to be more than a review of the past medical services provided and the payments made for these services. If peer review is only a forum for the airing of grievances and complaints against physician fees and the relevance of these fees to the services performed, then peer review should remain as a concept and not be enacted into legislation by the Congress.

Peer review, as was mentioned earlier in this statement, must be an ongoing evaluation process. There must be professional incentive for the practitioner to participate in such programs. The main thrust of a successful peer review program must be one of educational and forward-looking programming. The history of peer review programs of the College bears this out. As more pathologists participate in these voluntary programs, the results indicate a higher degree of professional achievement, better quality of the work performed, and a narrower allowable margin of error.

The College believes that the reason for this is the professional pride of the participant. The participant pathologist knows that his work is being reviewed by pathologists and is being compared to the work of other pathologists. Quality assurance, quality performance, and quality achievement become his professional goal.

TESTIMONY OF JOAN FOLEY, REPRESENTING THE COMMITTEE ON INCOME MAINTENANCE

I am Joan Foley. I speak here today for the Committee on Income Maintenance. We are a Committee of American citizens from all walks of life who are interested in the welfare of the American people as a whole and especially in the present system of welfare which was created over 30 years ago as a temporary measure and has not proven successful.

Our Committee has been functioning for the last four years, has held three conferences, and has been instrumental in having numerous bills introduced in the House by Congressman William Fitts Ryan and Congressman Leonard Farbstein, to wit: HR 13625, HR 586, HR 1634, HR 14773, and HR 4801.

The provisions which we feel must be included in a meaningful income maintenance bill have been sent to all members of the House, the Senate, and to the Governors of every state and have received very favorable reactions from all. Based on the favorable support we have received, not only from our legislators but also from the public as a whole, our Committee has adopted the following resolution:

RESOLUTION

We believe that the time has come for this nation to end poverty, and realizing that present, inhumane welfare system has been a tragic failure for millions of families, our Committee has resolved;

1. Congress should enact during the present term a meaningful income maintenance law.

2. Such a law should include the following provisions:

(*a*) Maintenance payments of at least $4,000 a year for a family of four, and payment of $2,500 for single persons as well as families, including senior citizens.

(*b*) Members of a family of an individual should be able to earn up to $8,000 a year on a sliding scale and not forfeit maintenance payments.

(*c*) Job requirement provisions should not be used to interfere with the bargaining efforts of a labor organization nor should they undercut the prevailing wage structure in a particular type of employment, nor should they undercut minimum wage standards.

(*d*) Under no circumstances should a mother be required to be separated from her young children or face the prospect of losing maintenance payments.

(*e*) Income maintenance legislation should be linked to a good job-training program and to a massive program to provide day care centers.

(*f*) In the event that a person cannot secure employment in the private sector of the economy, the federal government should be the "employer of last resort".

No more important problem confronts Congress this year than the reform of the destructive welfare system. The Committee on Income Maintenance urges that income legislation be the first order of business before the current Congress.

Very truly yours,

Mrs. BELLA ALTSHULER, *Chairman.*
Mr. FREDERICK NORTON, *Vice-Chairman.*

[Compliments of Councilman Theodore S. Weiss]

THE COUNCIL

NOVEMBER 16, 1971.

RES. NO. 644

Resolution calling upon the Congress to enact a meaningful income maintenance program during the current term

By Mr. Weiss, Mrs. Greitzer and Messrs. Silverman, Thompson, Friedland, Katzman, DiBlasi, Clingan, Sadowsky, Haber, Postel, Burden, Sharison and Mrs. Ryan—

Whereas, The present welfare system has failed in its original purpose of attempting to maintain an adequate standard of living for the unemployed and their families, and is utterly unable to provide a decent standard of living for the poor and the chronically unemployed; and

Whereas, It is inhumane, frequently forcing the separation of families and subjecting recipients to invasions of privacy and numerous other indignities; and

Whereas, It does not address the problems of the underemployed, the working poor and the near poor and fails to confront the overriding question of poverty itself; and

Whereas, The continued existence of poverty in the United States is morally repugnant, incompatible with democratic ideals and unnecessary given America's great wealth and resources; now, therefore, be it

Resolved, That the Council of The City of New York calls upon the Congress of the United States to commit itself positively to ending poverty in the United States by enacting a meaningful income maintenance program during the current term; and be it further

Resolved, That such a program shall include the following provisions:

1. An income floor of at least $4,000 per year for each family of four;
2. Payment for single persons as well as families;
3. Incentive pay on a sliding scale permitting a family of four to work without losing benefits under this program, until the total family income reaches $8,000 per year;
4. Classification of all benefits under this program and the conformance, with due process, of all administrative procedures relating to benefits;
5. No job requirements should (a) interfere with the rights or bargaining position of any labor organization or (b) undercut any prevailing wage rate in the particular industry or occupation;
6. Any job requirement should guarantee each beneficiary any rights granted to or held by any other worker in the particular industry or occupation, including, but not limited to, social security, unemployment compensation, union representation and collective bargaining, severance pay and seniority;
7. No job requirement should force the separation of a mother from her young children by threatening her with the loss of maintenance payments; and be it further

Resolved, That any income maintenance legislation be linked to:

1. Adoption as public policy the theory of the Federal government as the "employer of last resort," guaranteeing the right to a meaningful and productive job to any individual willing and able to work who cannot secure such employment in the private sector;
2. The provision of a massive and free program of vocational training and day care centers for all those desiring these services; and be it further

Resolved, That copies of this resolution be transmitted immediately to the President of the United States and the officers, floor leaders, appropriate committee chairmen and New York City members of each house of the Congress.

Referred to the Committee on Finance.

COMMUNITY SERVICE SOCIETY,
New York, N.Y., February 3, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Old Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: In the absence of an opportunity to appear before the Senate Finance Committee, we are filing for the Finance Committee's consideration and inclusion in its record the Statement on H.R. 1 prepared by our citizen committees and professional staff expert in the subject matter of the bill. A copy was sent to you November 3, 1971 by Elihu Schott, Mrs. David B. Magee, and David W. Smith representing respectively our Committees on Aging, Family and Child Welfare, and Health.

The first section is a discussion on how H.R. 1 approaches the three major objectives of the bill: improvement of the nation's income security programs; reduction of the numbers dependent on public assistance; improvement in the administration of Medicare and Medicaid. It also includes comments on some of the bill's social services provisions and on public accountability. The second part of the statement is an analysis of selected provisions of the bill, by title and section.

A summary highlighting the major points is attached, however, we commend the full statement to you for study.

Sincerely,

BERNARD C. FISHER.

HIGHLIGHTS OF STATEMENT ON H.R. 1

SOCIAL SECURITY PROVISIONS

Endorse:

—5% increase in benefit levels for OASDI beneficiaries.
—provision for automatic increases with increases in the cost of living.
—tying the level of increases in taxable earnings to the general level of covered earnings.
—liberalization of the retirement test.

Recommended:

—increase in the minimum benefits to $100 for an individual, $150 for a couple.
—exploration of the possibility of a variable retirement test formula permitting retention of a larger dollar earnings by those at the lower benefit levels.
—addition of two representatives of the public to the Trustees of the Trust Funds to assure that investment policies would not so strongly reflect the fiscal interests of the federal government.

MEDICARE PROVISIONS

Endorsed:

—extension of Medicare to disabled social security beneficiaries.
—modest addition of reimbursable medical expenditures.
—removal of current barriers to use of health maintenance organizations by Medicare beneficiaries.

Recommended:

—extension of Medicare to early retirees.
—inclusion of out-of-hospital prescription drugs as a reimbursable benefit.
—retention of the current requirement for provision of social services in Extended Care Facilities.

MEDICAID PROVISIONS

Opposed:

—restrictions on eligibility
by requiring assistance recipients with incomes in excess of the state's medically indigent eligibility standard to "draw down" the excess to pay medical bills before they can become eligible.
by not requiring the states to make Medicaid available to the newly eligible under the income maintenance provisions of H.R. 1.
—imposition of charges on Medicaid recipients
by permitting states to levy nominal charges on non-mandatory services which it is noted include such expensive items as prescription drugs and dental care.
by permitting states to impose deductible and co-payments on the medically needy.
by requiring states to impose a graduated premium fee on the medically needy.
—limitations on the scope of benefits
by allowing the states to reduce the range of non-mandated services without being subject to the maintenance of financial effort now in force.
by reduction in federal aid for certain types of institutional care after service is received for specified periods.
—elimination of the equipment that all states have in effect a comprehensive Medicaid program by 1977.

On the plus side:

—optional provision of services in Intermediate Care Facilities.
—inclusion of some provisions aimed at improving the quality of medical care for Medicaid recipients.
—encouragements for the delivery of care through health maintenance organizations.

ASSISTANCE TO NEEDY AGED, PERMANENTLY DISABLED AND BLIND (DAB)

Endorsed:

—creation of a federally financed and administered cash assistance program with a federally determined floor of assistance and nationally uniform eligibility conditions.

—proposals that the program be administered by the Social Security Administration.

Severely criticized:

—too low level of the proposed federal minimum which is below the poverty level and lower than the assistance level in many states.

—perpetuation of the differential treatment of the aged compared to the disabled and blind who are permitted higher income disregards.

Recommended as an offset to the low level of the federal minimum:

—requiring the states to supplement at least up to their previous payments (including the cash value of the food stamp bonus) with federal participation in the cost of such supplementation.

FAMILY ASSISTANCE PROVISIONS (FAP)

Opposed:

—the grossly inadequate federal minimum (below both the federal poverty level and the current assistance amounts in about half the states) and the failure to correct this by providing for a staged increase towards a more satisfactory living standard.

—failure to require states to supplement the FAP payment at least up to their current payment levels.

—exclusion of families headed by a full-time college or university student.

—counting income received in the preceding nine months as a resource even though at the time of application a family had no income or inadequate income.

—including as a resource the income of a step-parent whether or not he has legal responsibility for the support of his wife's children.

—exclusion of FAP recipients from the food stamp program which, while an inferior substitute for an adequate cash payment, is needed as long as assistance grants are woefully inadequate.

—perpetuation of the shocking discrimination against families with children with respect to level of the federal assistance payment (the minimum for a family of four is no more than the minimum for DAB couples and the discrepancy is even greater for large families).

—the stringent administration of eligibility conditions with such great emphasis placed in the bill and by the House Ways and Means Committee on strict administration that it could well lead to harassment of applicants and recipients.

On the plus side:

—the provision of federally financed and administered cash assistance program with nationally uniform eligibility requirements for families with dependent children.

—inclusion of the "working poor" in the program.

Recommended:

—provision of a minimum guarantee for adequate cash assistance for needy persons.

DAB AND FAP PROVISIONS

Objectionable provisions applying to both the Assistance to the Needy Aged, Permanently Disabled and Blind (DAB) and to the Family Assistance Plan (FAP):

—failure to include single persons or childless couples under age 65 who are not disabled.

—inclusion of a duration of residence requirement as a condition of eligibility for state supplementation.

—failure to give the states the fiscal relief they need. (The "hold harmless" provisions and access to federal assumption of the costs of administering state supplementation programs offer only partial fiscal relief.)

THE WORK PROGRAM PROVISIONS (OFF)

Opposed:
—the too low level of both the income disregard and the ceiling on deductible expenses in determining eligibility for FAP payments.
—the imposition of a coercive requirement on mothers of young children without regard for a mother's right to decide whether her working is in the best interest of her children or whether suitable day care facilities are available.
—failure to create a permanent program of public jobs to provide employment when private employment is not available.
—setting the minimum wage level for a job a person may be required to take in private employment not covered by minimum wage laws at only 75% of the already low federal minimum wage level.

Endorsed:
—the objective of encouraging and facilitating self-support.
—the centralization of responsibility for administration and financing of the work program in the federal Depa tment of Labor.

Recommended:
—provision of an effective earnings incentive by increasing the amount of the income disregard and the ceiling on deductible expenses in determining eligibility for FAP payments.
—making any requirement that mothers of young children accept work or training conditional on whether her working is in the best interests of her children and on availability of suitable child care arrangements.
—specification of principles to assure quality of child care services under standards developed by HEW and covering services purchased or contracted for, including private profit-making enterprises.
—inclusion of the definition of suitability of jobs or training a person is required to accept.

SOCIAL SERVICE PROVISIONS

Endorsed:
—the new provision for an increased appropriation for foster care and adoption with an absence in foster care of any limitation to cases in which a judicial determination has been made.
—the provision for payments to allow for the additional costs resulting from the adoption of physically and mentally handicapped children.
—the provisions which extend availability of family planning to the poor and near-poor.

Opposed:
—the imposition of ceilings on appropriations for social services.

Recommended:
—open-ended financing of social services.
—maintenance of state-wideness requirements.

PUBLIC ACCOUNTABILITY

Recommendations to strengthen public accountability:
—a requirement that rules and regulations which are not purely ministerial and which substantially affect the right of recipients to benefits and services be adopted only after publication and adequate public notice and opportunity for public hearing.
—provision for a participatory role for recipients in responding to policies and regulations affecting their lives.
—provision for local advisory committees in each state to evaluate the effectiveness of programs and services under each Title, membership to include representatives of those intended to benefit from the provisions of each Title.

STATEMENT ON H.R. 1—1971 SOCIAL SECURITY AMENDMENTS SUBMITTED TO THE SENATE FINANCE COMMITTEE BY THE SPECIAL COMMITTEE ON H.R. 1, COMMUNITY SERVICE SOCIETY OF NEW YORK, N.Y.

The 1971 amendments to the Social Security Act passed by the House of Representatives contain the most far-reaching changes in the nation's income maintenance system to be considered by the Congress at any one time since 1935

when the Act was enacted. The Congress is to be congratulated on undertaking so major a legislative overhaul as that embodied in H.R. 1. This is a massive piece of legislation making significant changes in a wide range of social policies. We consider some desirable, some undesirable. Therefore, we do not find it useful at this stage to adopt a position for or against the Bill as a whole. Instead, we are commenting on the Bill by reference to its main objectives.

Our concern is for the consequences of the proposed changes on the social and physical well-being of the citizens in our own community and throughout the nation. As a voluntary, nonsectarian social welfare agency, the Community Service Society since its founding in 1848 has been dedicated to strengthening family life and to the betterment of community life. Its Department of Public Affairs, through its citizen committees and staff, is that arm of the Society which engages in social and legislative action aimed at the improvement of community conditions, services and facilities.

Our analysis and comments on the Bill are the product of joint study by representatives of our Committees on Aging, Family and Child Welfare, and Health. These committees are concerned with the implementation of the Social Security Act and the related federal, state and local measures authorizing publicly funded and administered income support, health and social service programs. They have developed expertness in their respective fields. They have spoken over the years, both in support and in criticism of legislation and administrative actions affecting these programs.

Our statement is presented in two parts. Part I discusses the main objectives of the Bill and how the major provisions would, in fact, implement these objectives. In Part II we present a more detailed analysis, by titles and sections of the provisions discussed broadly in the first part of the statement and a few provisions of a more technical nature which are omitted from comment in Part I.

Part I—Analysis of H.R. 1 Objectives and Implementing Provisions

H.R. 1 appears to be directed to three main objectives. These are (1) improvement of the nation's income security programs, (2) reduction of the numbers dependent on public asssitance, and (3) improvement in the administration of those health programs with which the federal government is financially involved, namely, Medicare and Medicaid, and to a lesser extent, Maternal and Child Health Service. We also offer comments on the provisions of the Bill that affect the social services and public accountability.

A. IMPROVEMENT OF THE INCOME SECURITY PROGRAMS

The nation currently applies two different principles in its income security policies: provision of social insurance benefits as a right to insured persons in the event of inability to earn because of old age, retirement, permanent disability, death of a breadwinner and unemployment, and a system of assistance payments on the basis of demonstrated need in the individual case to those not covered by social insurance or whose insurance payments are inadequate for their needs. The assistance system in turn is in two parts: a group of federally aided programs for needy aged, blind and disabled and for families with dependent children and a wholly state or state/local program for all other needy people. H.R. 1 deals with both insurance and assistance.

1. Amendments to the federal old-age, survivors and disability insurance program

This is probably the most satisfactory part of the Bill. We welcome those amendments in Title I of H.R. 1 which increase the role of social insurance in providing income security by improving the level of benefits and liberalizing eligibility. In particular, we strongly support the 5% increase in benefit levels across the board. We are especially pleased that the Bill provides for automatic increases in the benefit levels with increases in the cost of living, as this will protect beneficiaries from erosion of the purchasing power of benefits as prices rise. The proposed increase in widows' and widowers' benefits from 82½% to 100% of the deceased spouse's benefit is also a move in the right direction. We believe, however, that the proposed increases in the minimum benefits are too meager and that an increase to $100 an individual and $150 a couple would be desirable. As our detailed comments in Part II indicate, we are in general in favor of other amendments such as those that would improve the benefit levels of persons long covered by the program or postponing retirement beyond age 65.

We are glad to see some liberalization of the retirement test though we suggest exploration of the possibility of a variable formula permitting retention of larger dollar earnings by beneficiaries at the lower level benefit levels.

We recognize that the liberalizations of the program will increase its costs and we are concerned about the increasingly heavy burden of the regressive wage and payroll taxes, especially on low income receivers. While we note with satisfaction the increase in the level of taxable earnings (both immediately and in the future by tying the level to increases in the general level of covered earnings), because this will involve tapping ever higher incomes and thus somewhat reducing regressivity, we would hope that the Congress would explore other sources of funds. In that connection our own studies indicate that the investment policies of the Fund Trustees have resulted in interest yields considerably less than could have been legally obtained and we suggest adding to the Trustees two representatives of the public to assure that investment policies would not so strongly reflect the fiscal interests of the federal government.

2. Assistance for the needy aged, permanently disabled and blind

The changes which Title III would bring about represent a major step forward. We strongly favor the creation of a federally financed and administered program which would introduce a long-needed federally determined floor of assistance and uniform eligibility conditions for the nation as a whole. This is indeed a major advance. We also support the use of the Social Security Administration as the agency to administer the program, as proposed by the Ways and Means Committee. This agency has an outstanding reputation for administering social security in a manner which emphasizes the rights of beneficiaries, respects their dignity and at the same time protects the interests of the insurance funds. In the hands of such an Administration there is good reason to expect the kind of non-discretionary and objective determination of both eligibility and payments amounts to which the long-period dependency of the aged, the blind and the permanently disabled so obviously lends itself.

We note, however, that the proposed level of the federal minimum is considerably below even the poverty level for aged individuals and slightly below this for aged couples. Although the Bill provides for a staged increase by 1975, it is to be expected that prices also will rise during this interval but the Bill does not require that the dollar minimum shall be automatically adjusted to increases in the cost of living.

Given the relatively low level of the federal minimum and the fact that it is lower than many states are now paying, it is regrettable that the Bill does not require the states to supplement the federal payments up to at least their current level. While Section 509 puts considerable pressure on the states (on pain of losing federal reimbursement under Titles IV, V, XVI and XIX of the Social Security Act) to supplement up to the amounts recipients would have received in June 1971 together with the bonus value of food stamps which were provided or available, a state could avoid this pressure by passage of state legislation specifically prohibiting it from supplementing the federal minimum. Given the present tendency of the states to lower their standards and cut welfare expenditures it seems likely that many will take advantage of this leeway. We urge amendment to require the states to supplement at least up to their previous payment levels (including the cash value of the food stamps bonus) and federal participation in the costs of such supplementation.

Furthermore, although as we stated above, eligibility conditions are uniform geographically, it is unfortunate that the Bill would perpetuate the differential treatment of the aged as compared with the blind and disabled who would be permitted more liberal disregards of earnings. We see no justification for this discrimination against the aged.

3. The Family Assistance Plan (FAP)

Title IV of the Bill replaces the existing Aid to Families with Dependent Children (AFDC) program with a new assistance program for families with children, the main feature of which is provision of a federally financed and administered assistance payment with nationally uniform eligibility requirements. Adoption of this principle is a major step forward and one we have long urged. Our satisfaction is, however, greatly diminished by the way the Bill implements this policy.

First, the federal minimum is far too low, and fails to reflect geographical differences in costs of living. The sum of $2400 for a family of four is well below

even the meagre 1970 poverty line ($3968), and for larger families the payment is even more inadequate due to the setting of a maximum of $3600 to total payments however large the family. The standard is even below the current assistance standards of about half the states and makes no provision for automatic adjustments in the dollar amount of the minimum with increases in the cost of living. We believe that the minimum guarantee should be substantially increased and that if, for financial reasons, it is initially set below the poverty level the Bill should provide for a staged increase toward a more satisfactory living standard as national income rises.

Second, given the low level of the federal minimum and its shortfall as compared with what many of the states are even now paying, it is unfortunate that the Bill does not mandate state supplementation up to at least current payment levels. For reasons we have already given, we do not believe that Section 509 is an adequate substitute for such a requirement.

Third, while we regard food stamps as an inferior substitute for an adequate cash payment and thus welcome the incorporation of the bonus value of food stamps in the basic federal cash payment, we believe it unfortunate, so long as the federal minimum falls so far short of even the current poverty standard and so long as state supplementation is so problematic, that recipients of FAP would not be permitted to buy or use food stamps.

Another new feature of FAP is the coverage of the working poor. The check to initiative and the inequity of denying assistance to those whose efforts at self-support yield them an income below assistance standards has long been apparent. While we welcome rectification of this injustice we also recognize that supplementation of earnings raises some difficult economic issues and in any case will greatly increase the numbers of FAP recipients. We would hope that, for the longer run, the Congress will continue to explore other ways of dealing with the problem of full-time earnings that are insufficient for family needs.

In any case, families other than those with working mothers are assured supplementation only up to the level of the federal guarantee, for the supplementary programs of the states are permitted to exclude families with both parents present and not incapacitated, regardless of whether the male parent is employed or unemployed.

The two assistance programs introduced by H.R. 1 do indeed mark a major step forward by introducing the important principle of a federal minimum standard, federally administered. But taken together and considered in the light of current needs in our public assistance programs and policies, they have serious shortcomings over and above those to which we have drawn attention when considering them individually.

First, neither one provides assistance for single or childless adults under age 65 who are not disabled. In addition, families headed by a full-time or university student are excluded. Quite apart from hardship to the families involved this last provision seems clearly inconsistent with the emphasis placed in Title IV on training as an aid to employability.

Second, the combined programs perpetuate the shocking discrimination in our assistance policies against families with children. As the Bill now stands, the federal minimum for a family of four is no more than the minimum for couples who are aged, blind or totally disabled, while for larger families the discrepancy is even more pronounced. And while we recognize that in the past, improvement in social provision for the needy has taken the form of gradual removal of one category after another from the total group in order to grant them more liberal treatment, we are concerned that the application of the policy in practice has tended to isolate what may be called a "discarded population" whose characteristics do not invoke popular sympathy, and on whom public resentment about the rising costs of public assistance can be concentrated. Thus the Committee on Ways and Means makes it clear that the Secretary of Health, Education and Welfare (HEW) is expected to provide a much more stringent administration of eligibility conditions for the FAP families than for the H.R. 1 Title III adult categories: for the latter a declaration system for applications would not be ruled out as it would be for the FAP population, nor would the verification and other procedures be so rigorous.

Third, both Titles would permit the states to establish duration of residence requirements as a condition of eligibility for state supplementary payments. Such a provision is not only socially undesirable but is also unconstitutional and we urge its removal.

Fourth, the burden of assistance costs on the states and localities is heavy and growing and is one of the reasons why reform is needed. The proposed "hold harmless" provisions (whereby the states are guaranteed that their expenditures on cash assistance payments will not exceed their total outlays for categorical cash assistance in calendar 1971) together with federal assumption of costs of administration of state supplementation (where a state agrees to federal administration) fall far short of giving the states the fiscal relief they need. Furthermore, the financial provisions of the Bill give least relative aid to those states which have been most adequately meeting need in the past or have been caring for relatively large numbers of assistance recipients. We believe that nothing short of federal assumption of the costs of assistance (including needed supplementation above the low federal minimum) will meet the problem.

B. REDUCTION OF THE NUMBERS DEPENDENT ON ASSISTANCE

It is obvious from many of the provisions of H.R. 1 and from the Report of the Committee on Ways and Means that a major objective of the drafters of the Bill has been a reduction in the numbers of assistance recipients. The Bill proposes to achieve this result in two ways: (1) by moving as many of the recipients as possible into self-support and (2) by tightening eligibility requirements and their administration.

1. The Work Program

Substitution of "Workfare" for "Welfare" is held by the Administration to be the heart of "welfare reform." We support the objective of the Opportunities for Families program (OFF), namely, encouraging and facilitating self-support. Nor do we question the propriety of requiring those who are clearly capable of self-support to accept appropriate training or suitable available work. But we have serious questions about the way these policies are applied in H.R. 1.

We wish to make it clear that there are some features of OFF with which we are in agreement. The proposal to disregard some fraction of earnings in determining whether a family is entitled to FAP payments will correct the present deterrent to earning whereby in most states earnings serve only to reduce the assistance payment. But we suggest that a disregard higher than the proposed $720 per year plus one-third of additional earnings would provide a more effective incentive to earn. Similarly, while we are glad to see that working mothers may deduct from their countable income for FAP purposes any charges they pay for child care services, we believe that the $2000 limit on this deduction (which covers also any irregular and student earnings) is too low in view of current costs per child of day care and similar child care services.

We are pleased too that the Bill recognizes one major weakness of current training programs, namely, the lack of available jobs for those whose training is completed, by providing for the creation of temporary public service jobs. However, the number of positions possible under the appropriation envisaged is insignificant in relation to the current number of unemployed job seekers whose numbers will be swelled by the newly trained OFF employables. A vastly greater work creation program will be necessary if the employment objectives of H.R. 1 are to be attained.

We also welcome the centralizing of responsibility for operation, administration and financing of work and training programs in the federal Department of Labor. In the past, diffused or shared responsibility for administration and the requirement of state financial contributions have severely limited the effectiveness of work and training programs.

Our objections to the OFF proposals relate mainly to two questions: (a) to whom should the pressure to accept work or training be applied and under what safeguards and (b) what kinds of jobs are people required to accept?

a. To whom should pressure to accept work or training be applied and under what safeguards?

The Bill specifies that all persons age 16 or over except those incapacitated or of advanced age, or caring for a sick household member or for a child under three, or regularly attending school if under age 22 shall be required to register for, and accept if offered, work or training. We strongly question the social desirability of imposing this requirement on mothers of young children who, we believe, should have the right to decide whether it is in the best interests of their children that they should work. It is a further weakness of the proposal that no account

is taken of the numbers of children in a family. We also find it particularly ironical that a woman with a husband in the home who is registered is not required herself to register, whereas the mother with no man to help share the burden of housekeeping and child care is required to do so.

The Report of the Ways and Means Committee implies that a mother will be required to accept work or training only if suitable alternative child care arrangements are available to her. But no such explicit safeguard is written into the Bill and this should be rectified. At present day care and other organized arrangements for substitute care of children of working mothers are shockingly inadequate even for mothers who are currently working, let alone for the increased numbers of women workers that are expected to result from the OFF program. The Bill does provide HEW with funds for an expansion of day care services and additional resources would be available if other child care proposals currently before the Congress should be enacted. But it is questionable how far even these funds will go in filling the gap.

It is presumably in recognition of this shortage that the Secretary of Labor who is given the responsibility of purchasing such care for OFF families, is authorized to the extent he cannot utilize the facilities developed by HEW, to purchase or contract for child care services "from whatever sources may be available" including public or private agencies "or other persons." The Report of the House Ways and Means Committee makes it clear that this includes private profit-making enterprises. We fear that this open-ended authority may lend itself to serious abuse. For although the Secretary of HEW is required to promulgate standards assuring the quality of child care services (with the concurrence of the Secretary of Labor), no guiding principles are laid down in the Bill. We believe that if society assumes the responsibility of pressuring mothers to work it must also accept the responsibility of defining standards of substitute child care.

b. What kinds of jobs are people to be required to accept?

It is of the utmost importance that the OFF program not be used as a weapon to force people to accept substandard jobs, or those that are in conflict with current national policies. We note that the Bill defines as unacceptable positions vacant as a result of a strike, lockout or other labor dispute and those where, as a condition of being employed, workers must join a company union or join or refrain from joining any bona fide labor organization. But, while the Bill specifies that wages, hours and working conditions of acceptable jobs must not be contrary to or less than those prescribed by applicable federal, state or local law, we regret that for the jobs available in private employment that are not covered by minimum wage laws, the wage level is permitted to be only 75% of the already low federal minimum. Furthermore, although individuals may refuse to participate in work or training programs "where good cause exists for failure to participate," "good cause" is not defined.

There should be reference to the suitability of the job or training for the particular registrant and reasonable standards defining suitability such as are prescribed for public service employment.

2. Tightening eligibility requirements and their administration

The second prong of the effort to reduce the numbers on assistance involves a tightening of eligibility and administration. Reference has already been made to the exclusion from eligibility of families headed by a ful-time college or university student. The numbers of eligible persons will also be reduced by the requirement that drug abusers and alcoholics must be undergoing treatment at an approved institution; by the counting as a resource, income received in the preceding nine months even though in the current quarter a family has no or inadequate income; and by including in resources, the income of a step-parent even though he has no legal liability for the support of his wife's children. We find these last two provisions especially objectionable.

Even more important in keeping down the numbers of recipients are the directives given in the Bill and elaborated in the Report of the House Ways and Means Committee for stringent administration. There is to be no declaration system for applications; statements by applicants are to be rigorously checked: recipients must immediately report changes in circumstances and make quarterly reports on income, in both cases under pain of severe penalties and at the end of two years must reapply for benefits. We are "strict constructionists" in the sense that we do not believe in lax administration or the admission to benefits of those not legally eligible. But we fear that the great emphasis placed in the Bill and

by the House Committee on stringent administration will lead to harassment of applicants and recipients and may even discourage some needy persons from applying.

C. IMPROVEMENTS IN ADMINISTRATION OF HEALTH PROGRAMS

The main thrust of the health amendments in Title II is clearly to improve the operating effectiveness of Medicare, Medicaid and the Maternal and Child Health Services. With most of the specific proposals for containing the costs of health programs by limiting the charges of providers, introducing incentives for economical operation, improving administration by encouragement of the use of mechanized equipment, improving the delivery system and the like we have no quarrel, although we recognize that time alone will tell whether the specific changes will achieve their intended result. We suspect that for many years to come the Congress will be grappling with the problem of assuring an efficient and economical operation of our health services while at the same time protecting quality.

But Title II also contains some substantive changes in the programs and some of the cost-oriented amendments are likely to have adverse repercussions on the nature of the Medicare and Medicaid programs.

1. Medicare

We strongly support the extension of Medicare to disabled social security beneficiaries although we would hope that it would prove possible to reduce the two-year waiting period. We also urge inclusion of the early retirees, a group whose age and income levels make medical expenditures especially heavy and onerous.

We are pleased that some modest additional reimbursable medical expenditures have been added but greatly regret the non-inclusion of the much more important out-of-hospital prescription drugs among the reimbursable benefits and strongly urge their inclusion. As our more detailed comments in the following section make clear, we also welcome a number of other amendments which make it easier for certain categories of people to secure supplementary medical insurance or entry to hospital. We believe that removal of current barriers to the use of Health Maintenance Organizations by Medicare beneficiaries is a step in the right direction. We hope, however, that the amendment removing the requirement for provision of social services in Extended Care Facilities will be eliminated. The patients in such institutions are likely to be persons for whom social services are of special significance.

2. Medicaid

The substantive changes proposed for Medicaid are numerous and serious. While there are a few desirable liberalizations such as the optional provision of service in an Intermediate Care Facility and, on a qualified basis, of care in institutions for the mentally retarded, inclusion of some provisions aiming at improvement of the quality of medical care for Medicaid recipients and encouragements for the delivery of care through Health Maintenance Organizations (all of which are discussed later in more detail), most of the changes are of a restrictive character.

We are strongly opposed to the changes which would (a) restrict eligibility, (b) impose charges on recipients and (c) narrow the scope of covered services.

(*a*) Assistance recipients with total incomes in excess of the state's medically indigent eligibility standard (usually 133.3% of the current payment to AFDC families) will be required to draw down the excess to pay medical bills before they become eligible for Medicaid. Quite apart from the hardship involved, this provision undermines efforts in other parts of the Bill to encourage earning by permitting recipients to retain some fraction of their earnings. We also urge elimination of the provision whereby states are not required to make Medicaid available to persons or families newly eligible for assistance under the income maintenance sections of H.R. 1. By definition these are low income people whose assistance payments will be too low to leave any leeway for meeting the costs of medical care.

(*b*) We strongly oppose the imposition of charges on Medicaid recipients. Even the "nominal" charges for non-mandatory services which the Bill would permit states to levy on cash assistance recipients are objectionable, for the payments they receive, even with state supplementation, will be barely, or not all, adequate for meeting recurrent basic needs and will leave no leeway for medical bills. It must not be forgotten that the non-mandatory benefits include such costly

items as drugs, dental care and the like. For similar reasons we oppose both the proposal to require the states to impose on the medically needy a premium fee graduated by income and the permission granted them to impose deductible and co-payment requirements.

Given the low income eligibility level for Medicaid in most of the states, eligible medically needy families will have no resources to cover the premium, while the co-payment and deductibles will deter many who should seek medical care from doing so. We are not impressed by the argument that such charges are necessary as a protection against overuse of health services. All evidence suggests that not overuse but underuse of health services is characteristic of the poor and in any case the main determination of the volume of service to be received by a patient lies in the hands of the physician, not the patient.

(c) The scope of medical benefits available under Medicaid is unfortunately narrowed by H.R. 1. The states would be permitted to reduce the range of non-mandated services without being subject to the maintenance of financial effort requirements currently in force. Given the financial pressures under which many states now operate, the consequence is likely to be a reduction of the benefits now available to the levels of those mandated. The scope of medical benefits is also likely to be restricted by the proposed reductions in federal aid for certain types of institutional care after service has been received for specified periods. We recognize that the intent of these amendments is to discourage unnecessary hospital or institutional occupancy and to encourage movement of patients to less expensive forms of care when medically indicated. But given the acute shortage of nursing homes and other alternative facilities for care we fear that the main result of these proposals will be to deny needed institutional care to many poor people, or if states are unwilling to do this, to add to the financial burdens of already hard-pressed states which will have to provide this care without federal aid.

We take particular exception to the proposed elimination of the requirement that states have in effect a comprehensive Medicaid program by 1977. The fate of the Medicaid program since 1965 has been a succession of reductions in benefits and coverage instead of the progressive expansion envisaged in the original legislation. This amendment is the final blow to the promise of an adequate program of health care for the poor and medically indigent.

D. AMENDMENTS TO THE SOCIAL SERVICES

Several sections of H.R. 1 directly affect the social services and their financing and administration. We welcome the new specific provision for appropriations for foster care and adoption. We are gratified that this additional federal aid for foster care will not be limited, as are the cash benefits under the family programs, to cases in which a judicial determination has been made, but will be available in respect of any child "for whom a public agency has responsibility." We are especially pleased that the adoption provisions include payments to allow for the additional costs resulting from adoption of physically or mentally handicapped children who are hard to place.

We welcome, too, the provisions which aim to extend the availability of family planning services to the poor and the near-poor. Society has no right to criticize the extent of out-of-wedlock births and the large families of those receiving public support so long as it withholds from them the knowledge and the means of more responsible family planning.

But we deplore the imposition of ceilings on appropriations for all except the child care and family planning services. Hitherto social services rendered to the federally-aided assistance categories have been subsumed under the Titles dealing with these groups and as such have been financed on an open-ended basis. We urge a return to the principle of open-ended financing and would additionally like to see removal of the closed-end grants now applicable to the Child Welfare Services under Title IV B of the Social Security Act. All these social services are almost everywhere inadequate in relation to the need for them and the imposition of ceilings will only further check their expansion. It is true that, commendably, the Bill provides that part of the appropriation for services to assistance recipients is to be set aside for states whose development of social services falls below the national average per recipient but the sum envisaged is small ($50 million) and the real problem is that the national average is itself too low. It is evident, too, from the Report of the Ways and Means Committee, that the

detailed spelling out of services for assistance recipients is intended as a restrictive device and we would prefer a more general definition such as is used in Title IV B or in the original Titles IV A and XVI of the Social Security Act.

We are troubled too by the provision that would permit the Secretary of HEW to remove the statewidenes requirement. Unless the conditions of such abrogation are narrowly defined (e.g., for the purpose of experiment or demonstration) and time-limited, elimination of the statewideness requirement can lead to discriminatory treatment of populations in certain areas.

We welcome the proposed separation of the administration of cash payments and of services. But we fear that the differing financial arrangements applying to the social services (according to whether they are rendered under one Title or Section or another) will foster a fragmentation of what should properly be a unified service system and will greatly add to the administrative burdens of the states.

Because we have always stressed the importance of simplified administration we look with apprehension to the vast responsibilities given to the Secretary of Labor in connection with the provision of a wide range of social services for the OFF families. The interposition of a second federal agency administering social services will greatly complicate and confuse administration at the local level and foster divided responsibility. In addition, the freedom given to the Secretary of Labor who has hitherto had no involvement in the administration, operation or supervision of social services to select his local administrative agencies, including profit-making agencies, we believe, is fraught with danger and may threaten established policies.

E. PUBLIC ACCOUNTABILITY

The Bill provides in numerous sections for the Secretary of Labor or HEW alone or in conjunction to adopt regulations that will establish standards, as for child care, or prescribe requirements, as for filing applications, or institute criteria, as for determining a disabeld person's ability to engage in activity.

It is clear that the rules and regulations to be adopted to implement the various Titles will be of critical importance, frequently of greater significance in their impact on the recipient than the language of the sections being implemented. Nevertheless, there is no provision for public hearings prior to their adoption. We submit that the opportunity for an exchange of views and through public analysis of issues which is exercised in committee hearings and floor debate prior to Congressional action on proposed legislation is equally essential in the administrative system. The Bill should include a requirement that rules and regulations which are not purely minfsterial and which substantially affect the right of recipients to benefits and services be adopted only after publication of the proposed rules and regulations and adequate public notes and opportunity for public hearing.

Another instance of failure to provide for public accountability is the absence of a participatory role for recipients in responding to the policies and regulations of the programs which directly affect their lives in such vital matters as their subsistence level, training, employment, child care and medical or other services. Even the provision establishing local committees to evaluate the effectiveness of manpower and training programs specifies as members representatives of labor, business, the general public and units of local government, thereby representing everyone except the persons most affected, the families registered for the OFF program. We recommend that the Bill provide for the appointment of local advisory committees in each state to evaluate the effectiveness of the programs and services offered under each Title and that the committees include in their membership representatives of those intended to benefit from the provisions of each Title.

PART II—ANALYSIS OF SELECTED PROVISIONS BY TITLE AND SECTION

TITLE I: PROVISIONS RELATING TO OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE (AMENDING TITLE II OF THE SOCIAL SECURITY ACT)

Sec. 101. Increase in cash benefits of 5 percent

Provides an across-the-board increase of 5% in social security cash benefits effective June 1972.

We support the proposed 5% increase in cash benefits effective at the earliest possible date, January 1972 if this be feasible. Additionally we recommend a $100

monthly minimum for an individual and $150 for a couple, thus raising benefits for the low level regular and the special age-72 beneficiary. We recommend that general revenues be applied to pay the additional cost of this proposed minimum.

There are good reasons to increase the minimum.

The proposed minimum monthly benefits are $74 for the retired individual and $111 for a couple, or, put in annual terms, $888 and $1332 respectively. For the special age-72 beneficiary the monthly payment would be $50.80 for a single person and $76.20 for a couple or $609.60 and $914.40 per year, respectively.

How well these payments cover minimum living needs may be judged by comparison with two standards:[1] (a) the lower budget level in the Spring of 1970 for persons and couples 65 and over for urban United States and (b) the 1970 poverty level for nonfarm persons and couples 65 and over—both adjusted upward by a 5% annual inflation factor, compounded through 1972.

The cash benefits for the retired worker at the minimum level would be close to $1200 *less* than the estimated 1972 nonfarm poverty level of $2052 and over $800 *below* the lowest budget of $1714 for an aged individual living in an urban area of the U.S. at the same time. Special benefits to age-72 individuals would be even further below the poverty and budget levels.

A couple aged 65 and over with the minimum social security cash benefit would be more than $1200 *lower* than the 1972 poverty level of $2589 for a retired couple and nearly $1800 *less* than the lowest budget of $3122 for an urban 65-and-over two-member family. Couples receiving special age-72 benefits fall even further below the standards.

The proposal to raise minimum monthly cash benefits to $100 for an individual and $150 for a couple will narrow but not close the gap between benefits and low budget or poverty levels.

The recommendation that general revenues be tapped for this increase is financially justifiable because, in lieu of a higher cash benefit minimum, old age assistance which is financed out of general revenue would likely be used as a supplement. Administrative costs would be cut down, too, with beneficiaries receiving checks under one, rather than two programs, each with its own criteria for eligibility.

Sec. 102. Automatic increase in benefits, contribution, and benefit base, and earnings test

Provides an automatic, once-a-year increase in cash benefits, provided that the Consumer Price Index has increased by at least 3% and that legislation increasing benefits had neither been enacted nor become effective in the preceding year.

Provides a parallel automatic increase in the contribution and benefit base, according to the rise in average covered wages, if wage levels had gone up sufficiently.

Also provides a comparable automatic increase in the exempt amount under the retirement test.

We support automatic cost of living adjustments to cash benefits, recognizing that this does not improve the economic status of older persons but merely serves to avoid further deterioration. We believe that such an adjustment should be linked to an increase in minimum benefits, as before discussed. We note with approval that the Congress may take interim action before the January 1974 effective date of this provision as well as subsequent action to increase general benefits.

Increasing the wage base subject to FICA tax by the same percentage that benefits are raised will assist in the program's financing. Furthermore, automatically raising the retirement test with the rise in averaging taxable wages at the same time the CPI adjustment takes place is an advantage in the proposed legislation.

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[1] The two standards differ significantly. The Spring 1970 lower budget level is $1555 for single persons; $2832 for couples (respectively $1714 and $3122 for 1972 using 5% as the inflation factor compounded through 1972.) The 1970 poverty level is $1861 for single persons and $2348 for couples (respectively $2052 and $2589 as updated.)

Sec. 103. Special minimum cash benefit for persons with a substantial employment record

Provides a special minimum for persons who worked 15 years or more under social security, such minimum to be computed at $5 times the number of years of covered employment up to a top limit of 30 years or $150.

We approve this provision. However, we question the non-application of a price rise adjustment to this benefit.

Sec. 104 and Sec. 113. Survivors' benefits

Provides in Sec. 104 an increase in cash benefits to widows and widowers from the current 82.5% of the deceased spouse's benefit to 100% of the amount the deceased spouse would receive if living. Survivors' benefits applied for before age 65 would be actuarially reduced.

Provides in Sec. 113 payment of reduced benefits to widowers at age 60 as is now done for widows at age 60.

We support the increase in cash benefits to dependent widows and widowers. We, however, favor a no-penalty provision for the widow or widower of an early retiree, and recommend that the widow or widower receive 100 percent of the benefit the retired worker would have received at age 65.

We favor the option given to 60 year old widowers to receive decreased survivor benefits, an option already given to widows.

Sec. 105 and Sec. 142. Financing

Provides in Sec. 105 an increase in the annual taxable earnings base from $7800 to $10,200 effective January 1972.

Provides in Sec. 142 new schedules of tax rates for OASDI and Medicare for the self-employed and for employees and employers. For the latter, the combined rate would increase from the current 10.4% to 10.8% in 1972, to 12.4% in 1975 and to 14.8% in 1977.

We approve the rise in the taxable earnings base to $10,200 effective in January 1972. This tends to decrease the regressivity of the tax.

We withhold approval of the proposed changes in the tax rates. We believe that tax rates should be reexamined subsequent to a change in the investment policy of the Trust Funds.

We strongly recommend that the interest rate pattern of the Trust Funds be altered with the objective of raising the interest income. The need for liquidity and safety of Fund monies is acknowledged, but the income of the Funds (notably the Old-Age and Survivors Trust Fund and the Disability Insurance Trust Fund which together totaled $40.3 billion as of April 1971) could be substantially raised within legal investment limits.

Setting the investment policy of the Funds, within the framework legislated by the Congress, is a three-man Board of Trustees. Managing Trustee is the Secretary of the Treasury; others are the Secretaries of Labor and of Health, Education, and Welfare. Official records[2] indicate that investment practice has favored the government to a significant degree through what is tantamount to loans at low interest rates.

For fiscal 1971, the overall interest rate was less than 4.8% for the Trust Funds.

As of April 30, 1971 it is significant that 42.9% or $17.3 billion of the OASDI Trust Funds was invested at 4.75% or lower interest rates; 26.4% at 3.875% or less; 13.4% at 2.75% or less. These investments were accumulated over a period of time. However, the 1970 rate on 3–5 year U.S. Government securities was 7.3%: in 1969 it was 6.85%. In fact, in every year beginning with 1966 the 3–5 year rate was over 5%. Long-term U.S. Government bonds moved steadily upward and beginning with 1966 never fell below 4.66%, reaching a high of 6.99% in June 1970.

Most of the OASDI Trust Funds are invested in special issues—$27 billion

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[2] Portfolio of OASDI Trust Funds, *Congressional Record*, June 23, 1971, p. H5813. Interest rates on government securities 1965–1971, *Federal Reserve Bulletin*, June 1971, pp. A33, A34.

out of $40.3 billion or 67%. Reinvestment would have no immediate or direct impact on the market. They could be redeemed at par with accrued interest and could be refunded immediately into higher yielding issues.

This recommendation in respect to investment policy is generally in accord with the recommendations of the 1971 Advisory Council on Social Security. We concur, too, in the Council's recommendation that the present three-man Board of Trustees be increased to five and include two nongovernment members representing the public interest.

Sec. 106. Increased benefits for persons retiring after age 65

Provides granting to the late retiree an increase of 1% in annual benefits, prorated at 1/12 of one percent monthly, for each year (or month) after age 65 in which benefits are unclaimed because of continued employment. Does not provide increased benefits to dependents and survivors.

We view this to be a positive first step to provide increased benefits for continued participation in the labor force. However, the annual increase of only 1% seems overly modest. For example, a person retiring at age 67.5 years would receive monthly cash benefits 2.5% higher than he would have received at 65. Moreover, during the post-65 period the worker would not have received benefits and he and his employer would each have contributed the FICA tax.

Sec. 107, Sec. 108 and Sec. 110. Benefit computational methods

Provides in Sec. 107 an age-62 computation point for men (rather than age 65) as is now the case for women.

Provides in Sec. 108 additional drop-out years—one additional year of low earnings, in addition to the five years provided under current law, for each 15 years of covered work.

Provides in Sec. 110 the computation of benefits based on the combined earnings of a working couple, each of whom had at least 20 years of covered earnings after marriage. Applicable only if higher benefits would result.

We support the proposed liberalizing changes in methods of benefit computation. But we offer recommendations for further improvement.

We suggest that the elimination of the differential between men and women in computing average wage be made applicable to current as well as future beneficiaries. The Bill applies the new provision to men first eligible to entitlement in January 1972. (Sec. 107)

Permitting an additional year of earnings dropout for each 15 years of covered employment is supported because it leads to a higher average wage base and therefore greater benefits. However, we urge consideration and study of the disregard of income earned many years ago in average wage calculation in order to raise the average wage used for benefit computation figures. Average taxable wages per worker, for example, in 1956 were only 58% as great as those in 1969. (Sec. 108)

Sec. 111. Retirement test

Provides a liberalization of the retirement test for persons between ages 65 and 72. Allowable earnings limit increased from $1680 annually to $2000 with a 50% offset against benefits for earnings in excess of $2000. In respect to the latter, current law provides that $1 shall be deducted from benefits for each $2 earned between $1680 and $2880 and that for each $1 of earnings above $2880 there is a loss of $1 in benefits. On a monthly basis, provides no loss in benefits for earnings below $166.67 as contrasted with $140 as of now.

We strongly favor liberalizing the retirement test.

We support raising the allowable annual earnings limit to $2000 or $2200, but we do not believe that this kind of adjustment truly joins the issue.

What we seriously question is the equity of a uniform retirement test and of a monthly exemption. We propose that a workable alternative and a variable formula be developed to avoid the unfortunate effects of a uniform retirement test on total income of beneficiaries at different benefit levels. Further, we recommend the replacement of the monthly retirement test with a quarterly retirement test.

First, as to the uniform test:

The effect of a uniform test is the forfeiture of cash benefits by the beneficiary of smaller monthly benefits at a significantly lower level of total income than the beneficiary of benefits in the middle and upper benefit range.

For example, under the current retirement test, a $100 a month ($1200 a year) beneficiary forfeits all cash benefits when his total earnings are $3500. The beneficiary of $200 a month ($2400 a year) does not lose all cash benefits until an earnings level approaching $5000 is reached and a $300 a month ($3600 a year) beneficiary would lose his entire social security payments only when he has earned close to $6000.

The figures can also be viewed in percentage terms. Under current legislation a $100 a month beneficiary with annual earnings of $3000 forfeits 60% of his benefits; a $200 a month beneficiary with the same earnings loses 30% of his benefits and a $300 a month beneficiary also earning $3000 has an offset of only 20% against his benefits. At an earnings level of $3500 the $100 a month beneficiary has lost 100% of cash benefits, the $200 a month beneficiary only 50.8% and the $300 a month recipient only 33.8%.

H.R. 1 liberalizes the retirement test, but retains the differential percentage loss. Under H.R. 1 a $100 a month beneficiary loses 41.6% of benefits with earnings of $3000; a $200 a month recipient with the same earnings loses 20.8% and a $300 a month recipient loses 13.8% of benefits.

The income tax does not remove the inequity brought about by the uniform test. Since social security cash benefits are not taxed, each beneficiary with, for example $3,000 of earned income and using the tax tables, will have the same tax liability. The social security beneficiary at the upper level of cash benefits will not pay any more in tax dollars than the social security beneficiary at the lowest end.

Since the beneficiary of lower monthly social security cash payments was, for the most part, the lower income level earner his poor economic status is perpetuated in his older age years.

We propose that a flexible retirement test, related to the amount of social security benefits, replace the uniform test in a way which will not penalize the beneficiary of higher benefits. However, it should permit the beneficiary at the lower end of the scale to retain a larger proportion of his benefits than he can currently.

Second, as to the monthly computation:

The retirement test, both today and in the proposed legislation, is applied on a monthly basis. Regardless of the amount of annual earned income no beneficiary loses a social security payment for any month in which his income falls below $140 (current legislation) or $167 (H.R. 1).

The monthly test creates two problems: one of equity and the other of administration. A quarterly test will minimize situations such as the following: a retired school teacher serving as a substitute forfeits all benefits for the month in which she has earned over $167; however, in the next month or two she may earn nothing or less than $167. On a quarterly basis she would not be penalized, for each quarter would allow earnings of $500 before benefits would be withheld. Another illustration is the case of a consultant working for one month and earning a fee of $10,000. He may still collect all benefits for 11 months, with no forfeiture except for the one month during which his earnings were $10,000.

Administratively the quarterly method is feasible and has an advantage over the current monthly reporting schedule. The Social Security Administration could readily pick up quarterly earnings figures from the quarterly reports on FIAC taxes submitted by the employer and showing both his share and the employee's share. Monthly earnings data rely on the reports of the social security beneficiary. It would likely be more accurate and certainly more prompt and simpler if FICA records were substituted for beneficiaries' reports data.

Sec. 122. Eligibility

Reduces the waiting period for benefits for disabled workers, disabled widows and disabled dependent widowers from six to five months.

We support this provision which is reported to affect nearly one million persons.

TITLE II: PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

A. Provisions relating to Medicare (amending title XVIII of the Social Security Act)

Sec. 201. Eligibility for coverage extended to disability beneficiaries

Extends eligibility for hospital insurance and supplementary medical insurance to a social security disability beneficiary two years after entitlement to disability benefits. Coverage extended to disabled workers entitled to social security or railroad retirement benefits, disabled widows and disabled dependent widowers between ages 50–65, and persons aged 18 and older receiving benefits because of disablement prior to age 22. Effective July 1, 1972.

We favor this proposed liberalization of eligibility.

Sec. 202. Extension of hospital insurance benefits to uninsured individuals

Extends eligibility for enrollment for hospital insurance on a monthly premium basis to a person who has attained age 65, is either a resident citizen or a lawfully admitted resident alien, and is not otherwise qualified for coverage. Initial monthly premium of $31 to rise as hospital costs rise.

We support the principle of enrollment on a monthly premium basis of persons otherwise ineligible for hospital insurance coverage. However, we question the utility of this proposal because of the size of the premium covering the full cost of protection.

Additionally, we urge that Medicare coverage be phased in for the early retiree, that is, the beneficiary between the ages of 62 and 65. A person taking early retirement—for whatever reason—not only receives actuarially reduced social security cash benefits but may very well have no health insurance protection. At least three reasons account for the lack of health insurance coverage for the early retiree.

Many persons claiming benefits at age 62 have been out of work for several months and, therefore, have no employer-financed coverage. Intensifying the unemployment problems is the major reason for the unemployment: illness. In its *Survey of New Beneficiaries*, published in 1971, the Social Security Administration found that "Health is the most important reason described by over half the group, whether they stopped working at age 62 or more than three years earlier." So, large numbers of those taking early retirement are unemployed and in poor health and have been both unemployed and in poor health for some time.

Even those employed just prior to early retirement are unlikely to be covered by the extension of their health insurance into retirement.

Finally, many early retirees, with their small cash benefits, are unable to pay for private health insurance coverage.

We recognize the benefits of health care coverage for early retirees. We recognize, too, that costs are a factor. Therefore, we suggest phased-in coverage.

Sec. 203. Setting supplementary medical insurance premium

Directs the Secretary of HEW[a] to determine a premium as of December of each year estimated to be necessary so that the aggregate premiums for the 12-month period beginning July 1 in the succeeding year will equal one-half of the total benefits and administrative costs of the supplementary medical insurance program. However, the premium generally would increase only if monthly social security cash benefits had increased since the last increase in the premium and would rise by no more than the percent increase in such benefits across the board.

We support the reasonableness of the proposed basis for increasing the supplementary medical insurance premium charges. We particularly favor the provision that, beginning with fiscal 1973, no increased premium may be charged unless there has been an increase in social security cash benefits, either as the result of the enactment of legislation raising the benefit level or as a result of the automatic cost of living benefit rise.

[a] In subsequent sections, HEW is substituted for Secretary of HEW.

Sec. 204. Deductible

Increases the annual deductible for supplementary medical insurance (Part B) from $50 to $60.

We regret the apparent need to increase the deductible for Part B of Title XVIII, but we do not oppose this change. However, we believe this should be accompanied by a change in present law with respect to the deductible for hospital insurance (Part A of Title XVIII). This now is $60 for each benefit period and is scheduled to go to $68 January 1, 1972 reflecting the increase in hospital costs. Since a patient may be admitted to and discharged from a hospital several times a year, he could be required to pay the deductible five times, totaling $300 a year as of now and $340 as of January 1, 1972. The payment of even two or three deductibles a year causes financial hardship to many. We, therefore, recommend the benefit period in respect to the deductible for Part A be defined as one year, which is the period used for computation of the deductible under Part B.

Sec. 205. Benefits and coinsurance

Increases from 60 to 120 days the lifetime reserve under which the beneficiary pays one-half of the deductible for hospital inpatient care. Shortens from 60 to 30 days the period in a spell of illness when coinsurance is not imposed for hospital inpatient care.

Benefits, that is to say the coverage of specified services for a specified duration or a specified volume under Parts A and B, are largely unchanged [4] in H.R. 1 *except* as they are affected by changes in provisions in respect to coinsurance or deductibles. We view the increase in the lifetime reserve for hospital inpatient care as a highly desirable liberalizing feature of the Bill. This may well be a trade off, compensating in part for the shortening from 60 to 30 days the period in a spell of illness when coinsurance is not imposed for hospital inpatient care. We rather regret this tightening measure, but we recognize that vast numbers will still be covered since the average hospital stay of Medicare patients is only 12.8 days and 91% of the discharges from hospitals—other than psychiatric or tuberculosis—represent stays of fewer than 30 days.

There is, however, a serious omission from the benefits. The cost of out-of-hospital prescription drugs is a serious financial burden to the elderly and the federal social insurance program provides a feasible and efficient mechanism to alleviate the problem. We urge the inclusion of such a program under Part A of Medicare.[5] We recommend a $1 co-payment per prescription or refill by the beneficiary, with payment of the balance to be made by the Social Security Administration to the vendor. At the same time we suggest that HEW undertake further study of a just and effective method of utilization conrol.

Sec. 206. Automatic enrollment in supplementary medical insurance

Provides automatic enrollment under Part B for individuals entitled to hospital insurance benefits.

We favor this proposal but suggest that the new social security beneficiary be informed of the reason for a deduction from his monthly cash benefit check. An insertion, for several months running, in the envelope with his check would appear a satisfactory way of informing the retired worker of the fact and cost of his coverage, and of his option to withdraw from part B coverage.

Discussed below are certain specifics directed to Medicare cost controls that affect large numbers of persons or embody broad principles—Sections 221–4, 226, 228, 234 and 236.

Sec. 221. Limitation on federal participation for capital expenditures

Authorizes withholding or reducing reimbursement amounts to providers of service under Medicare (Title XVIII and also Titles V and XIX) for defined costs related to certain capital expenditures that are inconsistent with state or local health facility planning. For this purpose, capital expenditures are defined as expenditures for plant and equip-

[4] There are modest changes in respect to physical and other therapy services (Sec. 251), coverage of supplies related to colostomies (Sec. 252), coverage of ptosis bars (Sec. 253), hospitalization for a noncovered dental procedure (Sec. 256), prosthetic lenses furnished by optometrist (Sec. 264).

[5] Available on request is a detailed fact sheet and outline of a proposed program.

ment in excess of $100,000; which change bed capacity; or substantially change services.

We strongly endorse the provision that capital expenditures as here defined would be reimbursed only when such outlays are consistent with state or local plans. Mushroom expansion without regard to overall needs is wasteful.

Sec. 222. Plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy

Authorizes HEW to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to hospitals, extended care facilities and other providers of services under Title XVIII (applicable also to Title V and XIX).

Clearly, the present system of provider reimbursement on the basis of "reasonsonable costs" carries little incentive for efficiency. We support the authorization for HEW to develop ways of testing the efficacy of the alternative whereby rates are set in advance of the period to which they are applicable. We inject a word of caution of about the possibility of lowering the quality of care *and* some escalation in costs. Advance rate setting may result in losses to providers when costs rise above those anticipated; the temptation to cut corners and reduce service is a real threat. Contrariwise, prospective rates can be escalated to avoid an unfavorable spread between the actual and estimated costs.

In respect to experiments with various reimbursement methods designed to increase efficiency and economy: We support this provision and particularly welcome its linkage to community wide peer, medical and utilization review mechanisms designed to assure that health services meet professional standards and that medically necessary services are given in the most appropriate and economical setting.

There is no provision for adoption into practice of effective experiments—an oversight that should be corrected.

Sec. 223. Limitations on coverage of costs

Provides authority to set cost limits for certain classes of providers in various service areas on a prospective rather than a retrospective basis. Requires public notice to beneficiaries of changes beyond reimbursable limits.

We support the requirement that providers be informed in advance of the approved reimbursable limits and that beneficiaries be advised of the nature and amount of extra charges. We would add to this a requirement for disclosure by the financial intermediary to both public bodies and the consumer of reimbursable costs in the locality for standardized services and procedures. In our view, this additional measure of public accountability is important.

Sec. 224. Limits on prevailing charge levels

Limits increases in physicians' charges through June 1972 for fee scales up to the 75th percentile of prevailing charges; after fiscal 1973 provides that physicians' fees may be increased only to the extent justified by economic changes; provides that charges deemed reasonable for medical supplies, equipment and services may not exceed the lowest level at which such items, comparable in quality, are widely available in a given community.

We recognize the need for setting limits on prevailing charge levels and concur as to the need for continuing study and attention to this thorny question. We note that the Bill authorizes HEW to develop "appropriate economic index data" as a basis for adjusting fees, but that the House Ways and Means Committee is fairly specific in its report on the items to be considered for such an index computation. We urge that such study be both sophisticated and objective as a means of providing a fee structure that is fair, defensible and supportable.

Sec. 226. Payments to health maintenance organizations

Adds a new section to Title XVIII providing for payments to health maintenance organizations.

We support the encouragement given to the development of health maintenance organizations as one acceptable, alternative mechanism through which patients

eligible for Medicare could elect to have all covered care, except emergency service, provided.

Sec. 228. Advance approval of extended care and home health services

Provides authorization to establish periods of time for which a patient is presumed eligible for extended care and home health services on certification by the patient's physician.

We are in agreement with this provision. The establishment of specific post-hospital time periods during which there is presumptive need for such services should encourage transfer to less costly types of care and should decrease the number of cases in which benefits are retroactively denied.

Sec. 234. Institutional planning

Requires that participating health facilities have a written plan reflecting an operating and capital expenditures budget.

We welcome the inclusion of this requirement which is clearly tied to other Sections, e.g., Sec. 221 and Sec. 222.

Sec. 236. Prohibition against reassignment of claims

Prohibits Part B Medicare payments being made to anyone other than a patient, his physician or other person providing the service (with limited exceptions).

We support this provision which seeks to close a loophole in the existing law and control undesirable collection practices that have resulted in inflated claims and escalated costs and beclouded the determination of reasonable limits.

Sec. 265. Deletes requirement for social service in extended care facilities

Prohibits HEW from requiring an extended care facility to furnish medical social services.

We are not persuaded by the arguments put forward in the report of the House Ways and Means Committee to support this Section which would nullify the HEW regulation requiring the furnishing of medical social services as a condition of participation for extended care facilities under Medicare. We urge the removal of this Section from the Bill and review of the regulations by HEW to determine their fairness in the light of experience to date.

Sec. 269. Requirements for nursing home administrators

Permits states to provide a permanent waiver from any licensure requirements for persons who served as nursing home administrators for the three-year period preceding the year the state established a licensure program.

We urge the deletion of this Section which would appear to permit administrators who could not meet licensure requirements to return to or remain in practice. We believe that the device of licensure upgrades service by upgrading administration. The public interest should be protected rather than private, vested interests which would seem to profit by this proposed permanent waiver.

B. Provisions relating to medicaid (amending title XIX of the Social Security Act)

Sec. 207(a)(v). Incentives for states to emphasize comprehensive health care

1. Increase in federal reimbursement:

Provides that States in contract with Health Maintenance Organizations (HMOs)* or other comprehensive health care facilities would receive 2% increase (up to 95%) in federal reimbursement percentage under the Medicaid program.

We strongly favor prepayment over the fee-for-service method of financing health care. We support the intent of encouraging new patterns for the delivery of health care and believe that the quality of health service can be significantly

*An HMO is an organization that offers to an enrolled population, a comprehensive system of health service, including preventive, ambulatory, hospital and related care on a capitation reimbursement basis.

improved under a program providing comprehensive coverage. We do not believe that there are sufficient safeguards in H.R. 1 to assure that improved patient care will necessarily result. We think that the Bill should stipulate that HMOs, or other comprehensive health organizations, that are formed in keeping with the Bill's provisions, must be under public or private non-profit auspices.

2. Decrease in federal reimbursement:

Provides that the federal medical assistance percentage would be decreased by one-third after the first 60 days of care, in any fiscal year, in a general or tuberculosis hospital or a skilled nursing home, unless the state establishes that it has an effective utilization review program.

For inpatient care in a mental hospital, federal reimbursement would be decreased by one-third after 90 days except that it may be extended for 30 days if the state can show that the patient will benefit therapeutically from such care. No federal reimbursement would be provided after 365 days care in a mental hospital.

We believe every effort should be made to use less costly facilities than hospitals when such care is appropriate and adequate to an individual patient's needs. We think, however, that some of the assumptions about need for hospitalization and length of stay on which the reductions are based do not give full weight to the fact that Medicaid covers persons under 65 as well as over 65 and that not all patients irrespective of age and condition require treatment of only short duration in "acute" hospitals. Moreover, the lack of facilities to provide different levels of care poses a major problem, especially for those who may need something less than full hospital care but who do need institutional care until well enough to be cared for at home. We are concerned that as a result of these amendments, appropriate and adequate health services may be denied those persons who are most vulnerable.

3. Computing reasonable reimbursement between skilled nursing homes and intermediate care facilities (ICFs).

Authorizes HEW to compute a resonable cost differential reimbursement between skilled nursing homes and ICFs.

The apparent purpose of this amendment is to assure that care in an ICF results in decreased costs to the Medicaid program. We support the measure as being administratively sound.

Sec. 208(a). Cost-sharing

Permits states to impose a nominal cost-sharing charge on cash assistance recipients for non-mandatory services under the Medicaid program. Requires states to impose on those not receiving cash assistance an enrollment fee premium or similar charge related to income, and permits co-payment provisions not related to income.

In addition to our basic objections to the imposition of charges on Medicaid recipients as stated in Part I, we believe the costs of administering these proposals would be prohibitive and that patient services would be unnecessarily delayed in the course of establishing eligibility for care.

Sec. 209(c) and (d). Determination of payments

Sec. 209(c) denies Medicaid coverage to those in receipt of cash assistance whose incomes are in excess of the medical assistance level established by the state. *Sec. 209(d)* permits states to deny Medicaid coverage to those persons who would be newly eligible for cash assistance under the income maintenance sections of H.R. 1. If a state chooses to provide Medicaid it would be required that recipients' incomes not be in excess of the state's medical assistance level.

We strongly object to both these proposals. Currently, states that have a Medicaid program are required to provide care under Medicaid for all recipients of cash assistance. We believe these amendments strike at the basic purpose for which the Medicaid program was first enacted, that is, to assure a program of health care for persons in financial need. *Sec. 209(d)* is ominous since it gives tacit approval to states to deny health care to needy families and at the same time releases the federal government from any responsibility for reimbursement to the states which so act, for health care payments for their needy families.

Sec. 221 (a). Limitation on federal participation for capital expenditures

Prohibits use of funds appropriated under the Social Security Act to support unnecessary capital expenditures; provides that reimbursement under such titles would support state health planning activities.

We are in full support of this provision. It takes into account that state and local health planning agencies have primary responsibility for determining the need for health facilities for given geographic areas and provides that capital expenditures under Title XIX of the Social Security Act would be related to the priorities established by the health planning agencies.

Sec. 222(a)(1). Plan for prospective reimbursement

Authorities HEW to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to hospitals, extended care facilities, and other providers of service under Title XIX in order to stimulate more efficient health care and thereby reduce costs, without adversely affecting the quality of services.

We favor this proposal in the belief that more effective patient care, more efficient use of health personnel and a decrease in medical costs could result from this kind of experimentation. There is no provision, however, that those experiments found effective might be authorized to be continued; we believe this oversight in H.R. 1 should be corrected.

Sec. 231. Deductions in care and services

Permits states to reduce the scope and extent of health services which are optional under Medicaid.

Currently, states may not reduce the level of their expenditures for their Medicaid program in successive years. We object to this amendment because it would permit the states that choose to do so, to deny or diminish the availability of vital health services which are defined, under the Medicaid statute, as optional. We believe the optional services are necessary components of adequate health care and should not be withdrawn.

Sec. 235(a). Payments to states for claims processing and information retrieval systems

Makes federal matching under this provision available to states for developing and instituting mechanized claims systems at 90% and 75% for operation of such systems.

We support this proposal because it should encourage rapid development of mechanized collection and retrieval systems to the end that the Medicaid reimbursement and related operations would be more efficiently administered.

Sec. 236(b). Prohibition against reassignment of claims

Prohibits Medicaid payments to anyone other than the patient, his physician or other service provider unless the provider is required as a condition of employment to turn over his fees to his employers.

We fully support this provision which would outlaw the use of fee collection agents by providers of services under Medicaid.

Sec. 239 (a) and (b). Use of state health agency

Sec. 239(a) requires states to provide that the state health agency, or other appropriate state medical agency, have responsibility for establishing and maintaining health standards for institutions in which Medicaid recipients may receive care or services. *Section 239(b)* requires that the state health agency or other appropriate state medical agency, be given responsibility for establishing a plan for the review by professional health personnel of the quality and appropriateness of care and services furnished to Medicaid recipients.

We fully support both of these amendments. The first should assure at least basic standards for the quality of care provided to Medicaid recipients. The second provision sensibly makes use of an existing mechanism to provide a service for the Medicaid program; the quality of care under Medicaid should be improved by this provision.

Sec. 240. Relationship between medicaid and comprehensive health care programs

Provides that states may enter into contracts with organizations that agree to provide care and services in excess of those offered under the state plan at no increase in costs.

We question this proposal in the absence of an acceptable minimum standard throughout a state. However, we see as desirable, experimentation that likely would emphasize preventive care and early treatment in order to contain costs, and on this basis support the proposal.

Sec. 254 (a)(1) and (a)(2). Inclusion of care in intermediate care facility

Sec. 254(a)(1) provides, as an optional service, care in an Intermediate Care Facility (ICF) as an additional benefit under Medicaid. *Sec. 254(a)(1)* provides that services in a public institution for mentally retarded persons would qualify for Medicaid coverage, if the primary purpose is to provide health or rehabilitation services, and if the patient is receiving active care.

Currently federal reimbursement for care in an ICF is not available under the Medicaid program. Each of these provisions, in our view, would be desirable additional elective benefits for Medicaid recipients.

Sec. 255(a). Coverage prior to application

Requires states to provide coverage for care and services furnished in or after the third month prior to application for Medicaid.

Under present law, a state may at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for Medicaid. We favor this amendment as being both sound and desirable.

Title III—Assistance for the Aged, Blind and Disabled

(New Title XX of the Social Security Act)

Sec. 2002 and Sec. 2803. Administration

Sec. 2002 provides that eligible aged, blind and disabled individuals shall be paid benefits by HEW. *Sec. 2003* provides that HEW make arrangements to carry out the assigned functions, including arrangements for determination of blindness and disability similar to those in effect in determining eligibility for social security disability benefits.

Although the Bill does not so specify the report of the Ways and Means Committee recommends that responsibility for administering the program of cash benefits to the needy aged, blind and disabled shall be assigned to the Social Security Administration (SSA). We welcome this recommendation. Persons receiving benefits under this program for the most part comprise a relatively stable group, similar to the OASDI beneficiaries. We believe that the SSA's long experience in administration of payment programs would enable it to administer this new program efficiently and humanely.

Services to the needy aged, blind and disabled would continue to be provided through federal-state financing and be administered by the states. Those in need of services would have contact with the local social services unit of the state administration. In our view, the administration both of the cash payments and services for this group of persons should be simplified and flexible because they are limited in ability to respond to complicated procedures by the very nature of their eligibility.

Sec. 2011(b). Cash assistance; amount of benefits

Prescribes the amounts payable in 1973, 1974 and 1975 to individuals, with or without an eligible spouse, whose non-excluded resources are not more than $1500. The Bill does not require that the couple be living together.

The Bill provides cash assistance in the amount of $1560 for a single person and $2349 for a couple. These amounts are increased to $1800 and $2400 respectively by 1975 and are to remain at that level thereafter. The level of assistance projected in the Bill is inadequate as evidenced by the fact that the poverty level as determined by the 1970 Census is $1861 for an aged individual and $2348 for

an aged couple; due to the inflationary factor this level had increased approximately 5% by 1971 and unquestionably will be even higher by 1975. The Bill should be amended to provide a level of assistance adequate to meet basic need.

Sec. 2012(b)(3), Sec. 2016 and Title V, Sec. 509. Exclusions from income; optional state supplementation; state supplementary payments during transitional period

Sec. 2012(b)(3) provides for exclusions from income: $85 of earnings plus one-half of the balance for the blind and disabled and $60 of earnings plus one-third of the balance for the aged. *Sec. 2016* permits states to supplement the federal payment. *Sec. 509 of Title V* requires the states to make supplementary payments to maintain their payment level of June 1971 plus the bonus value of food stamps unless they modify that level by affirmative legislative action to the contrary prior to July 1972.

Eligibility conditions for assistance would be uniform nationally. However, blind and disabled persons would receive more liberal income deductions than the aged and therefore the amount of assistance granted the different groups would not be uniform. The difference in disregards among the three categories should be corrected. Further inequities would result from the optional provision for state supplementation. We believe that needy persons should receive an adequate level of assistance to meet need. Therefore, the states should be required to supplement the federal payment at least to the current payment levels.

Sec. 2031(a)(2).—Protective payments

Authorizes payments of the benefit to a person other than the individual or his spouse (including an appropriate public or private agency) if HEW deems it appropriate.

Assistance payments may be made to a third party (including an appropriate public or private agency) who is interested in or concerned with the welfare of the receipent, if HEW deems this to be appropriate. While it is believed that this leeway may be in the best interest of an aged, blind or disabled recipient, the regulations and procedures governing determination of appropriateness should safeguard against excessive use of this provision. The conditions under which these payments would be ordered should be included in the Bill.

Sec. 2011(c) and Sec. 2031(c). Application process—period for determination of benefits; application and furnishing of information

Sec. 2011(c) provides that eligibility for and the amount of benefits shall be determined for each quarter of a calendar year and shall be redetermined at such time or times as may be provided by HEW.

Sec. 2031(c) directs HEW to prescribe requirements for filing applications, suspending or terminating assistance, furnishing data and reporting changes in circumstances and specifies the penalties for non-compliance by the applicant or recipient.

In our judgment the current annual redetermination is preferable to a quarterly review of eligibility and should be retained, especially in view of the relatively stable circumstances of this group of recipients. We favor the simple declarative form for determining eligibility over extensive investigations and recommend that the Bill provide for its use.

We further recommend that the Bill allow for flexible application of the requirements for reporting changes in circumstances with due consideration for the hardship which rigid application of penalties would impose on the very old and seriously disabled.

TITLE IV—THE FAMILY PROGRAMS

(New Title XX of the Social Security Act)

Sec. 2111, 2112, 2114. Operation of manpower programs; employable mothers; child care and other supportive services

1. Operation of manpower programs

Sec. 2114 requires the Secretary of Labor to develop an employability plan describing the manpower services, training and employment needed to enable each individual to become self-supporting and secure and retain employment and opportunities for advancement.

Several of the employment provisions must be changed to make them truly effective in helping persons achieve self-support. There must be a sufficient number of jobs, paying adequate wages and meeting acceptable working conditions. It is not realistic to mandate employment but fail to provide satisfactory training programs and sufficient work opportunities.

The Bill creates public service jobs paying at least the federal minimum wage, to supplement other employment opportunities but these are few in number and temporary. Federal reimbursement will not extend for more than three years of an individual's employment in a public service employment program. After that period a person must either be hired by the agency or terminated. Permanent public service jobs should be created to the extent needed to meet mandated employment requirements.

The Bill requires that wages for the public service jobs shall be at least at the federal minimum but permits wages in private employment, which a needy person could be required to take, at 75% of the federal minimum. The Bill should require that all mandated employment shall be at least at the federal minimum wage level; that conditions of work shall be of acceptable standard; and that the job a person is required to take shall be suitable to the person, with suitability defined with respect to such matters as a person's prior training and experience and the distance of work from his home.

2. Employable mothers; child care and other supportive services

Sec. 2111 includes as an individual who shall be considered available for employment, a mother of a child three years old or, until July 1, 1974, six years old.

Sec. 2112 provides that the Secretary of Labor shall make provision for the furnishing of child care services, in such cases and for so long as he deems appropriate for the individuals registered for employment or training who need such services to participate in the program through such public or private facilities as may be available or appropriate.

After 1974, mothers of children over three years would be required to accept employment or training (unless there is a husband in the home who is registered) whether or not suitable child care services are available. Considerable hardship to children could be caused if despite the authorization to the Secretary of Labor to make provision for such services suitable child care is not available. Furthermore, the requirement that a mother of young children shall be considered available for employment removes from her the right to determine if it is in the best interest of her child for her to work or remain at home; that decision should be based on the needs of a particular family, including the availability of suitable care for the children.

Sec. 2134. Child care standards; development of facilities

Directs the Secretary of HEW to establish standards assuring quality of child care services with the concurrence of the Secretary of Labor; to prescribe schedules to determine the extent to which families must pay the costs; and to coordinate child care services under Title XXI of the Social Security Act with other child care and social service programs.

Authorization of funds for child care services is provided but in an insufficient amount to meet the need and should be increased. HEW would be required to set standards of care. Setting and overseeing standards of care is particularly important since the Bill permits contracts for day care with profit-making as well as with public and nonprofit agencies. Adequate day care, not now defined, should be defined in the Bill and the standards set should be in line with these definitions. This is essential if mothers of young children are to be compelled to accept work or training.

Sec. 2152 (a) and (b) and Sec. 2152(d). Cash assistance: eligibility for and amount of benefits; period for determination of benefits

1. Eligibility for and amount of benefits

Sec. 2152 (a) and (b) prescribe benefits for eligible families at the rate of $800 per year for each of the first two members, plus $400 for each of the next three, plus $300 for each of the next two members, plus $200 for the next member, to a maximum of $3600, reduced by

non-excludable income; no benefit is payable of under $10 per month. Resources may not exceed $1500.

The nationwide minimum standard of payment for needy families with children would not be adequate. The payment levels—for example, $2400 annually for a family of four persons—is less than even the poverty level of $3968 for a family of four determined by the 1970 Census. And since no family could receive more than $3600 regardless of the number of family members, large families would be even further below this poverty line. Therefore, substantial increases in payment levels must be made if persons are to have an adequate level of existence—particularly since this Bill would freeze the federal payment at this level for the five years' duration of the Bill.

2. Period for determination of benefits

Sec. 2152(d) provides that payment of benefits shall be made on the basis of HEW's estimate of the family's income for the current quarter after taking into account income from the three preceding quarters and modifications for changes of circumstances.

The federal payment should be computed according to a family's current need. H.R. 1, however, provides that the portion of a family's income during the nine months preceding application for the FAP payment in excess of the payment level (including excludable income) would be deducted from benefits otherwise due at the time of application. In the case of such excess income, a family would not receive even the inadequate federal payment. This provision should be changed. Only need at the time of application should determine eligibility and amount of payment; it should not be assumed that persons have saved money from a prior period.

Sec. 2153(b). Work incentives; income disregard

Enumerates the items to be excluded in determining the income of a family such as a student's earnings; irregular income limited to $30 a quarter if earned or $60 a quarter if unearned; earned income used to pay the cost of child care as prescribed by HEW; $720 plus one-third of the remainder of earned income. The total exclusions of the first three cannot exceed $2000 for a family of four, up to maximum of $3000.

To encourage persons to work, the Bill provides that some income from earnings be retained and disregarded in computing eligibility for benefits. Out of earned income, $720 per year plus one-third of the excess earned would be excluded. Thus, payment to four-person families in which there is a working member would be made only if the allowable income is $4140 or less. Although child care costs are deductible, the total of these costs, irregular earnings and student earnings could not exceed $2000.

Work expenses such as transportation and taxes are not excluded in determining a family's income. Therefore, if these costs are higher than the retained income, a working family could find itself with less money at its disposal than if no member were employed. To provide a true work incentive, the Bill must permit retention of a larger share of earnings. Furthermore, the ceiling on income exclusions should be removed, particularly since these include the cost of child care services. If, for example, the cost of day care absorbed the total allowance for excluded income, a school child working irregularly would not be permitted to retain any of his earnings.

Sec. 2155 and Sec. 2156(b)(2). Exclusions from coverage; meaning of family and child; exclusions from state supplementation

1. Meaning of family and child.

Sec. 2155 defines those who qualify as family members and, therefore, are eligible for benefits under the family programs, as two or more related persons living together in the United States, at least one of whom is a citizen or alien lawfully admitted for permanent residence, and with at least one child dependent on one of the others. It expressly excludes families headed by full-time college students.

By definition, federal payments would not be made to needy single adults or childless couples who are not aged, blind or disabled nor to needy families headed by a full-time college student. Persons in these groups would be without access to public assistance except in those states which made provision for

their aid without benefit of federal reimbursement. A basic level of financial assistance should be made for *all* needy persons and the Bill amended to include these excluded groups in the federal system of income maintenance.

2. Exclusions from state supplementation.

Sec. 2156(b)(2) permits states to deny benefits to families with both parents present and neither parent incapacitated, regardless of whether the father is employed or unemployed.

There are exclusions within the groups eligible to receive FAP or OFF payments which we believe should be removed. States are permitted to exclude from supplementation of FAP or OFF payments, families in which both parents are present and neither is incapacitated regardless of whether the male parent is employed or unemployed. It should be required that the states include *all* needy families in their supplementary programs.

Sec. 2155(d). Forced responsibility of step-parent; income and resources of non-contributing individual

Excludes income and resources not available to other family members if it is derived from a family member other than a parent or a spouse of a parent.

The income and resources of a parent's spouse living with the family would be included in determining the family's eligibility for benefits even though the spouse does not have legal responsibility for the children and may have his own children elsewhere to support. This can result in needy children being denied assistance and thus penalized because of a parent's marriage. This provision should be changed so that the spouse's resources would not be included on behalf of those persons in the family for whom he does not have legal responsibility.

Sec. 2156 and Title V. Sec. 509. Uniformity in amounts of assistance; optional state supplementation; state supplementary payments during transitional period.

Sec. 2156 permits the states to make cash payments to supplement the federal payments and requires that the supplementary program respect the federal earnings disregard provisions. The states are not required to include families with a male parent present in their supplementary program. *Sec. 509* requires the states to make supplementary payments to maintain their payment level of June 1971 plus the bonus value of food stamps unless they modify that level by affirmative legislative action to the contrary prior to July 1972.

We are in full support of the provision for uniformity in the amount of federal payments based on uniform conditions for determining eligibility. The level of payments, however, is inadequate. Moreover, since supplementation is optional with the states and they are permitted to exclude certain groups from their supplementation program, if any, there would be inequalities in the amount of assistance among needy families with children in the various states. All persons should have a right to an adequate level of assistance which should not leave them in poverty. We believe the states should be required to supplement the inadequate federal payment at least to their current payment levels.

Sec. 2171(a)(2)(A) and Title V. Sec. 529. Indirect payments; vendor payments

1. Indirect payment of benefits

Sec. 2171(a)(2)(A) permits payment to any person other than a family member (including an appropriate public or private agency) if HEW finds that the family member to whom benefits are payable has such inability to manage funds that making payment to him will be contrary to the welfare of the children in the family.

Payments may be made to non-family members if it is found that the payments are not being used in the best interests of the family. The Bill should state the criteria for finding the family incapable of managing its own affairs and the conditions under which such third party payments may be ordered.

2. Vendor payments under the AFDC program

Sec. 529 of Title V effective immediately upon enactment authorizes the states to provide for non-recurring special needs which cost $50 or more by payment directly to the person furnishing the item.

This provision immediately applicable to the current AFDC program, permits states to pay the provider directly for goods or services costing $50 or more. This method of payment is contrary to the premise that needy families have a right to manage their own affairs, including making purchases and handling money, in the absence of proof that they are unable to do so.

Sec. 2171(c). Hearings and review

Requires notice and opportunity for hearings for anyone who disagrees with a determination with respect to eligibility for or amount of payments, if requested within thirty days. Final determination by HEW after a hearing would be subject to judiical review, except that HEW's findings as to facts shall be conclusive.

The Bill fails to specify certain fundamental standards for the conduct of hearings when a recipient challenges administrative decisions, such as adequate notice of the reasons for the initial determination. In providing that findings of fact are not subject to judicial review, the Bill does not add the necessary protection against arbitrary findings—that they must be supported by a clear preponderance of the evidence. Furthermore, the Bill should require that a recipient shall receive benefits pending the final decision.

Sec. 2152(c) and Sec. 2171(e). Application and biennial reapplication process

Sec. 2152(c) prohibits benefits being paid a family for more than twenty four consecutive months except on the basis of a new application filed and processed as though it were the family's initial application for benefits.

Sec. 2171(e) directs HEW to establish requirements for filing applications, suspension or termination of benefits, furnishing data and reporting changes in circumstances necessary to determine eligibility. Each family shall be required to submit a report within thirty days after the end of the quarter to determine eligibility for benefits payable for that quarter or be subject to penalty.

The Bill should prescribe a simplified method for determining eligibility for benefits both in the initial application and the biennial reapplication process. The Bill requires families to make quarterly reports of income and expenses within thirty days, under automatic penalty. It requires a family to file the new application to be treated as if it were an initial application despite the accumulated data of twenty-four consecutive months. We believe that the emphasis in the Bill on investigation, furnishing evidentiary materials and frequent routine reporting to substantiate eligibility for benefits, is costly and unnecessary in most cases and would impose needless hardships on families. Flexibility in the application and reapplication process should be permitted while at the same time assuring that benefits are paid only to eligible persons. We recommend provision be made for the use of the simple declarative statement where appropriate, a method now in use in many states.

Sec. 2102, 2151, 2156, etc. Administration; multiple sections

This Bill would necessitate a complicated administration requiring continuing contact among several federal, state and local agencies. Locally, there would need to be a tremendous increase in the state and local offices for providing cash assistance, services and employment.

The FAP program and the payments to OFF recipients would be administered by HEW. Other agencies would be involved to provide information to establish eligibility. If requested, HEW would administer a state's supplementary program and Medicaid eligibility. As an inducement, the state would pay HEW the amount of the supplemental payments and be relieved of responsibility for the administrative costs.

The OFF program of training, work and employment would be administered by the Department of Labor including such supportive services as day care. This can be done by direct federal administration or through contacts with state and local agencies.

Nearly all recipients would be required to have contact with many agencies. Among the local offices with which a head of a needy family may have to deal could be that of HEW administering payments and of the Department of Labor, and possibly with a day care center or some other office rendering a service Since the states would continue to administer the social service programs under

the present federal-state matching arrangements the recipient requiring service would need to have contact also with local service units of state administration. It is to be hoped that procedures will be devised to minimize and coordinate the multiplicity of agency contracts necessitated by this Bill.

TITLE V—MISCELLANEOUS[1] NEW SOCIAL SERVICES PROVISIONS

(Amending Titles IV and XI of the Social Security Act)

Sec. 511. Definition of services

Sec. 511(a) lists twelve services for individuals in a family receiving assistance to needy families with children, which the state plan may include in its service program. These are: family planning including medical services, child care, services to unmarried girls who are pregnant or have children, protective services, homemaker services, nutrition services, educational services, emergency services in connection with a crisis or urgent need, services to assist in training or employment, assistance in locating housing, services to abusers of drugs or alcohol, information and referral services.

Sec. 511(b) lists eight services for aged, blind or disabled persons receiving assistance under Title XX or other needy aged, blind or disabled persons which state plan may include in its service program. These are: protective services, homemaker services, nutrition services, assistance in locating housing, emergency services in connection with a crisis or urgent need, services to assist individuals to engage in training or employment, services to abusers of drugs or alcohol, information and referral services.

States should be encouraged to develop those service programs which would best meet their local needs. Specifying in the Bill the services to be offered limits the variety and scope of the states' programs. We prefer the broad statement of the purposes for which services are to be provided now in the law to an enumeration of specific services. However, if the states are to be limited to the services enumerated in the Bill, that list should be enlarged to include all the services that may be required to achieve the purposes of the Act.

Sec. 512. Authorization and allotment of appropriations for services

Authorizes an appropriation of a maximum of $800 million for payment to states for training of personnel, for services to the aged, blind and disabled and for services for any individual receiving assistance to needy families with children.

Although the program of matching grants to states for services to needy families and needy aged, blind and disabled persons would be continued, the Bill makes an important and, we believe, undesirable change. For the first time, a limit would be placed on the amount of money to be appropriated for services (except family planning and child care services which would be funded differently) to these groups of eligible persons. Under current law, there is a ceiling on appropriations for child welfare services to non-recipients of cash assistance but appropriations for services otherwise are open-ended. The federal government matches what the states spend.

We urge that the Bill be amended to restore open-ended appropriations, thereby encouraging, not discouraging, the states to develop the preventive, supportive and rehabilitative services which are needed. Furthermore, the financial plight of so many states and the lack of sufficient services is reason for giving consideration to the possibility of federal assumption of the cost of services.

Sec. 513. Adoption and foster care services under child welfare services program

Authorizes $150 million for the year ending June 1972 rising to $200 million for the year ending June 30, 1976 for payments for foster care (including medical care not available under any other state plan) for a child for whom a public agency has responsibility and for payments to a person adopting a handicapped child. Payments may be made to any agency, institution or person if the care meets standards prescribed by HEW.

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[1] For discussion of Sec. 509—State supplementary payments during transition period, see pp. 47 and 54.

For discussion of Sec. 529—Payment under AFDC program for nonrecurring special needs, see page 55.

The large numbers of children who are in need of foster care make it particularly necessary for their protection that the Bill define the standards of care required with respect to quality of care, health and safety. Because of the difficulty in finding good foster care for children, we commend the inclusion of funds for the cost of locating such resources.

Payments to a person adopting a physically or mentally handicapped child (based on financial ability to meet the medical and other remedial needs of the child) should expedite placement of hard-to-place children, especially those requiring costly medical care.

With respect to both the foster care and adoption programs, we believe the Bill should provide an open-ended not a close-ended appropriation.

Sec. 522. Statewideness not required for services

Permits HEW to make exceptions to the requirement that the plan for social services should be in effect in all political jurisdictions of the state. (Amends Title I, IV, X, XIV, XVI)

Although grants to states would continue to be based on an accepted state plan, the plan no longer would have to be enforced throughout the state. We consider this an unfortunate change in the law. It could result in uneveness within a state depending on the locality of the regular, continuing services offered and unevenness in their delivery.

COOK COUNTY DEPARTMENT OF PUBLIC AID,
Chicago, Ill., February 1, 1972.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Please find enclosed the statement I would like to present to you and your committee in your consideration of H.R. 1. Thank you for this opportunity to express my views. I know they may be somewhat narrow in scope as my view of the welfare problem is from my position in a local county department of public aid and the problems I see may not be as widespread as I think. However, my conversation with employees in welfare departments in other counties and states has convinced me that the problems about which I speak are serious enough to merit the attention of your committee. After all is said and done, the success or failure of any legislation your Committee and the Congress as a whole may pass will depend on how successfully the local county departments of public aid can implement such legislation.

Very truly yours,

WILBUR A. WEDER, MASW,
Research Analyst II.

It is my belief that during all the discussion that has centered around welfare reform during these past several years one vitally important part of the welfare problem has been almost totally ignored. That is the administration organization that will implement any welfare reform legislation which may be passed. We must ask ourselves whether or not we have an administrative organization that can implement welfare reform. At present, I firmly believe that we do not. I do not know the problems that might be inherent in the administrative organization at the National or State level so my comments will be limited to the local (county) level of welfare administration. First, I would like to enumerate some of the problems and then state what I think are possible solutions.

One of the greatest problems is the perceived lack of direction from State and HEW officials. New policies are not presented to the caseworker in a manner which will help the caseworker understand the new policies. County officials are reluctant to set policy guidelines that may later be changed or completely revoked by the State. Consequently, many issues go unresolved with the caseworker not knowing what he should do in a particular situation. This leads to a state of confusion on the part of employees and to "buckpassing" by officials at both the State and County level. There is a general feeling that no one in a position of authority is willing to accept the responsibility for making a decision or once he does, he does not want to be held accountable for it. Consequently, many programs have failed due to the fact that no one was willing to decide what to do at crucial points in its implementation.

A second problem is the development and training of staff. A bachelor's degree alone is not sufficient to make a person a caseworker. Yet, little training is given to the new worker and even less is given to those who are promoted through the system to the position of supervisors and higher. The result is that we have people in supervisory and administrative positions who were excellent caseworkers but know nothing about supervising other workers or how to handle the administrative part of their job. Contributing to the supervisors' problems is the lack of employee performance standards. There are no standards set by which a supervisor can evaluate employees performance. This leads to numerous problems between administrative and supervisory staff and casework staff. Also adding to the problems is the high turnover rate. (See Table). Although the turnover rate has been reduced considerably in the last two years, an annual turnover rate of 45.3% is extremely large. It creates a lack of continuity in the work as a new worker is always having to be trained. Also, the turnover rate can be expected to rise again once the economy improves and other jobs are available.

TURNOVER RATES[1] FOR PUBLIC AID EMPLOYEES 1968-71[2]

	Year			
	Current	1970	1969	1968
Total	30.8	38.1	41.2	36.6
C W	45.3	64.4	64.5	70.9
Non-C W	24.3	25.0	28.9	21.1

[1] Turnover rates are computed by dividing the total annual terminations for all reasons by the monthly average of staff on duty during the year and multiplying by 100.
[2] Turnover rates are based on figures from the Cook County Department of Public Aid, Chicago, Ill.

A third problem is one of understaffing. HEW recommended a weighted caseload of 180 cases. At present, we are working under a theoretical caseload of 300 weighted cases but in actuality each caseworker had a caseload of about 600 weighted cases or more than 3 times the recommended workload. As long as this degree of understaffing continues it is difficult to see how the caseworker is going to have time to do much besides seeing that each recipient receives his or her check each month.

These are the major problems I think we must resolve in our own administrative organization before we can even begin to think we can successfully implement welfare reforms. It should be possible to create a welfare administrative organization which can implement welfare reforms.

First, we must have people in the top positions who are willing to accept responsibility for their actions, who are willing to make decisions, and who are willing to be held accountable for the decisions they make. In other words, we must have responsible people who can be held accountable for the success or failure of those programs which are their responsibility.

Second, it should be mandatory for all states to provide adequate training programs for employees at all levels. This should go a long way towards improving our administration of whatever welfare system we may have.

Third, uniform employees performance standards should be established and maintained for all positions in the welfare administrative organization. An employee should know what is expected of him while his supervisor needs a fair and impartial standard by which to measure his performance.

Fourth, there must be adequate staffing so that an employee does not constantly labor under an overwhelming burden of paperwork, continual crisis, and a sense of never catching up with all that must be done.

Finally, if the preceeding four recommendations are implemented we may be able to reduce the turnover rate among caseworkers to a more reasonable level. A stable work force could be much more efficient than one which is constantly changing.

Once we have created a viable welfare administrative organization, then I believe we can seriously consider implementing any welfare reform legislation which Congress may pass.

WILBUR A. WEDER, MASW,
Research Analyst II, Department of Public Aid.

COUNCIL OF JEWISH FEDERATIONS AND WELFARE FUNDS, INC.,
New York, N.Y., January 21, 1972.

Senator RUSSELL B. LONG,
Chairman, Finance Committee, U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: In lieu of requesting the opportunity to present oral testimony at the hearing of the Finance Committee, I am submitting herewith the recommendations on Welfare Reform and Social Security adopted at our General Assembly. I trust that you will bring this to the attention of the members of the Committee for their consideration in drafting your Committee's report to the Senate, and that it will be entered into the record of the hearing.

Very truly yours,

MAX M. FISHER.

II. WELFARE REFORM AND SOCIAL SECURITY

The welfare system of America is grossly inadequate. The welfare reform measure passed by the House of Representatives would make a basic desired change in providing a federally financed national floor, but the legislation falls seriously short of a number of minimum requirements. The corrections should be made by the Senate, and then retained in the final action by the entire Congress.

The most important changes required to enable persons with the potentials for independence to become self-supporting, and to enable others—aged, sick, handicapped—to live in decency and dignity, include:

1. The Federal requirement that no state will lower its standard of assistance, with the provision of Federal funds to share in supplemental state payments above the Federal floor, in order to assure maintenance of standards.

2. Work training and placement provisions that will include:

(a) The right of mothers of school-age children to have the option of outside employment or to remain in their homes to care for their children, so that the best interests of the children may be served.

(b) Federal income standards in work programs, consistent with standards for others in the population, that will avoid exploitation of the poor.

(c) Assurance of post-training employment, including employment in public service.

(d) Allowance of greater earnings with less reduction of benefits for persons on public assistance to provide greater work incentives.

3. Protection of the legal rights of recipients of assistance.

4. A higher Federal floor for assistance, with Federal payments to be stepped up to the "poverty level" within a few years, to match the realities of living costs.

5. Broader coverage of persons in need, to include childless couples and single persons.

6. Provisions to keep families intact, to replace provisions that encourage desertion.

7. Increases in Social Security payments to bring them to the minimum of the "poverty level" for recipients.

8. Maintenance and expansion of the Food Stamp Program until assistance standards reach an adequate level.

9. Provision for research and development, to help assure accurate assessment of the programs and their results, so that further planning, revisions, and financing can be based upon the required facts.

Until such time as these necessary federal programs are enacted and implemented, the states must take actions to improve their welfare programs, many of which now exist at deplorably low levels.

We urgently call upon the Congress, with the strongest leadership of the President, to enact speedily the essential legislation.

COUNCIL OF PLANNING AFFILIATES,
Seattle, Wash., December 8, 1971.

Hon. RUSSELL LONG,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The Social Security Amendments of 1971, HR–1, should receive the benefit of full and public hearings so that a wide spectrum of re-

cipients and consumers, interested groups, and national organizations can be heard. We ask your assistance in seeking sufficient opportunity for such hearings.

After careful study of the issues in this legislation, the Board has taken note of the favorable features and principles in HR-1, and suggests guidelines for welfare reform we consider to be of highest priority. We urge your support of our position which you will find enclosed.

The Council of Planning Affiliates is an organization whose membership is made up of 180 public and private agencies and groups in the King County area concerned with health and welfare and recreation.

Thank you for your consideration.

Sincerely,

DAVID COLWELL, *President.*

COUNCIL OF PLANNING AFFILIATES,
Seattle, Wash.

To: COPA agencies and other interested organizations.
From: David Colwell, President.
Subject: Favorable Features of HR-1 and some Guidelines on Welfare Reform (1).

INTRODUCTION

We believe that many of the provisions of HR-1 which relate to Medicaid, the Family Assistance Plan and social services will have a negative impact on the people they are designed to help, are administratively infeasible, and reflect unsound social policy. These criticisms have been clearly and extensively voiced by the National Association of Social Workers, the Urban League, the Center on Social Welfare Policy and Law of Columbia University, the National Welfare Rights Organization, the Community Service Society of New York, and numerous other organization and individuals. In general, we must agree with these criticisms and believe that it is probably best that those features of the bill, subject to such criticism, be deleted entirely, rather than pass in their present form.

Nevertheless, HR-1 has a number of sound provisions, especially those which relate to Social Security, and we believe it would be unwise to lose sight of these positive features of the legislation. The current draft of HR-1 has been so widely criticized that the positive features of this omnibus bill tend to be overlooked. Thus, to oppose the *entire* bill places one in the position of opposing provisions long believed to be desirable by the social welfare community.

So as not to lose sight of some of these desirable provisions in HR-1, we cite them below and offer our support.

(1) Approved by the COPA Board November 23, 1971.

FAVORABLE FEATURES OF THE SOCIAL SECURITY (OASDHI) PROVISIONS IN HR-1

1. The bill provides for an automatic increase in future Social Security benefits in any year in which the Consumer Price Index rises 3% or more.

2. Authorizes a 5% increase in Social Security (OASDI) benefits effective June 1972. This increase would go to about 27.4 million people and cost $2.1 billion for the first year.

3. Increases widows benefits to 100% of the amount their deceased husbands would have received had they lived. This provides 3.4 million people with $764 million more in benefits the first year.

4. Establishes a special minimum benefit for people who have worked 15 or more years under Social Security. This would result in increased benefits costing $39 million for about 300,000 beneficiaries the first year.

5. Increases the amount of money a retired person may earn without losing benefits from $1680 to $2000 a year and permits a beneficiary to retain half of all earnings above $2000 beginning in the 1972 tax year. This change would cost $484 million for the first year, increase benefits for 700,000 people, and provide benefits for 390,000 more who were not eligible.

6. Reduces the waiting period for disability coverage from six to five months affecting 950,000 people at an annual cost of $105 million.

*7. Increases the wage base against which payroll taxes are levied from $7800 to $10,200 beginning January 1, 1972. (We question the wisdom of increasing the

*The starred items indicate our disagreement with the method of implementation as spelled out in the bill.

tax rate, payable by both employer and employees, to 5.4% in 1972–73, 6.2% in 1975–76 and 7.4% from 1977 on.)

8. Extends the Medicare program to about 1.5 million disabled people after they have been entitled to disability benefits for two years.

FAVORABLE PRINCIPLES INCORPORATED IN PUBLIC ASSISTANCE PROVISIONS OF H.R. 1

1. Repeals the present program of aid to the aged (OAA), the blind (AB), and disabled (APTD) and substitutes a new completely federalized plan administered by the Social Security Administration.

*2. Establishes a federally guaranteed national minimum level of benefits below which families with children cannot fall.

*3. Provides wage supplementation for low income families with dependent children.

*4. Increases federa' responsibility for low income families with dependent children.

*5. Establishes a public service employment program.

*6. Expands provision for day care.

7. Expands provisions for family planning services.

*8. Expands provisions for vocational training and rehabilitation.

9. Provides for the disregard of specified earnings and for work incentives.

GUIDELINES FOR WELFARE REFORM

We believe the following principles are of the highest priority in amending HR–1 and/or in developing other welfare reform legislation.

1. Complete federalization of public assistance with a poverty level guarantee for each person receiving assistance (now $3940 for a family of four).

2. Pending federalization of public assistance, the assurance that no client will receive less in mony grants and services than he is now receiving.

3. Pending federalization, the requirement that states which now pay more than the federal guarantee, supplement the federal payment up to the current assistance standards.

4. Pending federalization, the provision of federal incentives to states to supplement payments to reach or exceed the prevailing poverty level.

5. A return to the principles incorporated in the 1965 Social Security Amendments which provides the possibility of a comprehensive medical care program for low income families under Medicaid.

6. Yearly adjustments in assistance payments to reflect changes in the Consumer Price Index.

7. Establishment of need as the sole criterion eligibility for public assistance.

8. Implementation of an affidavit system for determining need.

9. Establishment of the principle of voluntary choice of manpower training for public assistance recipients.

10. Use of the federal minimum wage as a criterion of acceptable employment.

11. An open-ended federal appropriation for social service.

12. Expansion of funds for program development, research and evaluation.

13. Expansion of manpower, day care and public service employment programs beyond levels that are proposed in HR–1.

14. Improved accountability through unified administrative responsibility in one federal agency.

15. Establishment of case finding as a legal responsibility of public assistance.

16. Investigation of alternate means of meeting the income deficit of the poverty population, including, for example, family allowances, demogrants for the aged, use of income disregards, and various forms of the negative income tax, ongoing large scale public works programs with the government being the employer of first resort.

17. Withholding non-welfare funds for those States who fail to meet specified assistance standards.

The COPA Board wishes to express its gratitude for the assistance to staff of Professors Rino Patti and Ron Dear of the Legislative Committee.

*The starred items indicate our disagreement with the method of implementation as spelled out in the bill.

PROPOSED POLICY STATEMENT PREPARED FOR BOARD OF DIRECTORS, DENVER CHAMBER OF COMMERCE, BY TASK FORCE ON SOCIAL SECURITY, NATIONAL AFFAIRS COMMITTEE, METRO PUBLIC AFFAIRS DEPARTMENT

TASK FORCE ON SOCIAL SECURITY

Chairman

Glenn M. Walker, Managing Partner, Harris, Kerr, Forster & Company, Denver.

Staff

R. Bruce Shelton, Manager, Metro Public Affairs Department, Denver Chamber of Commerce.

Retirement and Survivors Benefits

Lee C. Ashley, Senior Vice President, First National Bank of Denver.
Roy Erickson, President, Erickson Memorial Company, Denver.

Disability Benefits

K. S. Mitchell, Management Control Officer, Denver Board of Water Commissioners.

Maintenance of Health, and Medical Care

James O. Shetterly, Vice President, Capitol Life Insurance Co., Denver.
John DeHaan, Assistant Director, Bethesda Mental Health Center, Denver.

Technical Assistance

John Henderson, Deputy Regional Commissioner.
Richard E. Mueser, Program Evaluation Officer, U.S. Department of Health, Education and Welfare, Denver.

TABLE OF CONTENTS

PROPOSED POLICY DECLARATIONS

SUPPLEMENTAL RECOMMENDATIONS

PROPOSED POLICY DECLARATIONS ON RETIREMENT, SURVIVORS AND DISABILITY BENEFITS

POLICY DECLARATION I

General

That the retirement, survivorship and disability benefits provisions continue to provide a "floor of protection," rather than fully adequate retirement benefits.

Private retirement and disability benefit plans should be encouraged to provide benefits additional to those provided under social security.

POLICY DECLARATION II

Coverage

Compulsory coverage of all residents of the United States is recommended.

POLICY DECLARATION III

Retirement Benefits

Benefits should be paid as a matter-of-right without the eligible individual having to provide indigence.

Benefits should continue to be paid in cash.

For purposes of computing the "primary insurance amount" (amount of benefit), the average monthly wage should be based on fifteen years for both men and women to age 65, with actuarially reduced benefits available at age 60.

Measures to encourage voluntary continuation of income production beyond retirement age are desirable.

Benefits should increase/decrease with changes in the national consumer price index, adjusted annually.

The lump-sum death benefit should be increased to a new fixed amount equal to that required for a modest funeral and thereafter adjusted annually according to the increase/decrease of the consumer price index.

The amount of benefits should be gradually moved toward/an actuarially computed amount based upon contributions by the individual. Minimum payments should be continued for those with inadequate coverage.

POLICY DECLARATION IV

Disability benefits

Disability benefits should be available at any age.

Benefits should increase/decrease with changes in the national consumer price index, adjusted annually, and should be based on the individual's current contribution level.

A graduated scale of income recovery, adjusted to a reasonable level for size of family, should be allowed before complete loss of benefits occurs.

POLICY DECLARATION V

Financing

The primary source of funds should continue to be the individual and his employer.

Contributions for employees should continue on a 50–50 employer/employee basis.

Self employed and all other residents should contribute on an individual basis at a reduced rate.

The taxable income base should be established at a $10,000 maximum effective January 1, 1972 with increases/decreases annually based on the consumer price index.

The tax rate should be adjusted not more frequently than biannually.

Federal and/or State welfare funds should be used to pay that portion of qualified benefits above the actuarial computation of benefits based on the individual's contributions to the fund.

Income tax treatment of Social Security taxes and benefits should continue on the present basis.

Financing should be on a current cost basis with trust funds maintained at a minimum of one year's expenditures.

POLICY DECLARATION VI

Administration

Provision should be made for independent audit, efficiency of administration and the continued use of a public advisory council.

Investment of trust funds should be made at reasonable rates of return with maturity dates consistent with the needs of the fund.

Advisory and Management Boards and Councils should include presidentially appointed members outside of government, subject to confirmation by the Senate.

Proposed Policy Declarations on Maintenance of Health and Medical Care

POLICY DECLARATION I

General

The Nation's goal for health care should be to assure access to adequate care for every American regardless of income.

POLICY DECLARATION II

Health care system

The Nation's health care system needs to be overhauled. Stronger elements of our present system (whether profit-making, private non-profit or public) should be retained and improved, and combined with additional elements to make a comprehensive new system which would include, in addition to improved treatment facilities, a strong educational program for maintenance of health and prevention of disease.

Such a new system should make maximum use of the private sector and judicious use of government funds.

To assure availability throughout the Nation of manpower adequate for delivery of health care, the government should continue and improve programs of loans and other financial incentive for training and use of professional personnel, and at the same time create new programs to train and place in service such nonprofessional personnel as are capable of providing the supportive services needed in modern health care, and whose services would permit a more efficient employment of professional skills.

POLICY DECLARATION III

Health insurance

The Nation should make comprehensive health insurance coverage (including catastrophe coverage) available to all Americans at the earliest date consistent with the availability of an adequate health care system. Action to improve the organization and delivery of health care should be taken concurrently with action to improve health care benefits.

Comprehensive private health insurance plans, qualified under national standards of benefits, should be encouraged through tax deduction incentive applicable to individual as well as to group plans.

POLICY DECLARATION IV

Cost control

Control of cost in the health care system should be based as much as possible on self-regulating economic factors, with health care facilities and insurance plans so designed as to encourage health care in the least expensive manner and with insurance plans requiring co-payments where feasible. In addition, periodic professional review of hospital utilization and physicians' services should be available, and community planning should be used to discourage costly duplication of facilities.

POLICY DECLARATION V

Financing

Payment of premiums for health insurance coverage should be the responsibility of the individual citizen. Employer participation should be permitted and encouraged.

The cost of coverage for those unable to pay should be met by contributions from welfare funds, graded by income and family size, to pay that portion the individual could not meet, with financially able persons required to pay the full premium.

Supplemental Recommendations on Retirement, Survivors and Disability Benefits

GENERAL

1. Private retirement plans should be encouraged to supplement retirement benefits of social security. To encourage such plans,

   a. Tax treatment should not discriminate between employer plans and individual plans. A reasonable tax deduction for 10 percent of gross earnings should be allowed for investment in qualified plans.

b. Qualified plans should be those in which the individual obtains a nonforfeitable vested interest payable only at retirement age or upon disability and should be legally protected from creditors.

c. Tax deductions should not be allowed for that portion of any plan not meeting the definition in sub-paragraph b.

COVERAGE

1. It is recommended that all U.S. residents be compulsorily covered by the Social Security Act. Such extension would add substantial protection for those who move from one segment of business activity, e.g., employee or self-employed to another segment, e.g., investing. It is likely that many of these persons will qualify for some benefits but may not have paid a fair share into the fund unless covered fully for their activities in all segments of business activity.

RETIREMENT BENEFITS

1. Encouragement of the production of income beyond normal retirement age is considered essential for the following reasons:

a. Since retirement benefits are intended as a floor-of-protection additional sources of income are required to maintain a reasonable standard of living and to reduce the risk of such persons being added to public welfare rolls.

b. The unfairness of the present system of penalizing a worker beyond retirement age but not an investor.

c. Continuation of activity can result in benefit to the individual's physical and financial welfare, thus benefiting the individual, his or her family and reducing the cost of welfare and health care.

d. The costs of social security vary greatly depending upon the relative size of the retired population. Measures to reverse the trend toward early retirement at age 60 could significantly reduce the cost of the program.

It is therefore recommended that a $3,000 annual income limitation (now imposed only on wage earners and self-employed) be maintained for early retirees but removed completely at age 65. The limitation should be adjusted annually by the consumer price index.

It is further recommended that social security taxes be applied to all income under the $10,000 maximum to age 65; thereafter, no social security taxes should be payable.

FINANCING

1. Self-employed and other individuals covered by social security should continue to enjoy payment of the tax at a reduced rate because their payments are made with after-tax dollars whereas 50 percent of employees' contributions are tax deductible by their employers.

Minority viewpoint.—Considerable emphasis was placed upon allowing an income tax deduction for all contributions, without discrimination, accompanied by an equal contribution rate by all persons. Such a plan could be an acceptable alternate.

2. Individuals newly covered under the proposals should not be entitled to full coverage or minimum coverage provisions of existing law, but would be entitled to an actuarial percentage thereof depending upon their contributions to the plan prior to retirement. To do otherwise would continue to dilute the equity of those who have paid into the plan for many years.

3. The value of compensation other than cash should be taxable as a part of the $10,000 taxable base. Reference is made to housing, meals or any other non-cash compensation received. Industries where this type of compensation is common are farms, ranches, and hotels as well as household employment.

Supplemental Recommendations on Maintenance of Health, and Medical Care

GENERAL

1. Access to adequate care should be provided in a manner that maximizes the advantage of individual freedom of choice and of flexibility to adjust to changing needs.

2. There should be a national program educating all Americas on ways to main-

tain good health, including prevention of disease, the content of proper nutrition and the role of mental responsibility for illness.

3. In assuring access to health services for all Americans, the federal government should not provide such care directly, purchase health insurance protection for everyone, nor initiate a federalized national health insurance system.

HEALTH CARE SYSTEM

1. The health care system should deliver comprehensive care, including health maintenance, primary, specialty, restorative and health-related services in extended care facilities.

2. To develop more and better health manpower, the following activities are encouraged:

(*a*) Para-medical personnel such as physicians' assistants or other non-professionals should be utilized to the fullest extent possible.

(*b*) University, community and junior college, and technical school educational programs should be developed, improved and expanded to provide more and better medical personnel.

(*c*) To provide services in areas of manpower or service shortage, the federal government should provide loans to students for costs of education in the health field, with the provision that such loans would be forgiven if such persons provide services in some area of shortage.

(*d*) Effort should be made to increase training in all aspects of the health care industry of such persons as minority groups, women, the financially disadvantaged, etc.

(*e*) Eliminate those portions of state licensing of many levels and types of medical personnel which are severely restrictive or unnecessary. Licensing for basic certification should be retained where necessary.

3. Guidance and assistance should be sought from the business community and university health education centers in developing better systems for delivery of health care.

4. Area-wide health care planning councils should be established and adequately staffed with competent personnel. The business community should support and participate in the work of such councils.

5. Care must be used to avoid the inflation and disappointment that may be caused by promising sservice that the system is not prepared to deliver (this result was seen with Medicare).

HEALTH INSURANCE

1. National standards of benefits should be established to provide adequate insurance to all individuals and groups, including catastrophe insurance.

2. Employees should maintain their right to bargain with their employer for coverages in excess of the minimum reequirements.

3. Any employer-employee group plan should be required to meet the national standards as a test for deductibility of the cost thereof for income tax purposes.

4. Persons not covered by employer-employee groups could purchase insurance through provider organizations such as Blue Cross, Blue Shield, Kaiser, group practice plans, etc.

5. Medicare and Medicaid should be phased out; the federal government should not provide insurance.

COST CONTROL

1. Area-wide health care cost control councils should be established and adequately staffed with competent personnel. The business community should support and participate in the work of such councils with primary motivation and responsibility provided by the medical profession.

2. These area-wide councils should establish acceptable charge rates for hospitals, doctors and other medical service groups on a prospective rather than on a retroactive cost-plus basis.

3. Hospitals, doctors and other medical service groups should accept established prospective rates as payment in full for individuals covered by an approved insurance plan.

4. Patients should be able to contract for medical services from hospitals, doctors and others not participating in the plan; however, the patient would be responsible for payment extra fees, if any.

5. Hospitals, doctors and other providers, as a condition for participation in the plan, should be restricted to fee and service schedule maximums as determineed by the area-wide council.

6. Doctors and others engaged in providing medical services of any kind should be required to subscribe to a conflict of interest code prohibiting investment in any hospital or related facility, drug supplier or other provider of services or supplies with whom he did business. (See similar Code of Ethics provision of the American Institute of Certified Public Accountants).

7. All hospitals, extended care and nursing home facilities should be required to adopt uniform accounting practices, financial reporting and cost finding systems. Data related to the appropriateness of such items as hospital admissions, duration of stay and treatment provided should be made available to the area-wide council.

FINANCING

1. All employers, public and private, should be required to provide all their employees a health plan meeting national minimum standards. Payment of the premiums for such insurance would be determined by employer/employee negotiation.

2. Welfare plans of the federal government should include provisions for payment of the health insurance premium for persons unable to pay. Primary responsibility for payment should remain with the individual, however, with premium contributions by the government graded by income and family size. Financially able persons would be required to pay the full premium.

3. Insurance carriers should be allowed to charge increased premiums for disabled, elderly or others to whom health insurance is not now available; however, such surcharge must be reasonable.

4. All persons should be allowed an income tax deduction for reasonable health insurance premiums actually paid, without discrimination among employees, self-employed or others.

STATEMENT BY MICHAEL D. BROMBERG, DIRECTOR, WASHINGTON BUREAU, FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman, and Members of the Committee, my name is Michael D. Bromberg, Director of the Washington Bureau of the Federation of American Hospitals. I would like to take this opportunity to present the views of our organization on H.R. 1.

The Federation of American Hospitals is a national non-profit association representing more than 550 investor-owned (proprietary) hospitals through its members and affiliated state organizations. Our member hospitals range from small rural facilities to large urban and suburban investor-owned comprehensive medical care institutions. There are presently more than 1,000 acute care short term investor-owned hospitals in the United States representing approximately 20% of the non-government hospitals. Our facilities comprise more than 67,000 beds located in 41 states and the territory of Puerto Rico. Member facilities include facilities owned by practitioners; groups of businessmen and community leaders and multiple hospital corporations.

The Federation was privileged to appear before this Committee on two previous occasions to discuss proposed amendments to the Medicare and Medicaid programs. During those previous appearances we submitted testimony together with a number of recommendations for amendments to the Title XVIII and XIX programs as well as to previous versions of H.R. 1. Our positions on H.R. 1 have been made known to the Committee before. We would like to take this opportunity to concentrate on two of the sections of H.R. 1 which we believe to be most important and to present our views on catastrophic health insurance and in particular the proposal sponsored by the distinguished Chairman of this Committee.

DETERMINATION OF MEDICAID REASONABLE COSTS (SEC. 232)

Section 232 of H.R. 1 authorizes the states to develop their own standards and guidelines for determining the reasonable cost of in patient hospital services under Medicaid and maternal and child health programs. This provision would change the position of Administration legal counsel and the courts that the

reasonable cost provisions of the Title XVIII and XIX programs should be determined in the same manner.

While Section 232 restates the Congressional intent of preventing hospitals or their private patients from subsidizing in-patient costs of Medicaid patients and vice versa, the delegation of the authority to interpret costs to the states can only bring about confusion and a lack of revenue predictability which in turn is likely to produce higher charges for noncovered patients.

In addition to these pressures on facilities there will be budgeting pressures on the states which will tempt the states, as they have been tempted before, to adopt arbitrary and unreasonable cost control regulations in order to reduce their own heavy fiscal burden under the Title XIX program. These pressures have already induced several states to attempt to impose some type of freeze on Medicaid charges which court decisions have held to be in violation of federal law.

We urge the Committee to delete Section 232 and prevent a return to the situation which existed prior to the adoption of existing regulations where reasonable costs were interpreted in some cases to be lower than actual costs.

Adoption of Section 232 would be inconsistent with what appears to be increasing support for substituting a federal program for the present Title XIX program. We support the suggestion recently made by the Chariman of this Committee for federal funding of the basic health benefits for the poor under Medicaid. The Federation favors elimination of Medicaid and adoption of a federal health insurance system for the poor financed out of general revenues. Passage of Section 232 would in our opinion delay that kind of system by granting reimbursement powers to the states.

PROVIDER REIMBURSEMENT REVIEW BOARD (SEC. 243)

Mr. Chairman, no issue has caused more frustration to the providers of health care under the Title XVIII program than the absence of adequate administrative or judicial review procedures. We have urged this Committee before to correct this situation and we now emphasize our belief that something must be done to bring the basic elements of due process to bear on the administration of the Medicare program. The Title XVIII program remains a unique exception to the basic principle that a party with a grievance shall have recourse to some impartial source.

Section 243 of H. R. 1 establishes a provider reimbursement review board with authority to hear controversies in excess of $10,000. While the Federation is certainly not satisfied with the scope or extent of this provision, we do believe that the concept of an administrative appeal board is a step in the right direction. We urge the Committee to strengthen the language of Section 243 by substituting for that provision one based upon the Senate version of H. R. 17550 reported by this Committee in December of 1970. Section 243 of H. R. 1 is deficient in several respects. Among the more important deficiencies are the absence of a provision allowing class actions and a limitation on the scope of the board's jurisdiction to "items and services" which could be construed to omit such important areas as depreciation and interest.

In addition to these changes we urge the Committee to add to the provider reimbursement review board section authorization for judicial review. The conflicting interpretations of the Title XVIII program by intermediaries has created an atmosphere of uncertainty—an atmosphere which is certainly not conducive to efficient management or fiscal predictability. The ever present danger of a new interpretation of a regulation set forth in an intermediary letter that would be applied retroactively can wipe out all efforts to achieve efficient and effective management forecasts of operations. We strongly recommend the establishment of procedures under which providers may seek administrative relief as well as the right to judicial review under the Title XVIII program.

CATASTROPHIC INSURANCE

The Federation is pleased to comment on S. 1376 introduced by Chairman Long. We support the concept of catastrophic health insurance for all Americans as a part of a broader national health insurance system which we hope the Congress will approve as soon as possible. In the meantime we applaud the efforts of the Chairman of the Committee and others in the Senate to obtain approval for a catastrophic health insurance system as part of a stop gap measure prior to the

enactment of national health insurance. We do, however, wish to emphasize that a catastrophic insurance program should not be considered as a substitute for a complete national health insurance program and we hope to have the opportunity to present our views on that subject to this Committee in the near future.

The Federation supports the concept of catastrophic health insurance for all Americans as a federally-financed part of any national health insurance system. Such a program could be administered and financed through payroll taxes similar to the Title XVIII program.

We differ with the Administration's proposal to include catastrophic coverage as part of the required employer health insurance coverage for two reasons. First, this would increase the cost of the employee's insurance premium, placing too great a burden on employers. Second, the area of catastrophic or extraordinary illness insurance is properly one for the federal government to undertake as a basic priority for the protection of all Americans.

A catastrophic insurance program should, in our opinion, go far beyond the benefits now provided by the Title XVIII program. Once the deductible under this major medical type of coverage is met, we believe that all illness-related expenses should be covered. This would include cost of prescription drugs, in-patient and out-patient psychiatric care, dental care, long term chronic illness care in nursing homes and all other illness-related care. None of the bills presently before this Committee would provide complete catastrophic protection and this, we believe, should be a high priority goal of the federally financed part of any national health system.

With respect to the various proposals for deductibles, the Federation favors a deductible based on 60 days in a hospital or medical bills or out-of-pocket institutional bills totaling $2,000 during a calendar year. Once those levels are reached, the federal government through the catastrophic protection program, would pay for 80% of all illness-related expenses incurred during the calendar year. We believe that deductible features mentioned above should apply on a family basis without regard to the number of persons in the family and without regard to the family's income. While there are strong arguments in favor of tying the deductible under a catastrophic program to the amount of income earned by a family, such a formula might well increase administrative costs.

In this case, we believe that any family, regardless of its income, which must meet the cost of 60 days in a medical care institution or medical bills totaling $2,000, has reached a point under which it should be protected from other financially burdensome health costs as a matter of right. Therefore, we support a Medicare-type approach to the catastrophic program under which every American will be entitled to protection from extraordinary health care costs as a matter of right and without being subjected to a means test.

We thank you for this opportunity to present our supplemental views on H.R. 1.

SILVER SPRING, MD., *January 27, 1972.*

HON. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR U.S. SENATORS: Your S.S Laws 223 (d) 1 and 3 deny that my fifteen (15) year brain tumor existed prior to brain surgery; therefore, I was supposed to have worked while growing it. I resent being discriminated against and murdered by these laws which is confirmed by Appeals Council Director of Social Security Administration as a result of my letter to Hon. John D. Erlichman, (see photocopies of each letter attached).

Also note the Appeals Council Director states: "there would appear to be no basis on which the claim could be pursued under existing law". Obviously, this is also taxation without representation.

Only Sadists would require a person to work while growing a brain tumor; and Murderers would deny Disability Benefits to those who survive brain surgery once and may undergo it again. Read attached Medical Reports, proof.

I have a Constitutional Right that Justice be done, and I request the same.

Respectfully yours,

MRS. IRENE C. HEAP.

SILVER SPRING, MD., *July 14, 1971.*

Hon. JOHN D. ERLICHMAN,
Director Assistant to the President for Domestic Affairs,
The White House, Washington, D.C.

DEAR MR. ERLICHMAN: The attached Laws 223(d) 1 & 3 deny the existence of all these disabling diseases that can be proven by major surgery or autopsies only.

I send you Medical proof of same.

I'm eligible for Old Age Benefits of Social Security if I live, but am denied Disability as per Law 223(d)3 that denied my 15 yr. Brain Tumor ever existed prior to brain surgery—so I'm being murdered by this asinine law.

Please, Sir, repeal the Laws 223(d) 1 & 3 and help all us disabled.

Thank you.

Respectfully yours,

Mrs. IRENE C. HEAP.

P.S. Lack of respect for laws and also poverty could be overcome by this quick solution.

[From the Washington Post, p. 23, Apr. 26, 1971]

FAILURE TO HELP DISABLED

Social Security disability laws have always violated the Constitution because they discriminate against disabled people. Ignorance of the medical profession doesn't give Congress the right—despite the recommendations of the Department of HEW—to enact laws that exclude some diseases and impairments from disability benefits. Rhetoric doesn't pay bills: now is the time for complete revision of the so-called "disability laws" to make them equitable for all citizens.

Because the brain, lungs and nerves do not grow outside the body, the present disability laws exclude many people with black lung, brown lung, multiple sclerosis, epilepsy, cancer, and brain tumor found by emergency surgery which machines couldn't detect. Because these diseases or impairments are not medically determinable in one year's time but result in disablement and death, and because some disabled can't prove their disablement for prior years due to statute of limitations under Section 6501 of the Internal Revenue Code, Congress discriminates against the disabled in more ways than one.

Obviously, if there are no earnings credited for 10 years or more for the above excluded disabled people, they are indeed disabled, and should receive disability benefits immediatley. Congress should be pressured into prompt reform of these inequitable laws.

IRENE C. HEAP, *Silver Spring.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., September 2, 1971.

MRS. IRENE C. HEAP,
Silver Spring, Md.

DEAR MRS. HEAP: Mr. Ball has asked us to write you regarding your letter to Mr. Ehrlichman, since the Appeals Council issued the last decision on your disability insurance claim.

Your correspondence indicates that you do not understand why your claim did not succeed under the prevailing law. The record shows that your applications were properly considered and that your rights were justly determined in the Appeals Council's decision of July 3, 1968. Although the claim was studied at all administrative levels of adjudication, no medical evidence was found to show that you met the disability requirement when you were insured for disability purposes.

The file in your case has been closed for about 3 years, and the reasons for denial have been explained in official determinations and in replies to many letters from you and from others who inquired in your behalf. The file reflects that you last met the earnings requirement for a disability insured status in September 1953—almost 18 years ago—and there would appear to be no basis on which the claim could be pursued under existing law.

Sincerely yours,

H. DALE COOK, *Director.*

SILVER SPRING, MD., *May 7, 1968.*

Re Irene C. Heap.

Mr. J. AMBROSE KILEY,
Attorney, 8700 Georgia Ave.,
Silver Spring, Md.

DEAR MR. KILEY: Concerning the date of origin of Mrs. Heap's meningioma, it may be said that the sphenoid ridge meningioma which I removed in April, 1965 had been present for many years before the first convulsive seizure. It is possible, as I have stated in previous correspondence to Mrs. Heap, herself, that the fainting episodes which began in 1953 were a symptom of the meningioma. The same might be said for the convulsive attack which occurred in 1956. The date of origin of this tumor can never be stated with certainty. I should feel it possible that the tumor might have been present for as long as 15 years before it was finally removed.

Very truly yours,

JOHN T. LORD, M.D.

SILVER SPRING, MD., *August 1, 1969.*

To Whom It May Concern:

This is to confirm that Mrs. Irene Heap has had brain surgery for a Meningioma. This kind of growth tends to be recurrent. Periodic re-evaluation by various diagnostic modes—skull x-ray, brain scan, etc. is medically indicated.

MORRIS PERRY, M.D.

WASHINGTON, D.C., *October 6, 1967.*

This is to certify that Mrs. Irene C. Heap was first seen for neurological consultation on June 17, 1964 while a patient at Holy Cross Hospital. She had complaints and symptoms and examination findings consistent with central nervous system disease of undetermined etiology. The possibility of a brain tumor as opposed to a degenerative disease was considered. Special tests were obtained, but failed to reveal the presence of a tumor. Her clinical picture looked more like a degenerative process and treatment was administered along these lines. The patient was examined again in early March of 1965, at which time it was noted that she was having increasing difficulty in ambulation. In early April of 1965 the patient was admitted to Holy Cross Hospital where she was admitted in a comatose state. The patient had extensive neurologic testing done during this hospitalization and a brain tumor, a meningioma, was removed.

Sincerely,

MARVIN C. KORENGOLD, M.D.

SILVER SPRING, MD., *November 27, 1967.*

To Whom It May Concern:

Supplementing September 1965 report in regard to Mrs. Irene C. Heap.

Please be advised that in 1964 while she was a patient in Holy Cross Hospital undergoing tests in search of a brain tumor, she had one of her dizzy spells while enroute from the bed to the bathroom which was located in her bedroom and she fell to the floor. As a result of this fall, I ordered a wheel chair placed by her bed and forbid her to walk.

On April 5, 1965, at her home, she had a dizzy spell in her bathroom and fell backwards into the bathtub, hitting the back of her head, a terrific blow. She called my office, and one of my nurses, Mrs. Royer answered the phone and told me, Mrs. Heap had fallen and hit the back of her head and wanted me to come to her home. I went to Mrs. Heap's home and then made arrangement at Holy Cross Hospital for admission that same day. She had the brain tumor surgery by Dr. John Lord the following day.

Very truly yours,

MORRIS PERRY, M.D.

TESTIMONY BY THE LUTHERAN COUNCIL IN THE U.S.A., PREPARED BY THE DIVISION OF WELFARE SERVICES

OPENING STATEMENT

This statement is submitted by the Lutheran Council in the U.S.A. before the United States Senate Committee on Finance as it gives consideration to the matter of legislation dealing with welfare reform. The testimony is based on posi-

tion statements adopted by the Lutheran Council and dealing with "The Role of Government in Social Welfare" and the "Elimination of Poverty."

The Lutheran Council in the U.S.A., organized in 1966, is a council of three participating Lutheran church bodies, namely, The American Lutheran Church, Lutheran Church in America, and The Lutheran Church-Missouri Synod. Among its functions as stated in the Constitution is the following:

"To represent the interests of the Council before . . .
2. The national government . . ."

INTRODUCTORY

There is critical and urgent need for early legislative action to bring about genuine reform of the public welfare system in this country. Congress has been involved in debate of issues in welfare reform for over two years. In the meantime, millions of our fellow Americans daily experience the grinding pain of poverty and remain deprived of that which in justice is due them. Moreover, the rising costs of the present system are producing fiscal crises in states and local governments which are confronted with the costs of welfare and other essential community services.

The attacks on the present welfare system are increasing in number and intensity. Many groups in our society, each prompted by its own unique motives, are demanding legislative action. Recipients of welfare benefits are calling for higher benefits and changes in administrative procedures; social welfare personnel are hoping to achieve a system which is truly helpful to people; public officials view with concern the mounting costs; and citizens view with dismay the rise in taxes.

It is important to bear in mind as we strive to achieve change that the social welfare system is not to be blamed for producing poverty any more than the health services delivery system is to be blamed for producing illness and disease. The public welfare system may not be as effective as we would like in alleviating poverty or helping the poor able to do so to get off the welfare rolls but the causes of poverty are not to be found in the public welfare program. Nor, are the causes of poverty to be found solely in the individual who is poor. Without neglecting the factors contributing to poverty which do lie within the individual's capacity to control, it is becoming increasingly accepted that there are factors in the social system which create poverty.

We wish to underscore this point because as we debate this issue of what is appropriate legislation in welfare reform, we should keep the focus on just that—reform of the welfare program. It must be the basic purpose of the welfare program to alleviate the needs of the impoverished in our society.

There are many casual factors producing poverty, all of which must be attacked—inflation, unemployment, illness, inadequate education, racial discrimination. It is a multi-faceted and complex problem, not responsive to simplistic explanations or superficial measures.

In summary, we urge the Congress as it debates the various proposals dealing with welfare reform, to focus on the objective of achieving the alleviation of the grinding pain of poverty in a way that is genuinely helpful to the poor. Certainly Congress will be dealing with critical causes related to poverty in other legislation, such as health services, education, housing, employment. Here we are dealing with the issue of how best to reform the welfare program and achieve a just and workable income distribution program.

Lutheran churches are presently maintaining many social service programs across the country, including services to children and families, the aging, the sick, and others. These agencies report to us their judgment that poverty so very often results from inadequate education, illness, racial discrimination, and unemployment which arise and persist in society.

SOME RECOMMENDED PRINCIPLES

As a contribution to this legislative process, we submit the following comments and observations in testimony on possible legislation which may be developed by Congress in this critically important area. We suggest the inclusion of the following principles in any legislation dealing with welfare reform.

1. Elimination of the categories in the present social assistance program and establishment of the single criterion of need

Out of all the nation's poor, the federal government has selected for assistance only those who meet certain defined eligibility requirements in specifically named

categories—the aged over 65 (Old Age Assistance), the blind (Aid to the Blind), the disabled (Aid to the Permanently and Totally Disabled), and children (Aid to Families with Dependent Children). Some states and local governmental units have developed programs of general assistance but this meets only a fraction of the needs of the nation's poor.

What is the morality of the standard by which our government selects certain groups as being more worthy than others of public support? What possible justification can there be for determining that a poor person 65 years of age or older is to be helped rather than the one who is 62, or 60? Blindness is a tragic handicap. But on what basis is it determined that a blind person is to be helped rather than one who is handicapped in some other manner?

In the legislation now before Congress, the persons in the so-called adult categories—aged over 65, blind or disabled, are to be covered by a single program. This is a step toward the goal we propose, namely, the elimination of categories. But it is removed from the so-called family programs which in turn are to be divided, one to be administered by the Department of Labor and the other by the Department of Health, Education, and Welfare. Such fragmenting of income maintenance programs poses serious administrative and program problems. Especially to be regretted is the continued favored treatment with respect to financial benefits for the adult person as over against children. The benefits for adults should not be reduced. Rather the benefits for children should be substantially increased.

A recent study by the U.S. Department of Health, Education, and Welfare reports that there are over 4 million persons under 65 living in poverty but not eligible for benefits under present programs of public assistance. Among these are 2 million persons in families without children and 2.3 million single persons. These people are fellow citizens in our American community. We urge that they be given the same recognition and support presently given to other special groups.

We also note that in the proposed legislation, in the section dealing with state supplementation, the federal government would be bound to recognize a residency requirement if a state imposes such a restriction. There are many reasons for eliminating such residency requirements. The major proportion of funds is coming from federal sources and all signs point to an increase of such federal participation. Moreover, the United States Supreme Court has found such residency requirements unconstitutional restrictions on the right to travel and in violation of the equal protection clause.

2. Provision for incentives in moving off public assistance for those for whom this is possible

Every study which is made of the poor who receive public assistance reports their readiness, even eagerness, to participate in plans for adequate self-maintenance and their desire to be self-directing and independent.

It must not be overlooked, however, that virtually the entire total case load of persons in the federally assisted programs are children (55.5%), mothers (18.6%), blind and disabled (9.4%), aged (15.6%). This entire group makes up 99.1% of the total as of April 1971 with the remainder, 0.9%, being able bodied fathers. When we speak of moving people off of public assistance, we must keep in mind that these are the people on the rolls—children, mothers, aged, blind and disabled.

The largest group of adults of working age are the 2.5 million mothers who are heads of families, most of them with no able-bodied male at home. According to a study recently released by the U.S. Department of Health, Education and Welfare, 14% of these mothers are presently at work, and another 7% are in work training programs. Another 35% would be potential employees if job training, jobs, and day care facilities for children were available. Some 4% to 5% of mothers have some employment potential but require social rehabilitation services. The remaining welfare mothers may not be considered as employable because they have small children at home, have major physical or mental incapacities or other barriers to work.

The same study reports that the average welfare family has been on the rolls for only 23 months. At any given time, about two-thirds of all welfare families (AFDC) will have been receiving assistance for less than three years. Only 7.3% have been on welfare for 10 years or more.

Although every provision should be made to assure persons moving off welfare rolls, it must be honestly faced that there will remain many for whom this is

not possible. These will be the aged, the disabled and handicapped, and mothers with sole responsibility for small children.

If working poor are included, and as we stipulate later in this testimony, we urge that this be done, a new set of circumstances arises presenting quite different social statistics.

3. Inclusion of the working poor with exemption of graduated levels of earned income and careful attention given to protection against inadequate wages

A major breakthrough in the public assistance program is a possibility in the welfare legislation now before Congress. For the first time, we may now develop legislation which would include provision for including the working poor. When this was first proposed, many found it quite unacceptable; but when they studied the matter and came to see its benefits to individuals and families, it was found a growing number of people have given it their support.

The proposal is based on the recognition that there are many in American society who, though employed, have incomes insufficient to maintain levels of health and decency. Moreover, it also recognizes that persons now on welfare could be encouraged and assisted in getting off public assistance if they were allowed to take employment and keep portions of earned income. A double social benefit is thus achieved by including provision for working poor in the public assistance program.

If those presently employed, though with inadequate incomes, were included, the family could be encouraged and assisted to remain together. Quite the opposite is true in the present program with its incentive to the father to quit his work and desert his family. The family would be assisted in securing essential needs—food, housing, clothing and other requisites. This would be a real contribution toward breaking the cycle of poverty since studies report that the greatest single cause of poverty is poverty. With the opportunity to secure these essential needs, the likelihood of children breaking out of the cycle of poverty is greatly increased. It hardly seems necessary to underscore that the family headed by a father working full time at low income may be just as needy as one headed by a mother.

Another social value of including the working poor is the benefit derived for those presently on welfare. With this provision, those now on the rolls would be encouraged to seek employment and increase earnings which they could retain. With such encouragement, the individual and society would both benefit. For as persons are able to work their way off welfare rolls, the financial and social costs to the community are materially reduced.

4. Provision of a basic floor of financial benefit by the federal government at an adequate level for health and decency

We approve the provision in proposed legislation which for the first time in the nation's history establishes the principle of a basic floor of income maintenance assumed by the federal government. The mobility of our people and the varied economic resources among the regions of the nation place upon the federal government an inescapable responsibility for leadership here, to provide the necessary resources. We believe the federal government should use its broad taxing power to bring about a greater degree of equity among the states in providing income maintenance and social welfare services.

All Americans are citizens of this nation and none should be denied or limited in their struggle to realize their full potential because of the circumstances of birth or residence in a particular geographical area.

Though we have taken no specific position with respect to the amount of grant to persons on public assistance, there are some observatioons we would like to make related to the issue.

(*a*) It would seem that this nation should establish a grant amount not below the figure which the government has already established as a poverty level, adjusted periodically to the cost of living. The proposed legislation establishes the practice of tying social security benefits to cost of living but welfare payments are frozen for five years.

(*b*) We urge Congress to correct the discrepancy in grant amounts in the so-called adult category and that which is proposed for the family programs.

(*c*) We urge Congress to eliminate the ceiling on grants to families. Under the proposed legislation, the maximum amount any family could receive would be $3600, regardless of size. There is no reason why a public assistance program should impose an arbitrary cut off on the number of people to receive benefits in

a family. Every child in the family has needs, whether he is first in the family or the sixth or ninth. To include all members of a family would be both equitable and inexpensive since only 4% of all AFDC families have more than eight members.

(*d*) Existent benefit levels should not be reduced by new legislation. While it is true that the benefit level in a number of states is presently below that set forth in the proposed legislation and the recipients in those states would secure an increase, it is also true that benefits in many states are already above levels set forth in some proposed legislation. However, the legislation leaves it optional with the states whether they decide to grant this differential or not. It is not likely that many states would elect to provide this supplement voluntarily. It would seem the only just solution would be to require states to grant this supplement of federal payments if their present benefits have achieved this level, but with federal participation in such supplementation.

5. Development of effective job training programs and related services, such as day care centers, homemaker services, family planning, health maintenance, and vocational counselling

It is in the best interests of the recipient as well as society that those persons on welfare for whom it is possible should be assisted in leaving the rolls.

We note with approval that the proposed legislation does provide for certain child care and related supportive services, manpower services, job training and employment programs. The development of effective programs in those areas would materially assist many persons to find employment.

We wish to make some comments on certain key matters.

(*a*) The proposed legislation provides that an individual would not be required to accept employment if wages and other employment conditions are contrary to those prescribed by applicable federal, state or local law or less favorable than those prevailing for similar work in the locality, or the wages are less than an hourly rate of three-fourths of the federal minimum wage under present law.

There is no equity in requiring a person simply because he is a public assistance beneficiary to accept employment at a lower figure than others in the community or less than the Federal minimum wage. This provision should be stricken.

(*b*) Provision should be made to require that job traning and employment services be related to the true job situation. Persons should be trained and referred to jobs which offer opportunity for service, growth, development and related to the skills and qualifications of the recipient.

(*c*) The day care programs which are projected in the proposed legislation should be available in adequate number and of such quality as to be truly growth programs for children and not merely custodial facilities.

Children should not be delivered to inadequate day care programs to meet a requirement that mothers train for or accept employment to which they may be referred. This would be not only prejudicial to the best interests of children but poor social policy; for we would not be adequately preparing children for wholesome, responsible adulthood.

(*d*) It may well be that the social and financial costs of the mother working and placing children in day care would outweigh those of a mother remaining at home to care for children. The work and training programs for mothers with small children should be developed on a voluntary basis.

6. Assurance that a mother with sole responsibility for her children will not be required to accept employment against her own best judgment as to that which is best for the welfare of the children

The proposed legislation provides that an individual is considered to be available for work unless such a person, among other conditions, is the mother or other relative caring for a child under age 6 and this age drops to 3 beginning July 1974.

Mothers have no more critical and urgent responsibility than to do all that is within their power to assure the development and growth of their children. Our society has long recognized the fundamental rights of mothers to make their own decisions as to how this responsibility can be best fulfilled. Provision has been made by society to deal with those special situations where mothers neglect, or do not adequately provide for, the proper care of their children.

Recognizing the validity of these appropriate safeguards, we believe that a mother should be permitted free choice in the decision as to what is in the best interests of her pre-school children; that is, whether she should take employment

or remain at home. We are aware of the argument that many mothers are already employed and that mothers receiving public assistance should not be given special privilege. But these mothers are employed by their own choice and our position is that mothers on public assistance should be given this same opportunity for free choice.

7. Protection against possible abuse of mandating employment by forcing acceptance of jobs which offer no constructive opportunity for development or which are not consistent with the worker's abilities

We believe firmly that a person should work to support himself and his family, should he have the capability of doing so. This principle of responsibility of one's own support is appropriately firmly imbedded in the social system of our country. This is substantiated by every study dealing with this area of concern which report that persons do want to be self maintaining and self-directing and resist accepting things done for them unless the situation is so compelling that they must accept assistance from others.

The fact that a person is unemployed and receiving social welfare benefits does not provide justification for mandating employment which offers no constructive opportunity for development.

A CONCLUDING STATEMENT

In conclusion, we affirm the need of this nation to rise to new heights of moral commitment to the well being of all its citizens. People are the nation's most precious resource and their welfare must be our first priority. All Americans wherever they live in this land, whatever their circumstances of birth, their social situation—children, the poor, the handicapped, the deprived, the aged—all should be enabled to walk in dignity, peace, and hope as responsible participating members of our national community.

Our society faces a stern challenge in this struggle of the poor to achieve release and freedom from their pain. Will it be possible for a free, pluralistic society operating within the framework of democratic institutions to mobilize the necessary resources and implement a total national effort in the elimination of poverty?

(The above testimony was prepared by the Division of Welfare Services, Lutheran Council in the U.S.A., 315 Park Avenue South, New York, N.Y. 10010. For further information, write Dr. Henry J. Whiting, Secretary for Social Research and Planning, at the above address.)

POCATELLO, IDAHO,
August 23, 1971.

Hon. LEN B. JORDAN,
Senator, U.S. Senate,
Washington, D.C.

DEAR SENATOR JORDAN: You will recall our long-standing correspondence relating to many aspects of the human services, particularly program, manpower, and training aspects. Frankly, the privilege of communicating with you has been one of the most rewarding aspects of my professional experiences in Idaho. And so, an opportunity has again developed to bring to your attention an area of concern relating to the delivery of health services that you may want to explore.

The National Association of Social Workers has recently emphasized with its membership our collective concern over recent action of the House of Representatives (HR 1) relating to a reduction of service standards in Medicare regulations through not requiring medical social work services in extended care facilities. The proposed deletion of these services suggests a lack of understanding of the broad goals of social services in a medical facility. Adoption of this reduction in standards would have the most serious long-range consequences for our senior citizens, particularly as the country may well be on the threshold of providing a more comprehensive system of health care to its citizens and particularly the elderly.

My concern in this regard is generated not only from my broad professional orientation but, more specifically, relates to part-time medical social work consultation I have provided up until about a year ago to one of our local convalescent homes. Our agreement was that I would spend up to one hour a week providing social work services to the convalescent home as required by Medicare

regulations. These services were provided over a period of about two years. When the Comprehensive Mental Health Program in this area became operational, I urged the director of the convalescent home to consider a contractual arrangement with that public service as provided for in their program. Subsequently the arrangement was included. The opportunity provided me sufficient experience to begin to appreciate the very real need for social work services as provided for by Medicare regulations. I came to recognize not only the need and opportunity for these services, but also the promise as well as the problems in implementing a part-time service of this nature.

More specifically, I submit the following comments, observations, and suggestions for your consideration:

1. Social work practice concerns itself with the social well-being of the client or patient in his real life situation. Economic, family, community, vocational, and psychological factors all enter the situation. The needs of the elderly in our changing society are as pressing as the young or middle aged.

2. Health, illness, and the aging process encompass—not only medical but social and economic components. Illness and old age effect people in different ways and are of particular consequence to the person, the family, and the community. Accordingly, any system for the delivery of medical services should not divide up the person or patient; the well-being of the whole person needs consideration for whatever treatment or rehabilitation are necessary. These health facts were recognized many years ago when medical social work services were first initiated in the Massachusett's General Hospital around the turn of the century by Dr. Richard Cabot. Since then the demand for social work services in medical facilities, public or private, has grown steadily.

3. The care attempted in an extended facility is comprehensive including recreation, physical therapy, and a variety of medical services to meet the needs of the individual, and the requirement for the provision of social work services as part of this total treatment picture becomes apparent if the service is indeed considered to be comprehensive, i.e., maximum fulfillment or functioning of the individual patient while in the facility.

4. Regarding my own experiences and the job to be done, the director and I decided that social work helps might typically include:

(*a*) An interview with the significant family members of the patient shortly following admission so that there could be an understanding of the background of the life experiences of the patient, the attitudes of the relatives toward the patient and his illness, and an active enlistment of the family to cooperate with the convalescent home staff for the maximum well-being of the patient.

(*b*) Bringing community agencies into the picture as necessary as for example, financial assistance and vocational rehabilitation for the patient and/or his family.

(*c*) Casework services with the patient to provide him an opportunity to talk about his feelings regarding his illness, stay at the convalescent home, and to enlist his cooperation with the staff for his benefit. This frequently meant, of course, dealing with negative feelings about another patient, a family member or a staff member.

(*d*) Case conferences or consultations with the nurses and aides directed toward a specific understanding of the particular patient and a more generalized review of the relationship between social and environmental factors and the patient's well-being.

(*e*) Coordination of the psycho-social aspects with the physician of the patient.

5. With the general and specific observations above in mind, it was increasingly obvious to me that the primary limitation related mainly to the severe limitation in time provided for these services. The director desired that I spend more than one hour per week. However, such services are expensive, so my time was necessarily limited for a financial reason. Perhaps our dilemma in this regard suggests one of the reasons for the proposal to delete social work services from Medicare standards. This is to say that there has never really been sufficient allocation of funds to implement the Medicare regulations. All of the medical social work consultations that I know of in Idaho and the Intermountain area have been on a very part-time basis, as in my case. Perhaps in some of the very largest facilities in large urban areas, social workers have functioned on a full-time basis. In short, the sound philosophy and program required by Medicare regulations may

have really never had a chance to be implemented because of the funding limitation and, very likely, the shortage of available, qualified personnel in the area of the extended care facility.

The above are some of the factors that I respectfully submit which have convinced me that there is a pressing need in extended care facilities for qualified medical social work services. There is no rationale to exempt these services in a modern extended care facility any more than there is from other medical facilities as has increasingly been recognized since the day of Dr. Cabot. On the basis of my own experience, I am certain that the requirement is fully justified and frankly, is a "must" if the elderly (and often not so elderly) patients in our extended care facilities are to receive the high level of health care we in America strive for. It seems to me that the problem, rather, is in program implementation. With planning, financial, and manpower resources, this aspect can be resolved. I would welcome an opportunity to further correspond with you as for example, citing specific case situations typifying convalescent care medical social services or any way you suggest.

Respectfully,

T. RUSSELL MAGER, ACSW.

POCATELLO, IDAHO,
September 24, 1971.

Hon. LEN B. JORDAN,
Senator, U.S. Senate,
Washington, D.C.

DEAR SENATOR JORDAN: Your concerns and activities in the broad area of human services was again reflected in your letter of September 2, 1971 with respect to the matter of furnishing of social work services in extended care facilities as I reviewed in my letter of August 23, 1971. In particular, I appreciated your thoughtfulness in sending me a copy of the excerpt from the House Ways and Means Committee report on H.R. 1. This was my first opportunity to be appraised of the reasons of the Committee in recommending deletion of these services now required under Medicare. With these specifics, I respectfully submit the following by way of additional comments for your consideration and the Senate Finance Committee.

The Committee seems to make two points in justifying their recommendation to delete the requirement for social work services. In the first place, they say that these services "represent a substantial cost to the extended care facility which cannot be justified by the value derived by its total patient population." Rather than repeating myself, I refer you and the Senate Finance Committee to my letter of August 23, 1971 in which my comments are primarily addressed to this objection of the Committee. In this letter I attempted to trace the history, philosophy, and operation of social services in medical facilities within the broad framework of concept of treating "the total person."

It is the second point of the Committee mentioned above that I would like to address myself to in this letter. The Committee does not understand the rationale for requiring social work services in an extended care facility when the same services are not required in the higher level of hospital care. Although this rationale seems plausible enough, I suggest that a closer scrutiny would reveal that social work services are much more urgently needed in an extended care facility than in a hospital. This in no way diminishes the need in a hospital as the history and our experience clearly indicates, and as I pointed out in my earlier letter. However, if one reflects on the social and psychological needs of an individual with a chronic and/or progressively worsening condition as are typically found in extended care facilities, I think it becomes evident that the services of a trained social worker are as pressing in this phase of our medical delivery system as actual medical and nursing services. The feelings of the extended care facility patient about his illness, the attitudes of his family, his financial situation, and the attitudes of the staff toward the patient are all areas of critical importance which the medical/social worker has a particular knowledge of and ability to deal in a professionally expert way with. This is a different situation than the psycho-social needs of a patient in a general medical hospital who typically will only be in the hospital a very brief period of time. Again, I don't diminish the needs of services in the hospital because as far as I'm concerned, these services should be required in hospitals as well. However, I only question the rationale of the Committee in drawing the conclusion that social work serv-

ices need not be required in the extended care facility because this has been a "progressively lower level of care."

It is hoped that the above will provide some much-needed clarifying information on the report of the House Ways and Means Committee report for the further information of yourself and the Senate Finance Committee.

Respectfully,

T. RUSSELL MAGER, ACSW.

DEPARTMENT OF EMPLOYMENT AND SOCIAL SERVICES,
MARYLAND COMMISSION ON THE STATUS OF WOMEN,
Baltimore, Md., February 1, 1972.

The Hon. RUSSELL B. LONG, *Chairman,*
Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: At its January meeting the Maryland Commission on the Status of Women adopted the enclosed resolution on the welfare provisions of H.R. 1.

We urge you to work for legislation which incorporates our suggested proposals.

Respectfully yours,

ANNE CAREY BOUCHER, *Chairman.*

Enclosure as stated.

RESOLUTION ON THE WELFARE PROVISIONS OF HR 1

Among Maryland's 224,000 current public assistance recipients there are:
40,000 aged, blind and disabled
1,600 employable males
140,000 children
43,000 mothers

Thus, women and children constitute more than 80 percent of the State's destitute who are supported by public funds.

The condition of these women and children is a matter of great concern to the Maryland Commission on the Status of Women—a concern which prompted the Commission to study current proposals pending before the Congress on this subject and to arrive at the following conclusions:

1. Assisted families should be maintained at a level no lower than the federally defined poverty level. This nation's children have a right to adequate levels of nutrition, clothing and shelter to enable them to achieve normal growth and development.

2. Mothers who are needed in the home should not be required to work.

3. Those who are required to work should have the safeguard at licensed child care arrangements. They should not be required to accept employment for less than the federally established minimum wage or without the same fringe benefits as other employees in the same employment. They should not be required to accept any employment which threatens their health and safety.

4. Those working, whose income is less than the federally defined poverty level, should receive assistance so they are not penalized for working by having less income than those who qualify for public assistance because they cannot work.

5. Benefits now provided in each State should become the floor below which the new levels cannot go. States should be required to supplement the Federal payment up to present levels with the aid of Federal matching funds equal to one-third of such State costs.

HR 1

The Maryland Commission on the Status of Women believes that HR 1, the measure which has been passed by the U.S. House of Representatives and is now pending before the Senate, fails to meet these objectives. It would provide a family of four only $2,400 on which to live for a full year—without the food stamps which they now receive.

It would require mothers of children as young as three years old to go to work.

It would permit mothers to be forced into menial jobs paying as little as $1.20 an hour on pain of losing public assistance.

It provides no protection against the forced placement of preschool children in unsatisfactory and/or unsafe care arrangements.

It would result in benefit reductions for millions of recipients throughout the nation.

THE RIBICOFF PROPOSAL

The proposal which appears to come closest to the Commission's objectives is that sponsored by Senator Abraham Ribicoff, Amendment No. 559 to HR 1. This measure was introduced with the support of 14 governors, including Maryland's Governor Marvin Mandel.

It would move over a four-year period toward complete Federal financing of all assistance programs, including the program for single persons and childless couples, which is now funded entirely by the States and localities.

Most importantly, payments during that period would begin at $3,000 for a family of four and would progress until, in the fifth year, they reach the poverty level.

In the interim, however, recipients would be protected against any reduction in present benefits.

Mothers with pre-school children would not be required to work, and those who are required to do so would not be compelled to accept employment paying less than the Federal Minimum Wage or jeopardizing their health or safety; now therefore be it

Resolved, That the Commission on the Status of Women supports, through all means available to it, Federal legislation which will enable families on public assistance as well as those working families whose earnings are less than the federally defined working level, to maintain a living standard no lower than the federally defined poverty level; will exempt mothers with responsibility for pre-school children from a requirement to work outside their homes; will assure that those who are required to work will receive at least the federal minimum wage for employment which does not jeopardize their health and safety; will assure satisfactory child care arrangements.

Adopted: January 19, 1972.

STATEMENT OF THE NATIONAL ASSEMBLY FOR SOCIAL POLICY AND DEVELOPMENT, INC.—FORUM ON SOCIAL ISSUES AND POLICIES[1]

JOINT STATEMENT ON WELFARE PROPOSALS IN THE 92D CONGRESS

This joint statement on the principles which we believe should govern any action for public welfare "reform" represents the view of those who have signed it in behalf of their organizations or as individuals engaged in the social welfare field. It has been deveoped and circulated for signature through the Forum on Social Issues and Policies of The National Assembly for Social Policy and Development. The Forum is an instrument for such voluntary pooling of viewpoint and permits those of like mind to speak with one voice to Congres on their common concerns.

These recommendations are based on a Statement on *Goals of Public Welfare Reform* adopted by Forum members in June, 1969 setting forth seven principles against which subsequent proposals for welfare reform might be evaluated and on the statement submitted to the 91st Congress with respect to then pending legislation incorporationg the proposed Family Assistance Plan.

The proposals now before the Congress are complex and incorporate drastic changes in the present public welfare system of the country. We wish to affirm our beliefs in adequate, humanistic and comprehensive protections against the hazards of poverty and insecurity created by modern society. In any changes of policy the needs, interests and dignity of all those receiving benefits and services

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[1] The Forum on Social Issues and Policies functions as an independent group of social welfare organizations and individuals concerned with social policy, under the auspices of The National Assembly for Social Policy and Development, for the purposes of: (1) exchanging views on pending social welfare policy issues, (2) identifying areas of common viewpoint on such issues and (3) cooperating on joint statements on specific issues at the option of each signatory organization and individual. This statement on pending proposals of welfare reform is the result of such process and reflects the judgments of those organizations and individuals listed as its sponsors.

This statement will be submitted to the Senate Finance Committee in connection with its hearings on HR 1 beginning on January 20, 1972 in lieu of oral testimony by Mr. Philip Bernstein, Chairman of the Forum on Social Issues and Policies of The National Assembly.

should be the paramount consideration and should not be sacrificed to current pressures of expediency.

We deplore any effort to make the present victims of societal maladaptation the scapegoats for the very failures that victimize them. We wish to re-affirm our special concern for the well-being of children on whose healthy development, nurture, and inclusion in the mainstream of a potentially bountiful society the future of our country depends. All measures for family income assurance and related social services (including child welfare and child care) must keep this concern for their welfare as their central point of focus.

In light of these goals it is recommended that pending proposals be evaluated in terms of the following principles to which the undersigned subscribe:

1. Structural reform is no substitute for adequacy of financing sufficient to improve the situation of all those who depend upon it.

Comment.—Pending proposals add substantially to the Federal financial investment in aid to low income people, especially in terms of broadened coverage and fiscal relief to the states. On the other hand they do nothing to improve the financial situation of 90% of present AFDC recipients living in the forty-five states now paying benefits above the proposed Federal floor. (HR 1 proposes a Federal payment of $2400 for a family of four with no food stamps and no mandated supplementation.) Unless the Federal role and financing is strengthened, there is serious danger that the situation of many will be seriously worsened by the division of the program into two separate components, with no Federal participation above the floor.

2. The level of minimum income assurances should be adequate in relationship to cost of living estimates

Comment.—The basic floor proposed by HR 1 falls far short even of the official poverty standard (let alone the lowest standard of the Bureau of Labor Statistics.) The Federal floor should be raised immediately to the official poverty level and means provided to advance toward a more realistic standard as defined by the Department of Labor's lower living standard.

3. Any transitional stages must be such as to (a) strengthen Federal standards, (b) protect the higher level of payment while raising the lower, and (c) maintain the level of state expenditure necessary to achieve these ends

Comment.—HR 1 contains no provisions projecting a plan for future upward adjustment protection of present standards, or an increasing assumption of Federal responsibility toward a level of adequacy. We recommend the addition of such provisions.

4. Benefits in kind and services extended to those aided by the plan should not be used to reduce assistance levels

Comment.—HR 1 assumes a major reduction in public assistance by work, training and rehabilitation requirements supported by provision of day care and other supportive services. We strongly support the extension of these services on a voluntary basis but believe that mothers should be permitted to exercise their own judgment as to whether their children's best interest requires their presence in the home. Rehabilitative and other services cannot fulfill their proper function if they are imposed under threat of reduction or discontinuance of essential aid. Similarly child welfare services, including those related to parental support, should be administered in the best interest of the child under existing provisions of state law.

5. Welfare reform should be such as to move toward greater inclusiveness and away from categorical distinctions

Comment.—HR 1 improves the present situation for needy families by including those with both parents in the home insofar as the basic Federal benefit is concerned. However, failure to make provisions for maintaining the present level of benefits and the virtual separation of voluntary state supplementation from the Federal program makes continued differential treatment inevitable.

It also makes no provision for childless couples and single individuals. This should be added.

Moreover, it perpetuates (and intensifies) present disparities of aid as between the adult categories and children. We do not find the adult standard too high but the children's standard too low.

The fragmented administration provided by these proposals is a major danger to responsible administration and a probable source of hardship and confusion to the potential or actual beneficiary.

6. Labor standards should be protected

Comment.—Entitlement to welfare payments should not be used to deprive children of needed adult care and supervision nor should they be used to depress wage and other labor standards. Therefore, no mother or other adult with primary responsibility for the care of a child or children should be required to take a job against her own best judgment of her children's need and no job should be regarded as mandatory which involves unsuitable conditions, a labor dispute, or pays less than the Federal minimum wage or the prevailing wage, if higher.

7. The legal and constitutional rights of recipients should be fully protected

Comment.—We see great dangers for the coercive and discriminatory application of the requirements of this bill which condition Federal aid on mandatory work requirements for mothers, mandatory work registration and assignment for those already working full time, mandatory vocational rehabilitation, a Federal liability on deserting fathers beyond the application of state laws and the placing of a lien on all future Federal payments to such fathers, an unlimited authority for third party payments, and a mandatory obligation to repay interim benefits received pending the outcome of a fair hearing which is adverse to the person appealing. We recommend the deletion or modification of all those provisions.

8. No improvements in the public welfare system should be such as to reduce the effectiveness of measures to prevent need or obscure the urgency of steps for their improvement

Comment.—It would be a tragedy if this or any other welfare measure served to dull the sense of urgency that should lead to strengthening and extending those basic measures of economic and social reform that prevent poverty before it occurs. Supplementation of full-time wages points up the need for a higher minimum wage; new provisions for training and child care, the need for expansion of the job market; higher old age assistance; the need for more adequate social security benefits; rising medicaid rolls, the need for universally available and rationally organized health services. These and other basic social reforms are the way to reduce the ultimate cost of welfare and are, therefore, relevant to this bill.

SIGNATORIES OF THE FORUM ON SOCIAL ISSUES AND POLICIES OF THE NATIONAL ASSEMBLY FOR SOCIAL POLICY AND DEVELOPMENT, INC.

Organizations

American Jewish Committee, Bertram H. Gold, Executive Vice President.

American Parents Committee, Inc., George J. Hecht, Chairman.

Board of Social Ministry, Lutheran Church in America, Refus Cuthbertson, Associate Secretary.

Child Welfare League of America, Inc., Joseph H. Reid, Executive Director.

Day Care and Child Development Council of America, Inc., Robert L. Bender, Associate Director.

Council of Jewish Federations and Welfare Funds, Philip Bernstein, Executive Vice-President.

Family Service Association of America, Clark W. Blackburn, General Director.

Florence Crittenton Association of America, Inc., Mary Louise Allen, Executive Director.

National Board, Young Women's Christian Association, Mrs. Robert W. Clayton, President.

National Council of Churches of Christ in the U.S.A., John McDowell, Director for Social Welfare.

National Council for Homemaker-Home Health Aide Services, Inc, Mrs. Florence Moore, Executive Director.

National Conference on Social Welfare National Board, Joe R. Hoffer, Executive Secretary.

National Federation of Settlements and Neighborhood Centers, Margaret Berry, Executive Director.

Travelers Aid Association of America, A. D. Bell, Jr., President.

United Church of Christ Board for Homeland Ministries, Hobart A. Burch, General Secretary (Health and Welfare).

Women's International League for Peace and Freedom, Rosalie Riechman, Legislative Representative.

Texas United Community Services, Warren B. Goodman, Executive Director.

Wisconsin Welfare Council, A. Rowland Todd, Executive Director.

Public Welfare Committee, Welfare Federation (Cleveland, Ohio), Richard E. Streeter, Chairman.

Welfare Recipient Advisory Council (Honolulu, Hawaii), Lena K. Reverio, Project Director, Lyn Hemmings, Project Director.

Community Services Council of Brevard County (Merritt Island, Florida), Kenneth M. Storandt, Executive Director.

Public Issues Committee, Family Service of the Cincinnati Area, Julien E. Benjamin, M.D., Chairman.

Department of Employment and Social Services (Baltimore, Maryland), Rita C. Davidson, Secretary.

Young Women's Christian Association of Roanoke Valley, Virginia, Gladys I. Mason, President, Board of Director.

Young Women's Christian Association of Lockport, New York, Mrs. Howard C. Loomis, Executive Director.

Young Women's Christian Association of Columbus, Ohio, Jean M. Hodil, Executive Director.

Greater Hartford Community Council, Mrs. R. Leonard Kemler, Chairman, Public Affairs Committee.

Lehigh Valley Community Council (Bethlehem, Pa.), Lillian M. Ribble, Planning Director, Francis J. Cosgrove, Executive Director.

Community Service Society (New York) Committee on Family and Child Welfare, Mrs. David B. Magee for the Committee.

Individuals

Mrs. Florence Moore, Executive Director, National Council for Homemaker-Home-Health Aide Services.

Mrs. J. Cabell Johnson, Trustee, The National Assembly for Social Policy and Development, Inc.

rMs. DeLeslei Allen, Trustee, The National Assembly for Social Policy and Development, Inc.

Mrs. Lois Whitman, Community Activities Dept., National Council of Jewish Women.

Mrs. Mary G. Walsh, Program Consultant, National Council for Homemaker-Home Health Aide Services.

Mary E. Blake, Director of Consultation and Field Service, National Federation of Settlements and Neighborhood Center.

Richard J. Bargans, Director of Personnel, National Federation of Settlements and Neighborhood Centers.

Ned Goldberg, Director of Development, National Federation of Settlements and Neighborhood Centers.

John F. Larberg, Senior Staff Consultant, The National Assembly for Social Policy and Development.

Joseph Reid, Executive Director, Child Welfare League of America, Inc.

Ms. Patricia Bennet, Day Care Consultant, The Salvation Army.

Mrs. Anita P. Robb, Social Welfare Secretary, The Salvation Army Central Territory.

Mrs. H. Edmund Lunken, Board Member, The National Assembly for Social Policy and Development, Inc.

Hobart A. Burch, General Secretary (Health and Welfare), United Church of Christ Board for Homeland Ministries.

Eli E. Cohen, Executive Secretary, National Committee on Employment of Youth.

Gordon A. Bingham, Social Work Consultant, The Salvation Army.

Edgar B. Porter, Associate Director, National Association of Hearing and Speech Agencies.

Edith M. Lerrigo, Executive Director, National Board, YWCA.

Nina M. Khinoy, Secretary, Family Service Association of America.

Mrs. Elizabeth F. Trimble, Regional Representative, Family Service Association of America.

Ellen P. Manser, Specialist, Family Development, Family Service Association of America.
W. Keith Daugherty, Assistant General Director, Family Service Association of America.
Mrs. Richard L. Ottinger, Social worker, Family and Child Services, Washington, D.C.
John M. Palmer, Executive Secretary, Community Services Council of Calhoun Co., Inc., Anniston, Alabama.
Gerard J. Cerny, Executive Director, Rome (N.Y.) United Fund.
Gwendolyn Kim, Community Social Worker, Legal Services Project, Waianae, Hawaii.
George N. Moorhead, Associate Director, Health, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
George Oraboda, Associate Director, Research, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
Charles R. McCudden, Associate Director, Health Facilities, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
Hiroshi Minami, Executive Director, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
Edward Estes, Associate Director, Planning, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
Jley Er, Information and Referral Director, Health and Community Service Council of Hawaii, Honolulu, Hawaii.
Henry H. Welch, Ph.D., Executive Director, Metropolitan Council for Community Service, Denver Colorado.
Mrs. W. June Abrams, Staff Associate, Association Greater Wilmington Neighborhood Centers.
Fern M. Colborn, Commissioner, Fayette County Redevelopment Authority, Mill River, Pa.
Marianna Jessen, Bureau of Indian Affairs, Washington, D.C.
Robert Z. Green, Director, Center for Urban Affairs, Michigan State University.
John T. McDowell, Director, Forsyth County Dept. of Social Services, Winston-Salem, N.C.
Corrine M. Callahan, Executive Secretary, New York State Welfare Conference, Inc.
Edward L. Peterson, Executive Director, United Fund of Wayne Co., Richmond, Indiana.
Phyllis J. Day, Special Projects Coordinator, United Community Services, Jackson, Michigan.
Frederick F. Cerny, Executive Director, Greater Utica Community Chest and Planning Council.
Kenneth M. Storandt, Executive Director, Community Services Council of Brevard County, Merritt Island, Florida.
Dr. Mildred Fairchild Woodbury, YWCA, Philadelphia Metropolitan Board (Formerly Director), Dept. of Social Work, Bryn Mawr College.
Joseph G. Mroz, Executive Director, Wilmington Senior Citizens Center, Wilmington Del.
Raleigh C. Hobson, Director, Social Services Administration of Dept. of Employment and Social Services, Baltimore, Maryland.
Sodelle Berger, Chairman, Evansville Friends of Welfare Rights, Evansville, Ind.
Joseph J. Dunne, Executive Director, The Community Council, Evansville, Ind.
Norman V. Lourie, Executive Deputy Secretary, Penn. Dept. of Public Welfare, Harrisburg, Pa.
John W. McGowan, Executive Director, Health and Welfare Council of Pulaski Co., Little Rock, Ark.
Wayne Vasey, Professor, University of Michigan School of Social Work.
Ellen Winston, Social Welfare Consultant.
Robert L. Popper, White Plains, New York.
Linda Glazer, Executive Director, United Community Services of Johnson County, Iowa.
Myron E. Wegman, Dean, School of Public Health University of Michigan.
James A. Forde, Schenectady, New York.
Wilbur J. Cohen, Dean, School of Education, University of Michigan.
Philip Booth, Associate Professor, School of Social Work, University of Michigan.

Harleigh B. Trecker, Prof. of Social Work, School of Social Work, Univ. of Conn., Greater Hartford Campus.
Mitchell I. Ginsberg, Dean, Columbia University School of Social Work.
Erna H. Bowman, Senior Caseworker, Member of Advocacy Com. Family Service Agency, Rochester, N.Y.
Kenneth C. Boyd, Executive Director, Family and Children Services, Davenport, Iowa.
A. Rowland Todd, Executive Director, Wisconsin Welfare Council.
Lawrence K. Koseki, Associate Director, Social Service, Health and Community Services Council of Hawaii.
Norman Van Klompenburg, President, S.D. Chapter, National Association of Social Workers.
Patricia R. Conrad, Social Worker Public Welfare Board of North Dakota.
Margaret B. Dolan, Prof. and Head, Dept. of P.H. Nursing, University of N.C., School of Public Health.
Hugo Adam Bedau, Prof. of Philosophy, Tufts University, Medford, Mass.
Mary M. Coleman, Staff Member, Family Service Association of America.
Thomas Rafferty, Staff Member, Family Service Association of America.
Alice S. Adler, Staff Member, Family Service Association of America.
Therese Skarsten, Staff Member, Family Service Association of America.
Peg Manning, Staff Member Family Service Association of America.
Alice S. Adler, Staff Member, Family Service Association of America.
Emily Bradshaw, Staff Member, Family Service Association of America.
Mark D. Feldman, Staff Member, Family Service Association of America.
Diedrich J. Tietjen, Staff Member, Family Service Association of America.
Marcel Kovarsky, Staff Member, Family Service Association of America.
June Thompson, Staff Member, Family Service Association of America.
Alice McCarthy, Staff Member, Family Service Association of America.
Marcia Kovarsky, Staff Member Family Service Association of America.
Marian Emery, Mary, Staff Member, Family Service Association of America.
Margaret Mangold, Staff Member, Family Service Association of America.
Patrick V. Riley, Staff Member, Family Service Association of America.
Bette Ryan, Staff Member, Family Service Association of America.
Mary Ann Jones, Staff Member, Family Service Association of America.
Pauline Cohen, Staff Member, Family Service Association of America.
Goldie Kleiner, Staff Member, Family Service Association of America.
Walter L. Smart, Associate Director, National Federation of Settlements and Neighborhood Centers.
Mrs. C. Kitty Dozhier, Health and Welfare Council of Pulaski County, Little Rock, Arkansas.
Mrs. Jean K. Post, Secretary to Regional Representative of South East, Family Service Association of America.

Statement of the National Association of Manufacturers on Title IV of H.R. 1

The National Association of Manufacturers appreciates this opportunity to express its views on the important matter of welfare reform, as embodied in Title IV of H.R. 1. NAM is a voluntary association of business concerns of all sizes, located in every state, and operating in all areas of industrial activity.

This statement is centered on Title IV because the so-called welfare crisis involves primarily the Aid to Families of Dependent Children program. The Association will also comment on Social Security and medicare.

We have specific comments on such details of Title IV as eligibility, work requirements, work incentives and administrative safeguards. However, we first want to put welfare reform into a broader context.

We are not starting from scratch to design a welfare program for needy families. The nation is faced with the consequences of permitting the AFDC program to continue for almost forthy years without fundamental re-evaluation of its applicability to contemporary problems. This mistake has been tragic in human terms and has severely strained fiscal resources. Therefore, we approach the Title IV proposal from two points of view: (1) that of intergovernmental relations and responsibilities within the federal system; and (2) that of welfare reform requirements.

TITLE IV AND THE FEDERAL SYSTEM

Our preference is for private sector solutions to social problems where possible, and for state-local solutions where government must be involved. But the size of the public assistance caseload and forty years of dependence on the public sector for its operation appear to rule out the possibility of a return to voluntary, private-sector financing.

If public assistance has become ingrained as a government function, where in our federal system does responsibility for it fall? There are actually three major aspects to welfare and public assistance programs—income maintenance, administration, and the provision of social services. The differences among them tend to be obscured by the discussion of costs and the question of who should finance the program.

It is a basic concept of public finance that the level of government providing the funds should have control over, and responsibility for, the way they are spent. The present AFDC program is a flagrant violation of this principle. The states determine the level of benefits and the federal government is required to provide financing on a matching basis. The federal share of public assistance payments for the current fiscal year was estimated in the 1972 Budget at 57 percent of total program costs. Specifically with respect to AFDC, the federal share is more than 80 percent of the payments to families in some states, with the median at 59 percent. In addition, the federal government pays 75 percent of the cost of soical services—also on an open-ended basis—and about half of the administrative costs. The *extent* of the federal government's heavy financial commitment to these programs is not widely recognized. At the same time, the Congress has no opportunity to review benefit levels or even to evaluate the effectiveness of the program. A recent survey by HEW's Social and Rehabilitation Services showed errors—approximating $500 million a year—mostly identified as the consequence of an inadequate quality control system and the absence of effective federal sanctions.

In addition to the lack of any real control over the accelerating costs of AFDC, under the present system widely differing benefit levels contribute to distortions in the labor markets, to serious rural and urban area dislocations, and social unrest. Along with many opponents of Title IV, we are concerned about the extension of government aid to the so-called working poor. However, to reduce the wide disparities in benefit levels between the states and, at the same time, deny aid to the working poor could lead to a complete disintegration of labor markets in certain states. The objective, of course, is to bring these people, many of whom accept welfare as a way of life, into the labor force and the productive economy—not to make support programs competitive with work. We are not certain what the precise effect of H.R. 1 would be on the labor markets and worker motivation—although the evidence in hand is not unfavorable and certainly does not tend to confirm the dire predictions of the most zealous opponents of Title IV.

We particularly approve the attempt in this legislation to bring social service costs, as well as income maintenance costs, under some sort of control. We believe that the actual administration of social services should be in the hands of state-local agencies.

THE CRITERIA FOR WELFARE REFORM

We support the basic work-oriented approach of Title IV, although we are well aware that it is not a cure-all. Both its more ardent proponents and its more zealous detractors appear to us to be expecting—or fearing—much more from this legislation than is realistic whether from the point of view of the beneficiary or the taxpayer. For example, although we have a great distaste for the concept of a flat-benefit guaranteed income, we feel there has been too much attention to semantics in this case. Right now, in fact, we have 54 "guaranteed income" plans and virtually everyone agrees that they do not work. Title IV requires welfare recipients to accept certain responsibilities to society at large—including the critical work requirement and retraining provisions—and in this sense it is not, in our opinion, a guaranteed income plan. In our view Title IV is neither an over-all solution to the problems of poverty nor a great give-away. It is an attempt to get some feasible national standards for assistance, to establish incentives for self-improvement, and to institute some more effective control over the financing and administration of these programs.

Members of this Committee have expressed considerable concern about the possibility that the work incentive might prove ineffective, or even a disincentive,

under certain circumstances and in certain localities if existing statutes relating to public housing, medicaid and other welfare-type programs were unchanged. However, it is well to remember that such results would obtain not from the structure of Title IV itself, but from the operation of existing categorical aid programs. It may well be impractical to restructure all these programs at once but it would not be impossible to do so to bring them in line with the basic goal of work-oriented welfare reform.

Because the goal is to bring a portion of the population into full participation in the economy, the basic economic facts cannot be ignored. We have the following recommendations to make with respect to four aspects of the bill with important economic implications—the work incentive, the wages to be accepted by beneficiaries, the eligibility of strikers for benefits and the importance of private sector employment.

ECONOMIC CONSIDERATIONS

1. *The Work Incentive.*—A great deal of the discussion of this bill is confused by comparison with the present situation under a number of federal-state programs. This is particularly true of the work incentive, which is a crucial aspect of the reform. Although the AFDC program was originally designed to provide temporary assistance to families, it has long since become a support program. That is the source of much of our dissatisfaction with it and much of our concern with the "welfare subculture" which has developed in its wake. Congress tried to remedy this, particularly by the establishment of the Work Incentive Training program. However, in many states the combination of limited work incentive and lax administration made this ineffective. The recent establishment of a federal work requirement in H.R. 10604 was a step to correct this situation. However, the WIN experience up to now does not give us a satisfactory basis for evaluating the work incentive in H.R. 1.

Obviously we cannot undo the AFDC experience, which will affect the motivation to work of those who have been brought up under it. Although Title IV gives us a place to start to redirect our efforts, it does not guarantee that the work incentive will be effective for all those able to work now receiving AFDC payments.

We feel that there has been an unfortunate over-use of the concept of "tax rate" in reference to the reduction of benefits as earnings increase. After all, the purpose of Title IV is not to provide continuing support for families but to give them an incentive to become self-supporting. We believe that the important aspect of the incentive is that a family should always have more income as its own efforts increase. The basic formula for providing benefits under Title IV appears to meet this requirement in principle, although some exceptions will undoubtedly arise. Under the circumstances—and particularly in light of the nagging matter of cost constraint—we feel that the formula presently incorporated in the legislation should be tried for an adequate period before any attempt is made to modify the incentive.

2. *Eligibility Requirements and the Problem of Strikes.*—As the legislation now stands, participants in long strikes could become eligible for benefits. The extent to which strikers have been availing themselves of public assistance has been brought to the public's awareness by the General Electric strike of 1969–70 and the 1970 General Motors strike, as well as by the International Telephone and Telegraph Corporation's court challenge of welfare payments to strikers in Massachusetts. The cost to the states is reflected in the fact that more then ten states are joining the International Telephone and Telegraph Corporation in asking the Supreme Court to re-hear that case.

However, much more is at stake than money. Public subsidy of strikers directly diminishes the deterrent to strike, thus increasing the number of strikes and their duration. Requiring taxpayers, including industry, to finance strikes—although indirectly—means that they are made to subsidize an economic weapon that is used against them. Public welfare funds should be used for the fundamental purpose for which they are appropriated and not to subsidize one side in an economic dispute.

The use of public funds to support strikers involves the government directly in labor disputes, contrary to our labor laws and their intent. Therefore, we urge amendment of the definition of eligibility so that strikers and their families will be barred from receiving benefits under this program.

3. *Wage Scales in Private Sector Jobs.*—In its present form, H.R. 1 would permit an individual to reject employment if the wage offered is below that locally

prevailing for similar work *or* less than 75 percent of the federal minimum wage for private employment and the full federal minimum for public service. Many jobs—an estimated 5.5 million—are not presently covered by federal minimum wage legislation. This provision, if unchanged, would extend the federal minimum wage legislation as a standard for wage payments without debate as to its effect on the economy or job opportunities for low-skilled people.

We support using the standard of "prevailing local rates for similar work," but are equally strongly opposed to use of the federal minimum as a standard for payment unless the job involved is already covered by federal wage-and-hour legislation. Our opposition is twofold. First, we believe that the minimum wage legislation and its possible extension should be debated in its own right and not "blanketed-in" in the name of welfare reform. Our second objection is the practical one that this level of payment will be self-defeating in that it will reduce the number of job opportunities available to the beneficiary population.

There is general agreement that the present AFDC crisis reflects the break-up of families whether by separation, desertion, divorce or illegitimacy. This social crisis has not occurred in isolation. It represents, in particular, a rejection of low-level jobs even by those who cannot do more productive work. This attitude has been supported in many areas by high benefits that compete with wages for those lower skilled jobs. The payment standard in this bill attempts to remedy this by arbitrary wage rates. This does not, however, solve the problem. Indeed, it may aggravate it.

What is needed is skill improvement; in many cases the very experience of holding a job is itself the best way to achieve that. Setting an artificial cost barrier will prevent many of these people from getting that first crucial job. The important thing is to replace welfare with work opportunity but there is no economic justification for an additional subsidy of paying a welfare recipient more than the economic value of his work.

4. *Transitional Function of Public Service Employment.*—The legislation anticipates 200,000 public service jobs in the first year, with incentives to the employing state and local governments to make this employment transitional. This incentive takes the form of a reduced federal contribution to the cost of such employment for each year the beneficiary holds one of these jobs. In order to strengthen this incentive, we recommend that the federal share be reduced more rapidly than is now contemplated and that it finally disappear entirely instead of continuing at a 25 percent rate after the fourth year.

One of the safeguards written into the bill, with respect to keeping this sheltered employment temporary, is the requirement that the employee's record be reviewed every six months to see whether he can go on to other work. It seems to us, that, with the many administrative problems relating to the implementation of the entire reform program, it would just not be feasible to have an effective review for a caseload of this size on a six-month basis at the beginning of the program. We suggest, therefore, that the first review be made after 12 months and be thorough and on the basis of objectives guidelines. From the beginning of the second year of operation, presumably July 1, 1974, the semi-annual review should become effective.

ADMINISTRATIVE CONSIDERATIONS

Appropriate administration is crucial to the success of this welfare reform program. The range of decisions formerly left to caseworkers—many of whom are not professionals—and the consequent overly permissive interpretation of rules has contributed to the explosion of the AFDC caseloads and specifically to the problems of WIN. We are, therefore, very pleased that the administrative provisions of H.R. 1 give promise of more uniform and stricter enforcement. The requirements for proving eligibility, the stronger penalty for parents who desert their families, and the requirement for reapplication after being on the rolls for two years, are examples of steps in the right direction. So is the wording of the provision that permits an individual to reject employment or training *only* if other opportunities are available to him, as well as within his demonstrated capacity.

Although H.R. 1 provides for checking on eligibility and for use of social security numbers to monitor family incomes, it is apparent that there is a general concern about fraud because, in the present program, there is considerable opportunity for fraud, and there have been numerous documented instances to vali-

date that concern. It is important to the acceptance and subsequent success of this program that the public be reassured on this matter. We are, therefore, suggesting that the experience of New York State with an Inspector-General be monitored with a view to adapting this type of independent office to the family programs.

The separation of the caseload so that employables are handled in a work-oriented atmosphere, for which the Department of Labor is responsible, is also a desirable innovation. We recognize that the mere separation of the caseload will not of itself obviate the need to emphasize constantly that the goal is employment and training for employment and not merely support. Setting up this program will take some time. Because of the possibility that executive reorganization would place both the Opportunities for Families Program and the Family Assistance Program in the same Department of Human Affairs, we believe that the legislation should be written to assure the continued separation of the caseloads under that circumstance.

SUMMARY

The size and rapid growth of the AFDC caseload make welfare reform a national priority. Major problems of the present program stem from the wide variation in benefits among states and the fact that the financing formula is a flagrant violation of the principle that the level of government primarily responsible for funding a program should have control over, and responsibility for, the way the funds are spent.

The specific work incentive and work requirement principles in Title IV of H.R. 1 merit serious attention of Congress with a view to early enactment. We particularly approve the attempt to bring social service costs under control but believe that the actual administration of necessary services should be in the hands of state-local agencies.

We believe this legislation would be strengthened by the following changes:

1. Denial of benefits to strikers and their families.
2. Use of local prevailing wages, rather than the federal minimum, or percentage of it, as the standard for acceptable pay rates for Opportunities for Families beneficiaries.
3. Recognition of the transitional function of public service jobs by a faster reduction and eventual phasing out of the federal contribution to state-local governments.
4. Consideration of adoption of the "Inspector-General" approach to checking on the administration of eligibility requirements and such related issues as search for deserting parents.
5. Assurance that the Opportunities for Families Program and Family Assistance Program caseloads will be administered separately even if the Department of Labor and HEW are eventually merged into a Department of Human Affairs as the result of executive reorganization.

Welfare reform is not without risks. However, the risks of not changing course are certainly greater. If we are fully aware that a new approach will need modification based on experience, we should avoid raising unrealistic expectations and be able to assuage unrealistic fears.

STATEMENT OF CARL C. MCCRAVEN, NATIONAL EXECUTIVE BOARD MEMBER, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE (NAACP), AND CHAIRMAN, HEALTH COMMITTEE, SOUTHERN CALIFORNIA NAACP

I appreciate the opportunity afforded me by the Senate Finance Committee, its Chairman, Senator Long, and the staff to express my views on the amendments to the Medicare and Medicaid programs contained in H.R. 1, Social Security Amendments Bill of 1971.

My brief remarks are based upon the following assumptions:

1. All American citizens have a right to equal access to health care services without regards to race, religion, economic status or locality.
2. Adequate health care is essential to young Americans in order for them to develop into self-sufficient citizens. This is particularly true for the poor who must look forward to earning at an early age if they are to escape the conditions of poverty in which they were born.

3. Good health care at an early age diminishes the likelihood of chronic health problems in middle age.

4. A condition of good health for American citizens is a national goal and the use of federal resources to bring it about a national policy.

The Medicaid history of the past year in California has raised serious questions as to whether these goals are, in fact, still national policy.

Preventive, comprehensive care, the basis upon which good health is achieved, was the original purpose of Title XIX of the Social Security Act. Instead of working toward that goal, California and, it appears, certain portions of this bill are devoted to returning us to sick care rather than health care. Sick care always has been expensive but for the poor it is tragic as well as expensive. The poor are sicker than the non-poor. They will remain sicker—and poor—until early preventive and educational health supervision breaks the cycle. The California cutbacks have removed all semblances of comprehensive care, ham-stringing the ghetto physicians and discouraging the poor from even attempting to enter the health system. In our concern we have become intimately acquainted with the effects on every level of the program reductions. This experience has caused us to have some very explicit concerns about certain portions of H.R. 1. I will discuss those portions, not intending that my lack of discussion of other provisions of the bill should indicate agreement or disagreement with them.

Section 230 of the bill would repeal that portion of the Medicaid law which requires that the states make efforts to provide comprehensive medical services to all the needy by July 1, 1977. That section, 1903(e), expresses the basis of the intent of Congress when the law was made. Its repeal would give federal sanctions to states wishing to be relieved of the responsibility of working toward that goal.

Section 208, dealing with cost sharing under Medicaid, extends cost sharing provisions while, in fact, we ought to be reducing or eliminating such provisions. Over the past year there have been constant attempts by state and federal government to solve the problem of provider misuse and other basic problems within our health care system by abridging the rights of the poor to health care. This is both unfair and shortsighted. The old saying, "throwing the baby out with the bath water," seems to best describe our state and federal policies on our health care problems. The mother of small children ought not be put in the position of deciding between physician visits and other fundamental necessities. Or indeed, between which of her children needs most to see a physician. Either supporters of this provision have never been poor or they have short memories. Let me remind you, a dollar a few days after payday is a lot of money when you are poor.

Furthermore, there is much evidence to refute the allegations that overutilization, which cost sharing is supposed to curtail, even exists. Except for the initial visit, the physician makes the decisions for subsequent visits and choice of treatment.

I am informed that utilization experiences of O.E.O. health programs have been documented in studies that show neighborhood health center enrollees average 4 to 5 visits to a physician each year, which is about the same as the national average. Further, although the national physician visit rate is 4.2 visits per year, the current Medicaid rate in California, without financial participation from the recipient, is 2.0 per beneficiary. The NAACP units for which I speak urge that Section 208 be amended to eliminate all cost sharing provisions under Medicaid.

Section 209, restricting eligibility and imposing a spend down requirement on families, involves complex differences in eligibility levels between states and the various programs for financial aid. Without discussing these technicalities I will simply state that Section 209 establishes a federally enforced Medicaid cutback and perpetuates bureaucratic harassment of the medically needy and needs to be re-drafted to insure that all medically needy receive Medicaid and that "medically needy only" categories not be reduced.

Section 205, cost sharing for Medicare recipients, is unfair to our senior citizens, especially those who are poor. Wouldn't it be much better to institute investigations of misuse and, in the process, weed out unscrupulous providers, thereby aiding the elderly as well as reducing possible misuse of federal funds?

Section 231 allows the states to reduce or terminate services or programs not required as part of the basic five services of Medicaid without approval or review by HEW. One non-required benefit is drugs. Our experience in California with cutbacks in the allowable drug formulary has shown the folly of such thinking. A special investigating committee of California Assemblymen headed by Assem-

blyman Gordon Duffy investigated the effects of the cutbacks early in 1971. They received a mountain of documentation of problems caused by forcing physicians to try to provide medical care without drugs. We feel that Section 231 should be repealed. Making the recipient pay the price for states' mismanagement of health care delivery further erodes the goal of comprehensive care.

The use of the HMO concept has, in general, indicated that it is a progressive step in the direction of reorganization of the delivery system, a necessity if we are to improve our level of health care. I have one major point to make about HMO's as they relate to Medicaid and Medicare. The poor people who utilize the services of HMO's will be highly dependent on their services for all of their medical needs. Since economy of operation is one of the purposes for founding HMO's, there exists a potential for underprovision of services. A built-in problem not unlike our present problem becomes apparent; the poor could be made to pay the price by again being denied necessary or high-level care. Consumer safeguards must be included to insure that the people who depend on services will be served comprehensively. There should be more explicit provisions in H.R. 1 for the complete range of high quality services. Among them should be:

(*a*) Full time staffs for the basic specialties with minimum physician/enrollee ratios.

(*b*) Only Board certified or eligible surgeons should perform surgery.

(*c*) HMO's should be required to refer patients to outside specialists when appropriate.

(*d*) Consumers and individuals representing consumer groups must be provided an opportunity to participate in decision-making in their health care programs through representation on governing boards and by the establishment of grievance hearings.

Thank you, Gentlemen.

STATEMENT BY NATIONAL COUNCIL OF SENIOR CITIZENS, SUBMITTED BY NELSON H. CRUIKSHANK, PRESIDENT

CONTENTS

SUMMARY OF RECOMMENDATIONS

Cash benefits

Supports Recommendations of 1971 White House Conference on Aging for an immediate 25% increase in Social Security.

Recommends introduction of general revenue financing reaching, eventually, one-third of the cost of the program.

Supports automatic cost of living adjustments, when Congress fails to act; higher minimum for workers with long coverage; increased benefits for workers able to postpone retirement; 100% widow or widowers' benefit; improved early retirement benefits; additional drop out years for benefit calculation; liberaliza-

tion of the retirement test from $1,680 to $2,000; improvement in method of computing benefits when workmen's compensation payments are involved.

Recommends changing from 20 years to 10 the period which a divorced wife must have been married to her former husband to be eligible for a wife's benefit.

Health care

Supports recommendations of 1971 White House Conference on Aging in support of the principles of the Kennedy-Harris National Health Security bill.

Recommends reformed Medicare-Medicaid system in a federally administered program covering all residents aged 65 or over without coinsurance or deductibles or premiums. Physicians and providers fees would be predetermined and all would need to agree to accept the program payment as full payment for a given covered service. Incentives would be included to choose comprehensive prepaid group practice with the program providing for consumer representation and public accountability at all levels.

Reaffirms support for proposal to merge Part B of Medicare with the Government-financed Part A (Hospital Insurance) thus freeing the elderly of the burden of spiralling premiums for doctor bill insurance.

Proposes immediate HEW development of a program of coordinated, continuous, comprehensive medical and social services for the aged for transmission to Congress to enactment within two years.

Supports provision in H.R. 1 to require the Secretary of HEW to conduct a study on the desirability of covering chiropractic services under Medicare. Emphasizes this should be done by a competent, recognized, scientific group wholly independent of the medical profession as such.

Supports the need for extending Medicare coverage to disabled Social Security beneficiaries under age 65.

Rejects proposals for so-called catastrophic health insurance.

Welfare

Supports Ribicoff amendment to H.R. 1.

Urges that States—with the aid of Federal matching grants—make supplemental payments to bring all welfare payments up to current levels.

Urges no mother with small children be required to work unless child care centers are easily accessible.

Asks protection for State and Local Government employees who currently administer welfare programs.

Supports provisions of H.R. 1 applying to adult categories with eligibility system which respects the dignity of the individual.

Supports authorization of $1.2 billion for 300,000 public service jobs as against $800 million proposed under H.R. 1 and urges these jobs pay no less than the federal minimum wage.

Mr. Chairman and Members of the Senate Finance Committee:

As President of the National Council of Senior Citizens, largest group of organized older peoples clubs in America, I welcome this opportunity to present our views on H.R. 1.

Some distinguished Committee Members may remember me from the days when I appeared before the Senate Finance Committee as Director of the AFL–CIO Social Security Department. You may recall that I served on Statutory Advisory Councils on Social Security in the 1948–49 period, the 1958–59 period and in 1964.

Perhaps, I should also add that I have served on the Health Insurance Benefits Advisory Council (HIBAC) since it was set up under the Social Security Amendments of 1965 to advise the Secretary of HEW with respect to the Medicare program.

My statement is directed to all aspects of H.R. 1, including Social Security cash benefits, health care and the welfare provisions of this legislation.

In saying this, I should point out that the National Council of Senior Citizens seeks a better life for all Americans—the young and middle-aged as well as the elderly. Our organization is not just a special interest group for the retirement generation.

I will begin with Social Security cash benefits.

CASH BENEFITS

20% increase needed

The National Council of Senior Citizens strongly supports the recommendation of delegates to the 1971 White House Conference on Aging for an *immediate*

25% Social Security increase as a first step toward achieving the Bureau of Labor Statistics' intermediate budget for a retired couple amounting to $4,500 a year as of Spring, 1970 (also recommended by delegates to the White House Conference on Aging).

I need not remind the Committee that nearly 5,000,000 men and women aged 65 or over are impoverished and millions more—2,000,000 more at the very least—are very, very, close to the poverty line. We all know some elderly men and women who are perhaps financially well off but rarely do we see the hardship and suffering of the millions of the elderly who are the poorest of the U.S. poor. The elderly do not parade their poverty. As a matter of pride, they do their best to hide it.

Nor need I remind the Committee that men and women age 65 or over represent more than 10 per cent of the population.

We all feel the impact of the steady rise in consumer prices—and there is little indication this rise will be slowed substantially with the present inadequate control machinery—but the elderly, living on fixed incomes, are hit harder than any other group by the continuous shrinkage of their purchasing power that has gone on month after month, year after year without letup.

The stark fact is that more and more low income elderly are being overwhelmed by the ever rising tide of inflation. During the 1960's and on into the 1970's, the aged poor increased while all other categories of the poor declined.

As the Senate Special Committee on Aging has often pointed out, there is a widening gap between what the elderly receive in retirement and what they were able to earn on the job. The average Social Security benefit of a couple retiring in 1950 met half the Bureau of Labor Statistics budget cost then, but subsequently dropped to a third of that cost, according to findings made by a task force of experts for the Senate Special Committee on Aging.

Mr. Chairman and Members of this Committee, we all know this is a matter of national priorities. I respectfully submit that a nation that can budget the astronomical total of $78 billion for arms and defense—as President Nixon requested for fiscal '73—can afford to provide a minimum level of comfort and security for the millions of elderly Americans in need of help.

A "floor of protection"

We hear a good bit of talk these days about the original intention of the Social Security program having been to provide a "basic floor of protection" for workers when they reach their retirement years. According to this theory benefits are to be held to a low figure and are to be supplemented by such things as savings, life insurance, home ownership, private pensions, etc.

Whatever the original theory may or may not have been this notion has now been proven to be illusory. The study of private pensions conducted by the Senate Special Committee on Aging shows that only a minority of workers, and these among the most favored in other respects, are in fact recipients of pensions in retirement.

Pension programs are too often characterized by high eligibility requirements, are payable only to those with extremely long terms of service in one industry or for one employer and in most cases make no provision for survivors.

The burdens of family finance during workers' earning years are so heavy that the possibility of having substantial savings is remote. Perhaps home ownership has proven, more than any other factor, a bitter disappointment in planning for economic security. The homes that were suitable for raising their families are totally unsuited for retirement. Many of them are in the decaying urban centers where property values are rapidly declining. Worst of all, property taxes have risen so rapidly in recent years that the home which was designed as a haven of security in old age has become an economic liability.

Regardless of any theories to the contrary about floors of protection, the stark fact is that today most people depend upon Social Security—and Social Security alone—for protection in their retirement years. We cannot escape the fact that if we are to do anything meaningful about poverty among older people in America we must make massive improvements in the cash benefit provisions of the Social Security system.

General revenue financing

Nor was it the intention of the framers of the Social Security Act that it always rely exclusively on the regressive payroll tax for financing. Early in the history of the Social Security Act, Social Security experts foresaw the

need for augmenting the Social Security tax with a substantial amount of Federal general revenue.

As a matter of fact, even without the use of greater Federal general funds, it is possible for Congress to raise the level of Social Security 20 per cent now if it accepts the rising earnings actuarial assumptions relating to the Social Security trust fund recommended by the prestigious 1971 Advisory Council on Social Security which published its report last April.

Dr. Arthur S. Flemming, newly named Consultant to the President on problems of aging and Chairman of the 1971 White House Conference on Aging, headed this Advisory Council on Social Security.

It is interesting to note that the 1971 Advisory Council chose to recommend a substantial contribution from Federal general revenues to meet much of the cost of the Medicare program. However, only a minority of its members recommended allocation of Federal general revenue to help finance the Social Security cash benefits program.

Mr. Chairman and Committee members, whether or not Congress agrees with the rising earnings actuarial assumptions relating to the Social Security trust fund recommended by the Advisory Council, there are compelling reasons for a large allocation of Federal general revenues for the Social Security cash benefits program. As you are aware, full-rate benefits were paid all covered workers in the early days of the Social Security program as if they had contributed to it all their working years. Today's workers are still paying this cost which amounts to an estimated one-third of the cost of the Social Security program.

The National Council of Senior Citizens urges that, as a matter of equity, general revenues be used to lift this burden from the backs of today's workers. One-third of the cost of Social Security program should, in fairness, come ultimately from Federal general revenues.

Social Security is a great national resource, benefiting the nation as a whole as well as individual Social Security recipients. It is proper and reasonable that the nation as a whole share in the cost of the program through allocation of substantial Federal general revenue to support it.

Social Security, as you are aware, is the main support of older people—the chief bulwark against poverty in later years—but it offers very inadequate protection for millions of beneficiaries.

Short of bold reform

H.R. 1 would improve the Social Security program but, unfortunately, this proposal falls far short of the bold reform that would make Social Security a truly viable method of assuring present and future retirees an adequate share of the economic abundance they helped create for the majority of our people.

Specifically, H.R. 1 would provide a higher minimum income for workers with long coverage under the Social Security system, increased benefits for workers able to postpone retirement, a long needed raise in the widow's Social Security benefit to make it equal to the primary benefit, improved early retirement benefits for workers retiring in the future, additional dropout years for the purpose of improving benefits for all workers and it would raise, from $1,680 to $2,000 a year, the amount of Social Security recipient may earn without reduction of benefits.

The National Council of Senior Citizens supports these provisions of H.R. 1 with the reservation, however, that the age-62 computation of Social Security benefits for men also apply to hundreds of thousands who have been eased out of the labor force prematurely during the current business depression.

H.R. 1 also includes desirable innovative features such as automatic adjustment of benefits in line with increases in the cost of living and automatic adjustment of wage base taxes credited for Social Security benefits.

The National Council considers the provision for an automatic cost-of-living adjustment a great improvement over earlier proposals in that it takes effect only in case the Congress fails to enact needed increases. There is thus hope that future increases will not be limited to mere increases in the cost of living but will take account of rising standards of living. The National Council, while wholeheartedly endorsing the principle of automatic adjustment, urges that such adjustment be pegged to a higher benefit level and to a higher wage base.

This is where H.R. 1 falls short of what is needed to make Social Security fulfill its goal, namely, replacement of income lost due to retirement, disability or death.

I consider H.R. 1 essentially a 'patchwork' program that does not come to grips with the main issue—an adequate income when working years are over.

The 5 percent Social Security increase proposed under H.R. 1 is another instance of 'patchwork' with the patch not covering the gap it should cover. H.R. 1 fails to provide for an increase in benefit levels preceding automatic adjustment of future benefits to price increases.

Under H.R. 1 as passed by the House, just as many beneficiaries will remain just as poor as they now are. They are trapped by a guarantee of poverty. Their financial condition may get worse—indeed, it is likely to as advanced age and deteriorating health deplete whatever resources they may have in addition to their benefits. They are literally frozen into poverty.

Furthermore, by not raising the wage base significantly, H.R. 1 fails to assure future retirees benefits reasonably related to their previous earnings—failing, at the same time, to provide more income for the system or to reduce the regressivity of the tax.

Major improvements needed

The National Council of Senior Citizens urges that the Senate, building upon the many desirable features of H.R. 1, take this opportunity to make major improvements that are long overdue.

Without a substantial Social Security increase, the elderly will be made to bear an unreasonable and unfair share of the cost of economic crisis.

Already, the elderly have waited more than six months for action on Social Security legislation—H.R. 1 was approved by the House of Representatives last July—while Congress was voting a whopping $8 billion in tax cuts for business and corporations.

Must the aged always be forgotten whenever there is an economic crisis? Because they do not riot or threaten violence, will they continue to be forgotten and abandoned?

Speaking for the 3,000,000 members of the National Council of Senior Citizens, I respectfully call upon the Administration and Congress to face up to the misery and suffering of millions of older Americans and do something about it.

This will require a reordering of national priorities. It is a development that is long overdue.

In the summary at the beginning of this statement I have listed those elements of H.R. 1 which the National Council of Senior Citizens supports together with our additional recommendations.

There is an additional change in the cash benefit program of Social Security which is not included in H.R. 1 but which, in our view, is required and desirable as a matter of simple equity, namely changing from 20 years to 10 the period which a divorced wife must have been married to her former husband to be eligible for a wife's benefit.

HEALTH CARE

Recommendations of the White House Conference on Aging

One doesn't need to be a health specialist to be able to detail the evidence of the chaotic state of present health care marked by both fragmentation and wasteful duplication of services, with overemphasis on costly hospitalization and incentives for unnecessary services.

It is easy, therefore, to understand why the delegates to the recent White House Conference on Aging urged priority consideration for the establishment of a comprehensive national health security program, financed through social security and general revenues, which would include the aged as well as the rest of the population.

The delegates to the White House Conference were prohibited by conference rules from identifying their support of specific legislative proposals by using the names of authors of bills or the bill numbers. Nevertheless, they came out strongly in support of the principles of the Kennedy-Harris National Health Security bill (S-3) when describing the kind of program they consider necessary to meet the health needs of all Americans.

It is significant that these delegates, the majority appointed by their Governor and cleared by the White House, representing all states and from all walks of life, indicated no support whatsoever for the Administration's health proposal which accepts the inevitability of the present "non-system" and merely pumps in more dollars without disturbing the status quo.

The White House Conference delegates urged that National Health Security be financed through wage and payroll taxes and contributions from Federal general revenues, ensuring that health care expenses would be a shared responsibility of the government, employers, and individuals. They insisted there should be no deductibles, copayments or coinsurance.

The delegates felt that the Government should assume responsibility for assuring an adequate supply of health manpower and essential facilities and for improving the organization and delivery of services.

In contrast, the Administration would set up two types of health insurance, providing a bonanza for the insurance industry which—as our experience with Medicare shows—has performed poorly while profiting richly. The Administration's health proposal perpetuates invidious distinctions in health care based on income and falls far short of universal coverage. The Administration's proposal relies heavily on deductibles and coinsurance—made no more palatable in actual practice by the euphemism of "cost sharing." This would inevitably cause the patient to postpone needed care.

The delegates to the White House Conference on Aging realized there might be some delay in Congress enacting National Health Security. However, they also recognized the desperate health needs of older Americans and so they called for an expansion of Medicare and Medicaid benefits until such time as a National Health Security program is enacted.

The White House Conference Report recommended new benefits including, at a minimum, Medicare coverage of out-of-hospital drugs, Medicare coverage of care for the eyes, ears, teeth and feet (including eyeglasses, hearing aids, dentures, etc.); and improved services for long term care and expanded and broadened services in the home and for other alternatives to institutional care.

Such expansion of Medicare, the White House Conference Report said, should include elemination of deductibles, coinsurance and copayments, and all provisions discriminatory to the mentally ill. It recommended the same age for eligibility for Medicare as for Social Security cash benefits. To achieve this expansion, the report called for greatly expanded use of general revenue financing for the Medicare program.

Reform of medicare and medicaid

Reform of the health care system for the Medicaid segment of the population most in need of medical care—cannot wait until the system is restructured for the total population. Recommended changes in Medicare-Medicaid could help pave the way for a reformed health care system for the total population.

H.R. 1 recognizes this concept including the provision to extend Medicare to persons entitled to disability monthly cash benefits under Social Security and Railroad Retirement programs after they have been entitled to disability benefits for two years.

The National Council of Senior Citizens calls on the Senate Finance Committee to support the recommendations of the White House Conference on Aging by adopting certain principles for the reform of Medicare-Medicaid which are compatible with National Health Security. We suggest these principles from our members' day to day experience with Medicare-Medicaid. They know what a blessing the Medicare program has been; they also know its deficiencis.

What has Medicare accomplished and where has it fallen short?

It has succeeded brilliantly in these major areas:

Most of America's 20 million older persons have been relieved of a major part of the crushing cost of medical care and the dread fear of financial catastrophe resulting from an acute illness.

Complexities that could have thwarted the Medicare program have been overcome. However, it must be noted that Medicare procedures still seem unnecessarily complex to the ordinary beneficiary.

Medicare has not lived up to expectations in these respects:

Preventing a dangerously rapid increase in the cost of medical services.

Hastening changes in the health delivery system that are necessary to improve the quality of care.

Meeting the needs for long-term care on the part of the very old and the chronically ill.

The reasons for these shortcomings are many and complex.

"Reasonable cost" and "reasonable charge"

First, with respect to the rising costs, much has been said about the failure of early Medicare planners to anticipate these increases. I submit that the mistakes that were made were not so much in the areas of utilization and estimates of need but in the basic concept incorporated in the Medicare law, namely, that the limit of liability under an insurance scheme could rest on the notion of "reasonable cost" and "reasonable charge."

Five years experience has shown that many of the so-called "reasonable costs" under Medicare Part A (hospital insurance) are simply cost-plus operations of an uncontrolled and unplanned hospital industry. The "reasonable charge" approach under Medicare Part B (doctor insurance) opened the way for charges often having little relationship to past practices as no one really knew what customary charges were.

The result was in all too many instances "reasonable charge" in practice became *all the charge the traffic would bear.*

Many providers followed the long established practice of considering the fact of a patient's being insured a factor in his ability to pay, and proceeded to add charges above the allowable amounts. After two years experience, the Social Security Agency finally got around to limiting the allowable amounts payable under Medicare but the net result in all too many cases was a decrease in the proportion of the total cost of medical care covered by the program. As if this weren't bad enough, the decrease in the coverage was accompanied by steadily rising premiums.

In 1965 the public and the Congress relied mainly on two factors to limit the liability assumed by the Medicare program.

Self restraint on the part of the medical professions, and

Controls exercised by Medicare insurance carriers and intermediaries.

Both proved woefully inadequate.

I am citing these well-known facts not in criticism of the program itself or even of the providers many of whom have done a conscientious job of carrying out the basic purposes of the program.

What seems to me most important is the lesson to be drawn, namely, that it is not possible simply to provide a method of payment that will greatly increase the effective demand for a limited supply of health services without also providing some control over the economic processes and without taking major steps to increase the supply.

Cost Control

H.R. 1 as passed by the House approaches this very vital matter of cost control, but falls far short of meeting the need in this area.

The limits established by the bill on provider costs recognized *as reasonable* and the limits on prevailing charge levels, and the provision for termination of payments to suppliers of services who abuse the Medicare or Medicaid programs are desirable steps in the direction of needed control. However, no real relief from escalating physician fees under Medicare Part B will be provided beneficiaries so long as physicians are permitted to charge patients through the direct billing method amounts above those established under the law as reasonable.

The National Council of Senior Citizens supports the encouragement to the development of Health Maintenance Organization contemplated in H.R. 1. It is hoped that when the measure becomes operative there would be some agreement as to what an "HMO" is.

The National Council of Senior Citizens also strongly supports the proposal in House-passed H.R. 1 that would authorize the Secretary to establish *periods* for which a patient would be presumed to be eligible for benefits in an extended care facility or for home health services. We hope this would eliminate the retroactive denial of benefits that have proven such a tremendous burden on elderly people and which have given rise to more complaints about the Medicare program than any other feature.

The Delivery System

Let me turn now to the second major short-fall of the Medicare program—its failure to make basic changes in the health care delivery system. It is hardly fair to refer to this as a "failure" because the program never attempted to alter the system and it didn't try simply because the law specifically forbade it to do so.

Back in the days when Medicare was being formulated, all of us—the pro-

ponents of the plan and our representatives in Congress—were constantly assuring the medical profession, the hospitals and indeed the public that we were not altering the system in any way at all. We were simply providing a method of payment for health services within the existing system. I'm convinced the public as well as health care providers wanted, even demanded such assurances in 1965.

But times have changed. Public opinion has changed. In the light of our present experience, not only with Medicare, but with Medicaid, and with a multitude of private health insurance schemes, the public is now convinced that there must be some major alterations in our health care system. The demands of the public in the 1970's in this respect are just the reverse of what they were in the early 1960's.

The consciously accepted limitations of the program also apply to the third major area of the public's dissatisfaction with Medicare, namely, the lack of provision for long-term care of the very old and chronically ill. Back in 1965 we were attempting no more than to provide for the elderly the protection available to the great majority of people still in their working years. Medicare was modelled on Blue Cross and Blue Shield, and these plans were deficient in the area of long-term care. Here, too, public attitudes have changed.

Mr. Chairman, my remarks thus far have made clear, I trust, that the National Council of Senior Citizens has strnog reasons for believing that National Health Security is the only answer to the health crisis with which we are faced. But the National Council is also realistic enough to recognize that Congress may have to take some time to develop such a comprehensive health care program for the total population.

Essentials of Reform

We therefore offer for your consideration the essentials of of a reformed Medicare-Medicaid system which—if not actually paving the way for National Health Security—would at least assure that health care suppliers do not continue on divergent paths. We are cautious about any claims of "paving the way" or "providing valuable experience" because we understand that a health program limited to only part of the population—and indeed the most vulnerable part—cannot possibly have the financial leverage for reform and restructuring which is basic to National Health Security.

In essence, our plan would merge Medicare-Medicaid in a Federally administered program covering all residents age 65 or older, all other Social Security beneficiaries, and the adult categories, the aged, blind and disabled receive cash assistance.

Benefits now provided under Medicare would be expanded and payable without coinsurance or deductibles. In-patient hospital services—regardless of prior hospitalization—would be coveerd for up to 120 days without limit if furnished in a nursing home owned by or affiliated with a hospital or comprehensive health service organization. Outpatient prescribed drugs would be covered on a comprehensive basis if furnished through a health service orgainzation. Otherwise, coverage would be limited to drugs needed for maintenance therapy or especially costly drug therapy.

Under the proposed program, services would be covered only if performed by a qualified "participating" provider who would have to agree to accept the program payment as full payment for a given covered service.

Participating physicians who chose to be remunerated on a fee-for-service basis would have their fees predetermined by the agency. Institutional providers would be paid on a prospectively aproved budget basis. Thus, the beneficiaries would be assured that they will not be billed for any covered services. At the same time, cost controls are built into the system.

Incentives would be included for both providers and beneficiaries to choose comprehensive prepaid group practice with its emphasis on preventive care and reduction of institutional care.

The new program, whether administered through new channels or by the Social Security Administration, would provide for consumer representation and public accountability at all levels.

Such a program, we know, will be an expensive one, concentrating as it does on the high risk groups. Without knowing the exact size of the price tag, certain financing principles can be agreed on at the start.

Federal general revenues should finance 100 per cent of the costs for beneficiaries other than those eligible for social security benefits. Social Security

beneficiaries should not have to pay any premiums. Some portion of the cost of their coverage should be borne out of Federal general revenues with the remainder financed by a payroll tax. The payroll tax should be the same for employers and employees.

These, in brief, are the principles for reforming Medicare-Medicaid that the National Council of Senior Citizens advocates.

The National Council, from its day-to-day knowledge of the problems that older people encounter with these programs as well as its experience in trying to fill gaps in protection, is well qualified to speak to the problem and to the principles for solution. Nothing short of National Health Security for the total population can have the financial leverage needed to restructure the Nation's health care system.

We believe, however, our proposal deserves consideration as a first step in reform.

Transferring part B to part A of medicare

The National Council of Senior Citizens has long been a supporter of the proposal to merge Part B of Medicare with Part A (which is solely government financed) to free the elderly of spiralling premium costs.

There appears to be a strange mixture of rhetoric and fiscal legerdermain in the Administration proposals in this area.

You will recall that a year ago at this time the President's health message to Congress suggested a severe cut in Medicare hospital benefits—down to the first 12 or 13 days of hospitalization instead of the present 60 days.

This cutback was coupled with an Administration proposal to eliminate the premium charge for optional Medicare (Part B) doctor insurance now amounting to $5.60 monthly and due to rise to $5.80 next July.

Fortunately, the House saw this as trading a horse for a rabbit.

In none of the President's subsequent public appearances did he make any further reference to eliminating the Part B premium until his address at the close of the White House Conference. No Administration bill was introduced last year to effect this change.

The President again raised the subject in his State of the Union message—but again he failed to say how he planned to eliminate the Part B premium payments, and no such Administration bill has yet been introduced in 1972.

Moreover, there is no provision in the health section of the budget message to finance this much-needed change.

Now the Administration is again proposing that the old folks' premium payments to the Part B program will be eliminated. This is all to the good, but the proposal includes the provision that the contribution from general revenues which now matches the premium payment would also be eliminated.

Benefits payments and administrative costs for fiscal '72 are running at an annual rate of $2.5 billion. Premiums and government contributions total about $2.6 billion leaving a very slight surplus to add to the already skimpy reserves.

The obvious conclusion is that if matching funds from general revenues are to be abandoned the loss must be made up either by raiding one or more of the other trust funds, or by increasing the payroll tax.

It is not possible to transfer monies from any of the other three trust funds without jeopardizing the solvency of the programs or foregoing much needed increases in benefits.

This is why we refer to the proposal as fiscal legerdermain. Combining Medicare Parts A and B and eliminating the direct premium payments in this way would be of no real benefit to the elderly. They would still be paying the cost—either through loss of important cash benefits, reduction of hospital benefits or through additional taxes born by younger members of their family who are still working. All of these alternatives are completely unacceptable to the members of the National Council of Senior Citizens.

Exclusion of chiropractic

While on the subject of proposed Medicare changes, I would like to refer again to the position of the National Council of Senior Citizens against including Chiropractic as a reimbursable service under the program. We note with some dismay the spate of bills that have been introduced in support of this proposal, and we are aware of the very vigorous efforts of this group to obtain this change in the Medicare law. The Chiropractors have even mounted considerable lobbying

efforts at the annual conventions of the National Council of Senior Citizens. But they did not succeed in persuading our delegates that Chiropractic would be of advantage if added as a Medicare service. In fact, they are convinced it would represent another serious health hazard. I, and one of the Vice Presidents of the National Council, served on the ad hoc committee on private practitioners set up by HEW in response to a Congressional mandate in 1969 to study this and other proposals. We went into this matter thoroughly and objectively. We made the findings of this group available to our delegates and found them wholly in support. Since that time I've been accused of being "brainwashed" by the AMA. I leave it to the members of this Committee who have known me for many years to judge the plausibility of such a charge!

While our position on this issue is well known and a matter of record we support the provision in H.R. 1 which would require the Secretary of HEW to conduct a study of the desirability of covering chiropractors' services under Medicare and to report to the Congress within 2 years. We believe this provision would be strengthened by adding the requirement that the study be made by some independent scientific group with recognized competence in the field of science, wholly independent of the medical profession as such.

Coverage for the disabled

As to the need for extending Medicare coverage to disabled Social Security beneficiaries under age 65, we submit that a disabled person, like a retired person, incurs high health costs at the same time individual income drops.

In fact, hospital and medical costs per person for the disabled are two to three times higher even than for the aged. Moreover, the proportion of severely disabled persons with any form of health insurance is lower than the proportion of the aged who had health insurance protection before the enactment of Medicare.

Members of the National Council of Senior Citizens consider the proposal to extend Medicare coverage to the disabled under age 65 fair, reasonable and fully justified by their needs.

Long-term care

One of the most serious health problems facing today's elderly is the problem of long-term care.

The absence of a program of coordinated, continuous and comprehensive medical and social services—for the aged and those persons suffering from long-term chronic illness—is a grave national problem for which a solution *must* be found.

The lack of such a program has produced fragmented and uneven care and services, hardships and deprivation, inefficiencies and spiralling costs and a shortage of proper facilities capable of providing the differing levels and kinds of care and services required by this growing segment of the population.

Present public programs for long-term health care are divided among medical facilities, construction programs, housing programs, public assistance programs and programs specifically for the aged. Each, however, is addressed to only a facet of the problem. There is no coordination with respect to various kinds and levels of care required by different persons or the relative need for facilities of several types.

Existing medical care and related institutional programs are not in themselves efficient mechanisms for dealing with all long-term care problems. This fact—coupled with the shortage of appropriate facilities—has resulted in much improper and wasteful use of acute care facilities.

The Congress should call on the Secretary of Health, Education, and Welfare to develop a program of coordinated, continuous, comprehensive medical and social services for the aged and those persons suffering from chronic illness which will include a uniform benefit package guaranteeing the full range of services needed for both ambulatory and institutional care. Attachment A lists these services.

High priority should be given to the development and financing of non-medical services to make it possible for the chronically ill to live independently, thus saving vast amounts now spent on institutional care.

The Secretary of Health, Education, and Welfare together with the Secretary of Housing and Urban Development should be directed by Congress to conduct a joint study of the need for appropriate facilities of various kinds required by such a program and of equitable means of meeting both the capital and operating costs.

We believe it should be possible for the Secretaries of both agencies to develop and transmit to Congress not later than two years after passage of the Act a consistent and coordinated program to meet the long-term care needs of older Americans.

Mr. Chairman, we believe that legislative proposals to get this program under way should be enacted as quickly as possible. Some work in this area has already been undertaken and further studies can be initiated immediately—without waiting for final enactment of National Health Security. Our hope is that the resulting long-term care program can be meshed quickly and easily into the National Health Security program.

Our current long-term care system is in such a mess that it can be described as a national scandal. We urge the Congress to move quickly to correct long-term case abuses, stop the commercial exploitation of the elderly sick and to begin to provide some peace of mind for all those who dread the approach of the days when they may need long term care.

Catastrophic health insurance

The bill introduced by Senator Russell Long, (D., La.) Chairman of the Senate Finance Committee, proposing catastrophic health insurance, would exclude the aged entirely, leaving them to Medicare.

However, other bills before Congress include the aged and we are so fearful of the consequences of the efforts to enact catastrophic coverage as a means of heading off comprehensive National Health Security, we wish to express our views on this matter.

One of the catastrophic coverage bills would eliminate Medicare and Medicaid for the aged.

We urge this Committee to recognize that catastrophic coverage is no substitute for comprehensive health coverage—though the inclusion of a realistic proposal against catastrophic health costs deserves serious consideration as part of a national health security program.

Any undue emphasis on catastrophic coverage right now would almost certainly undermine efforts now underway to give new emphasis to primary care and ambulatory services. The overwhelming emphasis on major illness would most certainly distort the allocation of national health care resources—turning them increasingly toward hospitalization and other institutional treatment and away from prevention, home care, and other neglected aspects of health care.

Experts in health care economics who do not come from the vested interests in the field tell us that national insurance limited to catastrophic coverage would accelerate the current inflation of health care costs.

We have had sufficient experience in the years of Medicare to realize that unscrupulous providers will raise their prices on the excuse that the family or individual will become eligible for catastrophic benefits. The net result would probably be a further boost in charges for all aspects of health care.

All the catastrophic coverage plans being produced share the fundamental idea that insurance should take over only after a family has shelled out hundreds or even thousands of dollars for medical expenses. Most people would be terribly disillusioned with the coverage—and the problems of providing a realistic national Health Security Program will have been made immensely more difficult.

WELFARE

Mr. Chairman and other distinguished Committee members, the next portion of my statement deals with welfare.

The welfare program has grown like Topsy ever since the Great Depression of the 1930's when President Franklin D. Roosevelt and Congress put it into operation to meet the frightening poverty of that day. A major overhauling of the welfare system is long overdue.

H.R. 1 proposes replacing uneven and too often completely inadequate Federal-State aid to families having dependent children with a Federally financed basic family benefit amounting to $2,400 for a family of four. For the first time, the Federal government would underwrite the needs of the working poor.

The basic amount of $2,400 for a family of four proposed under H.R. 1 is unrealistic. It is far too low to support a decent level of living in most communities of the nation.

The National Council of Senior Citizens sees an urgent need for an immediate guarantee of at least $3,000 a year for a family of four, as sought in

the Ribicoff amendment to H.R. 1, and we insist this basic income be raised substantially as quickly as our economic situation will permit.

The National Council of Senior Citizens welcomes the statement by Senator Abraham Ribicoff (D., Conn.), author of the Ribicoff amendment, at the opening of the Senate Finance Committee hearing on H.R. 1.

The Senator stated the Ribicoff amendment would set an initial payment level of $3,000 a year for a family of four with payment levels increasing each year so that, by 1976, no welfare recipient—whether a family with children, a single person or childless couple—would receive less than the poverty level adjusted annually for raises in living costs.

Under this amendment, States and local governments would pay a decreasing percentage of their calendar 1971 costs each year until 1976 when the welfare program would be financed entirely with Federal funds.

Even a basic benefit of $3,000 would be less than the amount now paid by some States.

We insist that no assistance recipient receive less after welfare reform than he now receives. Therefore, we urge that H.R. 1 be amended to require that States, with the aid of Federal matching grants make supplemental payments to bring welfare payments up to at least the level of current payments including food stamps.

The National Council of Senior Citizens also insists that H.R. 1 be improved with respect to work requirements.

No welfare recipient should be required to take a job paying less than the Federal minimum wage.

Further, the National Council insists no mother with small children be required to work, unless there are easily accessible child care centers for her children while she is on the job.

H.R. 1 recognizes the need for additional child care programs in order to create new opportunities for those who want to work but the Ribicoff amendment is more realistic in terms of existing need.

The Amendment would increase the authorization for child care programs to $1.5 billion, plus $100 million for construction and $25 million for training personnel. It would write into law Federal minimum standards for child care programs and protect mothers with children under three years from a requirement to work.

Also, the National Council of Senior Citizens asks that H.R. 1 be amended to provide protection for State and local employees who currently administer welfare programs and who—in the absence of specific provision to the contrary—could lose all job rights when the Federal government takes over full administration responsibility for public welfare.

The "adult categories"

Of special importance to our membership is the provision of H.R. 1 for a 100 per cent Federal takeover of public assistance for the blind, disabled and those age 65 or over.

The National Council of Senior Citizens strongly supports H.R. 1's guarantee that older people and other handicapped adults—regardless of where they live—will be assured a basic income. The record is all too clear, however, that, when the level of income support is left to the States, many needy individuals fare badly.

We support the provisions of H.R. 1 that would, over a two-year period, provide an annual income floor of $1,800 for an individual and $2,400 for a couple. Here, too, H.R. 1 should be amended to require that States now paying larger amounts continue to supplement the basic Federal guarantee.

Furthermore, we hope that improvements in Social Security benefits would greatly reduce the number whose incomes are so low they qualify under the means test of the new welfare program.

The National Council believes that the aged, blind and disabled should be entitled to a reasonable minimum of comfort and security as a matter of right—not as beggars pleading for a handout.

Our older citizens have contributed from their earnings toward a retirement pension in the form of Social Security benefits. They should not in their later years be forced to pass a means test and live as wards of the State.

Yet, this is what may happen if H.R. 1 is enacted as now written.

With Federal assumption of the administration and financing of welfare for the blind, disabled and aged there should be set up a system for determining eligibility and calculating the level of assistance in a manner that respects the dignity of the individual.

The goal of H.R. 1 is to provide incentives for welfare recipients to find jobs. If there is to be any real progress toward this goal, there must be job opportunities. The National Council strongly supports a provision of the Ribicoff amendment to authorize $1.2 billion for 300,000 public service jobs as against the $800 million proposed under H.R. 1.

These jobs should pay no less than the Federal minimum wage.

This is a reasonable approach to the job problem of those welfare recipients who are employable.

While most welfare recipients are unable to work, there are undoubtedly many able-bodied recipients ready and willing to work if they can find jobs. However, to expect them to locate jobs, in the private sector in the midst of an economic depression, is unrealistic.

Getting able-bodied welfare recipients into jobs and off the welfare rolls requires intelligent planning and concern for welfare job seekers. It cannot be done with mirrors.

ATTACHMENT A

MEDICAL AND SOCIAL SERVICES NEEDED BY THE AGED AND OTHER CHRONICALLY ILL PERSONS

1. *Service Categories to be included:*

Health Maintenance.
Diagnostic.
Therapeutic.
Restorative.
Long Term.

2. *Setting for Services:*

a. *Ambulatory services:* Physicians'[1] and dentists' offices; Ambulatory care centers (including community mental health centers); Organized outpatient and emergency departments of health care institutions

b. *Institutional services:* Hospital facilities (including use of community "day" hospitals); Extended care facilities; Nursing Home facilities.

c. *Health services in the home.*

3. *Scope of Services:*

The following services should be provided when medically indicated and properly ordered as appropriate to diagnosis, level of care, and setting.

Physicians' services, Dentists' services, Podiatrists' services, Optometrists' services and glasses, Nursing service, X-ray, laboratory and other diagnostic procedures, Physical occupational, and speech therapy, Mental health services, Drugs and drug supplies, Appliances and medical equipment, Medical social service, Home health aides, home maintenance services, Medically related homemaker services, Dietary and food supplements.

SUPPLEMENT TO STATEMENT BY NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

The National Council of Senior Citizens sees grave danger in a provision of H.R. 1—under the measure's Section 267—that nursing homes in rural areas be exempted from the Medicare requirement that such establishments have at least one full time registered nurse on the staff.

Needless to say, without a registered nurse, a nursing home cannot provide skilled nursing care and, if this provision should be enacted, Federal funds would be used to finance sub-standard care in rural nursing homes.

This the National Council of Senior Citizens strongly opposes.

NATIONAL FARMERS UNION
Washington, D.C., August 3, 1971.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: I am writing to express the views of National Farmers Union on certain aspects of H.R. 1, particularly on the social security provisions

[1] Including M.D.'s and Doctors of Osteopathy.

of the bill. I request that this letter be made a part of the published record of hearings currently underway on H.R. 1.

At Farmers Union's February 24-27, 1971, National Convention, our delegates adopted the following policy statement on social security:

"We urge early enactment by the 92nd Congress of social security amendments to be retroactive to Jan. 1, 1971. The social security amendments should include provision for: (1) increase of the minimum monthly paymentsto individuals to $100; (2) automatic increases in benefits thereafter tied to cost-of-living increases of one percent or more; (3) increased earnings of up to $3,000 without loss of social security benefits; (4) increased widow's benefit's to 100 percent of the amonut to which the husband has been entitled."

We are pleased that Congress enacted legislation earlier this year providing improvements in social security along the lines called for in this policy statement. However, the increases in benefit levels did not go far enough—particularly in light of continuing inflation that erodes the already-inadequate benefits.

H.R. 1 would increase the minimum monthly payment for individuals from $70.40 to $74.00.

I strongly urge that your committee increase the minimum monthly payment to individuals at least to $100 per month. The $3.60 per month increase in the House-passed bill is woefully inadequate. Today about 40 percent of all the American people over 65 live in rural areas, and our older rural people are often poor. Many older persons have been forced out of farming due to low farm prices and ever-escalating costs of production. These older persons who are forced off the farm would benefit greatly from a higher floor under Social Security payments.

For farmers, a substantial increase in minimum benefits is especially crucial in light of a provision written into H.R. 1 by the House Ways and Means Committee. The bill provides, for people who have worked for 15 or more years under social security, that benefits would be equal to $5 multiplied by the number of years coverage under the social security program, up to a maximum of 30 years. Thus, the highest minimum benefit under this provision would be $150 for a person who had 30 or more years of coverage.

This provision would move social security benefits upward for many people, and Farmers Union is very reluctant to question any measure that would increase benefits. At the same time, we are concerned about the effect of this approach on benefits to farmers. Farmers became eligible for social security coverage for the first time in 1955, and therefore no farmer could have more than 17 years of coverage as of January 1972 when the bill is designed to become effective. The highest minimum benefit for which any farmer could qualify in 1972 under such a provision is therefore $85 per month.

Unlike this provision for increases based upon years of coverage, a $100 floor under benefits of all social security recipients will not discriminate against farmers and others who came into the social security system in more recent years. I therefore urge your Committee to adopt a payment floor of at least $100 for all recipients as an alternative or addition to such a years-of-coverage provision. Or, I urge your Committee to restructure the years-of-coverage provision to allow special minimum benefits to those who came under social security later, so as not to discriminate against farmers and others that are caught through no fault of their own in such a situation.

Sincerely,

TONY T. DECHANT, *President.*

OHIO NURSES ASSOCIATION,
Columbus, Ohio, March 8, 1971.

Hon. WILLIAM B. SAXBE,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR SAXBE: The Ohio Nurses Association is an organization of registered professional nurses and serves as the official voice for the nursing profession in Ohio. Its purposes are to foster high standards of nursing practice, to promote the professional and educational growth of nurses, and to promote the welfare of nurses to the end that all people may have better nursing care.

ONA has received a copy of S. 892 from your Columbus office and we have discussed the bill with Mrs. Carolyn Peterson at your Washington office. In our

telephone conversation with Mrs. Peterson we indicated that ONA would communicate our concerns to you.

Some of our reasons for opposing your bill are:

1. ONA believes that the nursing care provided to eligible persons under Medicare and Medicaid programs should be of high quality. It is unfair to waivered licensed practical nurses and to their patients to expect them to assume the complex functions of a charge nurse. The Ohio Nursing and Rest Home Law and Regulations illustrate the complex nature of the nursing care provided in a nursing home giving skilled nursing care. The regulations state, "Skilled nursing care means those procedures commonly employed in providing for the physical, emotional and rehabilitation needs of the ill or otherwise incapacitated which require technical skills and knowledge beyond that which the untrained person posseses, *including without limitation* (emphasis added) procedures such as irrigations, catheterizations, application of dressings, and supervision of special diets; objective observation of changes in patient condition as a means of analyzing and determining nursing care required and the need for further medical diagnosis and treatment; special procedures contributing to rehabilitation; administration of medication by any method ordered by a physician such as hypodermically, rectally, or orally; and carrying out other treatments prescribed by the physician which involve a like level of complexity in skill in administration." If passed, S. 892 would permit waivered licensed practical nurses to be in charge of "skilled nursing care", as defined above, in Ohio nursing homes.

2. ONA seriously doubts that there are not enough qualified nurses to serve on all shifts in nursing homes in Ohio. In 1970 the Ohio State Board of Nursing renewed 58,385 licenses for professional nurses and 24,841 practical nurses (including those waivered) renewed their licenses as of January 1, 1971. There are 959 nursing homes in Ohio; ONA would be interested in knowing the names and locations of the "at least 200 nursing homes" that are unable to employ qualified nurses. We would appreciate the opportunity to learn the reasons why these nursing homes are having staffing problems and assist them with solutions. Our organization does not believe lowering nursing care standards is the answer.

3. In your introductory remarks you said, "The proposal I am offering would provide a testing mechanism within HEW to determine which of these 'waivered' nurses are competent to serve as charge nurses. In my State of Ohio alone, there are 10,000 waivered practical nurses; half of whom have even passed the State Board." Your statement is incorrect. The State of Ohio has waivered 15,246 LPN's. There have been two waiver periods in Ohio. During the 1956 waiver period 11,242 practical nurses received their license by waiver. Of these, only 1,920 passed the State Board examination. So far during the 1968–70 waiver period 3,730 nongraduates of approved schools have received their licenses by pasing the State Board examination.

4. The frustrations of poor working conditions aggravated by continuation of low standards and lack of recognition for sound academic preparation will only drive away qualified persons now serving in nursing homes. Sufficient qualified candidates will never be attracted to careers in nursing homes if opportunities for truly satisfying and rewarding experiences cannot be found.

ONA believes that under proper direction and supervision, waivered licensed practical nurses can devote their full time to the direct nursing needs of patients and will not be frustrated by responsibilities beyond their preparation and patients in Title XVIII and Title XIX nursing homes will receive competent nursing care.

The Ohio Nurses Association would appreciate the opportunity to meet with you at your Columbus office as soon as possible.

Sincerely,

DOROTHY A. CORNELIUS, R.N.,
Executive Director.

OHIO VALLEY GENERAL HOSPITAL ASSOCIATION,
Wheeling, W. Va., August 2, 1971.

Hon. ROBERT H. MOLLOHAN,
House of Representatives,
Washington, D.C.

DEAR MR. MOLLOHAN: The original Medicare-Medicaid legislation provided for hospitals to be reimbursed their "reasonable cost" for care rendered under

the programs. "Reasonable cost" was determined by regulation at the Federal level.

Currently pending House Ways and Means Committee H.R. 1 specifies that a State shall now define "reasonable cost" under Medicaid, so long as reimbursement does not exceed "reasonable cost" as defined by Social Security Administration for purposes of Title XVIII (Medicare).

It appears this is specifically designed to allow a State to reduce an already inadequate reimbursement for Medicaid. Hospitals in West Virginia are dissatisfied wtih the current Medicaid reimbursement. Many feel they are placing their hospitals' total assets in jeopardy by participating in the program.

Inasmuch as provider participation under Medicaid is tied, by law, to participation under Medicare both programs would be placed in jeopardy should hospitals not accept a State's decision to reduce Medicaid reimbursement. Such a decision would have serious repercussions on the health and welfare of the aged and indigent of West Virginia, however, it would preserve the system for those with the ability to pay.

We urge your support in correcting this amendment. H.R. 1 should be amended to enable improvement in reimbursement rather than a potential reduction in reimbursement or placing ceilings on reimbursement.

Very truly yours,

F. E. BLAIR,
Executive Director.

OREGON PHYSICIANS' SERVICE,
Portland, Oreg., August 9, 1971.

Re Professional Service Review Organizations.

Hon. ROBERT W. PACKWOOD,
U.S. Senate,
Senate Building,
Washington, D.C.

DEAR SENATOR PACKWOOD: We are deeply interested in the concept of "Peer Review," the idea of having practicing physicians manage the medical review of a health care payment system. This has been an integral part of the OPS-Blue Shield for many years. In fact, the Blue Shield Plans in the Pacific Northwest are probably the nation's oldest examples of the process.

In this connection, we have compared Senator Bennett's proposal for "Professional Service Review Organizations" with Section 222 of the House-passed version of H.R. 1 and we believe Section 222 has a distinctly better approach.

While Senator Bennett is certainly on the right track, it seems to us that the PSRO structure may be too rigid to fit local conditions across the country. Also, it will need a huge administrative framework to cope with the volume of paper work, largely duplicating the administrative programs already established by carriers and government agencies for medical claims review and payment. Section 222, on the other hand, permits flexibility, experimentation and development of local approaches. Here in Oregon, for example, PSRO would duplicate or replace much of our existing medical review structure. Under Section 222, however, our system might be expanded, developed further or tried in other states.

We would like to discuss this whole area of health care utilization and cost control with you in greater detail. It is becoming a major legislative subject and you will want to know the local situation.

We hope you can visit our office while you are in Oregon during the summer recess to see what we are doing in the field and review our results. If this can fit into your schedule, please let us know what time will be convenient.

If you should need background information on a national level, we would appreciate your talking to Mr. Hugh E. DeFazio, Jr., of the Washington, D.C., Blue Shield office.

Cordially yours,

S. MENASHE.

RUBBER MANUFACTURERS ASSOCIATION,
OFFICE OF THE PRESIDENT,
New York, N.Y., September 30, 1972.

Hon. ELLIOT S. RICHARDSON,
Secretary of Health, Education, and Welfare, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. SECRETARY: We very much appreciate the opportunity which we had to review with you the objectives of the Administration's Welfare Reform Program at the June, 1971 meeting of the Board of Directors of our organization.

Since that time, we have had a further opportunity to review this matter, and I wish to advise that the Rubber Industry is well aware of the flaws and inequities now existing in the current system. Consequently, the Rubber Industry fully supports the Administration's goal in achieving welfare reform through the enactment of H.R. 1.

We believe that it is vitally important to the welfare of our nation to achieve a Welfare Reform Program by the enactment of H.R. 1 in the current session of Congress.

Sincerely,

ROSS R. ORMSBY.

RUBBER MANUFACTURERS ASSOCIATION,
OFFICE OF THE PRESIDENT,
New York, N.Y., January 28, 1972.

Hon. RUSSELL LONG,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Rubber Manufacturers Association and its member companies are aware of the current hearings of your committee on H.R. 1.

Enclosed for the record of these hearings is a copy of a letter sent to HEW Secretary Elliot Richardson expressing the support of the Board of Directors of this association for the welfare reform provisions of H.R. 1.

Sincerely,

ROSS R. ORMSBY.

WASHINGTON, D.C., *January 17, 1971.*

Re H.R. Bill. No. 1. To eliminate limitation from the Social Security law on outside earnings.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee, New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is written to you to urge you to consider favorably the above Bill—A Senior Citizen sixty-five (65) or over, has a limited time to live at best. When he has no outside income and is forced to go to work, he is paying into the fund and pays his withholding taxes—so he is contributing. More often than not, the *only money he has coming into him or her*, is the small Social Security Benefit each month, and with the high prices and continuing raising of rents, utilities, etc. not to include bus fare, and in general, expenses to survive and be fit to work. $1680 or $2,000 a year is below the poverty level . . . .

It seems only fair to let a person 65 or older, keep what he may be able to earn without being penalized and, having his benefits taken away from him or her.

Why can't we encourage people to work, and not go on welfare?

So, please vote favorably for the above bill, in order that those Senior Citizens who must work, and have no other outside income, can survive. Otherwise, we may have mass suicides—and our welfare list will most certainly increase. . . . .

Thank you for reading this letter, and your consideration of this all-important benefit to those who need it.

Sincerely,

ROSEMARY THOMPSON.

Enclosures.

BAKERSFIELD, CALIF., *August 2, 1971.*

Hon. RUSSELL B. LONG,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: On July 10, 1971 I received your reply to my letter of June 24, 1971 which voiced my objection to the Family Assistance Plan now before the Senate Finance Committee. In your letter you indicated you would be glad to receive a written statement of my views for inclusion in the printed volume of hearings on the entire measure I greatly appreciate this opportunity and am forwarding the attached proposal for consideration.

Except for the enforcement of mandatory abortions I am quite confident the proposal is logical and workable and would provide a last chance for the Free Enterprise System to solve the problems of poverty and unemloyment.

It may be well to point out I am writing as an individual and do not represent any group of people or political party. I am not seeking publicity, a job, or any favor. This proposal is submitted without obligation and the ideas proposed are yours to pursue or use at your own discretion.

Respectfully yours,

JIM WALLACE.

A WORKABLE PLAN FOR THE ELIMINATION OF WELFARE IN THE UNITED STATES

Based upon two prime factors—

A. The majority of welfare recipients can work but will never be able to compete in a free enterprise labor market.
B. The government cannot afford vast public works programs where the entire expense is borne by the taxpayer.

Subject to five criteria for feasibility—

A. Adequate Wage
B. Taxpayer Savings
C. Public Acceptance
D. Preservation of the Free Enterprise System
E. Incentive System—for Employer, Enrollee and Taxpayer

Designed to—

A. Provide full employment without inflation
B. Lower Taxes
C. Lower the cost of goods and services
D. Abolish or consolidate the myriads of federally funded job training programs
E. Provide a base income above the poverty level
F. Restore free enterprise
G. Eliminate the degradation of welfare

FIVE BASIC PROVISIONS

I. Guaranteed employment

Either through subsidized jobs in private sector or Government work project.

II. Guaranteed minimum base wage

Government work project—minimum guarantee—$3,824 per year.
Subsidized job in private enterprise—minimum guarantee—$4,032 per year.

III. Auxiliary aide

Commodities Health insurance Housing allowance Child care Transportation	Allowances or subsidies based upon ability to pay and available to the general public and not connected with welfare.

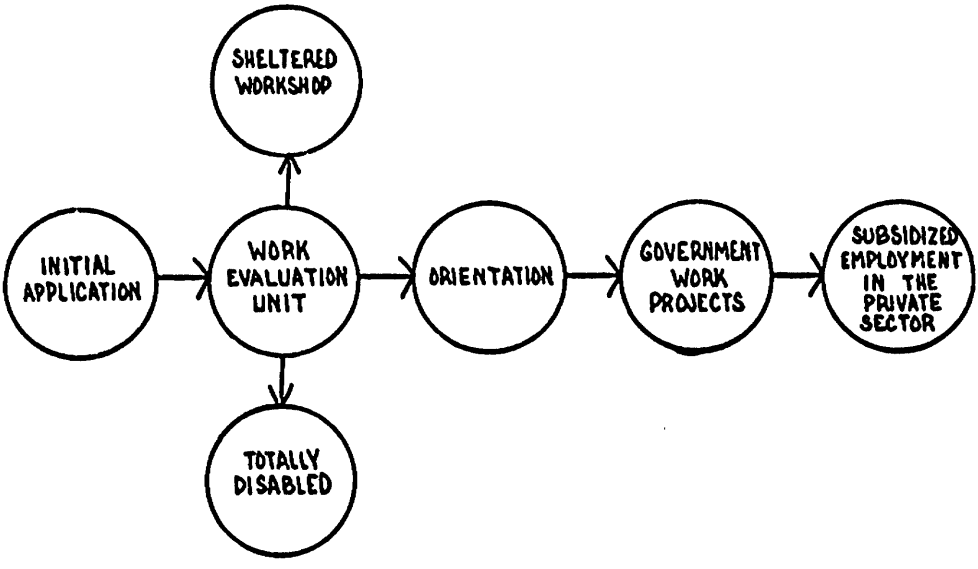
IV. Enrollee fringe benefits

Training credits based upon satisfactory work effort.

V. Sanctions

If the enrollee refused to participate without good cause, he/she would be removed from employment and become ineligible for any assistance or aide for one year anywhere in the United States. His/her family would be placed in protective custody and vendor payments.

FLOW CHART



BASIC PLAN

I. Initial application for aide

A. Check for eligibility.

II. Referral to work evaluation unit

A. Complete medical examination.
B. Work history evaluation.
C. Work sampling.
D. Testing.
E. Identification of all barriers to employment—mental, social, domestic, etc.

III. Totally disabled

A. Place on social security.

IV. Sheltered workshop

A. For those unemployable but needing activity therapy.

V. Orientation

A. For those employable.
B. Would cover such things as—How to find a job; What employers expect; Why work; Community resources; Interviewing techniques; Money management and family planning.

VI. Government work projects

A. Mandatory 60-day trial run before assignment to subsidized job in private sector.

B. Primary purpose would be to check for enrollee dependability and capability in a work situation.

C. Also a temporary holding area for those in transition between subsidized jobs in the private sector.

D. Pay—$1.65 per hour.

VII. Subsidized employment in the private sector

A. Maximum reimbursement—50 percent—exact amount to be determined by the characteristics of enrollee and the vocational skills that could be acquired.

B. Subsidation would be permanent in that employer could retain the enrollee as long as he desired but the percent of Government reimbursement would be reviewed once a year.

C. Minimum enrollee wage would be $2 per hour.

D. Participating employers would not be subject to "extra help" provisions but the number of subsidized enrollees could not constitute more than 5 percent of the employer's work force.

E. If a regular employee quits or is laid off by the employer, he must be replaced by another unsubsidized employee—or lay off the subsidized enrollee.

WELFARE DEPENDENCY AND RECIPIENT CHARACTERISTICS

Human nature is such that those unaccustomed to the work ethic will seldom stay employed if it is possible to revert back to "free money". Very few jobs are continually pleasant with no stress or strain. As long as welfare is available the temptation to quit or deliberately mess up and get fired is too great. By eliminating welfare for the employable and substituting guaranteed work, the basic evil of the system is removed. One of the fallacies of past and current programs for the low income or disadvantaged is the assumption that all they need is a few extra training dollars, counseling, a short vocational training course and "Eureka"—a permanently rehabilitated person. The truth is that most will never be able to function adequately without help. Their whole life style and orientation to living would have to be changed. This would take years and for many will never occur.

Many have been recycled through numerous training programs and are saturated with orientation and counseling. You don't train fish or seals by just talk, you have to bribe them. With people it is the same principle; not talk, counseling, or rhetoric; but jobs and money, which for them, only subsidized employment would produce.

MEANINGFUL TRAINING

Past social legislation dealing with vocational training for welfare recipients has always stressed work experience in government agencies. This was particularly true of the Community Work and Training Program, Title V, and the current Work Incentive Program (WIN). Basically this has been a good resource and has provided tangible results. However, there are some basic dangers in relying too extensively on government agencies for vocational training. Only a selected few are capable of providing meaningful training. Many first-line supervisors are too lax since it is free help and costs them nothing. Busy work is often substituted for training with absenteeism and enrollee morale a problem. In addition, many government agencies are inundated with free help from the multitude of programs that now exist. These programs have saturated the agencies far beyond their supervisory and training capacities. Government agencies offer only a limited scope of training and since there is no pressure to produce, most enrollees gain the wrong idea of the world of work.

While it would be wrong to advocate the abandonment of Governmental agencies for training, their use should be limited and consist mostly as a holding agency until a job is secured in the private sector.

FINANCIAL FEASIBILITY

The total cost of public works programs vast enough to absorb all the unemployed is prohibitive. While the cost of subsidized jobs for all would also be great, the money would be received directly by the employers and lower the cost of goods and services. Subsidized jobs would also have the effect of insuring a minimum wage sufficient to feed ones family without forcing many small firms into bankruptcy.

Guaranteed jobs would also make it possible to eliminate or consolidate the myraid of Federally Funded Job Training Programs. While many of these programs have had some success the average cost per success is around $10,000 per person. Guaranteed jobs would cost half that even if it meant a full 50 per cent reimbursement rate for each one.

SUBSIDIZED EMPLOYMENT

There is a difference between subsidized employment in the private sector and on-the-job training as it now exists. Subsidized employment does not bind the employer to a permanent hire, is not subject to time limits and avoids the extensive paperwork now associated with formal on-the-job training contracts. On-the-job training has various weaknesses. Only one out of ten employers are able to provide adequate training. In essence the government is buying a job. Since the employers and enrollee are aware of this situation, both easily become dissatisfied. The enrollee complains of a lack of training, meanial duties, employer prejudice, etc. The employer becomes frightened at the prospect of having to keep the enrollee after the contract ends and immediately begins to look for an excuse to fire him. While some employers try to camouflage the situation by keeping the enrollee four or five months after the completion of the contract, the vast majority quit or are discharged within six months. Subsidized employment with no prerequisite of hire and time limit would greatly relieve the pressure both to the employer and enrollee. It is only through this less threatening atmosphere that real progress can be made.

While subsidized employment may appear to be biased toward the employer, certain safeguards could avoid abuse. Employers showing a large percentage of enrollees entering unsubsidized employment would get preference of assignment. Those showing no movement would be used only as a last resort. Through the cooperation of the Chamber of Commerce, Labor Unions, Better Business Bureau, and other civic and citizen groups, positive results could be obtained.

Enrollee job-hopping between subsidized employment could be substantially reduced by adding "training credits." Enrollees completing 6 months of an assignment with a good performance rating would receive a percentage of their earnings as a cash bonus for training. They could use these training credits only for entry in a trade school, community college, night school, etc. If they leave prior to completion of 6 months for any reason other than entry on a full-time job, or a lack of work discharge by the employer, they would lose all credits. Thus the enrollee would be able to "earn" job training rather than the "dole system" used now.

Employer participation to subsidzed employment would be limited to those jobs with a starting rate of $2.00 per hour, thus avoiding cheap help.

The principle of subsidized employment is much more equitable than on-the-job training. The enrollee is not led to believe he is entering trade school type training of which the employer cannot produce. The employer is not harassed with compliance to training curriculums and is free to provide the vocational orientations he normally gives new hires and regular employees. Since the enrollee is told he has a job and not a pure training assignment, there is a better relationship with the employer and a greater willingness by the enrollee to become work oriented.

Many employers with on-the-job training contracts have reported instances where enrollees have refused to do work because they could not see the direct connection between what they were told to do and training. This has soured many employers on on-the-job training contracts and they refuse to sign another.

Under subsidized employment, the enrollee is not cemented to a job he may dislike, and through the accumulation of "training credits" can make his own vocational choice. He has the assurance he has "earned" it and is more careful and thoughtful concerning his selection.

Subsidized employment is far superior to wage supplementation as proposed by the Family Assistance Plan. In general, wage supplementation is a bottomless pit and unfair. Women on welfare now have wage supplementation and even though many have full-time jobs, are still on welfare. Often they are working beside someone who has the same size family, receiving the same wage and they are not receiving welfare. This creates bitter feelings and causes serious morale problems. It perpetuates the narcotic effect of welfare orientation and dependence. This has spawned generations of welfare recipients.

Subsidized employment would also provide the flexibility needed to conform with human nature. Many low income or disadvantaged are not used to a steady diet of work and must be gradually trained to accept this fate. Unemployment Insurance Coverage would provide this flexibility. At the end of each year of subsidized employment, the enrollee would be given the option of drawing his Unemployment Insurance Benefits while attempting to find an unsubsidized job. As he/she would be subject to the rules of the U.I. code, they could be disqualified for an inadequate job search.

If the 5 percent participation limit placed on employers did not produce enough jobs, then the percentage could be increased to the level necessary to provide full employment.

U.S. EMPLOYMENT SERVICE

During the 35 year history of the U.S. Employment Service, a great deal of debate has occurred concerning its effectiveness and purpose. While it must be admitted that considerable good has been accomplished, it has not fullfilled its purpose. No matter how many times the name is changed (Department of Employment, Department of Human Resources Development, etc.) the public still refers to it as "the Unemployment Office." So far it has lived up to that name. 90 per cent of the unemployed coming to the Employment Service Sections of the U.S. Employment Service are looking for a job, not advice, counseling, testing, conversation, or sympathy. For 35 years only 10 to 15 per cent have been able to secure jobs and of these, many were low pay, temporary, or part-time jobs. It is a wonder that the U.S. Employment Service still has any friends. The fact that the U.S. Employment Service has been only partially effective is not the fault of its employees since they could not manufacture jobs.

Guaranteed jobs would convert the U.S. Employment Service to a house of employment rather than a house of unemployment or sympathy.

POPULATION EXPLOSION

A great part of the current welfare problem lies in the fact that nearly all welfare recipients have large families. Only a fraction of the problem can be blamed on ignorance as most have had family planning information and access to professional medical assistance through use of their medical cards. The basic problem is the current welfare system which encourages large families by raising the grant each time a new child is born. By proper utilization of auxiliary aids in the areas of Commodities, Health Insurance, Housing Allowance, Child Care and Transportation, the need to pay cash grants based on the size of the family is eliminated.

While on a subsidized job in the private sector or on a government work project, all would be treated alike. The single man would get the same pay as the one with ten children. While the one with ten children would get greater assistance through commodities, health insurance, etc., he would get no extra money, thus eliminating one of the desires to have more children. To be really effective, however, mandatory abortions should be required on any mother becoming pregnant with her fourth child.

MASS PSYCHOLOGY

Two prime misconceptions play a commanding part in the feasibility of eliminating poverty and unemployment. These are (1) "The United States is the richest country in the World" and (2) "Why work unless you have a good job."

The facts are that the U.S. is hopelessly in debt and if the trend isn't reduced, will soon be unable to pay even the interest on the national debt. This statement, common among poverty pressure groups and politicians, gives the poor the false conception that the U.S. Government could put everyone on a government payroll at $10,000 per year and not miss the money. The second misconception of "Why Work unless you get a Good Job" is equally devastating.

Admittedly, the top 20 per cent have jobs with high pay and excellent working conditions but the majority still work extremely hard at low pay. Many a small business man, service station attendant, salesperson, etc., still work 50 to 60 hours per week under gruelling pressure.

When many welfare recipients try a job, find any pressure, they immediately quit as they feel they are being taken advantage of. Television is also largely responsible as they advertise affluence in a very subtle way. Most programs show a $50,000 home, with the man a lawyer, doctor, business executive, two cars, one a cadillac, another a sports car, a maid, etc. This gives the poor a wrong impression of the average man and helps develop a negative attitude of "Why work unless I get what they get".

In order to effectively right the wrong and tell it like it is, a mass education program must be instituted to again applaud the dignity of work based upon a just wage rather than riches.

REPUBLIC, WASH.

Senator WARREN G. MAGNUSON,
Senate Office Building,
Washington, D.C.

Strongly urge you to oppose Section 232 of H.R. 1, Social Security Amendment of 1971.

JAMES A. DAVIS,
President, Board of Trustees, Ferry County Memorial Hospital.

TACOMA, WASH.

Senator WARREN G. MAGNUSON,
Washington, D.C.

Tacoma General Hospital opposed to Section 232 of H.R. 1, the Social Security Amendments of 1971. Permission to State to define reasonable costs of hospitals under maternal and child health programs a great disadvantage to hospitals in Washington. Respectfully request careful consideration.

TACOMA GENERAL HOSPITAL,
W. L. HUBER,
Executive Vice President.

EPHRATA, WASH.

Senator WARREN G. MAGNUSON
Senate Office Building,
Washington, D.C.

McKay Memorial Hospital is vigorously opposed to section 232 of H.R. 1, proposed social security amendment permitting the State to define "reasonable cost" for reimbursement under Medicare would cause severe financial hardships to hospitals already under stress caused by the new restrictive rulings of F.D.P.A.

We urge you to assist this hospital and all hospitals in this State by working for deletion of section 232.

GERTRUDE M. PHILIPS,
Administrator, McKay Hospital, Soap Lake, Wash.

METALINE FALLS, WASH., *November 3, 1971.*

Hon. Senator WARREN G. MAGNUSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: The Commissioners of Public Hospital District No. 2 of Pend Oreille County and myself respectfully request that you oppose section 232 of H.R. 1, the Social Security Amendments of 1971.

Thank you for your assistance now and in the past.

Sincerely yours,

(MRS.) ROBERTA M. GARRETT, R.N.,
Administrator.

WENATCHEE, WASH.

Senator WARREN G. MAGNUSON,
Washington, D.C.

We would like to make known our opposition to section 232 of H.R. 1, the Social Security Amendment of 1971. Past experience provides a basis for reluctance to having such controls placed in the hands of the state authorities.

EYE AND EAR CLINIC INC., P.S.

LONGVIEW, WASH.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

I am opposed to section 232 of H.R. 1. This is a disastrous step backwards which will result in higher hospital costs.

Sister MARY KEOUGH,
Administrator, St. Johns Hospital.

SEATTLE, WASH.

Senator WARREN MAGNUSON,
Washington, D.C.

We urge you to oppose section 232 of H.R. 1, the Social Security amendments of 1971. Permitting the States to define "reasonable costs" for reimbursements to hospital would be very costly to the hospitals. An example is what the State of Washington is already doing with the past limit, deductibles and participation. The region 10 office of HEW assisted in having an unilateral decision by the State of Washington on May 1, 1971 reversed October 1, 1971 in regard to the Medicaid patients participation percentage.

We ask you to oppose section 232 of H.R. 1, social security amendments of 1971.

THE DOCTORS HOSPITAL, SEATTLE,
S. A. TUCKER, MD., *Director.*

TACOMA, WASH., *November 24, 1971.*

Hon. WARREN G. MAGNUSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I am writing you regarding H.R. 1 which is the Social Security Amendments Bill of 1971 and which includes one important change which is extremely distressing to all of the hospitals under the American Hospital Association, including Tacoma's leading hospital, Tacoma General Hospital, with which I have been connected for many years.

I believe it would be a great mistake to alter the present situation which assures hospitals that charges which are made for Medicaid will continue to follow and remain equal with the Medicare formula as I understand they do at the present time. The effect of Section 232 of H.R. 1 will be to eliminate the present standard for payment and leave it to the determination of each state as to what their interpretation of "reasonable costs" thereafter should be.

It is believed that such a change would undoubtedly mean that hospitals would receive inadequate reimbursement to cover their actual costs and needs.

Yours truly,

CORYDON WAGNER.

ISLAND HOSPITAL,
Aanacortes, Wash., November 17, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

MY DEAR SENATOR: I would like for you to know of our opposition to Section 232 of HR-1 of the Social Security Amendment of 1971.

To allow the states to define "reasonable costs" for reimbursement of hospitals under Medicaid and Maternal and Child Health Programs could work a hardship

on the hospitals of our nation. We do not make this statement lightly. The experience we have had in our own state leads us to this conclusion.

Sincerely,

RAY W. NIERMAN, *Controller.*

OVERLAKE MEMORIAL HOSPITAL,
Bellevue, Wash., November 11, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

SENATOR MAGNUSON: May I take this opportunity to express to you my opposition to Section 232 of HR 1, the Social Security Amendments of 1971. Section 232 would permit states to define "reasonable cost" for reimbursement of hospitals under Medicaid and Maternal and Child Health Programs.

It is a sad observation that passage of this Section would undoubtably mean reduced medical benefits to welfare patients. In view of the State of Washington's efforts to reduce its role in the maintenance of a welfare program in the face of increasingly difficult economic conditions and the fact that people whether employed or not require adequate health care, I urge you to oppose this measure.

Sincerely,

A. W. ARMSTRONG, *Business Office Manager.*

MOUNT CARMEL HOSPITAL,
Colville, Wash., November 12, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I strongly oppose Section 232 of H.R. 1, the Social Security Amendments of 1971.

Only a hospital can determine "reasonable cost." To allow a state to permit their own "reasonable cost" would be a disaster. A state would adjust its Public Assistance Budget to the point of reducing "reasonable cost" and, in effect, that would create higher cost to the hospital and to the taxpayer.

There are more than enough restrictions and regulations, not to mention all the new ones that will be effective January 1 ,1972.

I repeat, I oppose Section 232 of HR 1.

Sincerely,

JOHN C. BOYER, *Business Manager.*

DEACONESS HOSPITAL,
Spokane, Wash., November 15, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: After reading the proposals contained in Section 232 of H.R. 1, the Social Security Amendments Bill of 1971, as they pertain to the determination of "reasonable cost", I would like to tell you what I think about it.

In the event that this Amendment and Section were to pass, it would return the determination for establishment of a reimbursable program to the individual state welfare departments. The experience that we had here in the State of Washington was that less than 50% of the cost of hospital care of indigent persons was paid for under the program which existed prior to Medicaid. Under the Medicaid program, we are receiving approximately 80% of our cost, which while not entirely satisfactory, is certainly a great improvement over the old system.

With the increasing percentage of income received by hospitals coming from state and federal sources, it is evident that we cannot continue to operate on a break-even basis if we are to regress in the manner indicated above.

Anything you could do to see that Section 232 of H.R. 1 does not pass would be appreciated.

Sincerely yours,

HARRY C. WHEELER, *Administrator.*

ST. LUKES, GENERAL HOSPITAL,
Bellingham, Wash., November 17, 1971.

HON. WARREN G. MAGNUSON,
U.S. Senate Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: You are probably aware of the alarm with which the health care field views Section 232 of HR 1 which is now under consideration. I share this view and so do the members of our Board of Trustees and Medical Staff.

The reason is very simple. The states in the past have shown little regard for equity of payment to vendors of health services. This is not to say those opposing Section 232 feel they have a license to exploit the public, but there is no justification in not being paid recognized costs. The state of Washington has probably been as good as most but the Department of Public Assistance has traditionally totally disregarded vendor needs and seemingly have little sympathy for the fact that any underpayments by them must be paid for by other sick people.

I am confident that you are aware of the situation. I sincerely hope that you do not support giving the states a free hand in determining "reasonable costs" in this matter. The state has clearly demonstrated in the past that it could care less about the problems of the hospitals. When the rules were released from Washington on payment for Title XIX recipients the Department of Social and Health Services immediately took advantage of it in Olympia and this has been the pattern through the years. We plead for your support against this aspect of Section 232 in HR 1.

Sincerely yours,

JOHN W. KLUDT, *Administrator.*

ST. JOSEPH'S HOSPITAL,
Bellingham, Wash., November 12, 1971.

HON. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: This is to register a strong protest against Section 232 of H.R. 1, the Social Security Amendments of 1971. For each state to define "reasonable cost" for reimbursement of hospitals under Medicaid and Maternal and Child Health Programs would be unrealistic and unfair.

We urge you to vote against Section 232 of H.R. I and to do everything in your power to defeat it.

Sincerely yours,

Sister CATHERINE MCINNES,
Administrator.

TRI-STATE MEMORIAL HOSPITAL, INC.,
Clarkston, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I am writing to urge your outspoken opposition to Section 232 of H.R. 1. This Section appears to be a massive step backward if its intent is to refer back to the various states the prerogative of defining reasonable cost for reimbursement to hospitals caring for patients under the Medicaid Program.

Surely you are aware of Washington's long history of inequities to hospitals prior to the initiation of Titles XVIII and XIX when hospitals were at the mercy of budgetary leavings of the State Department of Public Assistance. Health care for the medically indigent has long been an unsuccessful dilemma when left to the discretion of the Welfare Departments of the separate state. Significant improvement in equality and standardization seemed apparent under the original concept of Title XIX. To pass the responsibility back to the states now is not the solution, it's the problem.

We respectfully and urgently urge you to strive for national uniformity in seeking a just solution to the problem of providing health care to the nation's economically disadvantaged.

Thank you for your consideration and efforts on this matter which is of prime importance, particularly to rural community hospitals.

Sincerely yours,

W. J. YEATS,
Administrator.

GRAYS HARBOR COMMUNITY HOSPITAL,
Aberdeen, Wash., November 2, 1971.

Hon. WARREN MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR: Your support is earnestly requested in opposing Section 232 of HR 1, relative to reimbursement of hospitals, under the Medicaid and Maternal and Child Health Programs.

Interpretation of certain provisions by local State authorities are becoming unreasonable and can only lead to additional complications. The term "reasonable cost", as provided in the bill at the present time, will have no limits, based on past experience.

Best regards,

PAUL BLOMQUIST, *Administrator.*

MARK E. REED MEMORIAL HOSPITAL, INC.,
McCleary, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I am writing to you in opposition to Section 232 of HR1 (Social Security Amendment of 1971). I am sure that you are aware that this section would permit states to define reasonable costs in reimbursement of hospitals under Medicaid and Maternal and Child Health Programs.

As president of the Southwest Washington Hospital Council, I speak for all our member hospitals in stating that our long experience has taught us that this section would be used to put hospitals in the position of subsidizing these programs. Hospitals have been "under fire" from all sides because of increasing costs, this type of legislation will make our position that much more difficult. Hospitals have demonstrated their ability to provide the high quality care expected by our patients, Government should demonstrate their ability to adequately fund the programs they legislate.

I hope I can rely on your support in opposing Section 232 of HR1.

Sincerely,

JOE HOPKINS, *Administrator.*

MCKAY MEMORIAL HOSPITAL,
Soap Lake, Wash., November 4, 1971.

Hon. RUSSELL D. LONG,
Senate Finance Committee,
Old Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: McKay Memorial Hospital strongly urges elimination of Section 232 of HR-1.

As a small non-profit hospital, operating on a cost to charges basis, we would be seriously hurt by the financial hardships that would result from giving Washington State Department of Public Assistance the freedom to put our services on a free schedule. What they choose to call "reasonable cost" would deal a staggering blow to our charge structure. The resulting "charity cases" would mean additional hospital costs charged to paying patients who are already burdened by high costs of hospitalization.

Hospitals cannot afford this restrictive legislation. Please come to our aid by deleting Section No. 232 before this bill goes to the Senate.

Sincerely,

GERTRUDE M. PHILPS, *Administrator.*

WILLAPA HARBOR HOSPITAL,
South Bend, Wash., November 2, 1971.

Hon. WARREN G. MAGNUSON,
U.S. Senator, Washington, D.C.

DEAR SENATOR MAGNUSON: Section 232 of H.R. 1, the Social Security Amendments bill of 1971 contains provisions harmful to hospitals. The section would permit states to determine "reasonable cost" under Medicaid and the Maternal and Child Health Programs.

All too often, "reasonable cost" to states means the amount of payment they choose to make rather than the real costs hospitals must incur in order to provide needy patients with good care. At South Bend and Ilwaco, Washington we provide care first and seek payment second. This policy is necessary to be sure no one comes to harm.

"Reasonable cost," defined at Olympia, begins with the theory that standards be established covering length of stay by diagnosis, deductibles, and participation payment by patients. These people would not be eligible for care if they had anything to pay with and each diagnosis is peculiar to the person to whom it is attached. Standards on length of stay ignore the individual in favor of the "average."

To sum up, if payment is allowed to be defined by states, it will likely be less than Medicare and private patients because states (State of Washington) have never used the opportunity to do otherwise.

Our small community hospitals are financially anemic now, but required to give complete service to all. Please consider this fact when you consider section 232 of H.R. 1, Social Security Amendments bill of 1971.

Yours truly,

GERALD W. BAKER, *Administrator.*

SEATTLE GENERAL HOSPITAL,
Seattle, Wash., November 3, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building, Washington, D.C.

DEAR SENATOR MAGNUSON: The Senate Finance Committee is about to consider HR-1, the Social Security Amendments Bill of 1971.

We wish to call your attention to Section 232 and ask that you seek its deletion from the bill.

The impact of Section 232, if enacted into law, is to permit state government to define the "reasonable cost" for reimbursement of hospitals providing service to Medicaid and Maternal and Child Health Programs. This release from the federal Medicare criteria for reimbursement is very apt to create a diminished payment practice to us for care of these patients. The problems of state finance are such that regulatory bodies will undoubtedly opt for less money to health care providers including hospitals. We are currently coping with this tactic as it relates to public assistance patients and a recent regulation establishing an arbitrary maximum period of hospitalization.

We ask that you support the present policy of requiring that Medicaid and Maternal Health and Infant care payment standards be equivalent to those applied under the Medicare reimbursement formula. Section 232 would eliminate this requirement.

Very truly yours,

PAUL S. BLISS, *Administrator.*

CASCADE VALLEY HOSPITAL,
Arlington, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: This hospital would appreciate a negative vote on Section 232 of HR 1, the Social Security Amendments of 1971. Experience indicates that the State of Washington will disadvantage district owned hospitals through the Medicaid system. It is our belief that local taxpayers are paying their fare share for health in the community and should not be burdened with an unfair Social Security amendment.

Sincerely

ALLEN K. REMINGTON, *Administrator.*

MEMORIAL HOSPITAL,
Odessa, Wash., November 3, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I am writing to express my strong objection to Section 232 of H.R. 1, the Social Security Amendments of 1971. The commissioners of this hospital district concur in this objection.

Hospitals in the State of Washington were forced to subsidize the State's program of medical care for indigent persons for many years. It was only with the advent of Federal intervention that we were finally to recover our actual *cost* on these programs. If these Federal requirements are removed, and the State is allowed to again determine "reasonable cost" it is certain that hospitals will again be forced to provide care at rates which bear no relationship to our cost of providing such care. The deficit between our cost and what we are paid by the State will then have to be added to the bill of the private patient instead of being equitably distributed among all tax payers in the State. The gross injustice of this situation is readily apparent.

I respectfully request that you favorably consider our position in this matter. Thank you.

Sincerely,

M. L. TRAYLOR, *Administrator.*

TRI-COUNTY HOSPITAL ASSOCIATION,
Deer Park, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: It has come to my attention that H.R. 1 in Section 232 would permit states to define "reasonable cost" for reimbursement to hospitals under Medicaid and Maternal and Child Health Programs.

I do not believe that individual states should have this authority and am opposed to Section 232.

I do not believe this to be in the best interest of patient, those who pay for the services or those rendering the services.

As long as the Federal Government is contributing to these programs they should assure the providers that the same guide lines are being used in establishing payments to all the providers.

Failure to do this will bring forth a multitude of provider reimbursement programs and I am sure in many cases will place an additional financial burden upon the privately paying patient.

We all know the providers have to have so much funds in order to stay in operation and to provide health care. This must come from those who use the providers facilities and if some do not carry their full share then others must carry more than their full share. Unfortunately this usually always ends up being the private pay patient.

Your efforts in providing fair and equable health care legislation is greatly appreciated.

Sincerely yours,

CHARLES L. LAMPSON, *Administrator.*

THE VALLEY MEMORIAL HOSPITAL,
Sunnyside, Wash., November 4, 1971.

Re HR 1.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR: As a concerned Administrator of a hospital I am writing to express my opposition to section 232 of HR 1 which will permit the State to set "reasonable costs" for care of Medicaid patients.

It is no secret that our legislature considers the payment of care for Medicaid patients to have one of the lesser priorities when it comes to budgeting and the result has always been insufficient funds to cover costs.

Title 19 changed this, in that it made the states use the same criteria as Title 18 in arriving at costs.

To allow the states to set their own criteria would again make care of the indigent a political football.

Don't take this step backward, don't let the purchaser of care also be the judge as to what will be paid. Rather let the Federal government retain this judgmental position. Vote to exclude this from HR 1 please.

Sincerely,

C. D. BENTLEY, *Administrator.*

YAKIMA VALLEY MEMORIAL HOSPITAL,
Yakima, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: We are writing to register the stronger possible opposition to Section 232 of HR 1. The Social Security Amendments of 1071. As you know, it has only been since the advent of Medicare and Medicaid that Washington hospitals have received reasonable cost for the care of indigent patients. We believe that the proposed amendment authorizing states to establish their own standards of payment for Medicaid patients' care would soon result in financial disaster to our hospital.

We respectfully recommend that the provisions under section 232 be deleted from the bill in question.

Thanking you for your consideration, I am

Sincerely yours,

MAX L. HUNT, *Administrator.*

PROVIDENCE HOSPITAL,
Everett, Wash., November 2, 1971.

Senator WARREN G. MAGNUSON,
U.S. Senate Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: Providence Hospital, Everett, Washington, is opposed to Section 232 of HR-1, the Social Security amendment of 1071, which permits the States to define "reasonable cost" for reimbursement under Medicaid.

Our past experience with the State Department of Public Assistance leads us to believe that Section 232 would work to our disadvantage.

Sincerely,

Sister LOUISE LEDEL, *Administrator.*

GENERAL HOSPITAL OF EVERETT,
Everett, Wash., November 3, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: Our hospital Board is most concerned with Section 232 of H.R. 1 in which it would permit each state to determine "reasonable cost" for reimbursement of hospitals under Medicaid and Maternal and Child Health Programs.

We have fared badly in dealing with the state in the past. Now they want to pay hospitals less than they are required to pay them under the Medicare formula.

Somewhere along the way a fair and equitable method of payment must be found. Section 232 of H.R. 1 *is not the answer.*

Your support is solicited and very much appreciated in the defeat of Section 232.

Sincerely,

STEPHEN C. SAUNDERS, *President, Board of Trustees.*

DAYTON GENERAL HOSPITAL.
Dayton, Wash., November 4, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: May we express our opposition to Sect. 232 of HR-1, the Social Security Amendments of 1971.

We understand Sect. 232 would allow the state to define "reasonable costs", for re-imbursements to hospitals for care provided patients under Medicaid and Maternal & Child Health Programs. Our experience up to 1967 and the passage of Title XIX in our state, indicates that arbitrary definitions of cost of care by our State Welfare Program was much below the cost of care. The hospital providing care of Welfare recipients did so in most cases, knowing that a financial deficit would result. There was no alternative, other than by State Legislative Action to re-coup these losses. With the advent of Medicaid, a more reasonable re-imbursement program was established. With the passing of Sect. 232, the Medicaid Program could revert to a re-imbursement program that would be impossible for hospitals in this state to live with.

We urge your opposition to Sect. 232 of HB-1.

Respectfully,

FRED SCHRECK, *Chairman of Board.*
CECIL MACKLIET, *Secretary.*

VIRGINIA MASON HOSPITAL.
Seattle, Wash., November 8, 1971.

Hon. WARREN G. MAGNUSON,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: We are very concerned with Section 232 of HR 1 which would provide the individual state with the authority to determine *reasonable costs* for care provided patients under Medicaid. Historically we have seen repeated instances where a state with financial problems will immediately trim expenses and benefits of programs such as Medicaid if given the opportunity to do so. This is inevitably accomplished at the expense of the providor of health care as well as the beneficiary.

We believe that failure to delete this section (Section 232) will significantly jeopardize hospital reimbursement programs. Further there is also a need to *standardize* reimbursement programs between states and this section of course moves in the opposite direction. For these reasons we would urge you to do everything possible to delete Section 232 from HR 1.

Sincerely,

AUSTIN ROSS, *Administrator.*

CENTRAL MEMORIAL HOSPITAL,
Toppenish, Wash., November 4, 1971.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

SIR: Please place Central Memorial Hospital and myself, as their administrator, on record as opposing Section 232 of HR 1, the Social Security Amendments of 1971.

Very truly yours,

CLARENCE M. PRITCHARD, *Administrator.*

WALLA WALLA GENERAL HOSPITAL,
Walla Walla, Wash., November 2, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: We wish to advise that we are definitely opposed to Section 232 of HR 1, regarding Social Security Amendments of 1071 and would appreciate your doing all in your power to defeat it.

From experience it appears that our good State of Washington will probably take advantage of Section 232 to the disadvantage of hospitals.

Thank you.

Sincerely yours,

J. A. DAILEY, *Administrator.*

HOLY FAMILY HOSPITAL,
Spokane, Wash., November 5, 1971.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: We would like to go on record as opposing Section 232 of HR 1, the Social Security Amendments of 1971.

As you know, this section permits states to define reasonable cost for reimbursement of hospitals under Medicaid and related programs.

We feel that in the State of Washington hospitals are already being subjected to unreasonable deductions as determined by the Department of Welfare. At a time when hospitals are being criticized for the high increase in costs, we feel that this would only accelerate charges to the patients.

We kindly request that you do what you can to delete this portion of the bill when it comes up for discussion and vote.

Sincerely yours,

Sister MARY AGNES, *O.P., Administrator.*
JAMES J. MURRAY, *Assistant Administrator/Fiscal Services.*

PUGET SOUND HOSPITAL,
Tacoma, Wash., November 8, 1971.

Re H.R. 1, Social Security Amendments of 1971.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: We would like to bring to your attention the serious implications of Section 232 of HR 1, the Social Security Amendments of 1971 and express how strongly we oppose this amendment.

Section 232 would permit states to determine "reasonable cost" under Medicaid and the Maternal and Child Health programs. Under this Section, standards for payment for these patients could be different from those for Medicare patients. Payments could not exceed the amount which would be allowed under the Medicare formula but could and probably would be less.

Prior to Medicaid, most states paid hospitals for care of the indigent on the basis of what was left in their budgets after all other budget needs had been met, and the amount rarely was sufficient to defray hospital costs. Only since the advent of Medicare and Medicaid have hospitals received payment for the reasonable cost of these services. Now the governors of the states have asked Congress to let them establish their own standards of payment for Medicaid patient care. They want to pay the hospitals less than they are required to pay them under the Medicare formula.

Some hospitals believe erroneously that they would fare as well with Medicaid reimbursement levels in the hands of the states; however, past programs prove the contrary. Medicare and Medicaid patients represent a substantial part of a hospital's patient load, and further restrictions on payments for the care of these patients might well affect the survival of many institutions. We feel that the provisions of Section 232 is a most serious challenge to the future of our hospital system.

We request that you recognize the seriousness of this problem and the possible effect of this amendment on our hospitals. We recommend that the provisions of Section 232 be deleted from the bill.

Yours truly,

ROBERT E. HUESERS, *Administrator.*

EVERGREEN GENERAL HOSPITAL,
Kirkland, Wash., November 4, 1971.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: Again I am writing you of my concern about legislation which would permit the states to define "reasonable cost" for hospital care under Medicaid and Maternal and Child Health programs. I refer to the proposed Section 232 of H.R. 1. I urge you to work for a change in this section to allow H.E.W. to make the definition.

Hospitals in Washington state know from long hard experience that "cost" to the Division of Public Assistance bears little relation to accepted accounting principles. I am sure you require no explanation of this system of inadequate appropriations and varying reimbursement formulae developed here in lieu of cost finding.

I will appreciate your help in improving this Medicaid legislation.

Cordially yours,

F. A. GRAY, *Administrator.*

ST. JOSEPH HOSPITAL,
Tacoma, Wash., November 10, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

MY DEAR SENATOR MAGNUSON: May I take this opportunity to express my concern over Section 232 of HR 1.

Experience tells me this is not the way to develop "reasonable costs" in this state. I solicit your vote in opposition to Section 232.

Please give it your serious consideration.

Very truly yours,

Sister MARGARET HUDON, *Administrator.*

GOOD SAMARITAN HOSPITAL AND REHABILITATION CENTER,
Puyallup, Wash., November 3, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: Since I understand that the Congress may adjourn this session by Thanksgiving and before that time will likely vote on the Social Security amendments of 1971 (H.R. 1), I would like to again mention the very real concern that I and my Board members have regarding Section 232 of this bill.

Section 232, as you no doubt know, deals with the definition of "reasonable cost" by the State for reimbursement purposes regarding Medicaid and Maternal and Child Health Programs. At the present time, the States have had to adhere to Medicare standards insofar as determination of reasonable costs go. In Washington, we are sure that passage of Section 232 would mean the State would set a reasonable cost level well below that of Medicare particularly in view of the State's financial problems. This would be an extremely deplorable situation for our hospital financially. Medicare does not reimburse us in full—they discount the bill by 10–20% and this means the private patients get stuck paying the difference for both Medicare and Medicaid patients—if a hospital served no one other than Medicare patients, they would be financially insolvent. If the State was allowed, as it would be in Section 232, to set reasonable costs at amounts still lower than Medicare, the hospitals would have no recourse but to continue passing the cost of these exorbitant discounts on to their private patients, and we feel the private patient is already picking up too large a burden. Another unfortunate result, if the hospitals are forced to absorb further costs of care, would be that two levels of standards of care might eventually exist, one for the non-Medicaid patient and another for the Medicaid patient. This would not be to the liking of the patients, the Government, or the hospitals.

We urge you to do what you can to have Section 232 deleted from H.R. 1.

Sincerely,

DAVID K. HAMBY, *Administrator.*

OKANOGAN-DOUGLAS COUNTY HOSPITAL,
Brewster, Wash., November 9, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I respectfully request your review of Section 232 of H.R. 1 of the Social Security Amendments of 1971.

This section appears to permit states to define "reasonable costs" for reimbursements to hospitals under Medicaid and Maternal and Child Health Programs.

This hospital, as well as others in our State, does not feel that the state has been reasonable in the defining of care and/or handling of funds under present programs, without being given further jurisdiction, with appropriated funds.

Your opposition to Section 232 will be gratefully appreciated by this Hospital District and its patrons.

Respectfully yours,

HOWARD M. GAMBLE, *Administrator.*

COULEE GENERAL HOSPITAL,
Grand Coulee, Wash., November 1, 1971.

Senator WARREN G. MAGNUSON,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MAGNUSON: The subject is Section 232 of H.R. 1, Social Security Amendments Bill of 1971.

Please do all possible to eliminate Section 232 and its intent. Allowing the various states to determine "reasonable cost" would be disasterous to the financial condition of all hospitals.

Enactment of Section 232 would indeed harm the Coulee General Hospital.

We are now—and when I say we I mean the Coulee General Hospital and the surrounding hospitals that I know of in eastern Washington—are seriously harmed by the arbitrary and capricious manner in which the Division of Public Assistance of the Department of Social and Health Sciences renders a final decision as to what we will be paid for skilled nursing care patients under the Welfare program. We at Coulee General Hospital, in fact, are losing $4.00 a day on the care of each and every medically indigent case. This is a very good example of what Section 232 would do to us in the acute care hospital phase of patient care.

Sincerely,

DELOS J. BRISTOR, *Hospital Administrator.*

WASHINGTON STATE HOSPITAL ASSOCIATION,
Seattle, Wash., November 1, 1971.

Hon. WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR: I am writing concerning Section 232 of H.R. 1, Social Security Amendments Bill of 1971, now before the Senate Finance Committee.

This section would permit states to determine "reasonable cost" under Medicaid and the Maternal and Child Health Programs for reimbursement of ho-pitals. Under this section, standards for payment for these patients could be different from those for Medicare patients; payment could not exceed the amount which would be allowed under the Medicare formula, but *could*—and almost surely would—be less.

Hospitals are seriously concerned about their future, if such a program is authorized by the Congress.

As you know, before Medicaid, most states paid hospitals on the basis of what was left in their budgets after all other needs had been met and the amount was insufficient to defray hospital costs. Medicare and Medicaid brought the payment of reasonable costs for the care patients being cared for under these programs.

Now, with state government finances at a low ebb, governors are asking Congress to permit them to establish their own standards of payment. It is clear

that they want to pay less for Medicaid patients than they are required to pay for patients under the Medicare program.

If Section 232 remains in the bill it will mark a long step backward.

Hospitals have a very real fear that, if payments are reduced, the survival of voluntary hospitals may be at stake. Hospitals simply cannot carry the financial load for welfare health care programs.

The hospitals of the state will be most appreciative if you will do all within your power to amend H.R. 1, as it is now written, to delete Section 232 and to insure that hospitals continue to receive reasonable payment—as determined at the national level and not at the state level.

Sincerely,

JOHN BIGELOW, *Executive Vice President.*

STEVENS MEMORIAL HOSPITAL,
Edmonds, Wash., November 2, 1971.

Hon. WARREN G. MAGNUSON,
U.S. Senator,
Washington, D.C.

DEAR SENATOR MAGNUSON: It has been brought to my attention that the states are attempting to amend H.R. 1 of Social Security Amendment Bill of 1971, Section 232, in such a way that it would permit the states to determine what is reasonable cost under Medicaid in the Maternal and Child Health Programs.

This Section's standards for payment for these patients could be different from those for Medicare patients. Payments could not exceed the amount that would be allowed for the Medicare formula and probably would be less.

Hospitals for many years have suffered from the arbitrary decisions made by the individual states as to the reimbursement for the medical care those patients who seek the state's aid in caring for their medical needs.

In this time of criticisms of hospitals and their charges, the revised reimbursement under Section 232 of H.R. 1 would give the public an indication that perhaps hospitals are really charging more than is absolutely necessary.

I, for one, representing a hospital district here in your legislative district would say that throughout each and every year, the hospitals walk a very fine line between breaking even and losing money. As you know, hospitals have no other source to look to other than patient charges for funds to continue services much needed by the many communities.

It would seem a bit regressive then, to allow states to cut the payment to the hospitals and base theirs on a different formula than that of the present formula required under the Medicare law of 1966.

I would appreciate it very much if you would lend your support to the hospitals' argument that change under Section 232 of H.R. 1 not be allowed.

Thank you for your interest and consideration.

Sincerely,

JON D. SMILEY, *Administrator.*

ST. HELEN HOSPITAL,
Chehalis, Wash., November 2, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: Section 232 of HR 1, now in the Senate Finance Committee, is very bad for Washington hospitals. Past experience has proven that if the level of payment for the care of indigent patients is left to the determination of Washington State, hospitals will not be paid even their reasonable costs. When the state does not pay its fair share, as was consistently the case before the passage of the Medicare Law, hospitals have no recourse except to pass on this deficit to private patients.

If Section 232 passes, it will be a disastrous step backwards for our hospitals. I earnestly urge you to use your influence to defeat Section 232 of HR 1.

Sincerely yours,

SISTER VIRGINIA PEARSON, *Administrator.*

MEMORIAL HOSPITAL, INC.,
Pullman, Wash., November 2, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: We ask that you take a position to oppose Section 232 of HR 1, the Social Security Amendments of 1971. Section 232 would permit states to define "reasonable cost" for reimbursement of hospitals under Medicaid and Maternal and Child Health Programs. The disadvantage to the individual hospitals are many because of the inconsistency of many of the states in their definition to "reasonable cost".

As you know, hospitals have been in a quandary as to the multitude of cost reimbursement programs established over the past several years. In my opinion, this would be another step in complicating the forms of reimbursement and would without question allow the states an addtional arbitrary tool to use in determining, not by law but by self-determination, what is or is not a "reasonable cost".

Sincerely,

ELMER O. EID, *Administrator.*

THE RIVERTON HOSPITAL,
Seattle, Wash., November 2, 1971.

Senator WARREN G. MAGNUSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR MAGNUSON: I would like to go on record as being opposed to Section 232 of HR 1, the Social Security Amendments of 1971.

Section 232 would permit states to define "reasonable cost" for reimbursement to hospitals under Medicaid and Maternal and Child Health Programs.

This approach has proved very unsatisfactory in the past in the State of Washington and we urge you to use every effort to see that Section 232 of HR 1 does not pass.

Sincerely,

ROBERT A. HANSON, *Administrator.*

STATEMENT OF LEON J. DAVIS, PRESIDENT, NATIONAL UNION OF HOSPITAL AND NURSING HOME EMPLOYEES, RWDSU, AFL–CIO

February 10, 1972.

To: Hearings on Social Security Amendments—H.R. 1.

COMMITTEE ON FINANCE,
U.S. SENATE,

1. ORGANIZATION AND MEMBERSHIP

I am Leon J. Davis, President of the National Union of Hospital and Nursing Home Employees, RWDSU, AFL–CIO, and President of the union's largest local, Local 1199 in New York City. Our union represents over 70,000 hospital workers in ten states. The greatest concentrations of members are in New York City, Connecticut, New Jersey, Baltimore, Philadelphia and Charleston, South Carolina. The union represents many different categories of hospital workers including service and maintenance workers, clerical workers, technical workers, and certain professionals such as psychologists, social workers, and licensed practical nurses. We also represent 6,000 pharmacists and drug store workers. We do not represent physicians or administrative personnel.

Local 1199 in New York City is the oldest and largest local of the National Union. It has collective bargaining agreements covering workers in more than forty voluntary (private, nonprofit) hospitals in New York City. These hospitals comprise about two-thirds of the city's voluntary hospital beds. They include a wide variety of hospitals, including community hospitals in both middle-class and ghetto neighborhoods, teaching hospitals and medical school hospital centers.

2. EVALUATION OF HEALTH RELATED PROVISIONS OF SOCIAL SECURITY AMENDMENTS

We oppose the way in which the social security amendments are being reviewed by Congress. Our opposition is based upon the patchquilt approach to solving our nation's enormous and complex social problem. We feel that each title of this kaleidoscope bill should be introduced ; separate legislation. This would enable public testimony and congressional review to scrutinize each bill on its own merits. The importance of needed social welfare reform warrants individual and close attention. The final product should not be compromised.

As a health union, we will limit our remarks to the strengths and weaknesses of the medicare and medicaid provisions of title II.

(*A*) *Medicare*

1. Extended Eligibility.—Health Insurance under Title XVIII, would be extended to those receiving disability benefits for two years, and hospital insurance would be offered to the uninsured for payment of full premium costs (initially estimated at $31 monthly). This measure would aid the 1.5 million long term disabled, and allow the 350 thousand uninsured over 65 to voluntarily purchase hospital insurance. The latter raises some skepticism since the premium cost would be prohibitive to the majority of the uninsured.

Extending coverage to the disabled is certainly a step in the right direction. However, we are opposed to the two-year waiting period before becoming eligible for Medicare benefits.

Instead, we would favor a six-month waiting period, which would coincide with the six-month waiting period for disability payments under Social Security.

Medicare was originally intended to serve the elderly who have chronic diseases requiring long term care, as would be the case with the disabled, who require long term rehabilitation services. Yet services under Medicare, as aptly pointed out by Dr. Paul Speur of the Physicians Forum, would best fit the needs of a healthy under 65 adult population, not those for whom the program was intended. This deficiency is totally ignored by H.R. 1.

2. Part "B" (Medical) Premiums and Eligibility.—Supplementary Medical Insurance (SMI) premium increases would be tied in directly with increases in Social Security. Considering that SMI premiums having increased 87% in the past five years, totally disproportionate to the meager increases in Social Security, this is a positive feature of H.R. 1.

Another positive feature is that H.R. 1 would automatically enroll beneficiaries into SMI. Up to now, many of those eligible, were not aware, or did not see the importance of subscribing to SMI. This would also have the advantage of eliminating the penalties imposed on those subscribers who do not enroll in SMI during the specified time period.

3. Deductibles and Co-payments and Cut-offs.—H.R. 1 would increase SMI deductibles from $50.00 to $60.00. But even more cruel to those on fixed incomes would be the increased hospitalization co-payments.

Present law provides for full in-patient hospital coverage (minus an initial $68.00 deductible) for 60 days. H.R. 1 reduces this to 30 days, after which the patient would pay according to the following schedule.

31st thru 60th day	$7.50
61st thru 90th day	15.00
Additional "lifetime reserve" 120 days	30.00

These additional economic barriers to medical care would be most burdensome to the most poor among the disabled and the elderly. It is our view that all deductibles and co-payments should be eliminated.

The only positive feature of this section is that the number of lifetime reserve days would be increased from 60–120 days.

4. H.R. 1 Eliminates the Requirements that Extended Care Facilities Provide Social Services.—And that a skilled nursing home have at least one full time registered nurse. These provisions serve to downgrade the quality of medical care and ignore the loneliness and despair of those confined to these institutions.

(*B*) *Medicaid*

1. Reduction of Services and Scope of Medicaid (Title XIX).—Presently medicaid has a "maintenance of effort" clause, which requires that a state maintain its aggregate expenditures to its share of Medicaid costs. Under H.R. 1.

this would apply only to the six mandatory health care services (in-patient hospital services; out-patient hospital services; x-ray and lab; skilled nursing homes; physicians' services; and home health services).

States would now be permitted to reduce or eliminate "optional" services, such as medication, dental care, eye glasses, etc.

Presently, under section 1903(E) of title 19, States are required to demonstrate they are making efforts in the direction of liberalizing eligibility requirements, and in broadening the scope of services in Medicaid. H.R. 1 repeals this requirement, thus legalizing the tragic cutbacks in services, and the narrowing of eligibility that has already taken place in New York and other states.

In addition, H.R. 1 reimbursement revisions would reduce payments by one-third to skilled nursing homes and General or TB hospitals after the first sixty days, and mental hospitals after ninety days. We see no justification for this provision.

2. Deductibles and Co-payments.—H.R. 1 would require states to collect premium payments graduated by income, from the medically indigent who are not receiving public assistance. In addition, states are permitted to impose deductibles and co-payments, *not* skewed to income.

For those receiving public assistance, states would be permitted to charge a co-payment and/or deductible for optional services (drugs, hearing aids, etc.). For basic coverage, public assistance families with earnings would be required to pay a deductible based upon income.

Once again, we see the use of coinsurance and deductibles as a means of restricting access to needed health care. Even as a devise to reduce program costs, cost-sharing features have proven to be ineffective. This was recently documented in hearings conducted by New York State Assemblyman Peter Berle. These hearings, which were designed to measure the efficacy of a recent New York State law that imposed a 20% coinsurance on Medicaid recipients, revealed that it was more costly to collect the 20%. Because collection was administratively impractical, many doctors and hospitals waive the co-payment charge.

3. Eligibility.—Present law requires a state to provide Medicaid to all public assistance recipients. With the inclusion of the welfare reform measure (FAP) in this bill, the state would be required to cover only those whose income falls below state income limits. It is our belief that states should not determine levels of eligibility. Some states, such as Alaska and Arizona, to this day, do not provide a medical aid program for the poor. The disparity in Title XIX benefits from state to state can be largely reduced if full financial responsibility was assumed at the federal level, with the program administered on a regional basis.

* * * * * * *

Both Medicaid and Medicare in H.R. 1 include numerous provisions aimed at controlling costs and experimentation with physician peer review. Of particular note is the Health Maintenance Organization (HMO) option provided for recipients of Medicaid and Medicare benefits. An HMO is generally conceived as some form of comprehensive pre-paid group practice. However, the definition of HMO is vague, as defined by HEW. It really does not have to be comprehensive, nor does it have to be a group, nor does reimbursement have to be on a capitation basis. Nonetheless, it has the potential of improving the delivery of health care, and it does begin to explore reimbursement methods other than the costly "reasonable" and "customary", fee-for-service system. Alternatives to the costly "reasonable" and "customary" fee-for-service system must be found. In New York we have observed the ease in which physicians increase their reimbursement profiles by simply requesting an increase from Blue Shield. If capitation payments are not used, physicians should be reimbursed on an established schedule basis. For example, relative value scales have been used with some success in California and New York.

3. CONCLUSION

Improvements in the availability and access to health care to the elderly and the poor are far and few between in H.R. 1. The Medicaid and Medicare section is a step backward that would reduce health services and increase deductibles and co-payments for those who can least afford it, and in Medicaid, eligibility would be tightened.

H.R. 1 emphasizes prudent fiscal management, but demonstrates lack of sensitivity to the health needs of the medically indigent. This measure will prevent the poor and the elderly from receiving adequate medical care. Also, decreased federal participation will place a heavy burden on already strained

budgets. If passed, H.R. 1 will only exacerbate our present health care crisis by using the same categorical programs that would continue to fragment the American people into different health classes with different health benefits.

4. RECOMMENDATION

In the 1966 Comprehensive Health Planning Act, Congress articulated the principle "that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person" and the commitment "to assure comprehensive health services of high quality for every person". Six years later, we still have not been able to fulfill this promise.

For many years, the 1,500 members of the Retired Members Division of our union has criticized the inadequacies of Medicare and Medicaid, and has called for a universal and comprehensive health plan for all. And just last month, the White House Conference on Aging called for "priority consideration" for Congressional passage of a "comprehensive national health security program which would include the aged as well as the rest of the population." The fact is, that Medicare and Medicaid, with or without the amendments being considered by this committee, falls woefully short of these goals.

The following is a "Statement of Principles on Health Care", which was submitted by the Local 1199 Executive Council, and the Local 1199 Health Care Committee to 300 participants attending our Annual Health Care Conference last June. The statement was unanimously adopted, and in closing, I would like to submit it for your consideration.

"We need a national policy committed to the principal that every American is entitled—as a matter of right—to the best health care that our nation's skill and technology can command. We need a delivery system that assures the availability of health services to all citizens.

Such a system must include:

A. Universal and Comprehensive Coverage.—Health care must be a matter of right, not privilege. *There must be one system for all.* Everyone must be entitled to care regardless of race, income, sex, age, religion, or any of the barriers that now create inequalities. Comprehensive care should include doctors, hospitals, medication, dental care, mental health care, nursing home and convalescent care and home health services. These services and facilities should be used to emphasize health maintenance, and prevent illness as well as to treat sickness.

B. Equitable Financing.—Health care should be removed from the profit-making arena and financed by the federal government from general revenues.

C. Sound Organization.—To develop a national system for the delivery of health care it is necessary to:

1. Create an organized service in which the providers of medical care work together with government and the community for common objectives.
2. Establish neighborhood medical facilities and community medical centers easily accessible to the people they serve and controlled by duly elected community boards.
3. Encourage the development of comprehensive group medical and dental practice with effective consumer participation.
4. Finance a recruitment and training program to meet health manpower needs and support medical and health research requirements.

We realize that the problem of the nation's health goes beyond what can be done to improve the delivery of medical care. To assure good health also means to provide decent food and housing, clean air and pure water.

We believe that our nation has the material and human resources required to fulfill these essential objectives. We believe that a national health budget must be adopted that makes the delivery of health care a matter of top priority.

VANCOUVER, WASH., *February 1, 1972.*

Hon. WILBER D. MILLS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

DEAR REPRESENTATIVE MILLS: I would like to voice my support for your bill HR 1 and especially for Senator Ribicoff's amendment pertaining to it which extends benefits to single and childless people as well.

In this day and age it seems quite impractical to continue governmental support through taxation subsidation of large families and financial penalty from refraining from them. It would seem much more equitable to encourage smaller families or at least to extend no advantage to families with larger families. It seems, in fact, that a reward should be in order for having less children and a progressive penalty be instituted for having more children.

We must move toward stabilization of our population in order to preserve the remaining resources this country possesses. If we do not anticipate the problems of providing for a geometrically accelerating population we may soon have few resources with which to support them with. This would result in a durastic decline in the quality of life we can provide each citizen.

I would appreciate inclusion of this letter in the record now under review by the Senate Finance Committee.

Sincerely,

STEVE HOLMAN.

STATEMENT PREPARED BY STATE REPRESENTATIVE ARTHUR L. BUCK, WYOMING, NATIONAL LEGISLATIVE CONFERENCE TASK FORCE ON HUMAN RESOURCES

ENACTMENT OF H.R. 1

It is the consensus that it might be better to defer enactment until pilot programs in a few states, both sparsely and heavily populated, to determine merits of the program before adoption nationally.

There was general concurrence with the statement of objectives for true welfare reform outlined by Chairman Russell Long:

1. It must discourage family breakup and foster family unity;
2. It must prevent cheating and dishonesty and when this fails, detect it and deal firmly with it;
3. It must reward efforts at self-help rather than rewarding idleness among the employable; and
4. It must provide adequate child care services for children of low-income working mothers and mothers on welfare.

Since there is considerable variation among the states in welfare volume and extent of services, some latitude should be left to the several states in administration of the program. (Only 3% of Wyoming's population, approximately 8,000 persons, are on welfare.)

NATIONAL MINIMUM INCOME STANDARDS

In view of inflationary developments, there is an obvious need for upward adjustment, at least to the level of that proposed in H.R. 1. (Wyoming presently allows $104 monthly for individuals and $178 for couples.)

FISCAL RELIEF OF FISCAL PROTECTION FOR STATES

States should have federal relief in the proposed program of national coverage in deference to the new residence requirement as determined by the courts. At least the states should have no additional liability.

FINANCIAL INCENTIVES TO WORK, OR INCOME DISREGARDS

Incentives should be retained. (The first $30 and one-third of additional income are permitted in Wyoming.)

WORK REQUIREMENTS AND SUITABILITY OF WORK

Should be determined by the individual state, depending on nature of relief rolls and availability of opportunity. (In Wyoming, opportunity is limited, both in the private and public sector. Retraining, also expensive, is essential in many cases.)

FEDERAL-STATE ADMINISTRATIVE RESPONSIBILITIES AND OPTIONS

Federal Regulations as a rule are not flexible enough to meet requirements of individual states. (Wyoming has no large urban areas which may be eligible for impact programs.)

DAY CARE AND CHILD DEVELOPMENT SERVICES

Is needed at low income level when pay of parent does not compensate for cost of child's day care which in many cases is inadequate and not socially to best interest of the child. (Child care centers in Wyoming at present are inadequately regulated.)

WELFARE ADMINISTRATIVE PROCEDURES

Procedures should be implemented by, in addition to interview, validation of statements involving checking with various federal social security and tax information sources.

In addition, a deserting parent would be obligated to the United States for the amount of any federal payment made to his family less any amount that he actually contributes by court order or otherwise to his family.

STATE ROLE IN ADMINISTERING MANPOWER, CHILD CARE AND SUPPORTIVE SERVICES IN THE OPPORTUNITIES FOR FAMILIES PROGRAM FOR EMPLOYABLE RECIPIENTS

Administration should be left to the states without the involvement of the Labor Department. Local agencies are more familiar with recipient needs in relation to actual working conditions and pay scales. (Employment is frequently limited to a short work week so that the employee does not qualify under existing statutes.)

STATE ADMINISTERED SOCIAL SERVICES

The concept of an "open-ended" appropriation should be restored, eliminating the ceilings as provided in H.R. 1.

DEPARTMENT OF HEALTH AND HOSPITALS,
Boston, Mass., February 1, 1972.

Hon. GAYLORD NELSON,
U.S. Senate,
Washington, D.C.

DEAR SENATOR NELSON: I would like to go on record in support of S. 2135, a bill to amend Title V of the Social Security Act concerning special project grants, introduced June 23, 1971.

As Director of Maternal and Child Health in the City of Boston Department of Health and Hospitals, I have intimate knowledge of the importance of these projects to the health of the poor children and mothers in Boston. The deleterious effect on their medical care that they would suffer if the projects were to be phased out or substantially reduced in scope before adequate replacement mechanisms were actually functioning would be irrevocable.

There are five Maternity and Infant Care Projects in Boston. They are operated in conjunction with five hospitals which together account for about 90 percent of the deliveries in this city. During the fiscal year ending June 30, 1971, the projects provided more than 12,000 prenatal visits to 1,869 women living in low income neighborhoods of the city. This is 17 percent of all of the women who had babies during that year.

Boston City Hospital is the major health provider to the poor of this City. The Department of Health and Hospitals is the grantee for funds which enable it to operate Maternity and Infant Care satellite units in three locations, with Boston City Hospital as their back-up. In 1971 (calendar year) there were 1,223 women who received their care in these three units; they accounted for slightly more than half of all deliveries at City Hospital. It is noteworthy that the provisional figure for the infant mortality rate in Boston in 1970 is 21.7 deaths per 1,000 live births, a 14 percent drop from the rate for the three year period, prior to the establishment of these projects. We expect the rate in 1971 will be even lower. Not only is prenatal care reaching a substantial number of the poor women in Boston within the neighborhoods where they live, but also the care they are receiving is having a salutary effect on the infant mortality rate.

It is more difficult to find objectives, statistical evidence of the impact of the Children and Youth Projects. We have not performed the analyses done elsewhere which document deductions in hospitalization rates, increased immuniza-

tion levels, and improvements in other parameters of child health. However, there is no reason to think that our experience will be any different from those that have been studied and reported. Children and Youth Projects in Boston are operated by four grantees with funds that come through the State Department of Public Health and a fifth with funds that come to the grantee (Massachusetts General Hospital) directly from the Maternal and Child Health Service in Washington. At the end of fiscal 1971, there were more than 22,000 children registered in the Projects operated by the first four above. These are all in facilities located in poverty areas of the City. We have evidence that more than 80 percent of the registrants in a center live within a mile of it. Children who previously had only episodic care, for which they had to travel long distances and wait in hospital clinics and emergency rooms, are now being reached with comprehensive ambulatory medical care in their own neighborhoods.

The acceptance of these services by the populations to whom it is directed may be typified by the experience of the Harvard Street Neighborhood Health Center which is operated by the Department of Health and Hospitals with Boston City Hospital as the back-up. This facility was seeing about 880 children per month in the first part of 1970. By the end of 1971 it was seeing 1,100 children per month, an increase of 25 percent and one which was stretching the capacity of the physical plant.

Many of our Title V Project facilities in Boston are working with some of the newer methods of delivering primary care in the neighborhoods. Nurse midwives, nurse practitioners, para-professional outreach workers, screening technicians, team medicine, problem-oriented record, are in evidence at one or another of the health centers funded under this legislation. Thus, while delivering good care to children who would not otherwise receive it, these projects are testing ways to improve the product and make limited resources stretch further without impairing quality.

Finally, I would like to emphasize the importance of a full five year extension of the authorization for these projects. One of the prime reasons for their success has been our ability to recruit interested, highly qualified personnel to staff them. While there has been some turnover in the staff, it has been less than in other programs serving similar populations, and there was no difficulty in finding replacements. The uncertainty surrounding the future of these projects, however, has impaired our recent recruitment efforts. To extend them for one year or even two will not improve the situation. I do not expect the Maternity and Infant Care or Children and Youth Projects to continue indefinitely. However, I am firmly convinced that a five year extension of the authorization will enable us to retain, or recruit anew, the qualified personnel that will be necessary to operate these programs. This extension could also help us plan for the successful integration of these programs into whatever total health program emerges from the deliberations of the Congress and is implemented nationally over the next few years.

Sincerely yours,

ROWLAND L. MINDLIN, M.D.,
Director, Maternal and Child Health.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS STATEMENT OF POLICY ON NATIONAL HEALTH INSURANCE PLANS, SUBMITTED BY JOHN J. SOLLEY, D.D.S. PRESIDENT

The Executive Committee of the Association, representing 90 institutional members and more than 1500 individual members, strongly endorses the principle that total health care, including dental care, should be made available to all the citizens of the United States, without regard to economic status. The Association is prepared to support any national health insurance plan which may be developed, provided that it represents a serious and realistic attempt to improve and expand the present systems of health care delivery among all health professions, including the dental profession.

The Association believes that an over-riding goal of any national health insurance plan should be to provide a single standard, quality health care service for all citizens and, to do so, any proposal should encompass the following principles:

1. Health care should be available to all, regardless of ability to pay.

2. Dental care—particularly preventive care—should be included as an integral part of total health care.

3. Qualified health professionals and health professions' educators should retain responsibility for program design and management and peer review procedures should be used to ensure that high standards of quality care will be enforced.

4. Consumer participation should be encouraged to develop and evaluate approaches to improve health care services at the community level. Consumer participation should also be encouraged in the decision-making for the design and governance of the delivery system.

5. Initial emphasis should be placed on providing total care for people who cannot afford or who do not now have ready access to health care facilities and services.

6. The existing system of health care delivery, whenever possible and appropriate, should be utilized; however, and concurrently, funds should be identified to develop new and improved delivery systems.

7. The health delivery systems should be structured to provide support to maintain and expand the supply of health professions' and allied health professions' manpower.

8. Evaluation and review procedures should be clearly stated and described to ensure maximum flexibility and effectiveness.

9. The intra- and extra-mural facilities of health professions' schools should be accorded vendor status to provide care and services for specific sections of the population.

10. Professionals and allied health professionals employed by schools of the health professions should be utilized in the development of new health care systems.

The Executive Committee has approved the foregoing principles which it believes will meet with the approval of its members and recommends that they constitute the basis for the Association to comment and react to any present and future proposals.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and members of the Committee: the American Optometric Association appreciates this opportunity to present its views of health care aspects of H.R. 1, the legislation before you to amend various Titles of the Social Security Act and further improve services to beneficiaries.

The American Optometric Association is a federation of optometric associations and societies in the fifty States and the District of Columbia, whose combined membership totals 17,221 individuals. There are 20,100 optometrists licensed in the Nation today, located in more than 5,400 cities and towns of all sizes.

Ready access to professional vision care from a practitioner selected by the Medicare or Medicaid beneficiary is a matter of great concern to the American Optometric Association. Those eligible to receive health care benefits under Part B of the Medicare (Title XVIII) program are now, in effect, denied this freedom of choice as well as comprehensive vision care services. In similar fashion, those who are eligible to receive benefits under the present Medicaid (Title XIX) program and others who might qualify for services upon enactment of the proposed Title XX (Federal Aid to the Aged, Blind, and Disabled) should also be assured of their right to select either a physician or an optometrist for the visual care allowable under the Titles of the Act.

The American Optometric Association believes that H.R. 1 as passed by the House of Representatives represents good legislation which will substantially improve the availability, quality, and delivery of health care services to beneficiaries. especially under programs authorized by Titles XVIII and XIX, as well as the new Title XX.

COMPREHENSIVE VISION SERVICES UNDER MEDICARE

Just as we have in each Congress since the present Medicare program was first considered, this organization supports the concept of providing a complete range of comprehensive visual care for Medicare beneficiaries, including eye examinations at regular intervals and, when financing permits, the provision

of corrective lenses or other services necessary to restore, preserve, or enhance the functional vision of Medicare beneficiaries. We still support and recommend adoption of a comprehensive vision care program of this type; however, until such time as the Congress finds such a plan economically feasible, we believe every possible means should be used to provide our elderly citizens with the most convenient access to all licensed practitioners for allowable services under the Title XVIII program.

SUPPORT FOR AMENDMENT OF SECTION 1861 (R), TITLE XVIII

While this statement is in support of the amendments contained in H.R. 1, certain aspects of the legislation are of concern to our membership.

From the inception of the Medicare program in 1965, beneficiaries who required visual care have been denied convenient access to the services of optometrists. It is our belief that exclusion of the services of optometrists was an oversight in the original legislation, which has been further compounded by administrative interpretation inconsistent with the intent of Congress.

When Medicare amendments were considered in 1967, and again in 1969, this Committee recognized the need to eleminate the serious inequity fostered by language of the law which required a beneficiary to seek the services of a physician rather than obtaining such services from an optometrist—even if the visual needs of the beneficiary had been met by an optometrist for many years.

On both occasions, the Senate Finance Committee approved an amendment to Section 1861(r) to include an optometrist in the definition of "physician" for purposes of Title XVIII. This amendment did not survive Conference. Therefore, the problems of unnecessary expense, inconvenience, and inequity are still present under Title XVIII today, with respect to the availability of covered eye care services for Medicare beneficiaries.

During the first session of the 92nd Congress, when the House Ways and Means Committee reconsidered the proposed amendment to Section 1861(r), the Committee members recommended its adoption. The amendment was subsequently passed by the House in its final action on H.R. 1 which is before you today.

We believe the Ways and Means Committee is to be commended for its action, which was fully in keeping with its previous posture stated in House Report 91-1096, which stated: ". . . the Medicare provisions as related to optometrists may need revision in that some optometric services when provided by a physician are covered, but may not be covered when provided by an optometrist."

Language of the House-passed bill, H.R. 1, is similar to language approved by your Committee in the 90th Congress and identical to language approved by this Committee and subsequently passed by the full Senate in the 91st Congress. Its intent and potential effects are clear: that is, any Medicare beneficiary who prefers to consult his or her own optometrist for purposes of obtaining covered services may do so.

The American Optometric Association urges Committee approval of the language passed by the House in the bill before you today.

TITLE XIX RECIPIENTS MAY BE DENIED OPTOMETRIC SERVICES

Under present language contained in Title XIX, it is not only possible, but a provable fact that in States whose Medicaid programs specifically provide for eye care, physicians can be and are being paid for the same services optometrists are qualified and licensed in that State to perform.

This is patently unfair to the Medicaid beneficiaries whose visual needs may be left unattended and from the viewpoint of America's optometrists, the situation is equally undesirable and inequitable.

In his comments on the floor in 1969 when the Senate considered and passed the "Anderson Amendment," Chairman Long made it clear that the Finance Committee's intent was to assure that if a State Medicaid program provided for eye care that an optometrist is licensed to perform, the State Medicaid program must also allow an optometrist to render and be paid for those same services.

We believe the Committee approach to this particular situation, as delineated by Senator Long, is entirely proper, justifiable, and equitable. However, past experience has shown that unless specific language is included in the appropriate Section or Sections of the Act, the good intent of Congress can all too easily

be circumvented through misinterpretation of the Act by those who administer the medicaid program in the States.

The American Optometric Association therefore urges that under Section 1905(a) of Title XIX, the present "number (15)" be renumbered as "(16)" and that a new "number (15)" be inserted, to read as follows:

> "(15) where a State plan approved under this title specifically includes in physician services authorized under '(5)' of Section 1905(a) the provision of services which an optometrist is also licensed by the State to provide, then such services may be provided by a physician skilled in diseases of the eye or an optometrist, whichever the individual shall choose."

SERVICES OF OPTOMETRISTS UNDER PROPOSED TITLE XX

H.R. 1, as passed by the House of Representatives, would repeal sections dealing with Aid to the Blind now contained in Titles, I, X, and XIV of the Social Security Act.

When the Ways and Means Committee and subsequently the full House of Representatives repealed all the language in Title X and replaced it with a new definition of blindness, the revised definition did not include the "Freedom of Choice" provision which had been part of the language of Title X and Title XIV.

We feel this was an oversight due to the fact that the Federal regulations presently permit optometrists to determine blindness.

Since, however, Federal regulations can be changed, it is therefore our contention that to assure beneficiaries under the new Title XX are not denied the services of optometrists, such services must be specified in the language of Title XX rather than relying upon administrative interpretation to assure freedom of choice of practitioner.

In order to carry out the intent of Congress regarding the utilization of optometric services under Assistance for the Aged, Blind, and Disabled we recommend that H.R. 1 be amended as follows: Under Section 2014(2) of H.R. 1, page 520, line 21 of the bill (dealing with the new Title XX of the Social Security Act) that the period after ". . . of 20/200 or less" be deleted and that the following new language be added: "provided 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 shall select."

OPTOMETRY'S POSITION ON PEER REVIEW

The American Optometric Association is deeply concerned about the concept of professional standards review under the various Titles of the Social Security Act. As the investigations of this Committee showed in 1970, considerable sums of Federal funds might have been saved and better health care might have resulted had more effective methods of review been initiated at the outset in both the Medicare and Medicaid programs. We concur with those who believe that revision of the review system is necessary and fully justified.

With information available from over half a decade of Medicare and Medicaid operation, it should now be possible to effect general improvements in the professional standards review sections of Titles XVIII, XIX, and other portions of the Act which rely upon peer review for maximum efficiency.

This association supports any system of professional standards review which holds promise of being feasible, fair, and productive of the desired result. The very phrase "peer review" dictates the manner in which such a system should operate: services provided by any health care practitioner to beneficiaries of a health program authorized by the Social Security Act should be reviewed by other practitioners of the same health discipline with respect to professional standards, ethics, performance and procedures.

Optometrists cannot and should not be permitted nor required to judge the efficacy of treatment or patient management provided by a physician or a dentist. Conversely, a physician or dentist should not be permitted nor required to pass judgment on the efficacy of services provided by an optometrist.

Well organized professional standards review mechanisms are generally available in every State for review of the performance of practitioners within each of the health professions. In the case of optometry, the experience of this profession in professional standards review dates back to early 1960's when a

peer review system became necessary under the newly-enacted Kerr-Mills legislation, forerunner of today's Title XIX program.

We would hope that any legislative proposal on peer review would include provisions to assure true peer review for all health care providers.

USE OF HMO'S BY MEDICARE AND MEDICAID BENEFICIARIES

H.R. 1 allows beneficiaries of Medicare and Medicaid programs the choice of health services from Health Maintenance Organizations (HMO's) where such groups exist. We view this as a desirable feature as a matter of convenience to beneficiaries and possible savings which might be effected by utilization of an HMO or similar comprehensive group practice.

The American Optometric Association is concerned, however, that beneficiaries who select the Health Maintenance Organization as a source of services should be assured that the full range of services allowable under Medicare or the particular State's Medicaid plan will be equally available in the HMO. We believe the Congress should direct the appropriate agencies administering these programs that any Health Maintenance Organization providing services to beneficiaries under the Act must make available all the basic health care services specified in Title XVIII and Title XIX, and that optometrists and other primary providers of health services should be spelled out by the Congress.

Only in this manner will unnecessary delays and confusion caused by administrative misinterpretation be avoided when the Medicare or Medicaid beneficiary seeks services through an HMO.

SUMMARY AND RECOMMENDATIONS

The American Optometric Association recommends Committee approval of H.R. 1 with further amendments set forth in this statement, in the following subject areas:

1. Title XVIII (Medicare).—We recommend adoption of the amendment to Section 1861(r) as passed by the House of Representatives and approved on two earlier occasions by the Senate Committee on Finance, which would define an optometrist as a physician for purposes of this Title;

2. TITLE XIX (MEDICAID)—We recommend Committee adoption of the amendment to Section 1905(a) which would assure the availability of optometric services to beneficiaries where those visual services are provided for under the State Medicaid program;

3. TITLES XVIII AND XIX (MEDICARE AND MEDICAID) ON PEER REVIEW.—We recommend that any legislative proposal dealing with peer review mechanisms insure a system of true peer review by the same health discipline being reviewed with respect to professional standards, ethics, performance, and procedures;

4. TITLE XVIII, SECTION 1886(a), HEALTH MAINTENANCE ORGANIZATIONS.—We recommend that the Committee adopt language which will assure a beneficiary who selects an HMO that the full range of services specified in Title XVIII and those a State Medicaid plan provides under Title XIX be made available in the Health Maintenance Organization setting; nd

5. TITLE XX (ASSISTANCE FOR THE AGED, BLIND, AND DISABLED).—We recommend adoption of the amendment to Section 2014(2) which would maintain the freedom of choice concept in determination of blindness for the beneficiary.

STATEMENT BY THE SPECIAL COMMITTEE ON H.R. 1, REPRESENTING THE COMMITTEE ON AGING, COMMITTEE ON FAMILY AND CHILD WELFARE, COMMITTEE ON HEALTH, IN THE DEPARTMENT OF PUBLIC AFFAIRS OF THE COMMUNITY SERVICE SOCIETY

The 1971 amendments to the Social Security Act passed by the House of Representatives contain the most far-reaching changes in the nation's income maintenance system to be considered by the Congress at any one time share 1935 when the Act was enacted. The Congress is to be congratulated on undertaking so major a legislative overhaul as that embodied in H.R. 1. This is a massive piece of legislation making significant changes in a wide range of social policies. We consider some desirable, some undesirable. Therefore, we do not find it useful at this stage to adopt a position for or against the Bill as a whole. Instead, we are commenting on the Bill by reference to its main objectives.

Our concern is for the consequences of the proposed changes on the social and physical well-being of the citizens in our own community and throughout the nation. As a voluntary, nonsectarian social welfare agency, the Community Service Society since its founding in 1848 has been dedicated to strengthening family life and to the betterment of community life. Its Department of Public Affairs, through its citizen committees and staff, is that arm of the Society which engages in social and legislative action aimed at the improvement of community conditions, services and facilities.

Our analysis and comments on the Bill are the product of joint study by representatives of our Committees on Aging, Family and Child Welfare, and Health. These committees are concerned with the implementation of the Social Security Act and the related federal, state and local measures authorizing publicly funded and administered income support, health and social service programs. They have developed expertness in their respective fields. They have spoken over the years, both in support and in criticism of legislation and administrative actions affecting these programs.

Our statement is presented in two parts. Part I discusses the main objectives of the Bill and how the major provisions would, in fact, implement these objectives. In Part II we present a more detailed analysis, by titles and sections of the provisions discussed broadly in the first part of the statement and a few provisions of a more technical nature which are omitted from comment in Part I.

Part I—Analysis of H.R. 1 Objectives and Implementing Provisions

H.R. 1 appears to be directed to three main objectives. These are (1) improvement of the nation's income security programs, (2) reduction of the numbers dependent on public assistance, and (3) improvement in the administration of those health programs with which the federal government is financially involved, namely, Medicare and Medicaid, and to a lesser extent, Maternal and Child Health Services. We also offer comments on the provisions of the Bill that affect the social services and public accountability.

A. Improvement of the Income Security Programs

The nation currently applies two different principles in its income security policies: provision of social insurance benefits as a right to insured persons in the event of inability to earn because of old age, retirement, permanent disability, death of a breadwinner and unemployment, and a system of assistance payments on the basis of demonstrated need in the individual case to those not covered by social insurance or whose insurance payments are inadequate for their needs. The assistance system in turn is in two parts: a group of federally aided programs for needy aged, blind and disabled and for families with dependent children and a wholly state or state/local program for all other needy people. H.R. 1 deals with both insurance and assistance.

1. *Amendments to the federal old-age, survivors and disability insurance program*

This is probably the most satisfactory part of the Bill. We welcome those amendments in Title I of H.R. 1 which increase the role of social insurance in providing income security by improving the level of benefits and liberalizing eligibility. In particular, we strongly support the 5% increase in benefit levels across the board. We are especially pleased that the Bill provides for automatic increases in the benefit levels with increases in the cost of living, as this will protect beneficiaries from erosion of the purchasing power of benefits as prices rise. The proposed increase in widows' and widowers' benefits from 82½% to 100% of the deceased spouse's benefit is also a move in the right direction. We believe, however, that the proposed increases in the minimum benefits are too meagre and that an increase to $100 an individual and $150 a couple would be desirable. As our detailed comments in Part II indicates, we are in general in favor of other amendments such as those that would improve the benefit levels of persons long covered by the program or postponing retirement beyond age 65.

We are glad to see some liberalization of the retirement test though we suggest exploration of the possibility of a variable formula permitting retention of larger dollar earnings by beneficiaries at the lower level benefit levels.

We recognize that the liberalizations of the program will increase its costs and we are concerned about the increasingly heavy burde nof the regressive wage and payroll taxes, especially on low income receivers. While we note with satisfac-

tion the increase in the level of taxable earings (both immediately and in the future by tying the level to increases in the general level of covered earnings), because this will involve tapping ever higher incomes and thus somewhat reducing regressivity, we would hope that the Congress would explore other sources of funds. In that connection our own studies indicate that the investment policies of the Fund Trustees have resulted in interest yields considerably less than could have been legally obtained and we suggest adding to the Trustees two representatives of the public to assure that investment policies would not so strongly reflect the fiscal interests of the federal government.

2. *Assistance for the needy aged, permanently disabled and blind*

The changes which Title III would bring about represent a major step forward. We strongly favor the creation of a federally financed and administered program which would introduce a long-needed federally determined floor of assistance and uniform eligibility conditions for the nation as a whole. This is indeed a major advance. We also support the use of the Social Security Administration as the agency to administer the program, as proposed by the Ways and Means Committee. This agency has an outstanding reputation for administering social security in a manner which emphasizes the rights of beneficiaries, respects their dignity and at the same time protects the interests of the insurance funds. In the hands of such an Administration there is good reason to expect the kind of non-discretionary and objective determination of both eligibility and payments amounts to which the long-period dependency of the aged, the blind and the permanently disabled so obviously lends itself.

We note, however, that the proposed level of the federal minimum is considerably below even the poverty level for aged individuals and slightly below this for aged couples. Although the Bill provides for a staged increase by 1975, it is to be expected that prices also will rise during this interval but the Bill does not require that the dollar minimum shall be automatically adjusted to increases in the cost of living.

Given the relatively low level of the federal minimum and the fact that it is lower than many states are now paying, it is regretable that the Bill does not require the states to supplement the federal payments up to at least their current level. While Section 509 puts considerable pressure on the states (on pain of losing federal reimbursement under Titles IV, V, XVI, and XIX of the Social Security Act) to supplement up to the amounts recipients would have received in June 1971 together with the bonus value of food stamps which were provided or available, a state could avoid this pressure by passage of state legislation specifically prohibiting it from supplementing the federal minimum. Given the present tendency of the states to lower their standads and cut welfare expenditures it seems likely that many will take advantage of this leeway. We urge amendment to require the states to supplement at least up to their previous payment levels (including the cash value of the food stamps bonus) and federal participation in the costs of such supplementation.

Furthermore, although as we stated above, eligibility conditions are uniform geographically, it is unfortunate that the Bill would perpetuate the differential treatment of the aged as compared with the blind and disabled who would be permitted more liberal disregards of earnings. We see no justification for this discrimination against the aged.

3. *The Family Assistance Plan (FAP)*

Title IV of the Bill replaces the existing Aid to Families with Dependent Children (AFDC) program with a new assistance program for families with children, the main feature of which is provision of a federally financed and administered assistance payment with nationally uniform eligibility requirements. Adoption of this principle is a major step forward and one we have long urged. Our satisfaction is, however, greatly diminished by the way the Bill implements this policy.

First, the federal minimum is far too low, and fails to reflect geographical differences in costs of living. The sum of $2400 for a family of four is well below even the meager 1970 poverty line ($3968), and for larger families the payment is even more inadequate due to the setting of a maximum of $3600 to total payments however large the family. The standard is even below the current assistance standards of about half the states and maks no provision for automatic adjustments in the dollar amount of the minimum with increases in the cost of living. We believe that the minimum guarantee should be substantially

increased and that if, for financial reasons, it is initially set below the poverty level the Bill should provide for a staged increase toward a more satisfactory living standard as national income rises.

Second, given the low level of the federal minimum and its shortfall as compared with what many of the states are even now paying, it is unfortunate that the Bill does not mandate state supplementation up to at least current payment levels. For reasons we have already given, we do not believe that Section 500 is an adequate substitute for such a requirement.

Third, while we regard food stamps as an inferior substitute for an adequate cash payment and thus welcome the incorporation of the bonus value of food stamps in the basic federal cash payment, we believe it unfortunatae, so long as the federal minimum falls so far short of even the current poverty standard and so long as state supplementation is so problematic, that recipients of FAP would not be permitted to buy or use food stamps.

Another new feature of FAP is the coverage of the working poor. The check to initiative and the inequity of denying assistance to those whose efforts at self-support yield them an income below assistance standards has long been apparent. While we welcome rectification of this injustice we also recognize that supplementation of earnings raises some difficult economic issues and in any case will greatly increase the numbers of FAP recipients. We would hope that, for the longer run, the Congress will continue to explore other ways of dealing with the problem of full-time earnings that are insufficient for family needs.

In any case, families other than those with working mothers are assured supplementation only up to the level of the federal guarantee, for the supplementary programs of the states are permitted to exclude families with both parents present and not incapacitated, regardless of whether the male parent is employed or unemployed.

The two assistance programs introduced by H.R. 1 do indeed mark a major step forward by introducing the important principle of a federal minimum standard, federally administered. But taken together and considered in the light of current needs in our public assistance programs and policies, they have serious shortcomings over and above those to which we have drawn attention when considering them individually.

First, neither one provides assistance for single or childless adults under age 65 who are not disabled. In addition, families headed by a full-time college or university student are excluded. Quite apart from hardship to the families involved this last provision seems clearly inconsistent with the emphasis placed in Title IV on training as an aid to employability.

Second, the combined programs perpetuate the shocking discrimination in our assistance policies against families with children. As the Bill now stands, the federal minimum for a family of four is no more than the minimum for couples who are aged, blind or totally disabled, while for larger families the discrepancy is even more pronounced. And while we recognize that in the past, improvement in social provision for the needy has taken the form of gradual removal of one category after another from the total group in order to grant them more liberal treatment, we are concerned that the application of the policy in practice has tended to isolate what may be called a "discarded population" whose characteristics do not invoke popular sympathy, and on whom public resentment about the rising costs of public assistance can be concentrated. Thus the Committee on Ways and Means makes it clear that the Secretary of Health, Education and Welfare (HEW) is expected to provide a much more stringent administration of eligibility conditions for the FAP families than for the H.R. 1 Title III adult categories: for the latter a declaration system for applications would not be ruled out as it would be for the FAP population, nor would the verification and other procedures be so rigorous.

Third, both Titles would permit the states to establish duration of residence requirements as a condition of eligibility for state supplementary payments. Such a provision is not only socially undesirable but is also unconstitutional and we urge its removal.

Fourth, the burden of assistance costs on the states and localities is heavy and growing and is one of the reasons why reform is needed. The proposed "hold harmless" provision (whereby the states are guaranteed that their expenditures on cash assistance payments will not exceed their total outlays for categorical cash assistance in calendar 1971) together with federal assumption of costs of administration of state supplementation (where a state agrees to federal

administration) fall far short of giving the states the fiscal relief they need. Furthermore, the financial provisions of the Bill give least relative aid to those states which have been most adequately meeting need in the past or have been caring for relatively large numbers of assistance recipients. We believe that nothing short of federal assumption of the costs of assistance (including needed supplementation above the low federal minimum) will meet the problem.

B. REDUCTION OF THE NUMBERS DEPENDENT ON ASSISTANCE

It is obvious from many of the provisions of H.R. 1 and from the Report of the Committee on Ways and Means that a major objective of the drafters of the Bill has been a reduction in the numbers of assistance recipients. The Bill proposes to achieve this result in two ways: (1) by moving as many of the recipients as possible into self-support and (2) by tightening eligibility requirements and their administration.

1. The Work Program

Substitution of "Workfare" for "Welfare" is held by the Administration to be the heart of "welfare reform." We support the objective of the Opportunities for Families program (OFF), namely, encouraging and facilitating self-support. Nor do we question the propriety of requiring those who are clearly capable of self-support to accept appropriate training or suitable available work. But we have serious questions about the way these policies are applied in H.R. 1.

We wish to make it clear that there are some features of OFF with which we are in agreement. The proposal to disregard some fraction of earnings in determining whether a family is entitled to FAP payments will correct the present deterrent to earning whereby in most states earnings serve only to reduce the assistance payment. But we suggest that a disregard higher than the proposed $720 per year plus one-third of additional earnings would provide a more effective incentive to earn. Similarly, while we are glad to see that working mothers may deduct from their countable income for FAP purposes any charges they pay for child care services, we believe that the $2000 limit on this deduction (which covers also any irregular and student earnings) is too low in view of current costs per child of day care and similar child care services.

We are pleased too that the Bill recognizes one major weakness of current training programs, namely, the lack of available jobs for those whose training is completed, by providing for the creation of temporary public service jobs. However, the number of positions possible under the appropriation envisaged is insignificant in relation to the current number of unemployed job seekers whose numbers will be swelled by the newly trained OFF employables. A vastly greater work creation program will be necessary if the employment objectives of H.R. 1 are to be attained.

We also welcome the centralizing of responsibility for operation, administration and financing of work and training programs in the federal Department of Labor. In the past, diffused or shared responsibility for administration and the requirement of state financial contributions have severely limited the effectiveness of work and training programs.

Our objections to the OFF proposals relate mainly to two questions: (a) to whom should the pressure to accept work or training be applied and under what safeguards and (b) what kinds of jobs are people required to accept?

a. To whom should pressure to accept work or training be applied and under what safeguards?

The Bill specifies that all persons age 16 or over except those incapacitated or of advanced age, or caring for a sick household member or for a child under three, or regularly attending school if under age 22 shall be required to register for, and accept if offered, work or training. We strongly question the social desirability of imposing this requirement on mothers of young children who, we believe, should have the right to decide whether it is in the best interests of their children that they should work. It is a further weakness of the proposal that no account is taken of the number of children in a family. We also find it particularly ironical that a woman with a husband in the home who is registered is not required herself to register, whereas the mother with no man to help share the burden of housekeeping and child care is required to do so.

The Report of the Ways and Means Committee implies that a mother will be required to accept work or training only if suitable alternative child care

arrangements are available to her. But no such explicit safeguard is written into the Bill and this should be rectified. At present day care and other organized arrangements for substitute care of children of working mothers are shockingly inadequate even for mothers who are currently working, let alone for the increased numbers of women workers that are expected to result from the OFF program. The Bill does provide HEW with funds for an expansion of day care services and additional resources would be available if other child care proposals currently before the Congress should be enacted. But it is questionable how far even these funds will go in filling the gap. It is presumably in recognition of this shortage that the Secretary of Labor who is given the responsibility of purchasing such care for OFF families, is authorized to the extent he cannot utilize the facilities developed by HEW, to purchase or contract for child care services "from whatever sources may be available" including public or private agencies "or other persons." The Report of the House Ways and Means Committee makes it clear that this includes private profit-making enterprises. We fear that this open-ended authority may lend itself to serious abuse. For although the Secretary of HEW is required to promulgate standards assuring the quality of child care services (with the concurrence of the Secretary of Labor), no guiding principles are laid down in the Bill. We believe that if society assumes the responsibility of pressuring mothers to work it must also accept the responsibility of defining standards of substitute child care.

b. *What kinds of jobs are people to be required to accept?*

It is of the utmost importance that the OFF program not be used as a weapon to force people to accept substandard jobs, or those that are in conflict with current national policies. We note that the Bill defines as unacceptable positions vacant as a result of a strike, lockout or other labor dispute and those where, as a condition of being employed, workers must join a company union or join or refrain from joining any bona fide labor organization. But, while the Bill specifies that wages, hours and working conditions of acceptable jobs must not be contrary to or less than those prescribed by applicable federal, state or local law, we regret that for the jobs available in private employment that are not covered by minimum wage laws, the wage level is permitted to be only 75% of the already low federal minimum. Furthermore, although individuals may refuse to participate in work or training programs "where good cause exists for failure to participate," "good cause" is not defined. There should be reference to the suitability of the job or training for the particular registrant and reasonable standards defining suitability such as are prescribed for public service employment.

2. Tightening eligibility requirements and their administration

The second prong of the effort to reduce the numbers on assistance involves a tightening of eligibility and administration. Reference has already been made to the exclusion from eligibility of families headed by a full-time college or university student. The numbers of eligible persons will also be reduced by the requirement that drug abusers and alcoholics must be undergoing treatment at an approved institution; by the counting as a resource, income received in the preceding nine months even though in the current quarter a family has no or inadequate income; and by including in resources, the income of a step-parent even though he has no legal liability for the support of his wife's children. We find these last two provisions especially objectionable.

Even more important in keeping down the numbers of recipients are the directives given in the Bill and elaborated in the Report of the House Ways and Means Committee for stringent administration. There is to be no declaration system for applications; statements by applicants are to be rigorously checked; recipients must immediately report changes in circumstances and make quarterly reports on income, in both cases under pain of severe penalties and at the end of two years must reapply for benefits. We are "strict constructionists" in the sense that we do not believe in lax administration or the admission to benefits of those not legally eligible. But we fear that the great emphasis placed in the Bill and by the House Committee on stringent administration will lead to harassment of applicants and recipients and may even discourage some needy persons from applying.

C. IMPROVEMENTS IN ADMINISTRATION OF HEALTH PROGRAMS

The main thrust of the health amendments in Title II is clearly to improve the operating effectiveness of Medicare, Medicaid and the Maternal and Child Health Services. With most of the specific proposals for containing the costs of health programs by limiting the charges of providers, introducing incentives for economical operation, improving administration by encouragement of the use of mechanized equipment, improving the delivery system and the like we have no quarrel, although we recognize that time alone will tell whether the specific changes will achieve their intended result. We suspect that for many years to come the Congress will be grappling with the problem of assuring an efficient and economical operation of our health services while at the same time protecting quality.

But Title II also contains some substantive changes in the programs and some of the cost-oriented amendments are likely to have adverse repercussions on the nature of the Medicare and Medicaid programs.

1. Medicare

We strongly support the extension of Medicare to disabled social security beneficiaries although we would hope that it would prove possible to reduce the two-year waiting period. We also urge inclusion of the early retirees, a group whose age and income levels make medical expenditures especially heavy and onerous.

We are pleased that some modest additional reimbursable medical expenditures have been added but greatly regret the non-inclusion of the much more important out-of-hospital prescription drugs among the reimbursable benefits and strongly urge their inclusion. As our more detailed comments in the following section make clear, we also welcome a number of other amendments which make it easier for certain categories of people to secure supplementary medical insurance or entry to hospital. We believe that removal of current barriers to the use of Health Maintenance Organizations by Medicare beneficiaries is a step in the right direction. We hope, however, that the amendment removing the requirement for provision of social services in Extended Care Facilities will be eliminated. The patients in such institutions are likely to be persons for whom social services are of special significance.

2. Medicaid

The substantive changes proposed for Medicaid are numerous and serious. While there are a few desirable liberalizations such as the optional provision of service in an Intermediate Care Facility and, on a qualified basis, of care in institutions for the mentally retarded, inclusion of some provisions aiming at improvement of the quality of medical care for Medicaid recipients and encouragements for the delivery of care through Health Maintenance Organizations (all of which are discussed later in more detail), most of the changes are of a restrictive character.

We are strongly opposed to the changes which would (a) restrict eligibility, (b) impose charges on recipients and (c) narrow the scope of covered services.

(*a*) Assistance recipients with total incomes in excess of the state's medically indigent eligibility standard (usually 133.3% of the current payment to AFDC families) will be required to draw down the excess to pay medical bills before they become eligible for Medicaid. Quite apart from the hardship involved, this provision undermines efforts in other parts of the Bill to encourage earning by permitting recipients to retain some fraction of their earnings. We also urge elimination of the provision whereby states are not required to make Medicaid available to persons or families newly eligible for assistance under the income maintenance sections of H.R. 1. By definition these are low income people whose assistance payments will be too low to leave any leeway for meeting the costs of medical care.

(*b*) We strongly oppose the imposition of charges on Medicaid recipients. Even the "nominal" charges for non-mandatory services which the Bill would permit states to levy on cash assistance recipients are objectionable, for the payments they receive, even with state supplementation, will be barely, or not at all, adequate for meeting recurrent basic needs and will leave no leeway for medical bills. It must not be forgotten that the non-mandatory benefits include such costly items as drugs, dental care and the like. For similar reasons we oppose both the proposal to require the states to impose on the medically needy

a premium fee graduated by income and the permission granted them to impose deductible and co-payment requirements. Given the low income eligibility level for Medicaid in most of the states, eligible medically needy families will have no resources to cover the premium, while the co-payment and deductibles will deter many who should seek medical care from doing so. We are not impressed by the argument that such charges are necessary as a protection against overuse of health services. All evidence suggests that not overuse but underuse of health services is characteristic of the poor and in many cases the main determination of the volume of service to be received by a patient lies in the hands of the physician, not the patient.

(c) The scope of medical benefits available under Medicaid is unfortunately narrowed by H.R. 1. The states would be permitted to reduce the range of non-mandated services without being subject to the maintenance of financial effort requirements currently in force. Given the financial pressures under which many states now operate, the consequence is likely to be a reduction of the benefits now available to the level of those mandated. The scope of medical benefits is also likely to be restricted by the proposed reductions in federal aid for certain types of institutional care after service has been received for specified periods. We recognize that the intent of these amendments is to discourage unnecessary hospital or institutional occupancy and to encourage movement of patients to less expensive forms of care when medically indicated. But given the acute shortage of nursing homes and other alternative facilities for care we fear that the main result of these proposals will be to deny needed institutional care to many poor people, or if states are unwilling to do this, to add to the financial burdens of already hard-pressed states which will have to provide this care without federal aid.

We take particular exception to the proposed elimination of the requirement that states have in effect a comprehensive Medicaid program by 1977. The fate of the Medicaid program since 1965 has been a succession of reductions in benefits and coverage instead of the progressive expansion envisaged in the original legislation. This amendment is the final blow to the promise of an adequate program of health care for the poor and medically indigent.

D. AMENDMENTS TO THE SOCIAL SERVICES

Several sections of H.R. 1 directly affect the social services and their financing and administration. We welcome the new specific provision for appropriations for foster care and adoption. We are gratified that this additional federal aid for foster care will not be limited, as are the cash benefits under the family programs, to cases in which a judicial determination has been made, but will be available in respect of any child "for whom a public agency has responsibility." We are especially pleased that the adoption provisions include payments to allow for the additional costs resulting from adoption of physically or mentally handicapped children who are hard to place.

We welcome, too, the provisions which aim to extend the availability of family planning services to the poor and the near-poor. Society has no right to criticize the extent of out-of-wedlock births and the large families of those receiving public support so long as it withholds from them the knowledge and the means of more responsible family planning.

But we deplore the imposition of ceilings on appropriations for all except the child care and family planning services. Hitherto social services rendered to the federally-aided assistance categories have been subsumed under the Titles dealing with these groups and as such have been financed on an open-ended basis. We urge a return to the principle of open-ended financing and would additionally like to see removal of the closed-end grants now applicable to the Child Welfare Services under Title IV B of the Social Security Act. All these social services are almost everywhere inadequate in relation to the need for them and the imposition of ceilings will only further check their expansion. It is true that, commendably, the Bill provides that part of the appropriation for services to assistance recipients is to be set aside for states whose development of social services falls below the national average per recipient but the sum envisaged is small ($50 million) and the real problem is that the national average is itself too low. It is evident, too, from the Report of the Ways and Means Committee, that the detailed spelling out of services for assistance recipients is intended as a restrictive device and we would prefer a more general definition

such as is used in Title IV B or in the original Titles IV A and XVI of the Social Security Act.

We welcome the proposed separation of the administration of cash payments to remove the statewideness requirement. Unless the conditions of such abrogation are narrowly defined (e.g., for the purpose of experiment or demonstration) and time-limited, elimination of the statewideness requirement can lead to discriminatory treatment of populations in certain areas.

We welcome the proposed separation of the administration of cash payments and of services. But we fear that the differing financial arrangements applying to the Social services (according to whether they are rendered under one Title or Section or another) will foster a fragmentation of what should properly be a unified service system and will greatly add to the administrative burdens of the states.

Because we have always stressed the importance of simplified administration we look with apprehension to the vast responsibilities given to the Secretary of Labor in connection with the provision of a wide range of social services for the OFF families. The interposition of a second federal agency administering social services will greatly complicate and confuse administration at the local level and foster divided responsibility. In addition, the freedom given to the Secretary of Labor who has hitherto had no involvement in the administration, operation or supervision of social services to select his local administrative agencies, including profit-making agencies, we believe, is fraught with danger and may threaten established policies.

E. PUBLIC ACCOUNTABILITY

The Bill provides in numerous sections for the Secretary of Labor or HEW alone or in conjunction to adopt regulations that will establish standards, as for child care, or prescribe requirements, as for filing applications, or institute criteria, as for determining a disabled person's ability to engage in activity

It is clear that the rules and regulations to be adopted to implement the various Titles will be of critical importance, frequently of greater significance in their impact on the recipient than the language of the sections being implemented. Nevertheless, there is no provision for public hearings prior to their adoption. We submit that the opportunity for an exchange of views and thorough public analysis of issues which is exercised in committee hearings and floor debate prior to Congressional action on proposed legislation is equally essential in the administrative system. The Bill should include a requirement that rules and regulations which are not purely ministerial and which substantially affect the right of recipients to benefits and services be adopted only after publication of the proposed rules and regulations and adequate public notice opportunity for public hearing.

Another instance of failure to provide for public accountability is the absence of a participatory role for recipients in responding to the policies and regulations of the programs which directly affect their lives in such vital matters as their subsistence level, training, employment, child care and medical or other services. Even the provision establishing local committees to evaluate the effectiveness of manpower and training programs specifices as members representative of labor, business, the general public and units of local government, thereby representing everyone except the persons most affected, the families registered for the OFF program. We recommend that the Bill provide for the appointment of local advisory committees in each state to evaluate the effectiveness of the programs and services offered under each Title and that the committees include in their membership representatives of those intended to benefit from the provisions of each Title.

TITLE I--PROVISIONS RELATING TO OLD-AGE, SURVIVORS AND DISABILITY INSURANCE

(AMENDING TITLE II OF THE SOCIAL SECURITY ACT)

Sec. 101. Increase in cash benefits of 5%

Provides an across-the-board increase of 5% in social security cash benefits effective June 1972.

We support the proposed 5% increase in cash benefits effective at the earliest possible date, January 1972 if this be feasible. Additionally we recommend a

$100 monthly minimum for an individual and $150 for a couple, thus raising benefits for the low level regular and the special age-72 beneficiary. We recommend that general revenues be applied to pay the additional cost of this proposed minimum.

There are good reasons to increase the minimum.

The proposed minimum monthly benefits are $74 for the retired individual and $111 for a couple, or, put in annual terms, $888 and $1332 respectively. For the special age-72 beneficiary the monthly payment would be $50.80 for a single person and $76.20 for a couple or $609.60 and $914.40 per year, respectively.

How well these payments cover minimum living needs may be judged by comparison with two standards:[1] (a) the lower budget level in the Spring of 1970 for persons and couples 65 and over for urban United States and (b) the 1970 poverty level for nonfarm persons and couples 65 and over—both adjusted upward by a 5% annual inflation factor, compounded through 1972.

The cash benefits for the retired worker at the minimum level would be close to $1200 less than the estimated 1972 nonfarm poverty level of $2052 and over $800 below the lowest budget of $1714 for an aged individual living in an urban area of the U.S. at the same time. Special benefits to age-72 individuals would be even further below the poverty and budget levels.

A couple aged 65 and over with the minimum social security cash benefit would be more than $1200 lower than the 1972 poverty level of $2589 for a retired couple and nearly $1800 less than the lowest budget of $3122 for an urban 65-and-over two-member family. Couples receiving special age-72 benefits fall even further below the standards.

The proposal to raise minimum monthly cash benefits to $100 for an individual and $150 for a couple will narrow but not close the gap between benefits and low budget or poverty levels.

The recommendation that general revenues be tapped for this increase is financially justifiable because, in lieu of a higher cash benefit minimum, old age assistance which is financed out of general revenue would likely be used as a supplement. Administrative costs would be cut down, too, with beneficiaries receiving checks under one, rather than two programs, each with its own criteria for eligibility.

Sec. 102. Automatic increase in benefits, contribution, and benefit base, and earnings test

Provides an automatic, once-a-year increase in cash benefits, provided that the Consumer Price Index has increase by at least 3% and that legislation increasing benefits had neither been enacted nor become effective in the preceding year.

Provides a parallel automatic increase in the contribution and benefit base, according to the rise in average covered wages, if wage levels had gone up sufficiently.

Also provides a comparable automatic increase in the exempt amount under the retirement test.

We support automatic cost of living adjustments to cash benefits, recognizing that this does not improve the economic status of older persons but merely serves to avoid further deterioration. We believe that such an adjustment should be linked to an increase in minimum benefits, as before discussed. We note with approval that the Congress may take interim action before the January 1974 effective date of this provision as well as subsequent action to increase general benefits.

Increasing the wage base subject to FICA tax by the same percentage that benefits are raised will assist in the program's financing. Furthermore, automatically raising the retirement test with the rise in average taxable wages at the same time the CPI adjustment takes place is an advantage in the proposed legislation.

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[1] The two standards differ significantly. The Spring 1970 lower budget level is $1555 single persons; $2832 for couples (respectively $1714 and $3122 for 1972 using 5% as the inflation factor compounded through 1972.) The 1970 poverty level is $1861 for single persons and $2.348 for couples (respectively $2052 and $2589 as updated.)

Sec. 103. Special minimum cash benefit for persons with a substantial employment record

Provides a special minimum for persons who worked 15 years or more under social security, such minimum to be computed at $5 times the number of years of covered employment up to a top limit of 30 years or $150.

We approve this provision. However, we question the non-application of a price rise adjustment to this benefit.

Sec. 104 and Sec. 113. Survivors' benefits

Provides in Sec. 104 an increase in cash benefits to widows and widowers from the current 82.5% of the decreased spouse's benefit to 100% of the amount the deceased spouse would receive if living. Survivors' benefits applied for before age 65 would be actuarially reduced.

Provides in Sec. 113 payment of reduced benefits to widowers at age 60 as is now done for widows at age 60.

We support the increase in cash benefits to dependent widows and widowers. We, however, favor a no-penalty provision for the widow or widower of an early retiree, and recommend that the widow or widower receive 100 percent of the benefit the retired worker would have received at age 65.

We favor the option given to 60 year old widowers to receive decreased survivor benefits, an option already given to widows.

Sec. 105 and Sec. 142. Financing

Provides in Sec. 105 an increase in the annual taxable earnings base from $7800 to $10,200 effective January 1972.

Provides in Sec. 142 new schedules of tax rates for OASDI and Medicare for the self-employed and for employees and employers. For the latter, the combined rate would increase from the current 10.4% to 10.8% in 1972, to 12.4% in 1975 and to 14.8% in 1977.

We approve the rise in the taxable earnings base to $10,200 effective in January 1972. This tends to decrease the regressivity of the tax.

We withhold approval of the proposed changes in the tax rates. We believe that tax rates should be reexamined subsequent to a change in the investment policy of the Trust Funds.

We strongly recommend that the interest rate pattern of the Trust Funds be altered with the objective of raising the interest income. The need for liquidity and safety of Fund monies is acknowledged, but the income of the Funds (notably the Old-Age and Survivors Trust Fund and the Disability Insurance Trust Fund which together totaled $40.3 billion as of April 1971) could be substantially raised within legal investment limits.

Setting the investment policy of the Funds, within the framework legislated by the Congress, is a three-man Board of Trustees. Managing Trustee is the Secretary of the Treasury; others are the Secretaries of Labor and of Health, Education, and Welfare. Official records[1] indicate that investment practice has favored the government to a significant degree through what is tantamount to loans at low interest rates.

For fiscal 1971, the overall interest rate was less than 4.8% for the Trust Funds.

As of April 30, 1971 it is significant that 42.9% or $17.3 billion of the OASDI Trust Funds was invested at 4.75% or lower interest rates; 26.4% at 3.875% or less; 13.4% at 2.75% or less. These investments were accumulated over a period of time. However, the 1970 rate on 3–5 year U.S. Government securities was 7.37%; in 1969 it was 6.85%. In fact, in every year beginning with 1966 the 3–5 year rate was over 5%. Long-term U.S. Government bonds moved steadily upward and beginning with 1966 never fell below 4.66%, reaching a high of 6.90% in June 1970.

Most of the OASDI Trust Funds are invested in special issues—$27 billion out of $40.3 billion or 67%. Reinvestment would have no immediate or direct impact on the market. They could be redeemed at par with accrued interest and could be refunded immediately into higher yielding issues.

This recommendation in respect to investment policy is generally in accord

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[1] Portfolio of OASDI Trust Funds, *Congressional Record*, June 23, 1971, p. H5813. Interest rates on government securities 1965–1971, *Federal Reserve Bulletin*, June 1971, pp. A33, A34.

with the recommendations of the 1971 Advisory Council on Social Security. We concur, too, in the Council's recommendation that the present three-man Board of Trustees be increased to five and include two nongovernment members representing the public interest.

Sec. 106. Increased benefits for persons retiring after age 65

Provides granting to the late retiree an increase of 1% in annual benefits, prorated at 1/12 of one percent monthly, for each year (or month) after age 65 in which benefits are unclaimed because of continued employment. Does not provide increased benefits to dependents and survivors.

We view this to be a positive first step to provide increased benefits for continued participation in the labor force. However, the annual increase of only 1% seems overly modest. For example, a person retiring at age 67.5 years would receive monthly cash benefits 2.5% higher than he would have received at age 65. Moreover, during the post-65 period the worker would not have received benefits and he and his employer would each have contributed the FICA tax.

Sec. 107, Sec. 108 and Sec. 110. Benefit computational methods

Provides in Sec. 107 an age-62 computation point for men (rather than age 65) as is now the case for women.

Provides in Sec. 108 additional drop-out years—one additional year of low earnings, in addition to the five years provided under current law, for each 15 years of covered work.

Provides in Sec. 110 the computation of benefits based on the combined earnings of a working couple, each of whom had at least 20 years of covered earnings after marriage. Applicable only if higher benefits would result.

We support the proposed liberalizing changes in methods of benefit computation. But we offer recommendations for further improvement.

We suggest that the elimination of the differential between men and women in computing average wage be made applicable to current as well as future beneficiaries. The Bill applies the new provision to men first eligible to entitlement in January 1972. (Sec. 107)

Permitting an additional year of earnings dropout for each 15 years of covered employment is supported because it leads to a higher average wage base and therefore greater benefits. However, we urge consideration and study of the disregard of income earned many years ago in average wage calculation in order to raise the average wage used for benefit computation figures. Average taxable wages per worker, for example, in 1956 were only 58% as great as those in 1969. (Sec. 108)

Sec. 111. Retirement test

Provides a liberalization of the retirement test for persons between ages 65 and 72. Allowable earnings limit increased from $1680 annually to $2000 with a 50% offset against benefits for earnings in excess of $2000. In respect to the latter, current law provides that $1 shall be deducted from benefits for each $2 earned between $1680 and $2880 and that for each $1 of earnings above $2880 there is a loss of $1 in benefits. On a monthly basis, provides no loss in benefits for earnings below $166.67 as contrasted with $140 as of now.

We strongly favor liberalizing the retirement test.

We support raising the allowable annual earnings limit to $2000 or $2200, but we do not believe that this kind of adjustment truly joins the issue.

What we seriously question is the equity of a uniform retirement test and of a monthly exemption. We propose that a workable alternative and a variable formula be developed to avoid the unfortunate effects of a uniform retirement test on total income of beneficiaries at different benefit levels. Further, we recomend the replacement of the monthly retirement test with a quarterly retirement test.

First, as to the uniform test:

The effect of a uniform test is the forfeiture of cash benefits by the beneficiary of smaller monthly benefits at a significantly lower level of total income than the beneficiary of benefits in the middle and upper benefit range.

For example, under the current retirement test, a $100 a month ($1200 a year) beneficiary forfeits all cash benefits when his total earnings are $3500. The beneficiary of $200 a month ($2400 a year) does not lose all cash benefits

until an earnings level approaching $5000 is reached and a $300 a month ($3600 a year) beneficiary would lose his entire social security payments only when he has earned close to $6000.

The figures can also be viewed in percentage terms. Under current legislation a $100 a month beneficiary with annual earnings of $3000 forfeits 60% of his benefits; a $200 a month beneficiary with the same earnings loses 30% of his benefits and a $300 a month beneficiary also earning $3000 has an offset of only 20% against his benefits. At an earnings level of $3500 the $100 a month beneficiary has lost 100% of cash benefits, the $200 a monthly beneficiary only 50.8% and the $300 a month recipient only 33.8%.

H.R. 1 liberalizes the retirement test, but retains the differential percentage loss. Under H.R. 1 a $100 a month beneficiary loses 41.6% of benefits with earnings of $3000; a $200 a month recipient with the same earnings loses 20.8% and a $300 a month recipient loses 13.8% of benefits.

The income tax does not remove the inequity brought about by the uniform test. Since social security cash benefits are not taxed, each beneficiary with, for example $3000 of earned income and using the tax tables, will have the same tax liability. The social security beneficiary at the upper level of cash benefits will not pay any more in tax dollars than the social security beneficiary at the lowest end.

Since the beneficiary of lower monthly social security cash payments was, for the most part, the lower income level earner his poor economic status is perpetuated in his older age years.

We propose that a flexible retirement test, related to the amount of social security benefits, replace the uniform test in a way which will not penalize the beneficiary of higher benefits. However, it should permit the beneficiary at the lower end of the scale to retain a larger proportion of his benefits than he can currently.

Second, as to the monthly computation:

The retirement test, both today and in the proposed legislation, is applied on a monthly basis. Regardless of the amount of annual earned income no beneficiary loses a social security payment for any month in which his income falls below $140 (current legislation) or $167 (H.R. 1).

The monthly test creates two problems: one of equity and the other of administration. A quarterly test will minimize situations such as the following: a retired school teacher serving as a substitute forfeits all benefits for the month in which she has earned over $167; however, in the next month or two she may earn nothing or less than $167. On a quarterly basis she would not be penalized, for each quarter would allow earnings of $500 before benefits would be withheld. Another illustration is the case of a consultant working for one month and earning a fee of $10,000. He may still collect all benefits for 11 months, with no forfeiture except for the one month during which his earnings were $10,000.

Administratively the quarterly method is feasible and has an advantage over the current monthly reporting schedule. The Social Security Administration could readily pick up quarterly earnings figures from the quarterly reports on FICA taxes submitted by the employer and showing both his share and the employee's share. Monthly earnings data rely on the reports of the social security beneficiary. It would likely be more accurate and certainly more prompt and simpler if FICA records were substituted for beneficiaries' reports data.

Sec. 122. Eligibility

Reduces the waiting period for benefits for disabled workers, disabled widows and disabled dependent widowers from six to five months.

We support this provision which is reported to affect nearly one million persons.

TITLE II—PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

A. PROVISIONS RELATING TO MEDICARE

(Amending Title XVIII of the Social Security Act)

Sec. 201. Eligibility for coverage extended to disability beneficiaries

Extends eligibility for hospital insurance and supplementary medical insurance to a social security disability beneficiary two years after entitlement to disability benefits. Coverage extended to disabled workers

entitled to social security or railroad retirement benefits, disabled widows and disabled dependent widowers between ages 50–65, and persons aged 18 and older receiving benefits because of disablement prior to age 22. Effective July 1, 1072.

We favor this proposed liberalization of eligibility.

Sec. 202. Extension of hospital insurance benefits to uninsured individuals

Extends eligibility for enrollment for hospital insurance on a monthly premium basis to a person who has attained age 65, is either a resident citizen or a lawfully admitted resident alien, and is not otherwise qualified for coverage. Initial monthly premium of $31 to rise as hospital costs rise.

We support the principle of enrollment on a monthly premium basis of persons otherwise ineligible for hospital insurance coverage. However, we question the utility of this proposal because of the size of the premium covering the full cost of protection.

Additionally, we urge that Medicare coverage be phased in for the early retiree, that is, the beneficiary between the ages of 62 and 65. A person taking early retirement—for whatever reason—not only receives actuarially reduced social security cash benefits but may very well have no health insurance protection. At least three reasons account for the lack of health insurance coverage for the early retiree.

. . . Many persons claiming benefits at age 62 have been out of work for several months and, therefore, have no employer-financed coverage. Intensifying the unemployment problems is the major reason for the unemployment: illness. In its *Survey of New Beneficiaries*, published in 1971, the Social Security Administration found that "Health is the most important reason described by over half the group, whether they stopped working at age 62 or more than three years earlier." So, large numbers of those taking early retirement are unemployed and in poor health and have been both unemployed and in poor health for some time.

. . . Even those employed just prior to early retirement are unlikely to be covered by the extension of their health insurance into retirement.

. . . Finally, many early retirees, with their small cash benefits, are unable to pay for private health insurance coverage.

We recognize the benefits of health care coverage for early retirees. We recognize, too, that costs are a factor. Therefore, we suggest phased-in coverage.

Sec. 203. Setting supplementary medical insurance premium

Directs the Secretary of HEW [1] to determine a premium as of December of each year estimated to be necessary so that the aggregate premiums for the 12-month period beginning July 1 in the succeeding year will equal one-half of the total benefits and administrative costs of the supplementary medical insurance program. However, the premium generally would increase only if monthly social cash benefits had increased since the last increase in the premium and would rise by no more than the percent increase in such benefits across the board.

We support the reasonableness of the proposed basis for increasing the supplementary medical insurance premium charges. We particularly favor the provision that, beginning with fiscal 1973, no increased premium may be charged unless there has been an increase in social security cash benefits, either as the result of the enactment of legislation raising the benefit level or as a result of the automatic cost of living benefit rise.

Sec. 204. Deductible

Increases the annual deductible for supplementary medical insurance (Part B) from $50 to $60.

We regret the apparent need to increase the deductible for Part B of Title XVIII, but we do not oppose this change. However, we believe this should be accompanied by a change in present law with respect to the deductible for hospital insurance (Part A of Title XVIII). This now is $60 for each benefit period and is scheduled to go to $68 in January 1, 1972, reflecting the increase in hospital costs. Since a patient may be admitted to and discharged from a hospital

[1] . . . nt sections. HEW is substituted for *Secretary* of HEW.

several times a year, he could be required to pay the deductible five times, totaling $300 a year as of now and $340 as of January 1, 1972. The payment of even two or three deductibles a year causes financial hardship to many. We, therefore, recommend the benefit period in respect to the deductible for Part A be defined as one year, which is the period used for computation of the deductible under Part B.

Sec. 205. Benefits and coinsurance

Increases from 60 to 120 days the lifetime reserve under which the beneficiary pays one-half of the deductible for hospital inpatient care. Shortens from 60 to 30 days the period in a spell of illness when coinsurance is not imposed for hospital inpatient care.

Benefits, that is to say the coverage of specified services for a specified duration or a specified volume under Parts A and B, are largely unchanged [4] in H.R. 1 *except* as they are affected by changes in provisions in respect to coinsurance or deductibles. We view the increase in the lifetime reserve for hospital inpatient care as a highly desirable liberalizing feature of the Bill. This may well be a trade off, compensating in part for the shortening from 60 to 30 days the period in a spell of illness when coinsurance is not imposed for hospital inpatient care. We rather regret this tightening measure, but we recognize that vast numbers will still be covered since the average hospital stay of Medicare patients is only 12.8 days and 91% of the discharges from hospitals—other than psychiatric or tuberculosis—represent stays of fewer than 30 days.

There is, however, a serious omission from the benefits. The cost of out-of-hospital prescription drugs is a serious financial burden to the elderly and the federal social insurance program provides a feasible and efficient mechanism to alleviate the problem. We urge the inclusion of such a program under Part A of Medicare.[5] We recommend a $1 co-payment per prescription or refill by the beneficiary, with payment of the balance to be made by the Social Security Administration to the vendor. At the same time we suggest that HEW undertake further study of a just and effective method of utilization conrol.

Sec. 206. Automatic enrollment in supplementary medical insurance

Provides automatic enrollment under Part B for individuals entitled to hospital insurance benefits.

We favor this proposal but suggest that the new social security beneficiary be informed of the reason for a deduction from his monthly cash benefit check. An insertion, for several months running, in the envelope with his check would appear a satisfactory way of informing the retired worker of the fact and cost of his coverage, and of his option to withdraw from part B coverage.

Discussed below are certain specifics directed to Medicare cost controls that affect large numbers of persons or embody broad principles—Sections 2221–4 226, 228, 234 and 236.

Sec. 221. Limitation on federal participation for capital expenditures

Authorizes withholding or reducing reimbursement amounts to providers of service under Medicare (Title XVIII and also Titles V and XIX) for defined costs related to certain capital expenditures that are inconsistent with state or local health facility planning. For this purpose, capital expenditures are defined as expenditures for plant and equipment in excess of $100,000; which change bed capacity; or substantially change services.

We strongly endorse the provision that capital expenditures as here defined would be reimbursed only when such outlays are consistent with state or local plans. Mushroom expansion without regard to overall needs is wasteful.

Sec. 222. Plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy

Authorizes HEW to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvan-

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[4] There are modest changes in respect to physical and other therapy services (Sec. 251), coverage of supplies related to colostomies (Sec. 252), coverage of ptosis bars (Sec. 253), hospitalization for a noncovered dental procedure (Sec. 256), prosthetic lenses furnished by optometrist (Sec. 264).

[5] Available on request is a detailed fact sheet and outline of a proposed program.

tages of various alternative methods of prospective reimbursement to hospitals, extended care faciilties and other providers of services under Title XVIII (applicable also to Title V and XIX).

Clearly, the present system of provider reimbursement on the basis of "reasonable costs" carries little incentive for efficiency. We support the authorization for HEW to develop ways of testing the efficacy of the alternative whereby rates are set in advance of the period to which they are applicable. We inject a word of caution about the possibility of lowering the quality of care *and* some escalation in costs. Advance rate setting may result in losses to providers when costs rise above those anticipated; the temptation to cut corners and reduce service is a real threat. Contrarywise, prospective rates can be escalated to avoid an unfavorable spread between the actual and estimated costs.

In respect to experiments with various reimbursement methods designed to increase efficiency and economy: We support this provision and particularly welcome its linkage to community wide peer, medical and utilization review mechanisms designed to assure that health services meet professional standards and that medically necessary services are given in the most appropriate and economical setting.

There is no provision for adoption into practice of effective experiments—an oversight that should be corrected.

Sec. 223. Limitations on coverage of costs

Provides authority to set cost limits for certain classes of providers in various service areas on a prospective rather than a retrospective basis. Requires public notice to beneficiaries of charges beyond reimbursable limits.

We support the requirement that providers be informed in advance of the approved reimbursable limits and that beneficiaries be advised of the nature and amount of extra charges. We would add to this a requirement for disclosure by the financial intermediary to both public bodies and the consumer of reimbursable costs in the locality for standardized services and procedures. In our view, this additional measure of public accountability is important.

Sec. 224. Limits on prevailing charge levels

Limits increases in physicians' charges through June 1972 for fee scales up to the 75th percentile of prevailing charges; after fiscal 1973 provides that physicians' fees may be increased only to the extent justified by economic changes; provides that charges deemed reasonable for medical supplies, equipment and services may not exceed the lowest level at which such items, comparable in quality, are widely available in a given community.

We recognize the need for setting limits on prevailing charge levels and concur as to the need for continuing study and attention to this thorny question. We note that the Bill authorizes HEW to develop "appropriate economic index data" as a basis for adjusting fees, but that the House Ways and Means Committee is fairly specific in its report on the items to be considered for such an index computation. We urge that such study be both sophisticated and objective as a means of providing a fee structure that is fair, defensible and supportable.

Sec. 226. Payments to health maintenance organizations

Adds a new section to Title XVIII providing for payments to health maintenance organizations.

We support the encouragement given to the development of health maintenance organizations as one acceptable, alternative mechanism through which patients eligible for Medicare could elect to have all covered care, except emergency service, provided.

Sec. 228. Advance approval of extended care and home health services

Provides authorization to establish periods of time for which a patient is presumed eligible for extended care and home health services on certification by the patient's physician.

We are in agreement with this provision. The establishment of specific post-hospital time periods during which there is presumptive need for such services should encourage transfer to less costly types of care and should decrease the number of cases in which benefits are retroactively denied.

Sec. 234. Institutional planning

Requires that participating health facilities have a written plan reflecting an operating and capital expenditures budget.

We welcome the inclusion of this requirement which is clearly tied to other Sections, e.g., Sec. 221 and Sec. 222.

Sec. 236. Prohibition against reassignment of claims

Prohibits Part B Medicare payments being made to anyone other than a patient, his physician or other person providing the service (with limited exceptions).

We support this provision which seeks to close a loophole in the existing law and control undesirable collection practices that have resulted in inflated claims and escalated costs and beclouded the determination of reasonable limits.

Sec. 265. Deletes requirement for social service in extended care facilities

Prohibits HEW from requiring an extended care facility to furnish medical social services.

We are not persuaded by the arguments put forward in the report of the House Ways and Means Committee to support this Section which would nullify the HEW regulation requiring the furnishing of medical social services as a condition of participation for extended care facilities under Medicare. We urge the removal of this Section from the Bill and review of the regulations by HEW to determine their fairness in the light of experience to date.

Sec. 269. Requirements for nursing home administrators

Permits states to provide a permanent waiver from any licensure requirements for persons who served as nursing home administrators for the three-year period preceding the year the state established a licensure program.

We urge the deletion of this Section which would appear to permit administrators who could not meet licensure requirements to return to or remain in practice. We believe that the device of licensure upgrades service by upgrading administration. The public interest should be protected rather than private, vested interests which would seem to profit by this proposed permanent waiver.

B. PROVISIONS RELATING TO MEDICAID

(AMENDING TITLE XIX OF THE SOCIAL SECURITY ACT)

Sec. 207(a)(1). Incentives for states to emphasize comprehensive health care

1. Increase in federal reimbursement.

Provides that states in contract with Health Maintenance Organizations (HMOs)[4] or other comprehensive health care facilies would receive 25% increase (up to 95%) in federal reimbursement percentage under the Medicaid program.

We strongly favor prepayment over the fee-for-service method of financing health care. We support the intent of encouraging new patterns for the delivery of health care and believe that the quality of health service can be significantly improved under a program providing comprehensive coverage. We do not believe that there are sufficient safeguards in H.R. 1 to assure that improved patient care will necessarily result. We think that the Bill should stipulate that HMOs, or other comprehensive health organizations, that are formed in keeping with the Bill's provisions, must be under public or private non-profit auspices.

2. Decrease in federal reimbursement.

Provides that the federal medical assistance percentage would be decreased by one-third after the first 60 days of care, in any fiscal year, in a general or tuberculosis hospital or a skilled nursing home, unless the state establishes that it has an effective utilization review program.

For inpatient care in a mental hospital, federal reimbursement would be decreased by one-third after 90 days except that it may be extended for 30 days if the state can show that the patient will benefit therapeutically from such care. No federal reimbursement would be provided after 365 days care in a mental hospital.

[4] An HMO is an organization that offers to an enrolled population, a comprehensive system of health service, including preventive, ambulatory, hospital and related care on a capitation reimbursement basis.

We believe every effort should be made to less costly facilities than hospitals when such care is appropriate and adequate to an individual patient's needs. We think, however, that some of the assumptions about need for hospitalization and length of stay on which the reductions are based do not give full weight to the fact that Medicaid covers persons under 65 as well as over 65 and that not all patients irrespective of age and condition require treatment of only short duration in "acute" hospitals. Moreover, the lack of facilities to provide different levels of care poses a major problem, especially for those who may need something less than full hospital care but who do need institutional care until well enough to be cared for at home. We are concerned that as a result of these amendments, appropriate and adequate health services may be denied those persons who are most vulnerable.

3. Computing reasonable reimbursement between skilled nursing homes and intermediate care facilities (ICFs).

Authorizes HEW to compute a reasonable cost differential reimbursement between skilled nursing homes and ICFs.

The apparent purpose of this amendment is to assure that care in an ICF results in decreased costs to the Medicaid program. We support the measure as being administratively sound.

Sec. 208(a). Cost-sharing

Permits states to impose a nominal cost-sharing charge on cash assistance recipients for non-mandatory services under the Medicaid program. Requires states to impose on those not receiving cash assistance an enrollment fee premium or similar charge related to income, and permits co-payment provisions not related to income.

In addition to our basic obections to the imposition of charges on Medicaid recipients as stated in Part I, we believe the costs of administering these proposals would be prohibitive and that patient services would be unnecessarily delayed in the course of establishing eligibility for care.

Sec. 209 (c) and (d). Determination of payments

Sec. 209(c) denies Medicaid coverage to those in receipt of cash assistance whose incomes are in excess of the medical assistance level established by the state. *Sec. 209(d)* permits states to deny Medicaid coverage to those persons who would be newly eligible for cash assistance under the income maintenance sections of H.R. 1. If a state chooses to provide Medicaid it would be required that recipients' incomes not be in excess of the state's medical assistance level.

We strongly object to both these proposals. Currently, states that have a Medicaid program are required to provide care under Medicaid for all recipients of cash assistance. We believe these amendments strike at the basic purpose for which the Medicaid program was first enacted, that is, to assure a program of health care for persons in financial need. *Sec. 209(d)* is ominous since it gives tacit approval to states to deny health care to needy families and at the same time releases the federal government from any responsibility for reimbursement to the states which so act, for health care payments for their needy families.

Sec. 221(a). Limitation on Federal participation for capital expenditures

Prohibits use of funds appropriated under the Social Security Act to support unnecessary capital expenditures; provides that reimbursement under such titles would support state health planning activities.

We are in full support of this provision. It takes into account that state and local health planning agencies have primary responsibility for determining the need for health facilities for given geographic areas and provides that capital expenditures under Title XIX of the Social Security Act would be related to the priorities established by the health planning agencies.

Sec. 222(a)(1). Plan for prospective reimbursement

Authorizes HEW to develop and engage in experiments and demonstration projects designed to determine the advantages and disadvantages of various alternative methods of prospective reimbursement to

hospitals, extended care facilities, and other providers of service under Title XIX in order to stimulate more efficient health care and thereby reduce costs, without adversely affecting the quality of services.

We favor this proposal in the belief that more effective patient care, more efficient use of health personnel and a decrease in medical costs could result from this kind of experimentation. There is no provision, however, that those experiments found effective might be authorized to be continued; we believe this oversight in H.R. 1 should be corrected.

Sec. 231. Deductions in care and services

Permits states to reduce the scope and extent of health services which are optional under Medicaid.

Currently, states may not reduce the level of their expenditures for their Medicaid program in successive years. We object to this amendment because it would permit the states that choose to do so, to deny or diminish the availability of vital health services which are defined, under the Medicaid statute, as optional. We believe the optional services are necessary components of adequate health care and should not be withdrawn.

Sec. 235(a). Payments to states for claims processing and information retrieval

We fully support both of these amendments. The first should assure at least basic standards for the quality of care provided to Medicaid recipients. The second provision sensibly makes use of an existing mechanism to provide a service for the Medicaid program; the quality of care under Medicaid should be improved by this provision.

Makes federal matching under this provision available to states for developing and instituting mechanized claims systems at 90% and 75% for operation of such systems.

We support this proposal because it should encourage rapid development of mechanized collection and retrieval systems to the end that the Medicaid reimbursement and related operations would be more efficiently administered.

Sec. 236(b). Prohibition against reassignment of claims

Prohibits Medicaid payments to anyone other than the patient, his physician or other service provider unless the provider is required as a condition of employment to turn over his fees to his employers.

We fully support this provision which would outlaw the use of fee collection agents by providers of services under Medicaid.

Sec. 239 (a) and (b). Use of state health agency

Sec. 239(a) requires states to provide that the state health agency, or other appropriate state medical agency, have responsibility for establishing and maintaining health standards for institutions in which Medicaid recipients may receive care or services. Section 239(b) requires that the state health agency or other appropriate state medical agency, be given responsibility for establishing a plan for the review by professional health personnel of the quality and appropriateness of care and services furnished to Medicaid recipients.

Sec. 240. Relationship between medicaid and comprehensive health care programs systems

Provides that states may enter into contracts with organizations that agree to provide care and services in excess of those offered under the state plan at no increase in costs.

We question this proposal in the absence of an acceptable minimum standard throughout a state. However, we see as desirable, experimentation that likely would emphasize preventive care and early treatment in order to contain costs, and on this basis support the proposal.

Sec. 254(a)(1) and (a)(2). Inclusion of care in intermediate care facility

Sec. 254(a)(1) provides, as an optional service, care in an Intermediate Care Facility (ICF) as an additional benefit under Medicaid. *Sec. 254(a)(2)* provides that services in a public institution for men-

tally retarded persons would qualify for Medicaid coverage, if the primary purpose is to provide health or rehabilitation services, and if the patient is receiving active care.

Currently federal reimbursement for care in an ICF is not available under the Medicaid program. Each of these provisions, in our view, would be desirable additional elective benefits for Medicaid recipients.

Sec. 255(a). Coverage prior to application

Requires states to provide coverage for care and services furnished in or after the third month prior to application for Medicaid.

Under present law, a state may at its own option, cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for Medicaid. We favor this amendment as being both sound and desirable.

TITLE III—ASSISTANCE FOR THE AGED, BLIND AND DISABLED

(NEW TITLE XX OF THE SOCIAL SECURITY ACT)

Sec. 2002 and Sec. 2003. Administration

Sec. 2002 provides that eligible aged, blind and disabled individuals shall be paid benefits by HEW. *Sec. 2003* provides that HEW make arrangements to carry out the assigned functions, including arrangements for determination of blindness and disability similar to those in effect in determining eligibility for social security disability benefits.

Although the Bill does not so specify the report of the Ways and Means Committee recommends that responsibility for administering the program of cash benefits to the needy aged, blind and disabled shall be assigned to the Social Security Administration (SSA). We welcome this recommendation. Persons receiving benefits under this program for the most part comprise a relatively stable group, similar to the OASDI beneficiaries. We believe that the SSA's long experience in administration of payment programs would enable it to administer this new program efficiently and humanely.

Services to the needy aged, blind and disabled would continue to be provided through federal-state financing and be administered by the states. Those in need of services would have contact with the local social services unit of the state administration. In our view, the administration both of the cash payments and services for this group of persons should be simplified and flexible because they are limited in ability to respond to complicated procedures by the very nature of their eligibility.

Sec. 2011(b). Cash assistance; amount of benefits

Prescribes the amounts payable in 1973, 1974 and 1975 to individuals, with or without an eligible spouse, whose non-excluded resources are not more than $1500. The Bill does not require that the couple be living together.

The Bill provides cash assistance in the amount of $1560 for a single person and $2349 for a couple. These amounts are increased to $1800 and $2400 respectively by 1975 and are to remain at that level thereafter. The level of assistance projected in the Bill is inadequate as evidenced by the fact that the poverty level as determined by the 1970 Census is $1861 for an aged individual and $2348 for an aged couple; due to the inflationary factor this level had increased approximately 5% by 1971 and unquestionably will be even higher by 1975. The Bill should be amended to provide a level of assistance adequate to meet basic need.

Sec. 2012(b)(3), Sec. 2016 and Title V, Sec. 509—Exclusion from income; optional state supplementation; state supplementary payments during transitional period

Sec. 2012(b)(3) provides for exclusions from income: $85 of earnings plus one-half of the balance for the blind and disabled and $60 of earnings plus one-third of the balance for the aged. *Sec. 2016* permits states to supplement the federal payment. *Sec. 509 of Title V* requires the states to make supplementary payments to maintain their payment level of

June 1971 plus the bonus value of food stamps unless they modify that level by affirmative legislative action to the contrary prior to July 1972.

Eligibility conditions for assistance would be uniform nationally. However, blind and disabled persons would receive more liberal income deductions than the aged and therefore the amount of assistance granted the different groups would not be uniform. The difference in disregards among the three categories should be corrected. Further inequities would result from the optional provision for state supplementation. We believe that needy persons should receive an adequate level of assistance to meet need. Therefore, the states should be required to supplement the federal payment at least to the current payment levels.

Sec. 2031(a)(2). Protective payments

Authorizes payments of the benefits to a person other than the individual or his spouse (including an appropriate public or private agency) if HEW deems it appropriate.

Assistance payments may be made to a third party (including an appropriate public or private agency) who is interested in or concerned with the welfare of the recipient, if HEW deems this to be appropriate. While it is believed that this leeway may be in the best interest of an aged, blind or disabled recipient, the regulations and procedures governing determination of appropriateness should safeguard against excessive use of this provision. The conditions under which these payments would be ordered should be included in the Bill.

Sec. 2011(c) and Sec. 2031(c). Application process—period for determination of benefits; application and furnishing of information

Sec. 2011(c) provides that eligibility for and the amount of benefits shall be determined for each quarter of a calendar year and shall be redetermined at such time or times as may be provided by HEW.

Sec. 2031(c) directs HEW to prescribe requirements for filing applications, suspending or terminating assistance, furnishing data and reporting changes in circumstances and specifies the penalties for noncompliance by the applicant or recipient.

In our judgment the current annual redetermination is preferable to a quarterly review of eligibility and should be retained, especialy in view of the relatively stable circumstances of this group of recipients. We favor the simple declarative form for determining eligibility over extensive investigations and recommend that the Bill provide for its use.

We further recommend that the Bill allow for flexible application of the requirements for reporting changes in circumstances with due consideration for the hardship which rigid application of penalties would impose on the very old and seriously disabled.

Title IV—The Family Programs

(New title XXI of the Social Security Act)

Sec. 2111, 2112, 2114. Operation of manpower programs; employable mothers; child care and other supportive services

1. Operation of manpower programs

Sec. 2114 requires the Secretary of Labor to develop an employability plan describing the manpower services, training and employment needed to enable each individual to become self-supporting and secure and retain employment and opportunities for advancement.

Several of the employment provisions must be changed to make them truly effective in helping persons achieve self-support. There must be a sufficient number of jobs, paying adequate wages and meeting acceptable working conditions. It is not realistic to mandate employment but fail to provide satisfactory training programs and sufficient work opportunities.

The Bill creates public service jobs paying at least the federal minimum wage, to supplement other employment opportunities but these are few in number and temporary. Federal reimbursement will not extend for more than three years of an individual's employment in a public service employment program. After that period a person must either be hired by the agency or terminated. Permanent public service jobs should be created to the extent needed to meet mandated employment requirements.

The Bill requires that wages for the public service jobs shall be at least at the federal minimum but permits wages in private employment, which a needy person could be required to take, at 75% of the federal minimum. The Bill should require that all mandated employment shall be at last at the federal minimum wage level; that conditions of work shall be of acceptable standard; and that the job a person is required to take shall be suitable to the person, with suitability defined with respect to such matters as a person's prior training and experience and the distance of work from his home.

2. Employable mothers; child care and other supportive services

Sec. 2111 includes as an individual who shall be considered available for employment, a mother of a child three years old or, until July 1, 1974, six years old.

Sec. 2112 provides that the Secretary of Labor shall make provision for the furnishing of child care services, in such cases and for so long as he deems appropriate for the individuals registered for employment or training who need such services to participate in the program through such public or private facilities as may be available or appropriate.

After 1974, mothers of children over three years would be required to accept employment or training (unless there is a husband in the home who is registered) whether or not suitable child care services are available. Considerable hardship to children could be caused if despite the authorization to the Secretary of Labor to make provision for such services suitable child care is not available. Furthermore, the requirement that a mother of young children shall be considered available for employment removes from her the right to determine if it is in the best interest of her child for her to work or remain at home; that decision should be based on the needs of a particular family, including the availability of suitable care for the children.

Sec. 2134. Child care standards; development of facilities

Directs the Secretary of HEW to establish standards assuring quality of child care services with the concurrence of the Secretary of Labor; to prescribe schedules to determine the extent to which families must pay the costs; and to coordinate child care services under Title XXI of the Social Security Act with other child care and social service programs.

Authorization of funds for child care services is provided but in an insufficient amount to meet the need and should be increased. HEW would be required to set standards of care. Setting and overseeing standards of care is particularly important since the Bill permits contracts for day care with profit-making as well as with public and nonprofit agencies. Adequate day care, not now defined, should be defined in the Bill and the standards set should be in line with these definitions. This is essential if mothers of young children are to be compelled to accept work or training.

Sec. 2152(a) and (b) and Sec. 2152(d). Cash assistance: eligibility for and amount of benefits; periods for determination of benefits

1. Eligibility for and amount of benefits

Sec. 2152(a) and (b) prescribe benefits for eligible families at the rate of $800 per years for each of the first two members, plus $400 for each of the next three, plus $300 for each of the next two members, plus $200 for the next member, to a maximum of $3600, reduced by non-excludable income; no benefit is payable of under $10 per month. Resources may not exceed $1500.

The nationwide minimum standard of payment for needy families with children would not be adequate. The payment levels—for example, $2400 annually for a family of four persons—is less than even the poverty level of $3968 for a family of four determined by the 1970 Census. And since no family could receive more than $3600 regardless of the number of family members, large families would be even further below this poverty line. Therefore, substantial increases in payment levels must be made if persons are to have an adequate level of existence—particularly since this Bill would freeze the federal payment at this level for the five years' duration of the Bill.

2. Period for determination of benefits

Sec. 2152(d) provides that payment of benefits shall be made on the basis of HEW's estimate of the family's income for the current quarter

after taking into account income from the three preceding quarters and modifications for changes of circumstances.

The federal payment should be computed according to a family's current need. H.R. 1, however, provides that the portion of a family's income during the nine months preceding application for the FAP payment in excess of the payment level (including excludable income) would be deducted from benefits otherwise due at the time of application. In the case of such excess income, a family woud not receive even the inadequate federal payment. This provision should be changed. Only need at the time of application shoud determine eligibility and amount of payment; it should not be assumed that persons have saved money from a prior period.

Sec. 2153(b). Work incentives; income disregard

Enumerates the items to be excluded in determining the income of a family such as a student's earnings; irregular income limited to $30 a quarter if earned or $60 a quarter if unearned; earned income used to pay the cost of child care as prescribed by HEW; $720 plus one-third of the remainder of earned income. The total exclusions of the first three cannot exceed $2000 for a family of four, up to maximum of $3000.

To encourage persons to work, the Bill provides that some income from earnings be retained and disregarded in computing eligibility for benefits. Out of earned income, $720 per year plus one-third of the excess earned would be excluded. Thus, payment to four-person families in which there is a working member would be made only if the allowable income is $4140 or less. Although child care costs are deductible, the total of these costs, irregular earnings and student earnings could not exceed $2000.

Work expenses such as transportation and taxes are not excluded in determining a family's income. Therefore, if these costs are higher than the retained income, a working family could find itself with less money at its disposal than if no member were employed. To provide a true work incentive, the Bill must permit retention of a larger share of earnings. Furthermore, the ceiling on income exclusions should be removed, particularly since these include the cost of child care services. If, for example the cost of day care absorbed the total allowance for excluded income a school child working irregularly would not be permitted to retain any of his earnings.

Sec. 2155 and Sec. 2156(b)(2). Exclusions from coverage; meaning of family and child; exclusions from state supplementation

1. Meaning family and child.

Sec. 2155 defines those who qualify as family members and ,therefore, are eligible for benefits under the family programs, as two or more related persons living together in the United States, at least one of whom is a citizen or alien lawfully admitted for permanent residence, and with at least one child dependent on one of the others. It expressly excludes families headed by full-time college students.

By definition, federal payments would not be made to needy single adults or childless couples who are not aged, blind or disabled nor to needy families headed by a full-time college student. Persons in these groups would be without access to public assistance except in those states which made provision for their aid without benefit of federal reimbursement. A basic level of financial assistance should be made for all *needy* persons and the Bill amended to include these excluded groups in the federal system of income maintenance.

2. Exclusions from state supplementation.

Sec. 2156(b)(2) permits states to deny benefits to families with both parents present and neither parent incapacitated, regardless of whether the father is employed or unemployed.

There are exclusions within the groups eligible to receive FAP or OFF payments which we believe should be removed. States are permitted to exclude from supplementation of FAP or OFF payments, families in which both parents are present and neither is incapacitated regardless of whether the male parent is employed or unemployed. It should be required that the states include *all* needy families in their supplementary programs.

Sec. 2155(d). Forced responsibility of step-parents; income and resources of non-contributing individual

Excludes income and resources not available to other family members if it derived from a family member other than a parent or a spouse of a parent.

The income and resources of a parent's spouse living with the family would be included in determining the family's eligibility for benefits even though the spouse does not have legal responsibility for the children and may have his own children elsewhere to support. This can result in needy children being denied assistance and thus penalized because of a parent's marriage. This provision should be changed so that the spouse's resources would not be included on behalf of those persons in the family for whom he does not have legal responsibility.

Sec. 2156 and Title V. Sec. 509. Uniformity in amounts of assistance; optional state supplementation; state supplementary payments during transitional period.

Sec. 2156 permits the states to make cash payments to supplement the federal payments and requires that the supplementary program respect the federal earnings disregard provisions. The states are not required to include families with a male parent present in their supplementary program. *Sec. 509* requires the states to make supplementary payments to maintain their payment level of June 1971 plus the bonus value of food stamps unless they modify that level by affirmative legislative action to the contrary prior to July 1972.

We are in full support of the provision for uniformity in the amount of federal payments based on uniform conditions for determining eligibility. The level of payments, however, is inadequate. Moreover, since supplementation is optional with the states and they are permitted to exclude certain groups from their supplementation program, if any, there would be inequalities in the amount of assistance among needy families with children in the various states. All persons should have a right to an adequate level of assistance which should not leave them in poverty. We believe the states should be required to supplement the inadequate federal payment at least to their current payment levels.

Sec. 2171(a)(2)(A) and Title V. Sec. 529. Indirect payments; vendor payments

1. Indirect payments of benefits.

Sec. 2171(a)(2)(A) permits payment to any person other than a family member (including an appropriate public or private agency) if HEW finds that the family member to whom benefits are payable has such inability to manage funds that making payment to him will be contrary to the welfare of the children in the family.

Payments may be made to non-family members if it is found that the payments are not being used in the best interests of the family. The Bill should state the criteria for finding the family incapable of managing its own affairs and the conditions under which such third party payments may be ordered.

2. Vendor payments under the AFDC program

Sec 529 of Title V effective immediately upon enactment authorizes the states to provide for non-recurring special needs which cost $50 or more by payment directly to the person furnishing the item.

This provision immediately applicable to the current AFDC program, permits states to pay the provider directly for goods or services costing $50 or more. This method of paymentis contrary to the premise that needy families have a right to manage their own affairs, including making purchases and handling money, in the absence of proof that they are unable to do so.

Sec. 2171(c). Hearings and review

Requires notice and opportunity for hearings for anyone who disagrees with a determination with respect to eligibility for or amount of payments, if requested within thirty days. Final determination by HEW after a hearing would be subject to judicial review, except that HEW's findings as to facts shall be conclusive.

The Bill fails to specify certain fundamental standards for the conduct of hearings when a recipient challenges administrative decisions, such as adequate

notice of the reasons for the initial determination. In providing that findings of fact are not subject to judicial review, the Bill does not add the necessary protection against arbitrary findings—that they must be supported by a clear preponderance of the evidence. Furthermore, the Bill should require that a recipient shall receive benefits pending the final decision.

Sec. 2152(e) and Sec. 2171(c). Application and biennial reapplication process

Sec. 2152(e) prohibits benefits being paid a family for more than twenty four consecutive months except on the basis of a new application filed and processed as though it were the family's initial application for benefits.

Sec. 2171(e) directs HEW to establish requirements for filing applitions, suspension or termination of benefits, furnishing data and reporting changes in circumstances necessary to determine eligibility. Each family shall be required to submit a report within thirty days after the end of the quarter to determine eligibility for benefits payable for that quarter or be subject to penalty.

The Bill should prescribe a simplified method for determining eligibility for benefits both in the initial application and the biennial reapplication process. The Bill requires families to make quarterly reports of income and expenses within thirty days, under automatic penalty. It requires a family to file a new application to be treated as if it were an initial application despite the accumulated data of twenty-four consecutive months. We believe that the emphasis in the Bill on investigation, furnishing evidentiary materials and frequent routine reporting to substantiate eligibility for benefits, is costly and unnecessary in most cases and would impose needless hardships on families. Flexibility in the application and reapplication process should be permitted while at the same time assuring that benefits are paid only to eligible persons. We recommend provision be made for the use of the simple declarative statement where appropriate, a method now in use in many states.

Sec. 2102, 2151, 2156, etc. Administration; multiple sections

This Bill would necessitate a complicated administration requiring continuing contact among several federal, state and local agencies. Locally, there would need to be a tremendous increase in the state and local offices for providing cash assistance, services and employment.

The FAP program and the payments to OFF recipients would be administered by HEW. Other agencies would be involved to provide information to establish eligibility. If requested, HEW would administer a state's supplementary program and Medicaid eligibility. As an inducement, the state would pay HEW the amount of the supplemental payments and be relieved of responsibility for the administrative costs.

The OFF program of training, work and employment would be administered by the Department of Labor including such supportive services as day care. This can be done by direct federal administration or through contacts with state and local agencies.

Nearly all recipients would be required to have contact with many agencies. Among the local offices with which a head of a needy family may have to deal could be that of HEW administering payments and of the Department of Labor, and possibly with a day care center or some other office rendering a service. Since the states would continue to administer the social service programs under the present federal-state matching arrangements the recipient requiring service would need to have contact also with local social service units of state administration. It is to be hoped that procedures will be devised to minimize and coordinate the multiplicity of agency contacts necessitated by this Bill.

TITLE V—MISCELLANEOUS[1] NEW SOCIAL SERVICES PROVISIONS

(AMENDING TITLES IV AND XI OF THE SOCIAL SECURITY ACT)

Sec. 511. Definition of services

Sec. 511(a) lists twelve services for individuals in a family receiving assistance to needy families with children, which the state plan may

[1] For discussion of Sec. 509—State supplementary payments during transition period, see pp. 47 and 54.
For discussion of Sec. 529—Payment under AFDC program for nonrecurring special needs, see page 55.

include in its service program. These are: family planning including medical services, child care, services to unmarried girls who are pregnant or have children, protective services, homemaker services, nutrition services, educational services, emergency services in connection with a crisis or urgent need, services to assist in training or employment, assistance in locating housing, services to abusers of drugs or alcohol, information and referral services.

Sec. 511(b) lists eight services for aged, blind or disabled persons receiving assistance under Title XXII or other needy aged, blind or disabled persons which state plan may include in its service program. These are: protective services, homemaker services, nutrition services, assistance in locating housing, emergency services in connection with a crisis or urgent need, services to assist individuals to engage in training or employment, services to abusers of drugs or alcohol, information and referral services.

States should be encouraged to develop those service programs which would best meet their local needs. Specifying in the Bill the services to be offered limits the variety and scope of the states' programs. We prefer the broad statement of the purposes for which services are to be provided now in the law to an enumeration of specific services. However, if the states are to be limited to the services enumerated in the Bill, that list should be enlarged to include all the services that may be required to achieve the purposes of the Act.

Sec. 512. Authorization and allotment of appropriations for services

Authorizes an appropriation of a maximum of $800 million for payment to states for training of personnel, for services to the aged, blind and disabled and for services for any individual receiving assistance to needy families with children.

Although the program of matching grants to states for services to needy families and needy aged, blind and disabled persons would be continued, the Bill makes an important and, we believe, undesirable change. For the first time, a limit would be placed on the amount of money to be appropriated for services (except family planning and child care services which would be funded differently) to these groups of eligible persons. Under current law, there is a ceiling on appropriations for child welfare services to non-recipients of cash assistance but appropriations for services otherwise are open-ended. The federal government matches what the states spend.

We urge that the Bill be amended to restore open-ended appropriations, thereby encouraging, not discouraging, the states to develop the preventive, supportive and rehabilitative services which are needed. Furthermore, the financial plight of so many states and the lack of sufficient services is reason for giving consideration to the possibility of federal assumption of the cost of services.

Sec. 513. Adoption and foster care services under child welfare services program

Authorizes $150 million for the year ending June 1972 rising to $200 million for the year ending June 30, 1976 for payments for foster care (including medical care not available under any other state plan) for a child for whom a public agency has responsibility and for payments to a person adopting a handicapped child. Payments may be made to any agency, institution or person if the care meets standards prescribed by HEW.

The large numbers of children who are in need of foster care make it particularly necessary for their protection that the Bill define the standards of care required with respect to quality of care, health and safety. Because of the difficulty in finding good foster care for children, we commend the inclusion of funds for the cost of locating such resources.

Payments to a person adopting a physically or mentally handicapped child (based on financial ability to meet the medical and other remedial needs of the child) should expedite placement of hard-to-place children, especially those requiring costly medical care.

With respect to both the foster care and adoption program, we believe the Bill should provide an open-ended not a close-ended appropriation.

Sec. 522. Statewideness not required for services

Permits HEW to make exceptions to the requirement that the plan for social services should be in effect in all political jurisdictions of the state. (Amends Titles I, IV, X, XIV, XVI)

Although grants to states would continue to be based on an accepted state plan, the plan no longer would have to be enforced throughout the state. We consider this an unfortunate change in the law. It could result in uneveness within a state depending on the locality of the regular, continuing services offered and uneveness in their delivery.

NATIONAL COMMITTEE FOR CAREERS IN THE MEDICAL LABORATORY,

Bethesda, Md., FEBRUARY 4, 1972.

To The Senate Committee on Finance.

From Thomas M. Peery, M.D., Chairman, National Committee for Careers in the Medical Laboratory.

For inclusion in the hearing record on H.R. 1, we wish to give you information that should encourage the adoption of Section 241, requiring the development and employment of proficiency examinations as an alternate way for health care personnel to demonstrate competence under Medicare standards.

We believe you should know of our experience in developing such proficiency examinations for clinical laboratory personnel, with the support of the Manpower Administration of the Department of Labor and the expert assistance of Educational Testing Service.

We found that experts in our field were enthusiastically ready to participate in test development, that appropriate employer organizations were ready to support the use of such examinations, and that candidates have been eager to come forward in hope the examinations will benefit them in their laboratory careers. The project got underway in July 1970; the first examinations were given in November 1971.

Fifteen hundred laboratory workers—most of them with military laboratory training and experience—took the examinations in November at 126 test centers, including 30 military bases (19 of them overseas). Test scores have recently been sent to the candidates. Those who did well can use their scores to gain recognition from present or prospective employers. Military-trained candidates in general did very well in comparison with those trained in civilian laboratory programs.

Enclosed are the following documents:

1. "Equivalency and Proficiency Testing in the Medical Laboratory Field," a summary of our study which led to the proficiency examinations project. A companion project for development of equivalency examinations for academic credit is also underway, funded by the NIH Division of Allied Health Manpower.
2. Interim Report on the proficiency examinations project, April 1971, describing the method by which the examinations were developed.
3. Press release and Bulletin of Information for candidates announcing the next administration of the examinations in May 1972.
4. Content and Norming booklet with scores of representative groups of laboratory technicians, against which to compare the scores of individual workers.

We understand that Medicare officials plan to make use of our proficiency examinations to qualify laboratory personnel in much the same way they would be required to do for other health occupations under Section 241 of H.R. 1.

3024

Information Concerning
the Content and Norming of

THE PROFICIENCY EXAMINATIONS FOR CLINICAL LABORATORY PERSONNEL

Sponsored by
THE NATIONAL COMMITTEE FOR CAREERS
IN THE MEDICAL LABORATORY

Administered by
Educational Testing Service
Princeton, New Jersey

With support from

American Academy of Microbiology
American Association of Blood Banks
American Association of Clinical Chemists
American Society of Clinical Pathologists
College of American Pathologists

Developed and administered under contract with THE MANPOWER ADMINISTRATION of the UNITED STATES DEPARTMENT OF LABOR

I. INTRODUCTION

The Proficiency Examinations for Clinical Laboratory Personnel are primarily concerned with the measurement of an individual's work-related knowledge and skills in the laboratory rather than with college curricular criteria requirements. They are designed to measure a person's competency to perform. Specific emphasis is on the Medical Laboratory Technician level, but questions appropriate for both higher and lower levels are included.

II. OBJECTIVES

The primary aim of the Proficiency Examinations is to help laboratory employers to obtain an objective evaluation of the knowledge and skills of

* The military-trained medical laboratory specialist, whose training and experience are comparable in some respects to training and experience in the civilian laboratory field, but are not recognized when he seeks civilian placement on separation from the service,
and
* The civilian laboratory worker who has had on-the-job training, whose experience and aptitude may qualify him to perform on a higher level, but who is prevented from advancement by formal educational and training requirements.

The examinations provide an opportunity for upward mobility for those who merit it.

There are no eligibility requirements. A candidate may take one or more of the Proficiency Examinations.

III. DESCRIPTION OF THE EXAMINATIONS

Consultants, committees, and test specialists developed and prepared these examinations.

See p. 13 for Committee of Examiners

Each of the four Proficiency Examinations for Clinical Laboratory Personnel contains 75 questions and each test takes about one hour to complete.

Since the tests are designed to be fair to people who have been trained in different ways, it is not expected that everyone will be able to answer every question.

The following outline gives a brief description of some of the subject matter included within each test.

1. *CLINICAL CHEMISTRY*

Equipment - centrifugation, filtration; pipettes, diluters, etc.

Instruments - principles, use and understanding - spectrophotometry and colorimetry; flame photometry and atomic absorption; osmometers, etc.

Chemical Principles and Application - Calculation and measurement; pH, solutions, buffers, etc.

Methodology - analysis related to enzymes, lipids, electrolytes, liver function, etc.

2. *MICROBIOLOGY*

Specimen and Culture Handling - collection; storage; disposal, etc.

Isolation and Identification - bacteriology; mycology, etc.

Serology - tests for disease and organism identification; pregnancy, etc.

Antibiotic Susceptibility by the Standardized Disc Test (Kirby-Bauer) - media, inoculation, etc.

Media - types; preparation

Equipment - microscopes; centrifuges; rotators, etc.

Quality Control - staining; reagents, etc.

3. *HEMATOLOGY*

Subject - white count; red count; hemoglobin; hematocrit; reticulocyte count; clot retraction; osmotic fragility; normal differential count, etc.

Method - manual; mechanized; quality; limits; departure from normal.

4. *BLOOD BANKING*

Compatibility - massive and/or multiple transfusions; patient identification; selection of blood for compatibility, etc.

Special Techniques - antibody detection, hemolytic disease work-up, etc.

Standards, General Procedures - collection and identification of donor blood; transfusion service records, etc.

NOTE: *A more complete description of content material and sample questions may be found in THE BULLETIN OF INFORMATION (available from NCCML).*

IV. SAMPLE QUESTIONS

Following are a few examples of the types of questions that may be found on each of the four proficiency examinations.

Examples:

Directions: Each of the questions or incomplete statements in the test is followed by five suggested answers or completions. Select the one which is best in each case and then blacken the corresponding space on the answer sheet.

(Clinical Chemistry)

1. The color formation in a serum bilirubin determination depends on
   (A) making the serum alkaline
   (B) adding sulfanilic acid
   (C) adding methyl alcohol
   (D) conjugating bilirubin with glucuronic acid to form bilirubin glucuronide
   (E) diazotization to form azobilirubin

2. Diazotized sulfanilic acid is used for the measurement of
   (A) bile acids
   (B) bile pigments
   (C) acetylsalicylic acid
   (D) sulfosalicylic acid
   (E) coproporphyrin

(Microbiology)

Directions: The group of questions below concerns a laboratory situation. First study the description of the situation. Then choose one best answer to each question following it and blacken the corresponding space on the answer sheet.

A sample of spinal fluid cultured in nutrient and thioglycollate broth gave some indication of growth by turning slightly cloudy in the broth after 12 hours of incubation at 37°C. A gram stain of this fluid showed a mixture of small gram-negative rods and gram-positive diplococci. However, on further incubation, the turbidity did not increase and transfer to nutrient agar plates showed no growth after 24 hours.

3. In order to grow and isolate the small gram-negative rods, a transfer should be made to
   (A) nutrient broth
   (B) nutrient agar
   (C) thioglycollate broth
   (D) chocolate agar
   (E) Streptosil broth

4. In the best interest of the patient a report should be sent to the attending physician stating which of the following?
   (A) Culture contaminated, please repeat
   (B) No growth after 36 hours
   (C) Small gram-negative bacillus and gram-positive diploccus seen in broth culture
   (D) No growth after 12 hours
   (E) Hemophilus influenzae and Diplococcus pneumoniae have been isolated

(Hematology)

5. If on a particular sample the red cell count is 3,500,000 per cubic millimeter and if 1.5 per cent of the red cells are reticulocytes, the number of reticulocytes per cubic millimeter is
   (A) 15,000 (B) 35,000 (C) 52,500
   (D) 72,000 (E) 350,000

6. Wright's stain causes the cytoplasm of lymphocytes to be colored.

   (A) purple (B) gray (C) yellow
   (D) pink (E) blue

(Blood Banking)

7. Enzyme-treated cells are unsatisfactory for detecting antibodies of the Duffy blood-type system because enzymes

   (A) destroy Duffy antibody molecules
   (B) destroy Duffy antigen sites
   (C) inactivate Duffy antibody molecules
   (D) mask other antibodies
   (E) give false positive antiglobulin (Coombs') tests

ANSWERS TO SAMPLE QUESTIONS

1. E	3. C	5. C	7. B
2. B	4. D	6. E	

V. INTERPRETING YOUR PECLP SCORES

The Proficiency Examinations for Clinical Laboratory Personnel were administered to two norming groups. All candidates in both groups had had at least one year, but no more than two years, of formal laboratory training. Each candidate had from one to five years of laboratory experience in a variety of military, hospital and independent laboratories throughout the United States. All these candidates took all four proficiency examinations. Group I consisted of 233 workers who received military laboratory training. Group II consisted of 129 workers trained in civilian hospital programs.

The possible range for each reported test score of the Proficiency Examinations for Clinical Laboratory Personnel extends from a low of 0 to a high of 75. The scores are the candidates' "raw scores." A raw score is the number of correct answers a candidate gave, minus one-fourth of his wrong answers. The PECLP test scores are meaningful only when related to the performance of the two norming groups described above.

The percentile rank is used to indicate how a candidate's score compares with the scores of the candidates in the norming groups. The relative standing of a PECLP score with respect to each group is expressed in the following tables as a percentile rank - the percent of candidates in a group who scored lower than that scaled score. For example, in comparison with norms for Group I, a candidate's score of 54 or 55 on the clinical chemistry test places him at approximately the 90th percentile; that is, about 90 percent of the candidates in this group obtained scores lower than his and, conversely, about 10 percent obtained higher scores. In comparison with norms Group II, a candidate's score of 54 or 55 on the clinical chemistry test places him at approximately at the 94th percentile.

Percentile Ranks for Group I:
Norming Administration November, 1971

233 Technicians Trained in Armed Forces

	PROFICIENCY EXAMINATION			
Score	Clinical Chemistry	Micro-biology	Hema-tology	Blood Banking
74-75		99	99.8	
72-73		98	99	
70-71		97	99	99.6
68-69	99	96	98	99
66-67	98	95	97	99
64-65	96	91	95	98
62-63	95	85	91	97
60-61	95	83	90	96
58-59	94	80	85	95
56-57	92	76	82	93
54-55	90	70	78	90
52-53	88	65	71	88
50-51	85	62	64	84
48-49	83	55	56	79
46-47	80	51	49	77
44-45	76	44	40	71
42-43	71	36	31	66
40-41	68	32	25	59
38-39	61	27	20	52
36-37	53	23	15	47
34-35	42	20	11	41
32-33	36	15	8	38
30-31	30	12	6	31
28-29	25	11	5	25
26-27	19	9	4	21
24-25	15	5	3	17
22-23	10	3	2	13
20-21	7	2	1	9
18-19	5	2	0.4	6
16-17	4	1	0.4	4
14-15	3	1	0.4	3
12-13	2	1	0.2	2
10-11	1	0.9		2
8-9	0.4	0.6		1
6-7		0.4		0.4
4-5		0.2		0.4
2-3				
0-1				
Mean	36.52	46.03	46.47	36.92

Percentile Ranks for Group II:
Norming Administration November, 1971

129 Technicians Trained in Civilian Hospital Programs

	PROFICIENCY EXAMINATION			
Score	Clinical Chemistry	Micro-biology	Hema-tology	Blood Banking
74-75		99		
72-73		98		
70-71		98		
68-69		98		
66-67	99	97	99	
64-65	98	97	97	
62-63	97	97	95	
60-61	96	96	93	99
58-59	96	95	91	99
56-57	95	94	88	98
54-55	94	92	84	97
52-53	93	91	78	95
50-51	93	88	73	94
48-49	92	84	67	90
46-47	91	81	63	89
44-45	88	77	57	87
42-43	86	74	51	84
40-41	84	73	43	81
38-39	81	64	34	77
36-37	76	60	29	71
34-35	71	56	23	64
32-33	67	51	20	60
30-31	61	48	14	55
28-29	54	41	10	50
26-27	48	39	6	44
24-25	38	35	5	37
22-23	30	29	4	32
20-21	22	22	2	28
18-19	16	16	2	23
16-17	12	13	2	19
14-15	7	9	2	14
12-13	5	5		9
10-11	3	3		5
8-9	2	3		4
6-7	1	2		3
4-5	1	2		1
2-3	0.4	1		0.4
0-1				
Mean	29.10	32.41	42.32	28.77

VI. USE OF TEST SCORES

Test scores are sent only to the candidate or those he designates. Examination results can be used by employers to place and upgrade laboratory workers. Medicare plans to use the results as an alternate way of qualifying workers for its technician level. Federal, state and local civil service commissions are interested in similar use of the examinations. The ASCP Board of Registry of Medical Technologists is considering possible use of the Proficiency Examinations to qualify candidates for the Medical Laboratory Technician certification examination.

Transcripts of test scores will be sent to persons designated by the candidate for a fee of $2.00 per set of scores.

VII. EQUIVALENCY EXAMINATIONS

A companion set of equivalency examinations for academic credit in the same four subjects is being prepared for use in the fall of 1972. These examinations are being designed by ETS for inclusion in the College-Level Examination Program of the College Entrance Examination Board.

For additional information about the Proficiency Examinations write to:

Program Director
Proficiency Examinations for
Clinical Laboratory Personnel
Educational Testing Service
Princeton, New Jersey 08540
(609) 921-9000
or
National Committee for Careers
in the Medical Laboratory
9650 Rockville Pike
Bethesda, Maryland 20014
(301) 530-6055

Committee of Examiners

Blood Banking

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Lt. Col. Frank Camp, U.S. Army Medical Research Laboratory (Fort Knox, Kentucky)

Ralph Lingeman, M.D., Veterans Administration Hospital (Washington, D.C.)

Mrs. Grace Neitzer, MT (ASCP), Michigan Community Blood Center (Detroit, Michigan)

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Miss Cornelia Van Benthem, M.A., MT (ASCP), Hackensack Hospital (Hackensack, New Jersey)

NATIONAL COMMITTEE FOR CAREERS IN THE MEDICAL LABORATORY,
Bethesda, Md.

For immediate release:

Proficieney Examinations, the new way by which medical laboratory workers may measure their skills and knowledge, will be given for the second time on May 6, 1972, at test centers throughout the country.

The clinical laboratory's need for this new program is demonstrated by the fact that nearly 2,000 laboratory workers sat for the first set of examinations on November 20 at 126 test centers here and abroad, including 30 military bases and three prisons.

Designed to evaluate the knowledge and skills of both the medical laboratory specialist trained by the military and the civilian laboratory worker who lacks professional certification, the new examinations are administered by the Educational Testing Service for the National Committee for Careers in the Medical Laboratory under a contract from the Manpower Division of the U.S. Department of Labor.

This Proficiency Examination Program offers four examinations in the laboratory areas of Blood Banking, Clinical Chemistry, Hematology, and Microbiology. All are one-hour paper and pencil tests, and a candidate may take one or more. His scores are sent only to him or to those he designates. Norming scores (results achieved by a representative group of laboratory workers) provide a scale against which candidates' individual scores may be measured.

Examination scores can be used by employers to place and upgrade laboratory workers. Medicare, and Federal, state and local civil service commissions are among the agencies planning to make use of the examinations. The Board of Registry of the American Society of Clinical Pathologists is considering use of the examinations to qualify candidates for the Medical Laboratory Technician certification examination.

Major organizations of laboratory employers which have cooperated in test development and are supporting the use of Proficiency Examinations are:

American Society of Clinical Pathologists,
College of American Pathologists,
American Academy of Microbiology,
American Association of Clinical Chemists,
American Association of Blood Banks.

Deadline for applications is April 8.

Application blanks and a bulletin of information describing the examinations, giving test questions, and listing test centers are available from:

Proficiency Examinations Project
National Committee for Careers in the Medical Laboratory
9650 Rockville Pike
Bethesda, Maryland 20014

or

Medical Technology Proficiency Examinations
Educational Testing Service
Princeton, New Jersey 08540

Only applications made on the official form will be accepted by ETS.

If a test center is not readily accessible, a candidate may request a special center. The Department of Defense has offered its cooperation in administering the examinations at bases not near the designated test centers. Deadline for requests for special test centers is March 25.

A SUMMARY:

Equivalency and Proficiency Testing

Related to the Medical Laboratory Field

NATIONAL COMMITTEE FOR CAREERS IN MEDICAL TECHNOLOGY
Bethesda, Maryland
March 1970

Pursuant to Contract No. NIH 70-4047 (PH 108-69-49)
between the U.S. Department of Health, Education, and Welfare,
National Institutes of Health, Division of Allied Health Manpower
and the National Committee for Careers in Medical Technology

NATIONAL COMMITTEE FOR

Careers in Medical Technology

9650 Rockville Pike, Bethesda, Maryland 20014

executive secretary DALLAS JOHNSON *phone* (301) 530-6055

SPONSORS AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS • THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS • COLLEGE OF AMERICAN PATHOLOGISTS

ROBERT W. COON M.D. CHAIRMAN • VERNA RAUSCH MT (ASCP) M.S. VICE CHAIRMAN • CLARENCE A. MC WHORTER M.D. SECRETARY-TREASURER • MAJ. GEN. JOE W. BLUMBERG M.D.
SARA MARIE CICARELLI MT (ASCP) • BERNARD P. MANN, JR., M.D. • A. WENDELL MUSSER M.D. • WARREN J. WALLACE MT (ASCP) • GEORGE E. WILLIAMS M.D.

As the work of medical laboratories has expanded in scope and complexity, manpower shortages have of course increased proportionately. Recruitment of new laboratory personnel is one answer to the problem; better utilization of present personnel is equally important.

Both recruitment and utilization of laboratory workers would be enhanced by development of a career ladder for the medical laboratory field. Such a ladder must allow upward mobility for workers who can demonstrate they have knowledge and ability equivalent to that expected from persons completing education and training for higher level positions.

Career mobility and equivalency were major subjects of discussion at the Conference on Manpower for the Medical Laboratory, sponsored by the National Committee for Careers in Medical Technology and the Cancer Control Program of the U. S. Public Health Service in October 1968. At that meeting, representatives of government and the professions concluded: "representatives of medical laboratory disciplines should initiate efforts with educational testing specialists to develop equivalency tests to provide increased mobility between levels and categories of laboratory careers."

As a first step in the effort to provide equivalency credit for laboratory workers, the National Committee contracted with the Allied Health Manpower Division of the U. S. Public Health Service to study the present role of equivalency and proficiency testing in the medical laboratory field, in related health fields, and in other fields where experiences are applicable to the laboratory. This report is the result of that study. The research was done by Mrs. Jean Linehan of the NCCMT staff.

The study points up the need for equivalency examinations in the field, and the present interest in and receptivity to the idea of equivalency among the professions and the educators.

Robert W. Coon

Robert W. Coon, M. D.

EQUIVALENCY AND PROFICIENCY TESTING RELATED TO THE MEDICAL LABORATORY FIELD

The need for an increasing supply of health manpower has been well documented.[1] A number of factors have produced an expanded need for medical laboratory personnel even greater than that for health workers in general:

> Demands on the medical laboratory for services which aid in the diagnosis and treatment of human ills are increasing rapidly because of such factors as population growth, automation, new technology, and expanded health programs providing better medical care to all socioeconomic groups. An estimated 900 million laboratory examinations were performed on specimens from the human body in 1963; the number has been estimated to have reached about 1.4 billion during 1968. The rate of increase is expected to be even greater during the next several years.[2]

In 1975, according to a Labor Department estimate, an increase of 60% above the 100,000 medical laboratory personnel currently employed will be required, just to keep up with present procedures.[3]

While recruitment of new personnel is important to fill these needs, it is generally agreed that at least part of the solution to the increasing manpower shortage in the medical laboratory field is better utilization of those already employed. Ideally, the first step to improve utilization should be a thoroughgoing alanysis of the tasks to be performed in the laboratory. The task analysis would include assessment of the level of skills and personnel necessary to perform the tasks. Then educational programs would be designed -- and periodically redesigned -- to match the revised job descriptions.

Better utilization of health personnel would enhance career mobility within the system. Career mobility refers to the upward and lateral movement of personnel from one job to another as they gain knowledge and experience, with no artificial barriers erected to prevent such movement on the part of individuals who are qualified by virtue of knowledge and skills to perform the required tasks. Upward mobility includes the idea of the "ladder," allowing for promotion on the basis of measured abilities from the level of the aide, to that of the assistant, to that of the technician, to that of the technologist, and beyond. Horizontal mobility between health professions is based on the idea that a "core" of knowledge and skills is common to many health occupations, and would allow an individual to move from one field to another without duplicating the "core" training he had already completed. A system which provided for vertical and horizontal mobility would eliminate dead-end jobs and clarify the routes from one position to another. Those workers with ability and motivation could continue to advance.

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1. Among other places, in Education for the Allied Health Professions and Services, a report of the Allied Health Professions Education Subcommittee of the National Advisory Health Council, U.S. Department of Health, Education, and Welfare, 1967.
2. Guide Class Specifications for State Public Health Laboratories, U.S.Department of Health, Education, and Welfare, October 1969.
3. Technology and Manpower in the Health Service Industry, 1965-1975, U.S. Department of Labor, 1966.

Career mobility in the medical laboratory would make the profession more attractive, facilitate recruitment, retain present laboratory workers, and encourage re-entry into the field by those who for a variety of reasons have left it.

Basic to the concept of career mobility is the need to evaluate each individual's present abilities, regardless of the route he traveled to attain them, in order to allow his placement on the most appropriate rung of the career ladder. Proficiency and equivalency testing programs can serve as a basis for this evaluation. Proficiency testing assesses an individual's knowledge and skills related to performance at a specific task level. Equivalency testing equates learning gained off campus with the requirements of on-campus courses and formal training programs; it may lead to the actual granting of academic credit or may be used simply as a substitute for formal academic requirements.

Some Quotations on Equivalency and Proficiency Testing

A number of influential voices have been heard in recent years advocating the granting of credit for learning in other than formal and traditional programs. Many have advanced the need for equivalency testing -- in general, for the health professions, and specifically for the medical laboratory field. Some of the most pertinent are presented here.

John W. Gardner, in Goals for Americans, said in 1960:

> Many people who study outside the formal system do so for reasons having to do with their own fulfillment, and care little for academic credit. Others are concerned only with the immediate acquisition of skills, and credit is irrelevant here too. But many others do wish to obtain academic credit. We shall serve these people far more effectively when we have devised a flexible system of credit by examination. Such a system would assess and certify accomplishment on the basis of present performance. The route that the individual has traveled to achieve cmmpetence would not come into question. Such a system would permit many individuals to participate in higher education who now -- by the nature of their jobs or other obligations -- cannot do so.[1]

> Concern was expressed by the Senate Finance Committee in 1967 that:...The reliance placed on specific formal education, training, or membership in private professional organizations might sometimes serve to disqualify people whose work experience and training may make them equally or better qualified than those who meet the existing requirements. Failure to make possible the fullest use of properly trained health personnel is of particular concern because of the shortage of skilled health personnel in several fields.[2]

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1. Gardner, John W., "National Goals in Education," Goals for Americans: The Report of the President's Commission on National Goals, Prentice-Hall, 1960.
2. Senate Finance Committee report on the Social Security Amendments of 1967.

"Attention to equivalency of training is vital in both the professional and technical curriculums," according to the 1967 report of the National Advisory Health Council's Allied Health Professions Educational Subcommittee, which went on to say:

> Upward mobility should be encouraged but should be linked realistically with the capabilities of the individual. While it is desirable to have certain courses in a junior college accepted to credit in a senior college, it is perhaps more important to adopt the principle of credit for attainment in a field which could be tested by examination. There should be less concern for formal course requirements, and more for grasp of knowledge and skill. Programs should be designed to facilitate progress from the technical to the more advanced levels of education and practice in the health occupations.[1]

According to a report prepared by the NIH Bureau of Health Professions Education and Manpower Training, Division of Allied Health Manpower, and transmitted to the President and the Congress by the Secretary of Health, Education, and Welfare in April 1969:

> Methods must be developed to determine whether knowledge and skills acquired in other than formal academic settings are equivalen to the measures of "satisfactory" performance established in recognized educational institutions.
>
> The need for equivalency examinations for the allied health professions and occupations is based on the premises that: (1) students should not be required to repeat work that they have mastered; (2) objectives of course work can be achieved in other than classroom situations; (3) acquisition of knowledge and skills can be measured by examination and performance; and (4) educational institutions can use the results of these examinations as a basis for advanced placement or academic credit awards.
>
> Equivalency examinations have far-reaching implications for the health occupations. They could be used to accelerate the formal academic programs of potential health workers. They could also serve as bases for occupational mobility. The potential uses of equivalency examinations have special significance for many allied health workers who are locked in dead-end jobs, but who would be willing to undertake advanced academic training if they were given recognition for principles and techniques that they have already mastered. An example is the medical corpsman who is trained in the armed forces, but who cannot accept similar employment in civilian life because his military training and experience cannot be transferred readily to civilian employment requirements in many allied health occupational categories.[2]

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1. Education for the Allied Health Professions and Services, U.S. Department of Health, Education, and Welfare, 1967.
2. Report to the President and the Congress on the Allied Health Professions Personnel Training Act of 1966, as Amended, U.S. Department of Health, Education, and Welfare, April 1969.

Speaking as president of the Association of Schools of Allied Health Professions, J. Warren Perry, Dean of the School of Health Related Professions of the State University of New York at Buffalo, said to the A.M.A. Congress on Medical Education:

> A logical extension of the credit-by-examination concept must be conceived, developed, and fostered for the allied health professions. This is already being interpreted as one of the major needs if the mobility concept is to be achieved. The relationship of proficiency or equivalency testing procedure as might be applied to the allied health professions is self-evident, though putting it into practice will not be a simple task. If tests can be developed that will establish the common core elements involved in various health fields, measurement of the level of performance on a test might substitute for the actual taking of some of the now required courses in many fields. Based upon effective measurement devices of such proficiency or equivalency levels, it would not be necessary for an individual to begin at the very lowest level or rung of a ladder in an allied health field, but rather one could be admitted into an educational program or level of clinical functioning based upon his measured capabilities.[1]

R.L. Matkin, Assistant Secretary of the Council on Dental Education of the American Dental Association, has expressed his personal observations on the subject of equivalency examinations for health professions:

> The individual institutions conducting approved (accredited) educational programs should, in my judgment, be the agencies that determine equivalency. The equivalency could involve individual courses or the total program. For example, it seems appropriate that the responsible department or division of a school could develop "challenge" examinations in each subject matter area of a specific curriculum. The "challenge" examination should be as difficult as the usual final examination of the course. If the student is successful, he should be given credit for the subject matter area and not be required to take the course. Conversely, if the student is unsuccessful, he should be required to enroll in the course, provided he has met other criteria such as the usual pre-requisites, etc., expected of other students.
>
> Carrying this process to the ultimate, it may be possible that an individual would be able to successfully "challenge" all courses in a specific curriculum. If this is the case, it would seem reasonable that the institution would certify that the individual has knowledge and skill equivalent to its usual graduates and the individual should be considered eligible for certification or licensure examination.[2]

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1. Perry, J. Warren, "Career Mobility in Allied Health Education," J.A.M.A., Vol. 210, No. 1, October 6, 1969.
2. R.L. Matkin, in correspondence dated August 26, 1969.

Ralph C. Kuhli, Director of the American Medical Association's Department of Allied Medical Professions and Services, has expressed his personal support for equivalency testing for people with foreign education and experience, for discharged military medics, and for individuals with long and distinguished experience and training in a health occupation, as follows:

> Any and all useful education and experience should be credited, rachet-like. A person should always be able to go on if he can, if he wants to, and if he can afford it. Professions which do not allow credit for previous education and experience remind me of a limited access highway: once you get on it, you have to drive for miles before there's any chance to turn off or change direction.[1]

A conference on Manpower for the Medical Laboratory, bringing together persons from government and the professions, came out strongly in favor of equivalency testing for medical laboratory personnel:

> Recommendation 14: Representatives of medical laboratory disciplines should initiate efforts with educational testing specialists to develop equivalency tests to provide increased mobility between levels and categories of laboratory careers.
>
> Equivalency tests would make it possible for individuals to obtain science credits needed for advancement through recognition of self-study, experience, maturity, and skills gained on the job. Methods developed to equate experience with education and training can be used to evaluate correspondence, television, and continuing education courses as well as to enable graduates of armed forces laboratory programs to enter college or medical technology training without meeting traditional academic requirements.
>
> Efforts should be made to ensure recognition of equivalency tests by boards certifying and licensing laboratory personnel, and for admission to and advanced standing in colleges and universities.
>
> Development of equivalency tests would enhance the appeal of laboratory careers. The recognition of knowledge gained outside of formal education to fulfill academic and clinical requirements would give persons with initiative and ability opportunities for advancement.[2]

Speaking at the September 1969 meeting of the American Society of Clinical Pathologists, C. R. Macpherson, Chairman of the Board of Schools of Medical Technology, voiced both support for mobility and concern about the ways to achieve it:

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1. Ralph C. Kuhli, in correspondence dated July 25, 1969.
2. Manpower for the Medical Laboratory: The National Conference on Education and Career Development of the National Committee for Careers in Medical Technology, U. S. Public Health Service, 1968.

> Upward mobility in the laboratory is a very important concept, but its implementation presents problems. At present, to go from the assistant level to that of medical technologist, the worker has to go back to school and get a baccalaureate degree, which is impractical -- or impossible -- for most.
>
> We must study the possible mechanisms for upward movement, remembering that whatever we select cannot violate sound academic principles.[1]

Roma Brown, President of the American Society of Medical Technologists, has expressed the hope that the career ladder in the medical laboratory will "be viewed as a realistic continuum at every performance level," continuing:

> Constricture or an imposed ceiling will create a suppression on the rest of the system. Multiple mechanisms to achieve and recognize increased competency that are feasible for the individual must be structured. This will require innovative approaches by the educational system and cooperation by the service facility to encourage the individual to formally advance along the career line ....
>
> This will require a combined effort of the profession and the educational institutions to insure that educationally sound and professionally valid criteria are established. Measurable behavioral objectives need to be defined. Effective instruments for evaluating equivalency gained in both the informational and skill competency need to be developed. Management methods should be utilized that result in motivation of the individual to achieve maximum utilization of resources in the profession.[2]

Why Equivalency Testing?

The quotations presented above point to the need for equivalency and proficiency testing in general, in the health occupations, and in the medical laboratory field specifically. A summary of ideas for the medical laboratory field included in these quotations follows:

* There are increased demands on medical laboratories, and future demands will be even greater.
* Present shortages of skilled personnel in the medical laboratory field are expected to become a more serious problem in the future.
* Laboratories often are unable to utilize people to the full extent of their capabilities.
* Laboratories cannot give people the status to match the work they are often actually doing, and cannot move them up, because no standard system exists for granting credit for skills and knowledge gained outside formal educational programs.

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1. Tape recording of the session on "New Directions in Medical Technology Education and Evaluation," September 17, 1969.
2. From a paper entitled "Career Mobility: An Inquiry by a Health Profession Organization," read at the Association of Schools of Allied Health Professions meeting, November 1969.

* There is no route from the technical to the professional level in the laboratory except by returning to the beginning of the professional educational program.

* Laboratory workers who wish to upgrade themselves by returning to school find it difficult if not impossible to get credit for knowledge and skills they already possess, and thus must pursue contents and skills which they have already mastered. Since the return to school often requires sacrifices for the worker and his or her family, this additional handicap makes the return even more difficult and therefore less likely.

* Medical corpsmen who have obtained laboratory training and experience in the Armed Forces cannot move into the civilian health field at a level equal to their qualifications because they cannot get appropriate credit for their skills and knowledge.

* Workers in a health occupation find it difficult, if not impossible, to move to another health field unless they enter training programs again at the beginning.

* Elimination of dead-end jobs would make the medical laboratory field more attractive for recruitment and retention and re-entry of personnel.

Scope and Procedures of This Study

This study has been undertaken by the National Committee for Careers in Medical Technology, under contract with the Bureau of Health Professions Education and Manpower Training, Division of Allied Health Manpower, to collect and summarize information about equivalency and proficiency testing practices in the medical laboratory field, in other health fields, and in still other fields where experiences are applicable to the laboratory.

Equivalency testing refers to examinations used to equate non-formal learning with learning achieved in academic courses or training programs. Such tests may be designed to enable colleges and universities to grant academic credit for off-campus learning. They also may be used by employers or certifying bodies to qualify individuals whose non-formal study and on-the-job learning is deemed equivalent to that expected from a formal program.

Proficiency testing refers to the measurement of an individual's competency to perform at a certain job level -- a competency made up of knowledge and skills, and related to the requirements of the specific job. Such testing is therefore not only a measure of the knowledge gained through didactic instruction but also an assessment of job capabilities.

"Equivalency testing" and "proficiency testing" are thus not mutually exclusive terms. "Equivalency testing" relates to why an examination is given, and "proficiency testing" to what it attempts to measure. Equivalency tests for liberal arts subjects are not proficiency tests, of course, but equivalency tests in occupational fields usually are proficiency tests. Proficiency tests can be used for purposes other than equivalency to formal educational programs. The more closely an educational program is designed to relate to a specific job level, the more likely it is that an equivalency test for that educational program would also serve as a proficiency test to qualify individuals for that job.[1]

In undertaking this study, a review was made of available literature in the general field of psychological testing, in educational testing including testing for academic credit, and in testing in the health occupations. Books, periodicals, speeches, and reports were consulted. An annotated bibliography is included at the end of this report.[2] While the need for career mobility and for equivalency testing -- and the principles which support these concepts -- are well documented in the literature (see quotations on the preceding pages), it was necessary to go beyond a bibliographic search to learn what individuals and groups have done, are doing, and are planning to do in equivalency and proficiency testing.

Contacts have been made by letter, telephone, and in personal interviews with representatives of organizations in the health professions, with staff members of testing agencies, with laboratory directors, with state health department and licensing personnel, with Federal officials concerned with health manpower needs, with faculty members of colleges and of allied health schools, and with representatives of other organizations who had ideas and experiences to share.[3]

Testing programs described in this report are grouped in four sections:

1. Tests in the medical laboratory field,
2. Tests in other health fields,
3. Tests in non-health fields, and
4. Some non-test procedures for equivalency.

For each test covered in the report, we have included available information on the purpose for and methods used in its development, its format, content, and what it attempts to measure. We have also explored its uses, it candidates and their objectives, their relative success, what they have done with the test results, and retake procedures. We have examined a number of test instruments; many others were not available for review, due to test security reasons.

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1. In the test descriptions which form the bulk of this study, the term "proficiency testing" has for the most part been avoided, because it has a specific meaning in the medical laboratory field -- referring to evaluation of a laboratory's performance as a whole, not to that of an individual.
2. See annotated bibliography beginning on page 87.
3. See list of organizations and persons who have contributed information and ideas to this study, beginning on page 118.

A Practical Application Underway

During the progress of this study, the National Committee for Careers in Medical Technology has initiated the development of a battery of tests for use in the medical laboratory field. An initial purpose of the tests would be to offer equivalency credit toward part or all of a junior college medical laboratory technician program. Such tests could be taken by persons with laboratory experience who wish to move upward, or by military laboratory personnel who wish to obtain employment in the civilian health field. The test battery would include academic and clinical content related to the requirements of the majority of educational programs for medical laboratory technicians. The tests would be job-oriented because the junior college M.L.T. programs are themselves job-oriented. A performance evaluation would probably be included, in addition to the written examinations.

The test battery would be developed by the College-Level Examination Program of the College Entrance Examination Board, with the help of an ad hoc steering committee representing the American Society of Clinical Pathologists; the American Society of Medical Technologists; the junior college programs, through the American Association of Junior Colleges and the Council on Associate Degree and Certificate Programs of the Association of Schools of Allied Health Professions (A.S.A.H.P.); and the baccalaureate programs, through the Council on Baccalaureate and Higher Degree Programs of the A.S.A.H.P. -- for the present coordinated with staff work by the National Committee for Careers in Medical Technology.[1]

The Tests

Few generalizations can be made about the varied assortment of tests reported on here, since their purposes and construction are so varied. Yet it is possible to find some common characteristics among them.

Tests Designed for Academic Credit

The idea of giving college credit on the basis of examinations is not new. The University of Illinois began offering such examinations in 1895, and many other colleges and universities have had similar programs. The concept has had greatest impetus, however, since the founding of the New York State College Proficiency Examination Program (CPEP)[2] in 1962, and the College-Level Examination Program (CLEP)[3] of the College Entrance Examination Board in 1965. Both programs are designed to provide a way for mature individuals to demonstrate education achieved through means other than on-campus courses. Both offer examinations in subjects equivalent to college courses. CLEP also offers General Examinations which are designed to measure general educational background of students who have the equivalent of a year or two of college. Nearly 500 colleges nationwide have indicated they are willing to grant credit for the CLEP examinations -- and the number continues to grow. Likewise, the majority of colleges and universities in the State now grant credit on the basis of the New York CPEP tests.

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1. See detailed description beginning on page 28.
2. See detailed description beginning on page 45.
3. See detailed description beginning on page 49.

The most liberal credit-by-examination program in the allied health fields probably is the one offered by Division of Health Sciences at Northeastern University, where a new equivalency examination in respiratory therapy has recently been developed. The program offers up to one-third of the credits needed for the associate degree. Anyone who passes it and can also pass CLEP tests for the courses making up the remaining two-thirds of the program may earn an associate degree from the University solely by examination.[1]

Miami-Dade Junior College in Florida is developing a credit-by-examination program which will allow for as much as 45 credits in its 60-credit program. Students in the Division of Allied Health Studies who are licensed or certified in their particular field are given credit for all the technical courses, provided they take one on-campus laboratory course in their field.

Examinations are being given at a number of institutions for licensed practical nurses who wish some credit on entering training programs, registered nursing, and/or for non-baccalaureate RN's who wish to return to school for their degrees. The New York College Proficiency Examination Program has developed a battery of tests in the nursing field which are accepted for credit by more than half of the nursing programs in New York State. SUNY at Buffalo grants up to 32 credits for the four nursing examinations offered in 1968 and 1969 by the New York CPEP program. Nursing schools, such as those at Indiana University, California State College at Los Angeles, Medical College of Georgia, the University of Arizona, and others, have made up their own tests to offer such credit, or use tests designed by the National League of Nursing for other purposes, such as selection and guidance of applicants for admission or comprehensive testing of achievement at the end of senior year.[2]

Syracuse University has a comprehensive credit-by-examination program, which makes use of CLEP and CPEP tests, as well as tests developed by its own faculty, to grant up to 30 semester hours of credit. Similar programs are underway at Boston University and Louisiana State University. There is no limit to the number of credits attainable by local and standardized examinations at Beaver College in Pennsylvania. Brooklyn College and the University of Oklahoma offer some credit in their special baccalaureate degree programs for adults on the basis of examinations.

The above are not a representative sampling of the use of credit-by-examination programs but are merely examples of the kinds of programs currently offered. In a limited survey by J.A. Hedrick[3] ten years ago, 171 of 300 North Central colleges and universities granted credit by examination. No recent figures are available, but the trend seems to be toward greater use of such programs as standardized tests have become available. Most allied health schools are just beginning to consider the problems of equivalency testing. But it is a subject of considerable concern to them today, as evidenced by the fact that both the two-year and four-year Councils of the Association of Schools of Allied Health Professions indicated at their organizational meetings in November 1969 that equivalency and career mobility would be a major program emphasis in the coming year.

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1. For more information about these and other credit-by examination programs, see the section on Credit-by-Examination Programs of Colleges and Universities on page 52 of this report, and the section on Practices of Allied Health Schools in Granting Credit by Examination, on page 57.
2. For further information on examinations for nurses, see the section on Nursing Examinations on page 37 of this report, as well as the bibliography.
3. See Bibliography, item number 61.

Test Eligibility and Prerequisites

There are no prerequisites for taking equivalency tests designed to give academic credit -- particularly those of CLEP and CPEP -- unlike virtually all licensing, certification and employment examinations. To fulfill the basic concept behind equivalency, tests must measure current knowledge, no matter how it has been gained.

Many of the tests covered in this report do not pretend to offer this kind of equivalency, of course. Most are buttressed by eligibility requirements, and thus by themselves do not attempt to do a complete job of measuring an individual's knowledge and skills. For example, the Board of Registry of Medical Technologists has very specific education and training requirements for the medical technologists who wish to become eligible for its Registry Examination.[1] The National Board of Medical Examiners gives the first two parts of its examination to students in medical school and Part III to those just finishing a year of internship.[2] The American Board of Pathology requires a full pathology residency, or eleven years of experience in pathology, following graduation from medical school.[3]

In virtually every case, the licensing, certification and employment tests covered in this report are given only to persons who have completed a certain course of study or to persons who have had a certain number of years of experience. The equating of experience with education on a formal basis -- with so many years of experience being equivalent to so many years or credits of education, as is the case with the U.S. Civil Service and many other agencies -- is a pattern emphasizing "time served" just as much as is reliance purely on years of formal education. Some experts believe it is possible and advisable to devise tests so good that they would do the necessary screening job themselves. Dr. George P. Vennart, Chairman of the Board of Registry of Medical Technologists, has stated that the Board's registration examination will not be truly effective until it is such a good measure of knowledge, techniques and attitudes that it can be opened to everyone, irrespective of the route he traveled to gain the requisite knowledge, techniques and attitudes, or of the time involved in doing so.[4]

Other Equivalency Tests

As noted above, several equivalency tests are designed to waive academic credit, not to grant it, and thus to qualify an individual for promotion or certification.

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1. See detailed description beginning on page 1.
2. See detailed description beginning on page 31.
3. See detailed description beginning on page 6.
4. For Dr. Vennart's statement, see page 3 of this report.

The CLEP General Examinations are used in this way by a number of state agencies. In one state, bar examiners require the examinations of all applicants for the bar exam who do not have college degrees. The library certification board in another state uses the examination to enable a candidate for certification to demonstrate knowledge which is equivalent to two years of college. At least one major company has used the examinations similarly for promotion purposes.

The U.S. Public Health Service has sponsored an examination for certain directors of independent laboratories, the successful completion of which would qualify their laboratories to participate in the Medicare program, despite their lack of the required education and experience qualifications. Laboratory directors without a bachelor's degree in a laboratory science plus at least six years of pertinent laboratory experience can demonstrate through this test that they possess adequate knowledge and skills to perform the job. These directors must pass the general portion of this multiple-choice examination, and those of the five specialty portions for which they want their laboratories to qualify. The proficiency examination was developed by the Professional Examination Service of the American Public Health Association, and has been given since 1967 to 474 non-degree directors, 394 of whom have passed and thereby qualified their laboratories to participate in the Medicare program.[1]

A proficiency test with a similar purpose is now being developed for the U.S. Public Health Service to evaluate the knowledge and skills of state-licensed physical therapists who do not have full professional training but who wish to qualify for full participation in the Medicare program. The examination is being constructed by Cybern Education Inc. for administration early in 1970.[2]

Proficiency Testing

As noted above, proficiency testing attempts to measure the knowledge and skills necessary to perform a certain task. Virtually every testing method can be and is employed for proficiency testing in the health fields.

Multiple-choice written examinations are most often used to test knowledge, although there are or have been several essay or short-answer written examinations.

Performance tests, which measure skills and the ability to apply knowledge to the job, have traditionally consisted of a "work sample" done under the eye of a trained observer. Only a few of these are currently in use. But new techniques are enabling testing agencies to simulate situations in which the candidate can demonstrate his "performance" on paper without actually doing the job.

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1. See detailed description on page 8.
2. See detailed description on page 41.

Written Examinations

The large majority of examinations described in this report are written examinations, with several hundred multiple-choice questions, measuring mostly recall of information. The content may be theoretical, such as might be included in an educational program, or it may be completely job-oriented without regard to formal courses. The sponsoring organizations generally assert that a major aim is to test thought processes beyond mere recall of isolated facts. Probably fewer of these tests than their sponsors claim actually test these thought processes.

In their 1968 study for the World Health Organization on the worldwide use of examinations in medical education, Josef Charvat, Christine Maguire and Victor Parsons identified the overemphasis on recall of isolated fragments of information as a major fault of testing in the medical field. They noted that efforts are underway to make examinations include more interpretive items.[1]

In this regard, the plans of the Board of Registry of Medical Technologists for development of its future examinations for registered medical technologists are among the most forward-looking. The Board's goal is to produce an examination in which 20% of the questions will test the recognition or recall of isolated information (e.g., 'What is X?"), 40% will test the simple interpretation of limited data (e.g., "How do you interpret X? What does it imply? Knowing X to be true, what would you expect to be true about Y?"), and 40% will test the evaluation and the application of knowledge to the solution of a specific problem.

Performance Testing

While there is concern in many testing agencies about the need to evaluate performance, there is no agreement on whether any of the ways of performance testing are reliable or valid, whether they can be made sufficiently objective, whether they actually test anything not included in paper-and-pencil examinations, and thus whether they are worth the cost they entail.

Some specialists in testing believe that those who know what to do, can do it. They say performance tests correlate so well with written tests that performanke testing adds nothing to evaluation of a candidate. Others believe it is both possible and useful to devise tests which measure an individual's ability to perform in an actual job situation. Examples of these contrasting views follow.

A traditional so-called "practical" performance test was originally part of the Registry Examination of the Board of Registry of Medical Technologists, but was dropped when analysis of the results showed the practical portion was not screening out anyone who passed the written test.

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1. See Bibliography, item number 25.

The only practical examinations including work samples in the medical laboratory field today appear to be state civil service examinations in Illinois and California and a series of licensure examinations in New York City.

In Illinois, candidates for Laboratory Technician ratings must demonstrate their ability to perform specific laboratory tasks and their knowledge of equipment and techniques in twenty minutes before an interviewing board. The board asks questions about procedures and equipment, and requires performance of a simple procedure such as a blood count. It rates candidates on personal qualities, job knowledge, practical application, and an over-all assessment of ability. The State Department of Personnel developed the practical test to identify those who do not understand laboratory procedures even though they may be able to answer written questions. Of those who pass the written test, more than 15% fail the performance test.[1]

The California State Personnel Board has designed a new performance test in the laboratory field for a different purpose -- to meet the needs of persons who have trouble with the content of written tests for entry level positions. The new test for Laboratory Assistant I, which takes the place of the written examination, calls for the candidate to identify laboratory equipment, to read charts regarding the decontamination of equipment, and to segregate laboratory items so as to show which are usable and how they must be sterilized.[2]

New York City's Bureau of Laboratories in the Department of Health gives practical examinations supplementing its written tests for certification of laboratory personnel -- from laboratory directors on down -- who do not have the required education and experience. Laboratory directors are examined by three competent specialists for one-half day, with no pre-determined pattern. Examiners aim generally at answering the question: "Would you leave this candidate in charge of your own laboratory?" Laboratory supervisors are tested for two hours by two examiners; technologists and technicians are tested for one hour by one examiner each. Each candidate on these lower levels is given one structured problem to work out.[3]

Some of the problems besetting practical examinations in the laboratory field were illustrated by the work sample intended to form part of a battery of tests administered to medical technicians at Veterans Administration hospitals. The Educational Testing Service administered these tests in connection with its joint study with the Civil Service Commission of test and job performance of Negroes and whites. The one-hour work sample suffered from space limitations and from lack of appropriate and uniform equipment. Although this work sample produced no usable results, experts at Educational Testing Service believe it suggested another set of more productive (and more costly) procedures, including the use of uniform, high quality equipment, and the presence of professional medical laboratory observers.[4]

A 1959 study of various means of selecting dentists for Regular Corps commissions in the U.S. Public Health Service reported high correlations between practical and written examinations, and suggested therefore that other methods may be fairly satisfactory substitutes in situations where practical examinations are not feasible.[5]

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1. See detailed description beginning on page 15.
2. See detailed description beginning on page 16.
3. See detailed description beginning on page 13.
4. See detailed description beginning on page 18.
5. See detailed description on page 39.

At that first meeting, the Committee agreed on the scope of the project and the procedures for carrying it out. At its second meeting on April 29, 1971, the Committee reviewed the progress of the project and developed guidelines for administering and publicizing the examinations and promoting their use.

II. TEST CONSTRUCTION

A. Educational Testing Service

A subcontract was arranged with Educational Testing Service of Princeton, New Jersey, for the actual test development. ETS has a background in test construction that is well known and respected. Its tests are in use throughout the United States and abroad.

Experience to date confirms the wisdom of this choice. An excellent working relationship has been established with ETS and we are impressed with its test-making procedures and its readiness to make changes in those procedures to fit our requirements.

The subcontract went through a number of revisions to ensure complete agreement on what was expected, and therefore was not actually signed until January 5, 1971. In the interim, ETS expended considerable funds and effort on the project. Detailed cost figures have revealed that the agreed-on fixed fee of $155,800 will not cover all expected expenses; however, ETS is willing to put venture capital into this project, recognizing it as valuable experience in a new field of test-making.

B. Examining Committees

In accordance with suggestions made at the Advisory Committee meeting, NCCML selected Examining Committees in clinical chemistry, microbiology, hematology, and blood banking. In order to complete the project within the time limits imposed by the contract, it was necessary to hold the first two-day work sessions of these committees in Princeton, New Jersey, during the last two weeks in August, and nearly all the specialists selected for Examining Committees arranged or rearranged their schedules to be on hand. We are fortunate to have the valuable contributions of seventeen selected experts in the clinical laboratory field including pathologists, Ph.D. scientists, medical technologists, and outstanding technician-level personnel from both civilian and military laboratories.

Chairmen of the Examining Committees are: Clinical Chemistry, Martin Rubin, Ph.D., of Georgetown University Hospital; Microbiology, Gerald Needham, Ph.D., of the Mayo Foundation; Hematology, Robert Langdell, M.D., of the University of North Carolina; and Blood Banking, Lt. Col. Frank R. Camp, MSC, of the U.S. Army Medical Research Laboratory at Fort Knox.

C. Timing

Careful review of the timetable indicated we would indeed have two final forms of each of the four examinations by the scheduled contract completion date of June 30, 1971. Since the norming information to accompany the examinations is to be based on the norming examinations to be administered in July, the analyzed data will not be available until some time in September. Consequently, we sought and received an extension of the original contract period to September 30, 1971, the completion date of the ETS subcontract.

D. Test Content

A major assumption was made that properly-constituted Examining Committees could come together in Princeton for two days and agree on the knowledge and skills, weighted for importance, to be expected of workers performing successfully in each of the four areas of the clinical laboratory.

Both the National Advisory Committee and ETS have been pleased with the results.

The test specifications developed by the Examining Committees in August included content outlines with indications of weights deemed appropriate for content areas and for knowledge, comprehension, application, and other abilities. These specifications were circulated to the Advisory Committee, and then much more widely in a Progress Report to more than 200 persons interested in the project. Although this type of approach had been disparaged as "armchair task analysis" by some who advocate long-term observation, recording, and analysis of actual work processes to obtain such information, all reactions to the test specifications were favorable including a commendation on progress from a particularly firm advocate of on-the-job task analysis.

E. Type of Examination

The Advisory Committee endorsed the NCCML-ETS premise that the examinations could be paper-and-pencil tests, simulating real conditions as much as possible. It was felt that observation of actual performance in a laboratory would not only increase the cost and problems of administering the examinations, but would reduce the objectivity of the results. Those for whom the examinations are being designed, it was pointed out, will have been working in laboratories and this fact alone presumes some practical competence.

F. Job Level of Examinations

Each Examining Committee's specifications include a statement defining the proficiency level to be measured. For example, the statement in the blood banking test specifications says: "The proficiency level to be measured by the examination should be that of a Medical Laboratory Technician (MLT), who stands professionally between the lowest level, that of a Certified Laboratory Assistant (CLA), and the degree position of Medical Technologist, MT(ASCP). The test should have enough range to locate people considerably above the average MLT."

Since the aim is to identify a range of capabilities, we plan to administer the examinations for norming purposes to working technicians and technologists and publish two sets of normative data.

G. Test Items

In addition to the seventeen Examining Committee members, other technical experts were invited to write test questions. About 95% of those solicited did agree to write items, and virtually all of them actually came through.

The four Examining Committees met again late in the fall for an intensive review of the questions--more than 400 in each field, and nearer 900 from the enthusiastic item writers in one area. Each committee revised and reworded and reworked them to produce the 250 questions in each field to be used for pretesting.

One clinical chemist estimated she had spent the equivalent of five eight-hour working days at home on her Examining Committee duties--not counting the time she spent in Princeton--and said it had been a stimulating experience.

H. Guidelines for Pretesting and Norming

NCCML assembled a small subcommittee in November to consider the logistics of obtaining appropriate populations for pretesting and norming. It decided on the desired qualifications of those who would participate in the pretesting and norming phases of test development, as follows:

*900 participants would be needed for pretesting and 1200 for norming.

*Participants should understand the project and its hoped-for impact on laboratory careers and should be motivated to do a good job. There are no funds to pay honoraria, or even to provide lunch.

*Participants should have been working successfully in a clinical laboratory for at least a year. This was spelled out as a general requirement, and we will rely on the judgment of the supervisor who volunteers the employee's time, not on any documentation of the word "successfully."

*A random mix of specialists and generalists can be expected to yield hoped-for pretesting and norming results. Thus all participating generalists and specialists would be examined in all four subject matter areas.

*Participants will be selected to reflect a geographical spread and various types of facilities, e.g. (1) military hospital laboratories, (2) civilian hospital laboratories, including VA hospitals, PHS hospitals, and private hospitals, and (3) independent laboratories.

*For norming purposes, new participants will be chosen from the same sources in two groups of 600 each with these additional specific requirements:

Group I: Baccalaureate Level -- MT(ASCP) certified or with a baccalaureate degree.

Group II: Technician/Assistant Level -- CLA(ASCP) certified; or MLT(ASCP) certified; or workers meeting Medicare technician standards (this last includes those who have been technician trainees in acceptable laboratories for two years, or those who have completed the one-year laboratory course in one of the Armed Services).

Separate normative information will be reported for the two groups, thus making the examinations useful to candidates on different levels wishing to demonstrate their capabilities. It has also been suggested that employers who supervise large staffs may wish all employees to take the Proficiency Examinations later on for the purpose of establishing local norms.

I. The Pretesting and Norming Process

The pretesting completed in March located ambiguities and tested the discriminating abilities of each question. ETS test experts are delighted with the results, saying this is the best pretest they have ever had in a biological science field. ETS will use this analysis and the test specifications to choose questions for the two final forms of each examination. The Examining Committees will review the examinations before they are printed.

Military laboratory cooperation was easily obtained as a result of the approval and assistance of the Armed Forces Institute of Pathology and the Army Surgeon General's Office. The Veterans Administration headquarters pathology service secured the cooperation of laboratories in six VA hospitals. And three Public Health Service hospitals were involved.

Private hospital participation came from four state or metropolitan hospital associations, through the American Hospital Association. Local pathology and medical technology societies and hospital administrators helped to assemble workers from small and large, urban and rural hospitals.

Fifty-five directors of independent laboratories volunteered to cooperate as a result of an NCCML mailing sent to all laboratories approved under Medicare to publicize the Proficiency Examinations project and to solicit participation of ten or more workers for pretesting and norming. Many others with staffs too small to participate in pretesting and norming indicated their interest in the project.

III. RELATION TO EQUIVALENCY EXAMINATIONS PROJECT

A. The Equivalency Examinations

From the beginning, the Proficiency Examinations project was planned to dovetail with a related project--the development of Equivalency Examinations for academic credit in the same four clinical laboratory fields.

The Equivalency Examinations are also being prepared by Educational Testing Service, under contract with the NIH Division of Allied Health Manpower. When completed in September 1972, the four examinations will become part of the College-Level Examination Program (CLEP) of the College Entrance Examination Board. CLEP general college examinations are now accepted for credit by more than 600 colleges and universities. NCCML staff members were instrumental in initiating this contract and continue to be involved in an unofficial supportive role. Our Manpower Administration contract includes an agreement to promote both sets of examinations.

B. Coordination

Two members of the Advisory Committee for the Proficiency Examinations project are also on the Advisory Committee for the Equivalency Examinations project. (One of them is chairman of the latter.) The NIH project officer and another member of the Equivalency Advisory Committee are resource persons for the Proficiency project. And the science staff members at ETS are actually developing both sets of examinations. There is, however, no overlapping among the Examining Committees, by design.

The fact that ETS would do test construction for both projects is viewed as a valuable saving in time, money, and staff. Originally it was thought the savings would occur as the Proficiency project learned from the Equivalency project. The fact is that the Proficiency project got off to a much faster start and has broken some of the trails for the Equivalency project.

C. Definition and Differences

There has been some confusion over the existence of both projects, largely because the words "Equivalency" and "Proficiency" have been used interchangeably in the past although they do not mean the same thing. NCCML has made an extensive effort to publicize both the Equivalency and Proficiency Examinations projects, and to clarify the differences between them, according to the following definitions approved by both advisory committees:

> Proficiency Examinations are designed for job placement and are used to measure an individual's competencies to perform certain tasks at certain levels. Such tests enable employers to place workers at appropriate job levels on the basis of their knowledge and skills rather than their paper credentials. (Proficiency examinations for personnel should not be confused with the proficiency testing of laboratories, in which blind samples are used to check the accuracy or proficiency of a laboratory as a whole.)
>
> Equivalency Examinations are designed for academic credit and are used to equate non-formal learning with learning achieved in academic courses or structural classroom work. Such examinations enable colleges to grant academic credit for off-campus learning.

As the only professional organization in the laboratory field specifically committed to publicizing both projects and explaining their different functions, NCCML has tried where possible to mention both projects at the same time. And the existence of both projects has, on balance, made it easier to explain the very different specific purposes of each one--both leading to the general mutual purpose of providing appropriate recognition and upward mobility for military laboratory specialists in particular, and laboratory workers in general.

In addition to their specific differences in purpose, these two practical differences between the projects are important:

*The Equivalency Examination specifications begin with a course outline; Proficiency Examination specifications begin with a list of on-the-job tasks. The examination questions are written accordingly.

*The Equivalency Examinations will be normed on students finishing the appropriate college-affiliated courses; the Proficiency Examinations will be normed on people who have been working in laboratories.

ETS test development experts report that the two examinations are actually turning out to be as different as are their aims and procedures.

IV. ADMINISTRATION

A. General Background

In November, NCCML assembled a Subcommittee on Utilization of the Examinations to give initial thought both to administration of the examinations and to the various ways the examination results might be used to benefit laboratory workers and the laboratory field.

The Subcommittee recommended that we try one or more methods of administering the examinations, with the thought that experience will prove what modifications should be made in the system. Some of the agencies suggested as possible administrators of the examinations were: state health departments, state personnel departments, certifying bodies, federal civil service, military testing officers, and the Educational Testing Service. Test security considerations preclude the administration of the tests by employers.

It seems desirable to offer the Proficiency Examinations as widely and as often as practical, while maintaining necessary test security.

B. Administration Possibilities

ETS has submitted at our request a proposal for administering the examinations twice a year at 50-100 locations. Under the proposed plan, ETS would provide the following services:

1. Develop and print Bulletin of Information.
2. Set up centers, secure supervisors, and pay honoraria.
3. Print and mail test booklets and answer sheets.
4. Receive applications and produce and mail tickets of admission.

5. Machine score answer sheets; produce and mail score reports.

6. Develop and print supervisors manuals.

7. Provide item and test analysis and form equating.

The Deputy Assistant Secretary for Education of the Department of Defense has said the Department 'would be pleased to cooperate with ETS in proctoring these examinations at base education centers when test centers are not readily accessible to members of the Armed Forces."

The National Advisory Committee at its April 29 meeting voted to designate the Educational Testing Service as the initial administrative agency for the Proficiency Examinations, supplemented by the Department of Defense. Arrangements would be subject to review by both ETS and the Advisory Committee. A small group will be appointed to consider specific details, according to these guidelines:

1. No eligibility requirements will be established.

2. A candidate may take one or more of the four Proficiency Examinations.

3. The candidate should have the option of designating where his test scores are to be sent (to himself, his employer, an agency, etc.) Scores on the four examinations should be reported separately, so that the examiner can designate which score(s) are to be reported.

4. The candidate should pay to take the examinations. It may be that an employer or agency would reimburse this expense to the individual, or in the pilot phase, it may be possible to offer the examinations at no charge.

5. Candidates should be allowed to retake any examination at least once, using the other form, and possibly additional times at appropriate intervals.

6. Subscores should be reported, if they can be based on sufficient numbers of items.

7. Test security must be maintained.

V. PROMOTIONAL EFFORTS

A. Articles and Mailings

Our major publicity efforts to date have been in the form of articles in publications in the laboratory field and by direct mail to laboratory directors.

Our own newsletter, GIST, carried a detailed story on the project to a mailing list of 13,000. Articles have also appeared in Laboratory Medicine (circulation 55,000), an official publication of the American Society of Clinical Pathologists; Lab World and Medical Laboratory Observer, both independent journals; ASM News of the American Society for Microbiology; the Comprehensive Health Services Career Development Technical Assistant Bulletin of the National Institute for New Careers; and in the initial newsletter of the MEDIHC program, a DOD-HEW-sponsored effort to counsel medical corpsmen into civilian health careers. (See page12). An article will appear soon in the journal of the American Association of Clinical Chemists.

Our bi-monthly Progress Reports on the Proficiency Examinations project go to a mailing list of more than 200 interested persons.

Information on the project and a request for help in pretesting and norming were sent to the directors of 2800 independent laboratories approved for Medicare. A similar letter to laboratory directors of 5500 hospitals approved for Medicare has recently been mailed, with a copy of the GIST issue featuring the Proficiency Examinations story.

We are building a mailing list for a future publicity release, including nearly 200 individuals who have requested the summary of our 1970 report on "Equivalency and Proficiency Testing Related to the Medical Laboratory Field."

B. Professional Meetings

The Co-Chairman of our Advisory Committee discussed the project and distributed copies of the appropriate GIST at the meeting of the Association of Schools of Allied Health Professions in Chicago in November.

Our Executive Secretary brought word of the project to the March meeting of the National Health Council, at which occupational barriers to effective use of health manpower were discussed.

We are currently helping to shape a session on Proficiency and Equivalency Examinations for the October 1971 annual meeting of the American Society of Clinical Pathologists and the College of American Pathologists.

C. Official Endorsements

Official endorsements of the Proficiency Examinations have already come from three professional societies representing the great majority of employers of laboratory personnel.

The Board of Directors of the American Society of Clinical Pathologists at its late February meeting passed the following resolution:

> The Board of Directors of the American Society of Clinical Pathologists endorses the development of proficiency examinations for clinical laboratory personnel. Pathologists look forward to the possibility of objective evaluation of the job qualifications of military laboratory specialists and others who lack degrees or certification, with a view to placing these workers in laboratory jobs at appropriate levels.

In a similar move, the House of Delegates and Board of Governors of the College of American Pathologists accepted the NCCML report on the project, adding:

> We encourage the College to promote programs which provide continuing education, periodic evaluation, and mechanisms for advancement of laboratory personnel.

Most recently, the Board of Governors of the American Academy of Microbiology adopted the following resolution:

> The Board of Governors of the American Academy of Microbiology endorses the development of proficiency examinations for clinical laboratory personnel. The concept of objective evaluation of job qualifications and performance for individuals lacking formal degrees or certification with the view of placement in laboratory jobs, at appropriate levels, is encouraged and supported.

Efforts are currently underway to have similar resolutions presented at meetings of other laboratory employers. Such official endorsements should encourage both employers and agencies to make use of the examination results.

D. Military/Civilian Careers Brochure

A brochure has been prepared outlining a broad spectrum of career opportunities for laboratory workers both in and out of the Armed Forces. The brochure shows parallel career ladders in the military and in civilian clinical laboratories; it also shows opportunities in the laboratory for those with one year of post-high school training, two years of college, four years of college, and post-baccalaureate education. It encourages upward movement on these ladders, all the way to the top. The brochure was paid for by the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, and was prepared in cooperation with the American Association of Blood Banks, the National Registry in Clinical Chemistry, and the National Registry of Microbiologists.

One section of the brochure describes the forthcoming Proficiency and Equivalency Examinations and points out their usefulness to military laboratory specialists wishing to transfer their training and experience to appropriate levels in civilian laboratory jobs. It suggests that interested persons write to NCCML for more information.

This brochure will be distributed to those working in laboratories as well as to those in laboratory training programs in all three services. Transition officers will make it available to corpsmen nearing the end of their military service. It will also go to veterans or soon-to-be veterans through the MEDIHC system (see below).

E. Work with MEDIHC

NCCML has helped to set up a network of special resource people who can be helpful in distributing information on the Proficiency and Equivalency Examinations in a personal way to members of the military. This network consists of 50 pathologists appointed by the American Society of Clinical Pathologists to help with Operation MEDIHC.

The MEDIHC program (Military Experience Directed into Health Careers) is a joint effort of the Department of Defense and the Department of Health, Education, and Welfare to identify medical corpsmen before their separation from the services and to counsel them into civilian health careers. NCCML has worked with the national offices of MEDIHC since the project began late in 1969. In 1970, the American Society of Clinical Pathologists designated NCCML to staff pathologists' efforts to assist the MEDIHC program. ASCP has appointed a national coordinator, John B. Fuller, M.D., and a pathologist in each of the states to assist the HEW-designated state MEDIHC agency in counseling military laboratory specialists into jobs and/or further training in the civilian laboratory field.

Periodic memoranda from the ASCP MEDIHC coordinator and the NCCML staff provide these 50 pathologists with current information and an exchange of ideas on how best to encourage veterans to continue their laboratory careers. Some of these pathologists met for a session on MEDIHC at the Las Vegas ASCP-CAP meeting in February. Another MEDIHC session is scheduled for the annual pathology meetings in October.

VI. INITIAL UTILIZATION EFFORTS

The Proficiency Examinations project is producing a tool that can remove the barriers to appropriate employment of laboratory workers, if it is used. NCCML can and must publicize the existence and potential of that tool but it will be up to employers and agencies to actually put the tool to work.

While neither NCCML nor the Department of Labor will be able to control the ways in which the examination results are used, NCCML has a responsibility to identify the needs, anticipate the possibilities, and conduct an education program to make them known.

We have used the assistance of two groups in an effort to foresee possible uses of the Proficiency Examinations.

The first is the Subcommittee on Utilization of the Proficiency Examinations mentioned earlier in this report.

The second is the Career Ladders Subcommittee of an Interdisciplinary Task Force for Manpower in the Medical Laboratory, formed in September of 1970 to re-examine recommendations made at a 1967 NCCMT-sponsored national conference on Manpower for the Medical Laboratory, to further define objectives, establish priorities, and develop action programs. The Career Ladders Subcommittee was charged with identifying barriers to employment and upward mobility of laboratory workers, and suggesting action to remove those barriers. Its report is due in May. Ideas which have evolved from the discussions of both of these groups have been incorporated in the recommendations which follow.

VII. DIRECTIONS FOR IMPLEMENTATION

Following construction of the Proficiency Examinations, the availability of this new tool should be exploited in the best interests of laboratory workers and employers. The next steps involve administering the examinations, promoting their availability with potential candidates, and developing acceptance and use of the results by employers and agencies. It would also be advisable to experiment with use of the examinations before and after refresher training.

A further aim should be to provide information on this project to those concerned with other health occupations. At the same time, a coordinated effort should be made to promote use and acceptance of the Equivalency Examinations.

We therefore recommend the following directions for implementing the project:

A. Administration

Decisions of our National Advisory Committee on a plan for initial administration of the Proficiency Examinations are detailed in section IV of this report. We hope to be able to negotiate with Educational Testing Service to administer the examinations for one year, with supplementary administration by the Department of Defense. It is recognized by all concerned that the administrative setup should be reviewed and changes made on the basis of experience with it. It may be possible and advisable to add other administering agencies, for example.

The subcontract with ETS hinges on the funding of the administration process. While ETS has been willing to invest some of their own capital in test development for this project, they are unwilling to risk a loss on test administration. Thus a means should be found to guarantee the cost of administering the examinations in the first year.

With the understanding that candidates should pay to take the examinations, experience with the first year's administration should be reviewed in the hope of devising a viable self-supporting administration system for the future. If it is not possible to support the administration of the examinations through fees, help should be sought from agencies interested in the success of the program.

B. Publicity to Potential Candidates

Military laboratory specialists are easier to reach with information about the Proficiency Examinations than are civilian workers. The distribution of the military/civilian careers brochure throughout the services is a first step. When the examinations are ready for administration, specific information on where to apply for and take the examinations should be similarly distributed. An updated version of the brochure should be produced when both Equivalency and Proficiency Examinations are being offered in the fall of 1972.

A briefing meeting on the availability and usefulness of the examinations should be held for Army, Navy, and Air Force laboratory training personnel, as well as those involved with Transition and MEDIHC.

The Subcommittee on Utilization strongly recommended providing career information for military laboratory specialists long before the final months of their military service, when they are bombarded with competing material. Besides, it is too late to do much planning ahead, when they are concentrating on getting out. Thus we are gratified that the Army and Air Force laboratory systems will distribute the careers brochure to all their laboratories.

In addition, there is the possibility of including a session on laboratory careers in each of the training courses in the three services, with emphasis on the career ladder and the opportunity for upward as well as lateral mobility in both military and civilian laboratories. Corpsmen should be encouraged to get the necessary academic credit as well as the training involved. This will be easier to do with the advent of the Equivalency Examinations.

Publicity through other media should be sought, as well, including articles in the service publications, a video tape being developed by the MEDIHC program for use in Army training courses, announcements for bulletin boards, and others.

Another NCCML effort, not directly related to the Proficiency Examinations project but having a similar purpose, is to encourage the military to provide each medical corpsman with a documented record of his training and experience. The Nathan report has also identified this as a needed step for assisting military-to-civilian transition.

To reach civilian laboratory workers with the Proficiency Examinations message, articles and announcements should be placed in hospital and laboratory publications. Mailings to directors of independent and hospital laboratories should reach lower-level personnel who could benefit from the examinations.

C. Promoting Acceptance by Employers and Agencies

1. Employers

Endorsement by the professional societies is but a beginning for a program to encourage laboratory directors to use Proficiency Examination results for the appropriate placement of laboratory personnel. Further publicity on the purposes of the examinations, and particularly on the meaning of the normative data, will be helpful. Articles in publications and presentations at meetings are the major ways of bringing the facts to this group, which includes hospital administrators as well as pathologists, clinical chemists, and microbiologists.

The Certifying Board of the American Dental Assistants Association has recently dropped the observed work sample which formerly was a major part of its examination. The major reason for the change was that virtually everyone who passed the written examination also passed the performance examination. The latter had required the services of some 1,200 examiners, and the Certifying Board concluded the money and manpower expended were not worth the results. The new written test incorporates most of the former practical problems through the use of photographs and other means. Several practical problems are still included in the test, but each of these has a product, such as developed and mounted Xrays, which the candidate sends to the Board's headquarters for evaluation.[1]

Most of the agencies and organizations interviewed for this present study "have no plans" for performance tests. One that does is the New York College Proficiency Examination Program, which is developing guidelines for a practical examination in medical surgical nursing to supplement its written test. The performance portion of the examination will be made available to individual colleges of nursing to administer themselves.

New developments in testing indicate that it is possible to devise performance tests which do not call for actually doing the job. One alternative requires identification and comparison of pictured or oral phenomena, in which answers fit into a multiple-choice format. The practical portions of the American Board of Pathology examinations, for example, make use of slides, photographs and fixed specimens in this way.[2] The National Board of Medical Examiners uses movies and photographs in its "Part III" evaluation of clinical competence.[3] The California licensing examination for laboratory directors who are bioanalysts includes a three-hour practical examination consisting of slides to identify.[4]

Simulation of practical problems in a pencil-and-paper format is a development in performance testing which is attracting increasing attention. The Orthopaedic Training Study[5] and the National Board of Medical Examiners[6] have developed "programmed testing" in which a candidate follows through on paper with a clinical diagnosis and treatment situation in which the way he answers each question determines the information he will have available to answer the following questions. This type of testing is sometimes called a "tab test" because the candidate pulls off a tab or erases a special coating under which he finds the information he thinks necessary for the diagnosis. Such programmed testing bears further study for its possible uses in the medical laboratory field.[7]

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1. See detailed description on page 40.
2. See detailed description beginning on page 6.
3. See detailed description beginning on page 31.
4. See detailed description on page 11.
5. See detailed description beginning on page 35.
6. See detailed description beginning on page 31. Note also that the Part III examination of the National Board has correlated between 0.30 and 0.65 with the other two parts, which are written, indicating Part III is indeed measuring something the other parts do not.
7. For a sample of a suggested programmed test in the medical laboratory field, see page 23 and Appendix 5 on page 78.

Another procedure which may be adapted usefully for the testing of individual performance is "proficiency testing" for quality control, designed to test the performance of a specific laboratory as a whole.[1] Such programs have been available to laboratories for years, through the College of American Pathologists and the American Association of Bioanalysts, and through individual states. They have recently become mandatory for laboratories under Medicare provisions and Federal interstate licensing regulations administered by the National Communicable Disease Center.

"Proficiency testing" programs of this kind involve the mailing of samples, which the laboratory is to process in its regular manner along with the day's regular work. The laboratory's report of its findings is compared with results obtained by several selected reference laboratories and with results from other participating laboratories. Comprehensive reports are provided for all participants. Errors in results can aid laboratory directors in the correction of weaknesses in laboratory performance.

The Clinical Laboratories Improvement Act of 1967 requires laboratories which engage in interstate commerce to undergo such "proficiency testing." Such laboratories must be licensed through the National Communicable Disease Center (CDC), unless they are accredited by the College of American Pathologists and take part in the College's comprehensive "proficiency testing" program. CDC licensing requires laboratories to participate in CDC's own "proficiency testing" service.

The CDC program serves as a standard against which the states can measure their own "proficiency testing" programs. An incentive to improvement of such state services is that they may be substituted for the CDC "proficiency testing" program when CDC deems them to be sufficiently stringent. To date only the programs of Wisconsin and New York (excluding New York City) have been so judged.

Questioned for this study, the directors of the major "proficiency testing" programs agreed that this sort of procedure could readily be used for testing individuals, rather than entire laboratories. This is the stated aim of the newly-established Educational Performance Proficiency Program sponsored by the American Medical Technologists.[2]

Problems of Transferring Laboratory Experience

A maze of different systems confronts the individual attempting to plan a career in the health field, and specifically in the medical laboratory. The only unhampered route to a career as a medical technologist begins with college and leads through clinical training in an AMA-approved school of medical technology to a baccalaureate degree. Any delay or deviation from that route is severely discouraged by the confusing array of systems.

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1. See detailed description beginning on page 9.
2. See detailed description on page 22.

There is very little relationship between the educational system and the world of the working laboratory. It is usually not possible for a laboratory worker to gain academic credit for his experience, or for the learning he may have obtained in ways other than through formal academic courses. There is no accepted articulation between the newly-established associate degree medical laboratory technician level of training and the baccalaureate medical technologist course of study.

The military and civilian and governmental laboratory systems are so constituted that it is difficult to transfer experience from one to the other. Military-trained laboratory workers cannot get recognition in the civilian laboratory field commensurate with their military training and responsibilities. There is current interest in various manpower units of Federal agencies regarding the employment of military-trained medical personnel in the civilian health sector. However, military laboratory specialists cannot transfer even into equivalent government positions because U.S. Civil Service regulations require formal educational background.

No procedures exist in either Federal or state civil service systems for laboratory workers to proceed from the technician level to the professional technologist level without formal academic study. The Medicare program and the Interstate laboratory licensing program administered by the National Communicable Disease Center both now require participating laboratories to submit to tests of over-all laboratory proficiency for quality control purposes; yet both programs have personnel qualification requirements as well. And these requirements do not allow for learning outside formal academic programs.

Professional certification through the Registry of Medical Technologists provides some measure of uniformity in the field, as do model state licensing systems. Yet both require only formal education and provide no real alternatives to the "accepted" route for becoming a medical technologist.

The Need for Equivalency Examinations

A major impediment in transferring experience from working situations to the educational system, or from military to civil service to private laboratory systems, is that no means now exists to measure a laboratory worker's knowledge and skills as related to the job or as related to academic requirements. Proficiency testing, on the one hand, and equivalency testing, on the other, could help to provide the necessary bridges between these systems.

The encouraging trend noted in speeches, articles, correspondence and conversations is that many individuals and organizations representing the health professions are concerned about evaluating the capabilities of people working in the health fields, and particularly in laboratories, and are considering new ways of giving those workers recognition for what they have learned. There is a growing acceptance of knowledge gained outside the classroom and of the possibility of measuring that knowledge.

Meanwhile, testing agencies and experts have developed more sophisticated examination techniques for evaluating the whole spectrum of learning, including not only recall of isolated facts but also the ability to use these facts and to understand relationships. New simulation methods, including paper and

pencil tests, have been devised for testing performance abilities. Methods of job analysis are being employed -- particularly the critical incident technique -- to define the knowledge and skills which are necessary for each job. With this information, test preparation can be aimed specifically at the job under consideration. Tests in the health fields, as in most fields, are subject to continuous re-examination to assure that they measure what they are intended to measure.

The findings of this study point both to the need for equivalency testing in the medical laboratory field and to possible ways of meeting that need. A battery of examinations could and should be developed to evaluate the knowledge and skills of laboratory workers.

Efforts to achieve career mobility in the medical laboratory field should proceed concurrently in these three directions:

* Identification of skills and knowledge which are needed currently as well as needs in the future to perform the various tasks in the medical laboratory;

* Redefinition of educational programs to prepare workers specifically to perform these tasks; and

* Development of tests which measure on-the-job proficiency and can thus be used for equivalency purposes to grant academic credit, and/or recognition of competence.

To delay the third for completion of the other two might be logical, but would in fact be tantamount to doing nothing about equivalency, since both task analysis and educational change are long-term undertakings. The need for equivalency examinations is immediate.

The examinations thus should be constructed within a flexible framework that would permit modifications as task analysis provides agreement on what is required of medical laboratory personnel, and as educational programs continue to change in order to train personnel for the tasks to be done.

II. A BRIEF HISTORY OF EQUIVALENCY TESTING *

By Sarah Allene Wise, MT(ASCP)

Historically the development of equivalency examinations was a result of the identification of two purposes for which they were given. These purposes, to award academic credit and determine partial fulfillment of job requirements, required the development of two corresponding types of tests. These purposes are not mutually exclusive as could be assumed by such an arbitrary division; there is a point at which job mobility may, and often does, depend on acquired academic credit. Historically, these two types of tests have developed somewhat concurrently; but presently the trend is to provide a single instrument which can serve both purposes.

History

Early in its development, equivalency testing focused on the superior high school student who desired credit or advanced placement. The result of a number of schools attempting to meet this need was the availability of a variety of such examinations, many of which are currently used for this same purpose. These examinations are known by various titles: the anticipatory-examination; the exemption examination; proficiency examinations and advanced placement examinations.

By the end of World War II, the literature indicates that many schools had become interested in developing methods for evaluating various learning experiences which had not been acquired in an academic classroom setting. In 1945 the Commission on Accreditation of Service Experience was established by the American Council on Education to review the educational programs of the Armed Services and make recommendations for credit for such experiences. At about the same time, the General Education Development Tests of the United States Air Forces Institute were constructed to allow credit to servicemen for a variety of educational achievements obtained in the military service. By the successful completion of these equivalency examinations, a serviceman (and later non-service persons) could earn a high school equivalency certificate.

Paralleling the development of equivalency tests for academic credit was the development of tests designed to ascertain a candidate's qualifications for meeting the requirements for a job. The equivalency examination, as used in job mobility, has been recognized for many years by industry, government agencies and organizations as a means of evaluating an employee's qualifications for moving to a better paying job or a new position with new responsibilities. Originally this mobility was dependent upon work experience alone, but with the increased availability of facilities for higher education, the various levels of employment frequently became geared to the acquisition of academic credit or its equivalent. Many forces -- educational, economic and individual -- acting at the same time brought into focus the importance of the acquisition of academic credit or its equivalent to meet this additional job requirement.

Several educational institutions have prepared tests whereby an individual's experience can be evaluated and possibly equated to the first and second year of college. In 1960, the New York College Proficiency Examination Program was developed which provided a measure of the learning equivalent to the first and second year of college and, in addition, provided a measure to be used in the

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* Quoted by permission of the author from an unpublished master's thesis entitled "A Method for the Preparation of a Challenge Examination in Medical Technology," University of Vermont, 1969.

partial fulfillment of the requirements for teacher certification. Thus, one instrument was developed which could be used for the dual purpose of evaluation for credit and/or job requirement. This examination was for use in a limited geographical area. On a national scale, the College Level Examination Program was prepared by the College Entrance Examination Board. The program began in 1965 and was expanded later to provide an equivalency instrument which can serve either of the purposes of equivalency. As indicated in its literature, the College Entrance Examination Program provides test results which can be used by universities or colleges to provide credit, or by some organizations, licensing bodies "and agencies other than colleges and universities" as a fulfillment of some requirements.

Within the past few years, various groups and organizations have been interested in the development of methods for evaluating the learning acquired from off-campus experiences. Much of this emphasis has been a result of pressure, directly or indirectly, from the findings and observations of various programs and studies by the United States Department of Health, Education, and Welfare and the Department of Labor. Many of the studies have been concerned with the development of career ladders, new careers, subprofessional employees, and/or suggestions for a more flexible means of job mobility. The ideas which were reported in these studies have become closely associated with equivalency examinations since, frequently, examinations provide the means of achieving mobility in employment. These examinations, then, evaluate the acquisition of learning associated not necessarily with specific academic experiences but with those of possible equivalent value. Much of the current work in equivalency testing is directed toward such evaluation.

Many current university and college catalogues indicate that equivalency examinations are available to students who desire credit or advanced placement. These are often prepared by the institution itself, however many use as equivalency measures various tests from the College Level Examination Program. Organizations and groups in a variety of occupational fields have employed the College Level Examination Programs to determine partial fulfillment of their qualification requirements. The need for equivalency examinations in the health field has been stressed by many authors; but only recently has this become a major concern for several organizations and professional representatives in the health field.

Nursing educators have been investigating and studying this problem for several years. In 1967 a conference on manpower problems in the medical laboratory was held by representatives of various government agencies and of the professions interested in the medical laboratory field. As a result of its discussions, the conference made several recommendations, one of which was that "efforts ... (should be made) ... to develop equivalency tests to provide increased mobility" in the medical laboratory field.

proficiency examinations for clinical laboratory personnel

INTERIM REPORT JUNE 30, 1970–APRIL 30, 1971

NATIONAL COMMITTEE FOR CAREERS IN THE MEDICAL LABORATORY

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NATIONAL COMMITTEE FOR

Careers in the Medical Laboratory

9650 Rockville Pike, Bethesda, Maryland 20014

executive secretary DALLAS JOHNSON *phone* (301) 530-6055

chairman THOMAS M. PERRY M.D.

SPONSORS: THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS • COLLEGE OF AMERICAN PATHOLOGISTS

Project on Proficiency Examinations for Clinical Laboratory Personnel

The National Committee for Careers in the Medical Laboratory, sponsored by the American Society of Clinical Pathologists and the College of American Pathologists, was founded in 1953 as an intersociety committee to promote the recruitment of medical technologists. In this capacity, the Committee is responsible for stimulating the recruitment of candidates for employment in medical laboratories and facilitating their training and retraining. The Committee has carried out an extensive program of basic research studies, education surveys, films, recruitment, and scholarship programs.

The Committee's work on career mobility in the laboratory field began with a conference in October 1967 on "Manpower for the Medical Laboratory," bringing together persons from government and the professions to consider problems of recruitment, education, and utilization of laboratory personnel. In March 1970, the Committee published "Equivalency and Proficiency Testing Related to the Medical Laboratory Field."

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This report was produced by the National Committee for Careers in the Medical Laboratory under Contract #82-22-70-35 with the Manpower Administration, U.S. Department of Labor, under the authority of the Manpower Development and Training Act. Organizations undertaking such projects under Government sponsorship are encouraged to express their own judgment freely. Therefore points of view or opinions stated in this document do not necessarily represent the official position or policy of the Department of Labor. Submitted to Seymour Brandwein, Associate Director, and William Throckmorton, Project Officer, Office of Research and Development, Manpower Administration.

TABLE OF CONTENTS

SUMMARY

The National Committee for Careers in the Medical Laboratory is developing a battery of Proficiency Examinations in clinical chemistry, microbiology, hematology, and blood banking. The aims of the project are: (1) to overcome undue barriers to employment and promotion, and (2) to provide laboratory employees an opportunity for upward mobility on the career ladder.

The examinations will enable employers to obtain an objective evaluation of the capabilities of both military-trained and civilian laboratory workers.

The Proficiency Examinations project has met with interest and enthusiasm not only in the laboratory field but as a prototype for other allied health professions. Individual cooperation from specialists essential to the success of test development has been readily achieved.

Test development, subcontracted to the Educational Testing Service of Princeton, New Jersey, is proceeding on schedule. The examinations will be completed and validated by Fall of 1971.

This interim report of Progress outlines the directions for next steps to implement the project and encourage utilization of the examinations:

1. Develop a procedure for administering the Proficiency Examinations during the first year, and review it with the aim of working out a self-supporting system for the future.

2. Make the Proficiency Examinations known to potential candidates, civilian and military, through a publicity campaign involving brochures, articles, mailings, and meetings.

3. Promote acceptance of the Proficiency Examinations by laboratory directors and specialists, hospital administrators, etc., through mailings and articles, and by speeches, symposia, and exhibits at their annual meetings, encouraging them to use the examinations in employing workers.

4. Investigate areas where artificial barriers to career mobility exist, and seek ways to use the Proficiency Examinations in removing those barriers. These areas include licensure, Medicare regulations, state and federal civil service requirements, and military personnel regulations.

5. Inform other health occupations associations and agencies about the experiences of this project, to assist in the development of proficiency examinations in other health fields.

PROFICIENCY EXAMINATIONS FOR CLINICAL LABORATORY PERSONNEL

Interim Report of Progress

June 30, 1970, to April 30, 1971

I. ORGANIZATION

A. The Project

The National Committee for Careers in the Medical Laboratory (formerly the National Committee for Careers in Medical Technology) signed a year's contract through the Office of Research and Development of the Manpower Administration, U. S. Department of Labor, on June 30, 1970, to develop four Proficiency Examinations in the fields of clinical chemistry, microbiology, hematology, and blood banking.

B. Purposes

The Proficiency Examinations Project has two primary aims: (1) to overcome undue barriers to employment and promotion, and (2) to provide laboratory employees an opportunity for upward mobility on the career ladder. Proficiency Examinations will enable employers to obtain an objective evaluation of the knowledge and skills of:

> The military-trained medical laboratory specialist, whose training is comparable in some respects to training in the civilian laboratory field, who has a year or more experience in laboratory work; but who on separation is denied entry at any but the bottom level, which he cannot afford to take.
>
> The civilian laboratory worker employed at a lower level, who has received most of his training on the job, whose experience and aptitude may qualify him to perform on a higher level, but who is prevented from "getting ahead" by formal educational and training requirements.

The proposal for this project was developed in a favorable climate for support and action. The need for retaining both military and lower-level civilian laboratory workers was well recognized and there was general agreement that Proficiency Examinations (and Equivalency Examinations for academic credit -- see page 6) could serve as an important means to this end. The NCCML study on "Equivalency and Proficiency Testing Related to the Medical Laboratory Field" increased interest in such examinations as tools for appropriate placement of workers in a number of health occupations. The House Ways and Means Committee called attention to that study in its May 1970 report and pointed out that:

> "...Both recruitment and utilization of laboratory personnel would be greatly enhanced by the use of equivalency and proficiency examinations. The use of such examinations would greatly increase career mobility in the laboratory field, thereby making the profession more attractive generally, facilitating the recruitment and retention of laboratory workers, and encouraging re-entry into the field by those who have left it."

As to the chances of encouraging military-trained laboratory specialists to enter the civilian health field, our proposal cited the findings of Colonel James J. Young in his Ph.D. thesis published by the University of Iowa that many corpsmen wanted to make such a transfer but were discouraged by the lack of recognition of their experience and skills. After we began the Proficiency Examinations project, the report by Robert Nathan Associates on "Transferability of Military-Trained Medical Personnel to the Civilian Sector" documented further the fact that such corpsmen do represent a rich source of civilian health personnel, "if they can be provided opportunities for training, employment, and advancement commensurate with their education."

C. Advisory Committee

The Proficiency Examinations project was launched in July 1970. Despite the fact that it was summer, NCCHL was able to assemble an outstanding interdisciplinary National Advisory Committee of eleven persons and to bring them together for a meeting on July 28 with resource people and test development experts. Each member was chosen for what he or she could contribute to the Proficiency Examinations program, not as a representative of any organization. The Committee members are:

Maj. Gen. Joe M. Blumberg, M.D., USA (Ret.), Co-Chairman
(pathologist)

Mrs. Loula Woodcock, MT(ASCP), Co-Chairman
(supervising medical technologist)

Howard L. Bodily, Ph.D.
(microbiologist)

Col. James L. Hansen, M.D.
(pathologist)

Clarence R. Jones, MLT(ASCP)
(former Air Force laboratory specialist; administrative and technical assistant to laboratory director)

Robert S. Melville, Ph.D.
(clinical chemist)

A. Wendell Musser, M.D.
(pathologist; chairman, Advisory Committee for Equivalency Examinations project)

John Peterson
(hospital administrator)

Mrs. Martha Phillips, MT(ASCP), MS
(medical technologist; chief of VA allied health training)

Harvey I. Scudder, Ph.D.
(allied health educator; member, Advisory Committee for Equivalency Examinations project)

(Harold I. Lewack of the Department of Labor, now deceased, was originally a member of the Committee.)

2. Medicare Regulations

The Community Health Service Division of Health Standards is preparing a report for the House Ways and Means Committee on the progress it has made since last May in consulting "with appropriate professional health organizations and educational institutions to develop proficiency testing and educational equivalency mechanisms for use in determining the qualifications of laboratory personnel under the Medicare program."

The Committee asked for this report by July 1, 1971, in its Report on the Social Security Amendments of 1970, quoted in section I of this paper. The Committee indicated a particular interest in assuring eligibility under Medicare for qualified former military laboratory specialists.

The Senate Committee on Finance included in its Social Security bill last fall a requirement for the use of Equivalency and Proficiency Examinations to qualify health care personnel who do not meet specific formal educational, certification, or training criteria. The bill died at the end of 1970, but a similar amendment has been introduced in the current session by Senator William B. Saxbe of Ohio. His bill, S.892, now in the hands of the Senate Committee on Finance, provides:

> "The Secretary, in carrying out his functions relating to the qualifications for health care personnel...shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, 1975, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, X-ray technicians, psychiatric technicians, or other health care technicians or technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements."

The Division of Health Standards currently describes some 30-40 positions under Medicare.

It appears from developments in both House and Senate committees that Equivalency and Proficiency Examinations may be written into law to offer an alternative method for qualifying laboratory personnel--most likely on the technician level--under Medicare. If the Proficiency Examinations being developed by NCCHL prove acceptable to those who set Medicare personnel standards, they can be used for this purpose.

3. State Licensure

Ten states, Puerto Rico, and the City of New York now license laboratory personnel other than the director. Licensure legislation affecting laboratory personnel standards is under consideration in another 25 states.

The American Hospital Association and the American Medical Association have called for a moratorium on additional licensure and proposed a national task force to recommend means of improving licensure practices.

The Department of HEW is now working on a study of major problems associated with licensure (and with certification and other qualifications for employment of health personnel). The report, due on July 1, 1971, was mandated by the 1970 Allied Health Bill. It is to include specific recommendations for steps to solve the problems identified.

While NCCHL does not have an official position on licensure, we would suggest that if and when laboratory licensure legislation is written, it should include possibilities for upward career movement by use of Equivalency and Proficiency Examinations. Such provisions are clearly spelled out in the laboratory licensure law now pending in the Texas legislature. The proposed Texas law would allow use of this alternate method of qualifying for any level of laboratory personnel from technician up to director.

It is legally possible for most if not all licensing boards in states with present legislation to make use of the NCCHL Proficiency Examinations instead of writing their own.

4. State and Federal Civil Service Regulations

Federal Civil Service regulations offer higher level laboratory positions only to those with formal education. A veteran who may have had a responsible career laboratory position in the Medical Corps cannot get a similar job in the U.S. Civil Service laboratory system. Similar problems exist with state civil service regulations.

NCCHL has suggested to the U.S. Civil Service Commission's Task Force on Job Evaluation that an alternative method for qualifying laboratory personnel for Civil Service ratings via Equivalency and Proficiency Examinations should be set up. This initial suggestion should be pursued.

State civil service model classification schedules have been drawn up by a joint committee of the Association of State and Territorial Public Health Laboratory Directors; the Office of State Merit Systems of the Department of Health, Education and Welfare; and the Laboratory Division of the Center for Disease Control. While they do not now contain any possibility for movement from technician level to professional level without meeting formal educational requirements, it may well be that the climate will be favorable for suggesting upward movement within state civil service regulations via examinations, when those model classification schedules are up for revision.

5. Military Entry Regulations

While the Proficiency Examinations project was designed partly to facilitate the transfer of military laboratory personnel to civilian laboratories, it has come to our attention that the examinations can prove useful to workers making the reverse transfer.

Military level for those who already have laboratory training and/or experience is based on the certification level attained in civilian laboratory work. For instance, an ASCP-certified Medical Laboratory Technician entering the Army can obtain the 92B30 rating, equivalent to that achieved by going through the year-long Army laboratory course. Other training or laboratory experience is currently not recognized.

Officials in the Army Surgeon General's office have indicated they will welcome the possibility of using Proficiency Examination results to measure capabilities of those coming into the service with a background of laboratory experience.

6. International Reciprocity

Another group of laboratory workers who will be able to benefit from the Proficiency Examinations are those who have received their training in other countries and now wish employment in American clinical laboratories.

Laboratory training in other nations varies considerably in length and depth, and therefore in comparability to American standards.

American employers interested in hiring foreign-trained laboratory workers have had no objective way of evaluating their knowledge and capabilities. The Proficiency Examinations can provide such an evaluation. The possibilities for official reciprocity of various kinds should be explored.

7. Certification

Suggestions have been made that the Proficiency and Equivalency Examinations, taken together perhaps, might offer a substitute for the eligibility requirements for the medical laboratory technician and even medical technologist certification examinations offered by professional societies. Some associated with the National Registry of Microbiologists have indicated an interest in looking at registrants' performance on the Proficiency Examinations with the possibility of incorporating these examinations in the certification process.

D. An Experiment: Refresher Training Through Project Transition

With the Proficiency Examinations available, it will be possible to identify for an individual laboratory corpsman specific areas in which he needs more training or experience, and to follow up this assessment with a refresher training course in order to better prepare him for civilian laboratory employment.

NCCML has entered preliminary discussions with the Office of National Projects of the Department of Labor Manpower Administration and with Department of Defense Project Transition representatives about possible pilot projects in which:

1. Six months before their anticipated separation, laboratory specialists would take one form of the Proficiency Examinations.

2. Through analysis of the examination results, each individual's specific needs for refresher training would be identified.

3. Specific additional training would be offered each individual via several different methods:

   a. The training of perhaps 200-300 hours may be arranged for released time during working hours, or after hours if released time is not possible. A third, less desirable, alternative would be immediately after separation for those who cannot be released and who may be moonlighting or for other reasons are not available during or after hours.

   b. The training may be given in a military hospital, a VA hospital, or a private hospital; it may be a cooperative effort with a college or university and/or a school of medical technology.

   c. Taped lectures for supervised individual learning will be available this fall as a result of a NCCML project currently in progress. More than sixty tapes, covering all the major laboratory areas, are being prepared by recognized experts. And hopefully in another year there will be sets of slides to go with the tapes.

4. At the end of the refresher training, the specialist would take the other form of the Proficiency Examinations to assess his progress and hopefully to demonstrate he is ready for civilian employment at better than entry level.

E. Providing Information to Other Health Occupation Groups

Many other health occupations have similar manpower problems and interests to those of the clinical laboratory field. Interest in the possible development of Proficiency and Equivalency Examinations is evident in a number of these fields. Those responsible may wish information about our experiences in order to profit from them.

Advisory Committee members should be called on to provide information at meetings and conferences of various health groups. The Coordinator of the Proficiency Examinations Project serves as a member of the Committee for Equivalency and Proficiency Examinations of the Association of Schools of the Allied Health Professions, a group particularly interested in these developments.

A report should be published and widely distributed when the pattern of administration and potential use has become viable. Every effort should be made to transfer the benefits of this Proficiency Examinations program to other health occupations which can profit from them.

F. Promoting Use and Acceptance of the Equivalency Examinations

While the Equivalency Examinations will have a certain built-in acceptance as part of the CLEP program, much can be done to promote understanding and use of them for the granting of credit by educational institutions. The meeting on Proficiency and Equivalency Examinations in October in connection with the ASCP-CAP annual meeting is designed specifically for laboratory school directors. The American Society of Medical Technologists has scheduled a session on Equivalency Examinations at their annual meeting in June. Both of these meetings should offer the opportunity to gain a favorable reaction to the examinations, and possibly also to gain some help in the norming process.

Combined publicity for the Equivalency and Proficiency Examinations for those who could benefit from taking them will be in the best interests of both projects. Clarification of their different purposes can be achieved by treating them together where possible.

VIII. FOR THE FUTURE

Two recommendations which deserve continued thought now and action in the more distant future involve:

A. Evaluation of Case Histories

The true test of the Proficiency Examinations project will be whether the examinations are indeed taken by laboratory workers and the results used by employers to place those workers appropriately. A follow-up study should be undertaken on the examinees to see how they have profited from the results.

B. Revision and Updating of the Examinations

Changes in laboratory processes and ways of using personnel will surely make parts of the examinations out-of-date in time. And test security considerations usually impose a time limit on the usefulness of any examination. These facts should be recognized and the need anticipated in advance for a program to review the examinations and revise them as necessary.

PROFICIENCY EXAMINATIONS FOR CLINICAL LABORATORY PERSONNEL

COMMITTEES OF EXAMINERS

Clinical Chemistry

Mst. Sgt. James R. Brown, Medical Field Service School (Fort Sam Houston, Texas); Howard Rawnsley, M.D., Hospital of the University of Pennsylvania Medical School; Martin Rubin, PH.D., Georgetown University Hospital, *Chairman;* Mrs. Loula Woodcock, MT (ASCP), Scripps Memorial Hospital (La Jolla, California).

Microbiology

Lt. Walter Cox, M.Sc. (USNR), National Naval Medical Center (Bethesda, Maryland); Sgt. John James, USAF Medical Center (Wright Patterson, Ohio); Jesse Marymont, M.D., Wesley Medical Center (Wichita, Kansas); Gerald Needham, PH.D., Mayo Foundation (Rochester, Minnesota), *Chairman;* Miss Cornelia Van Benthem, M.A., MT (ASCP), Hackensack Hospital (Hackensack, New Jersey).

Hematology

Major Joseph H. Keffer, M.D., Anderson Pathology Associates (Anderson, South Carolina); Robert Langdell, M.D., University of North Carolina Medical School, *Chairman;* Mrs. Doris Y. Mahon, Walter Reed Army Medical Center (Washington, D.C.); Mrs. Gwendolyn N. Taylor, MT (ASCP), Medical University of South Carolina.

Blood Banking

Lt. Col. Frank Camp, U. S. Army Medical Research Laboratory (Ft. Knox, Kentucky), *Chairman;* Ralph Lingeman, M.D., Veterans Administration Hospital (Washington, D.C.); Mrs. Grace Neitzer, MT (ASCP), Michigan Community Blood Center (Detroit, Michigan); Lt. Col. Harold Neuman, USAF Medical Center, Andrews Air Force Base (Washington, D.C.).

Address registration forms and all correspondence regarding registration, test centers, admission tickets, and score reports to:

PROFICIENCY EXAMINATIONS FOR CLINICAL LABORATORY PERSONNEL
EDUCATIONAL TESTING SERVICE
PRINCETON, NEW JERSEY 08540

CONTENTS

INTRODUCTION

The Proficiency Examinations for Clinical Laboratory Personnel are administered by Educational Testing Service (ETS) of Princeton, New Jersey. They are sponsored by the National Committee for Careers in the Medical Laboratory (NCCML), with backing and support from the American Society of Clinical Pathologists, the College of American Pathologists, the American Academy of Microbiology, the American Association of Clinical Chemists, and the American Association of Blood Banks.

The examinations were developed under contract with the Manpower Administration of the United States Department of Labor.

Examinations are given in the fields of *clinical chemistry, microbiology, hematology,* and *blood banking* (*immunohematology*). A candidate may take one or more of the four examinations.

The Proficiency Examinations are designed to help employers obtain an objective evaluation of the knowledge and skills of:

The military-trained medical laboratory specialist, whose training is comparable in some respects to training in the civilian laboratory field and who has a year or more of experience in laboratory work, but on separation often leaves the field because his training and experience are not recognized and he has to start at the bottom.

The civilian laboratory worker employed at a lower level, who has received most of his training on the job, whose experience and aptitude may qualify him to perform on a higher level, but who is prevented from advancement by formal educational and training requirements.

During the 1971-72 academic year, ETS will administer the Proficiency Examinations for Clinical Laboratory Personnel on Saturday, *November 20, 1971,* and on Saturday, *May 6, 1972,* at testing centers throughout the continental United States. For this pilot year's administration, costs are being covered by the Manpower Administration and there is *no fee* for candidates.

Please read the following sections of this *Bulletin* carefully. They contain detailed information important to know if you plan to take these tests.

HOW TO REGISTER

Fill out the registration form in this *Bulletin* and send it to Educational Testing Service, Princeton, New Jersey 08540. It must be *received* in Princeton *no later than four weeks before the test date.* Allow five days for first class mail delivery. Registration forms, as well as requests for test center changes, will not be processed if received after a closing date. It is to your advantage to send in the form as early as you can. Early registration allows time to clear up any irregularities that might delay the issuing of your test scores.

Administration date	*Registration closes*
November 20, 1971	October 22, 1971
May 6, 1972	April 7, 1972

If possible, ETS will establish special centers for candidates who must travel over 100 miles to a test center. In addition, the Department of Defense has agreed to set up centers for members of the Armed Forces when test centers are not readily accessible to them. Requests for a special center, along with the completed registration form, must be received by ETS *six weeks before the test date.* If you request a special center, do not fill in item 7 on the registration form. Registration closing dates for special centers are:

Administration date	*Registration closes*
November 20, 1971	October 8, 1971
May 6, 1972	March 24, 1972

If your religious convictions prevent you from taking tests on Saturday, you can request that ETS arrange for testing on the following Monday. Submit with your registration form a letter signed by your minister or rabbi confirming your affiliation with a recognized religious body that observes its Sabbath on Saturday. In item 7 on your registration form, print the word MONDAY before the city, state, and center number. The registration closing date for Monday testing is the same as for special centers.

WHERE TO TAKE THE TESTS

The list of ETS test center locations for administration of the Proficiency Examinations for Clinical Laboratory Personnel is given on page 7. No centers will be established outside the continental United States, except for members of the United States Armed Forces.

Study the center list and then select the city most convenient for you on the date for which you are registering. You may ignore state borders if there is a city in a neighboring state nearer than any in your own state. Enter the center number in item 7 of your registration form (unless you are applying for a special center).

Educational Testing Service makes every effort to assign you to the center of your choice. However, there are times when more candidates apply for one center than can be accommodated. When this occurs, it is necessary to assign those candidates whose registration forms were received last to another center as near as possible to the requested one.

Sometime during the month preceding the tests, ETS will send you an admission ticket bearing the date of the tests and the address of the center to which you must report for assignment to a testing room. You will not be admitted to the test center without your admission ticket. If you lose your ticket, write to or wire the ETS Princeton office immediately for special authorization to take the test. Payment for an authorization wire is the responsibility of the candidate. Last-minute authorization cannot be guaranteed, but ETS will make every effort to help you.

The mailing label you complete as part of your registration form will be stapled to the admission ticket ETS sends you. This label gives you information about when to report for the tests and other important details. The registration number you will be required to grid on your answer sheet is also printed on the mailing label, so be sure to take it as well as your admission ticket to the test center.

CHANGE OF CENTER: If, in an emergency, you find it necessary to take the tests at a center other than the one you originally specified, you should wire or write to the ETS Princeton office requesting such a change. Do *not* return your admission ticket and do *not* submit a new registration form.

Whenever possible, ETS will send you authorization, by letter or collect telegram, to take the tests at the center you now request. However, no center changes can be made unless your request reaches the Princeton office *four weeks or more before* the test date. Under normal circumstances, supervisors at one test center will not admit a candidate who presents an admission ticket for another center unless the candidate also presents a letter or telegram of authorization from ETS.

72-573 O - 72 - pt. 6 -- 23

CENTER LIST

The Proficiency Examinations for Clinical Laboratory Personnel will be given in the following cities on November 20, 1971 and May 6, 1972.

Alabama
302 Birmingham

Arizona
102 Phoenix

Arkansas
106 Little Rock

California
117 Los Angeles
125 San Francisco

Colorado
134 Denver

Connecticut
505 Hartford

District of Columbia
564 Washington

Florida
320 Miami
318 Jacksonville

Georgia
333 Atlanta

Idaho
139 Boise

Illinois
349 Chicago

Indiana
365 Indianapolis

Iowa
146 Davenport
147 Des Moines

Kansas
157 Dodge City
161 Topeka

Kentucky
382 Louisville

Louisiana
164 Baton Rouge

Maine
588 Augusta

Maryland
611 Baltimore

Massachusetts
630 Boston

Michigan
394 East Lansing

Minnesota
175 Minneapolis

Mississippi
411 Jackson

Missouri
185 St. Louis

Montana
192 Helena

Nebraska
204 North Platte

Nevada
210 Las Vegas
211 Reno

New Jersey
695 New Brunswick

New Mexico
217 Albuquerque

New York
736 New York City
746 Syracuse

North Carolina
425 Greensboro

North Dakota
227 Bismarck

Ohio
436 Cleveland
438 Columbus

Oklahoma
240 Oklahoma City

Oregon
246 Eugene

Pennsylvania
772 Philadelphia
775 Pittsburgh

Rhode Island
809 Providence

South Carolina
453 Charleston

South Dakota
255 Rapid City

Tennessee
468 Knoxville
471 Nashville

Texas
264 Dallas
268 El Paso

Utah
252 Salt Lake City

Vermont
827 Montpelier

Virginia
851 Richmond

Washington
289 Seattle
291 Spokane

West Virginia
878 Charleston

Wisconsin
486 La Crosse

Wyoming
296 Casper

ON THE DAY OF THE TESTS

This is the schedule for each testing date:

8:30 a.m. — Candidates report to center

12:45 p.m. (approximately) — Session closes

Each of the Proficiency Examinations (clinical chemistry, microbiology, hematology, blood banking) lasts approximately one hour. Together the four examinations will take four hours, and they will be given in a single morning session. You may take just one, two, three, or all four. Candidates taking fewer than four tests will be dismissed at the appropriate time.

No candidate will be admitted to an examination room after the tests have begun.

In order that all candidates may be tested under equally favorable conditions, standard procedures and regulations are observed at every test center:

- Supervisors have been asked to arrange for testing rooms free from noise or disturbance. All visitors will be excluded.
- Each testing room should have a clock visible to all candidates. Candidates should also bring watches.
- All centers will give tests according to the same schedule. No candidate will be permitted to continue a test beyond the allotted time.
- Candidates should bring three or four No. 2 pencils, or a mechanical pencil with a soft lead, and an eraser. *No pencils or erasers will be furnished at the center.*
- Candidates are not permitted to bring books or papers of any kind (including scratch paper) into the examination room and are strongly urged not to bring such materials with them at all. Similarly, the use of dictionaries, books, slide rules, rulers, or papers of any kind is not permitted. If a candidate is found to have such material with him, he will not be allowed to continue the tests. Scratch work may be done in the margins of the test books.
- Candidates who wish to leave the room during a rest period or during the tests must have permission from the supervisor.
- If a candidate is discovered engaging in any kind of misconduct — giving or receiving help, using notes, books, or papers of any kind, removing test materials or notes from the testing room, or taking part in an act of impersonation — his tests will not be scored.
- Educational Testing Service reserves the right to cancel any test score if, in the opinion of ETS, there is adequate reason to question its validity. Before exercising this right, ETS will offer the candidate a retest.

TAKING THE TESTS

The Proficiency Examinations for Clinical Laboratory Personnel were prepared by the examining committees of pathologists, clinical chemists, microbiologists, and medical technologists listed on the inside front cover of this *Bulletin*. The test questions are designed to measure the proficiency of laboratory workers at the technician level.

All four one-hour examinations consist of multiple-choice, paper-and-pencil questions. Timing and instructions are printed in the test book. Remember to read carefully the directions for each section.

It is important to use your time as economically as possible. Take the questions in order, but do not waste time on those which contain extremely difficult or unfamiliar material. If you complete a section of a test before time is called, go back and reconsider those difficult questions.

The tests are designed so that the average person taking them will answer correctly only a certain percentage of the questions. No one is expected to get a perfect score, and there are no established passing or failing scores.

Your answers will be recorded on a separate answer sheet. From the five lettered answers for a question, you will choose the *one* you think is best. The example illustrates how answers are to be marked.

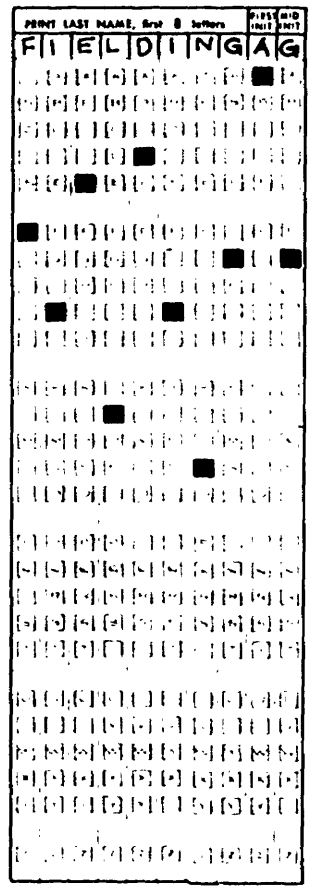
Chicago is a
(A) state
(B) city
(C) country
(D) town
(E) village

Sample Answer Spaces

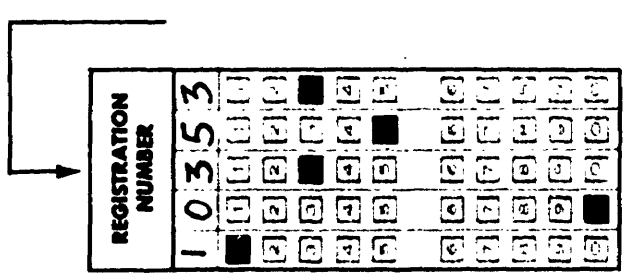
Blacken the space with the letter corresponding to the answer you wish to give.

Before the tests begin, you will fill in certain sections on your answer sheet including your name, sex, and birth date. An illustration of the name section is shown on page 10. It has been filled out by an imaginary student, Alexander G. Fielding. He first printed the letters of his last name in the large boxes at the top. (If his last name had contained more than 8 letters, he would have filled in only the first 8 of them.) Then he printed his first and middle initials. He then blackened the small lettered space in each column corresponding to the letter in his name at the top of that column.

Sample of the answer sheet name section



You will similarly print and grid your registration number, as in the following example:



These procedures must be followed so that your answer sheet can be correctly identified and your scores properly reported.

WHO RECEIVES SCORE REPORTS

Educational Testing Service will report scores directly to the candidate. Upon request, ETS will also send copies of a candidate's scores to prospective employers. The charge for this latter service is $2.00.

For comparison, the candidate will also receive information on test scores that were earned by a representative group of qualified workers who are already satisfactorily holding down jobs in these fields in clinical laboratories.

A candidate's request that his tests not be scored will be honored provided the request is received by ETS within a week after he has taken the tests. Preferably the candidate should make this request by notifying the supervisor before leaving the testing room.

USE OF TEST SCORES

Examination results can be used by employers to place and upgrade laboratory workers. Medicare plans to use the results as an alternate way of qualifying workers for its technician level. Federal, state, and local civil service commissions are interested in similar use of the examinations. The ASCP Board of Registry of Medical Technologists is considering possible use of the examinations to qualify candidates for the MLT certification examination.

CORRESPONDENCE WITH ETS

If for some reason you find it necessary to correspond with ETS after your registration form has been submitted, be sure to specify:

1. the name of the tests (Proficiency Examinations for Clinical Laboratory Personnel), and
2. the date you either took the tests or plan to take them.

To avoid errors in reporting scores, always use the same form of your name in signing all documents and in any correspondence with ETS. Do not write "John J. Jones, Jr." one time and "J. Jones" or "John Jones" another time. Such inconsistency makes identification of papers difficult.

TEST CONTENT

The subject matter covered by the four examinations is indicated by the following outlines.

Clinical Chemistry

1. *Equipment*—centrifugation, filtration; pipettes, diluters; balances; glassware.
2. *Instruments: Principles, Use, and Understanding*—spectrophotometry and colorimetry; flame photometry and atomic absorption; automated equipment (auto-analyzers); fluorimetry; blood gases (ion-specific electrodes); electrophoresis; calculating devices (slide rule, machine, computers); isotopic instruments (well counters); osmometers; chromatography.
3. *Chemical Principles and Applications*—calculation and measurements units; identity and sources of biological specimens, specimen handling, preservation, collection; pH, solutions, buffers, water, normality, molarity, osmolarity; quality control.
4. *Methodology*—enzymology; proteins, including cerebrospinal and other body fluids; other nitrogenous materials; lipids; carbohydrates, including tolerance tests; electrolytes; endocrine procedures; liver function; toxicology; urine chemistry; gastric analysis; vitamins.

Microbiology

1. *Specimen and Culture Handling*—collection of specimens; transportation (intra and extra); storage; disposal and disinfection.
2. *Isolation and Identification*—bacteriology; parasitology; mycology; mycobacteriology.
3. *Serology*—tests for disease identification; tests for organism identification; pregnancy; miscellaneous.
4. *Antibiotic Susceptibility by the Standardized Disc Test (Kirby-Bauer)*—media; inoculation; discs; interpretation.
5. *Media*—types; preparation.
6. *Equipment*—microscope (light, dark-field, fluorescent); centrifuge; sterilizing equipment; anaerobic equipment; incubation equipment; rotators.
7. *Quality Control*—staining; reagents; media.

Hematology

1. *Subject*—white count; red count; hemoglobin; hematocrit; normal differential count; reticulocyte count; sedimentation rate; platelet count; prothrombin time; partial thromboplastin

time; coagulation time; bleeding time; clot retraction; fibrinogen and lysis; sickle preparation; electrophoresis (hemoglobin); LE preparation; osmotic fragility; immunoglobulins; general techniques; urine sediment examination; indices.

2. *Method*—manual; mechanized; quality; limits of the method; departure from the normal.

Blood Banking (Immunohematology)

1. *Immunology and Genetics*—genetics; antigen-antibody reactions.
2. *Blood Group Systems*—A, B, O; Rh; other.
3. *Compatibility*—routine procedures; massive transfusions; multiple transfusions; exchange transfusions for hemolytic disease; Rh immune globulin; transfusion of blood components; patient identification; selection of blood for compatibility.
4. *Special Techniques*—antibody detection; antibody identification; elution techniques; transfusion reaction work-up; hemolytic disease work-up; auto-immune disease.
5. *Standards, General Procedures*—donor requirements; collection of blood; identification of donor blood; care of donor; storage and transportation; preparation of components; transfusion service records; blood group reagents and equipment.

SAMPLE QUESTIONS

Each Proficiency Examination is designed to measure both what you know of the subject matter commonly associated with the area and how effectively you can use the scientific knowledge you possess.

Questions measuring your *knowledge* of medical technology emphasize the process of remembering facts that you have learned. Questions testing the *application* of this knowledge require not only that you know a law, principle, or concept, but also that you recognize its application in a particular situation. Since the goal of most medical technology education is to learn to apply material from the discipline, application questions are especially important.

To give you some idea of what the test questions are like, the following samples are included here. These questions are similar to the ones you will encounter on the tests. Each question is coded to tell you which area it concerns. The codings are as follows: *CC* (Clinical Chemistry), *M* (Microbiology), *H* (Hematology), and *BB* (Blood Banking).

Directions: Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the one which is best in each case and then blacken the corresponding space on the answer sheet.

1. [*H*] Wright's stain causes the cytoplasm of lymphocytes to be colored
(A) purple (B) gray (C) yellow (D) pink (E) blue

2. [*CC*] The color formation in a serum bilirubin determination depends on
(A) making the serum alkaline
(B) adding sulfanilic acid
(C) adding methyl alcohol
(D) conjugating bilirubin with glucuronic acid to form bilirubin glucuronide
(E) diazotization to form azobilirubin

3. [*CC*] Diazotized sulfanilic acid is used for the measurement of
(A) bile acids (B) bile pigments (C) acetylsalicylic acid (D) sulfosalicylic acid (E) coproporphyrin

4. [*H*] If on a particular sample the red cell count is 3,500,000 per cubic millimeter and if 1.5 per cent of the red cells are reticulocytes, the number of reticulocytes per cubic millimeter is (A) 15,000 (B) 35,000 (C) 52,500 (D) 72,000 (E) 350,000

5. [*CC*] The primary function of sodium fluoride preservative in specimens for a glucose tolerance test is to
(A) inhibit glycolysis by blood cells
(B) prevent the growth of bacteria
(C) retard the nonenzymatic oxidation of glucose
(D) prevent hemolysis
(E) destroy other reducing substances

6. [*CC*] In the colorimetric determination of creatinine by the use of picric acid (the Jaffe reaction), the final reaction mixture must be
(A) buffered (B) acid (C) alkaline (D) neutral (E) cooled in ice

7. [*H*] All of the following are important in the determination of the erythrocyte-sedimentation rate EXCEPT
(A) the hematocrit
(B) the tube position
(C) the mean corpuscular hemoglobin value
(D) a 24-hr. delay between collection and determination
(E) changes in plasma composition

8. [*BB*] Enzyme-treated cells are unsatisfactory for detecting antibodies of the Duffy blood-type system because enzymes
(A) destroy Duffy antibody molecules
(B) destroy Duffy antigen sites
(C) inactivate Duffy antibody molecules
(D) mask other antibodies
(E) give false positive antiglobulin (Coombs') tests

9. [*H*] The prothrombin time is dependent on the plasma concentration of all of the following EXCEPT factor
(A) II (B) V (C) VII (D) VIII (E) X

Directions: The group of questions below consists of five lettered headings followed by a list of numbered phrases. For each numbered phrase select the one heading which is most closely related to it and blacken the corresponding space on the answer sheet. One heading may be used once, more than once, or not at all in each group.

Questions 10-12[*M*]

(A) Blood-tellurite agar plate
(B) Lowenstein-Jensen agar slant
(C) Thayer-Martin agar
(D) Litmus milk
(E) Mueller-Hinton agar

10. Used in identification of Clostridia

11. Used to isolate Mycobacteria

12. Used in the isolation of Neisseria gonorrhoeae

Directions: For each of the questions below, ONE or MORE of the responses given are correct. Decide which of the responses is (are) correct and on the answer sheet blacken space
A if *1, 2, and 3* are correct;
B if only *1 and 2* are correct;
C if only *2 and 3* are correct;
D if only *1* is correct;
E if only *3* is correct.

Directions Summarized

A	B	C	D	E
1,2,3 only	1,2 only	2,3 only	1 only	3 only

13. [*BB*] Which of the following may cause a serum to react with all cells, including the patient's own cells?
(1) Cold agglutinins and rouleaux
(2) Acquired hemolytic anemia
(3) Panagglutinin and cold agglutinins

14. [*BB*] Uses for the antiglobulin (Coombs') test include which of the following?
(1) Tests for sensitized red cells or red cells coated with 7S(IgG) antibody
(2) Tests for in vivo sensitization of the red cells
(3) Diagnosis of auto-immune hemolytic anemia

Directions: **The group of questions below concerns a laboratory situation. First study the description of the situation. Then choose one best answer to each question following it and blacken the corresponding space on the answer sheet.**

Questions 15-16[M]

A sample of spinal fluid cultured in nutrient and thioglycollate broth gave some indication of growth by turning slightly cloudy in the broth after 12 hours of incubation at 37°C. A gram stain of this fluid showed a mixture of small gram-negative rods and gram-positive diplococci. However on further incubation, the turbidity did not increase and transfer to nutrient agar plates showed no growth after 24 hours.

15. In the best interest of the patient, a report should be sent to the attending physician stating which of the following?

(A) Culture contaminated, please repeat.
(B) No growth after 36 hr.
(C) Small gram-negative bacillus and gram-positive diploccus seen in broth culture.
(D) No growth after 12 hr.
(E) Hemophilus influenzae and Diplococcus pneumoniae have been isolated.

16. In order to grow and isolate the small gram-negative rods, a transfer should be made to

(A) nutrient broth
(B) nutrient agar
(C) thioglycollate broth
(D) chocolate agar
(C) Streptosil broth

ANSWERS TO SAMPLE QUESTIONS

1. E	6. C	11. B
2. E	7. C	12. C
3. B	8. B	13. A
4. C	9. D	14. A
5. A	10. D	15. C
		16. D

VANCOUVER, WASH., *February 1, 1972.*

Hon. AL ULLMAN,
House of Representatives,
Washington, D.C.

DEAR REPRESENTATIVE ULLMAN: I would like to voice my support for two bills presently under consideration by the House Ways and Means Committee. These include the Ribicoff amendment to H.R. 1, which was recently passed by Congress and H.R. 850, (S. 869).

Senator Ribicoff's amendment involves extension of benefits to single as well as married people under H.R. 1's family assistance plan.

H.R. 850 (S. 869), involves equalization of tax rates for single and married people.

In this day and age of astronomically accelerating populations and diminishing resources to support them, a policy supporting large families over people who choose to remain single is not only prejudiced but antiquated. We cannot hope to curb the rapidly increasing population and stabilize conditions if we continue to encourage large families and to penalize single people taxwise for remaining so.

I would appreciate it if you would submit a copy of this letter to be included in the record in support of both bills. Thank you.

Sincerely,

STEVEN G. HOLMAN.

STATEMENT BY DAVID A. BRODY, DIRECTOR, WASHINGTON OFFICE, ANTI-DEFAMATION LEAGUE OF B'NAI B'RITH

The Anti-Defamation League welcomes this opportunity to submit its views on H.R. 1, which incorporates the principles of the Administration's original welfare reform proposal.

The Anti-Defamation League is the educational arm of B'nai B'rith, which was formed in 1843 and is America's oldest and largest Jewish service organization. It seeks to improve relations among the diverse groups in our nation and to translate into greater effectiveness the principles of freedom, equality and democracy. It is dedicated to securing equal opporunity and justice for all Americans regardless of race, religion, color or national origin.

For more than three decades we have watched a welfare system started as a temporary relief measure to help the victims of the Great Depression of the 1930's grow into a crazy quilt, patchwork and often contradictory series of programs which have caused the break-up of families, fostered dependency rather than independence and helped to destroy individual dignity and self-esteem. The lack of any national program with minimum national standards has led to glaring inequities in welfare benefits among the 54 separate welfare ssytems and has been a factor in the vast migration from our rural areas to urban centers, intensifying many of the ills which our major cities now face and which today finds one and one quarter million people on the welfare rolls of New York City alone—a number which exceeds the total population of the city of Houston, the nation's sixth largest city.

Our present welfare system has become increasingly costly and financially burdensome and rather than being a stabilizing social force, has created growing resentment and divisiveness among our people. Instead of furnishing incentives to employment and avenues to self-sufficiency, it has served to destroy the individual's hope of independence and has discouraged people from getting off the welfare rolls.

We must agree with President Nixon when in August 1969 he said: "Whether measured by the anguish of the poor themselves, or by the drastically mounting burden of the taxpayer, the present welfare system has to be judged a colossal failure. . . . it is failing to meet the elementary human, social and financial needs of the poor." H.R. 1, which passed the House of Representatives on June 22, 1971 by the substantial margin of 288–132, embodies the Administration's response to the urgent need for a complete overhaul of our welfare policy. It represents a dramatic and constructive effort which for the first time seeks to bring rationality to our welfare system. Rather than simply trying to patch up further an unwieldly, ineffective and often self-defeating system, the Administration has taken the initiative of offering a totally new program aimed

not only at eliminating the inequities and human indifference which characterize our present welfare approach, but directed toward new objectives and social goals. Whatever the shortcomings of H.R. 1, and we will speak of these later, they cannot overshadow the major breakthrough in the field of welfare reform which the principle of H.R. 1 represents.

H.R. 1 calls for an income floor of $2400 for a family of four. It also allows a working poor family to retain the first $720 of its earnings plus one third of the remainder until earnings reach $4320 a year when federal benefits end. Under this plan, the working poor would for the first time be qualified on a nationwide basis for assistance. By allowing a family to retain a portion of its earnings, the bill would provide an incentive for those welfare recipients able to do so to go to work.

H.R. 1 represents a forward-looking program, but it is one which we believe must be strengthened and improved in several respects. The $2400 federal payment is plainly not enough for a family of four. It constitutes less than two-thirds of the current poverty level of $3944 for a family of four.

Although the bill would permit a family on welfare to keep a part of its outside earnings, the fact is that the vast majority of those now on the welfare rolls have no other income and are completely dependent on their welfare payments for their existence. There is a popular misconception that those receiving welfare are lazy, shiftless people unwilling to work. The statistics, as HEW has pointed out, suggest otherwise.

The fact is that most welfare recipients cannot be put to work. Contrary to the popular myth only 126,000 of the more than 13 million Americans who constituted the federally assisted welfare population as of April 1971—fewer than 1%—were employable males. Fifty-five percent or more than 7 million were children. The others included the aged ,blind, disabled and 2.5 million welfare mothers some of whom work and many others as a recent six state study shows would also prefer work to welfare if adequate child care facilities were available. In light of these statistics, it is essential that the level of payments be increased if those on welfare are to have more than a meager subsistence income.

We are, of course, not unmindful of the increase in the cost of the program if the basic benefit levels were to be raised. But, the need to do so is plain and compelling. For that reason, we support the proposal—Amendment No. 559—co-sponsored by a bipartisan group of 22 Senators led by Senator Ribicoff. The Ribicoff amendment would provide a more realistic payment of $3000 for a family of four. In addition, unlike H.R. 1 which makes no provision for any increase in the minimum payment, the Ribicoff amendment would raise the payment level each year until the poverty level was reached in 1976. Annual adjustments in the federal payment would also be made to reflect the rise in the cost of living. Finally, a more liberal "earnings disregard" of 40% would enable the working poor to receive benefits until earnings reached $5720 per year.

The number of people eligible to receive welfare payments under the Ribicoff plan would of course be substantially more than under H.R. 1. But, this is a price we must be prepared to pay if we truly believe that all Americans should be able to enjoy a decent living with some degree of dignity and self-respect.

The Ribicoff package contains a number of other improvements over H.R. 1. It provides stronger work incentives by increasing from the one-third in H.R. 1 to 40% the percentage of earned income that can be retained. The amendment would also require that welfare recipients able to work be assigned to jobs paying no less than the federal minimum wage. Under H.R. 1 referrals to jobs can be at wages as low as ¾ of the minimum wage thus establishing a category of "welfare" jobs and doing little more than keeping an individual from becoming another unemployment statistic.

While H.R. 1 would require mothers with children over the age of three to register for work, the Ribicoff amendment would exempt mothers with children under six. In addition, mothers would also be exempt from the work requirement in the absence of suitable child care services. The amount made available for child care services under the Ribicoff proposal is more than double the amount provided for in H.R. 1.

Single individuals and childless couples would also be eligible for welfare assistance, whereas H.R. 1 has no coverage for these categories.

Finally, unlike H.R. 1 which does not require states which pay higher benefits under the current law to maintain those benefits, the Ribicoff amendment man-

dates states to maintain current payments to protect individuals against loss of benefits. The federal government which would pay 30% of these supplemental payments would also gradually assume the entire cost of the welfare program until by 1976 the system would be fully federalized.

In conclusion, we want to re-emphasize that notwithstanding the imperfections in the proposed new family assistance plan, we applaud the Administration's initiative in moving to scrap our long out-moded welfare structure. The time has now come for this Committee to report a bill to the floor so that a meaningful welfare reform program which will provide a decent level of life for the millions of our nation's less fortunate who either cannot work or cannot earn enough to support their families can be enacted into law. The Ribicoff amendments, we submit, embody such a program and we therefore urge the Committee to give its support to those amendments and report them to the Senate for its approval.

STATEMENT OF THE NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE, INC., SUBMITTED BY ROSE G. MARTIN, EXECUTIVE DIRECTOR

The National Association for Practical Nurse Education and Service (NAPNES) is a nonprofit organization founded in 1941 for the purpose of improving and expanding the nursing services which licensed practical nurses render to the citizens of this country. NAPNES' membership of 37,000 includes practical nursing educators and other professional nurses, physicians, hospital and nursing home administrators, and lay persons, as well as licensed practical nurses. All of these categories are represented on the NAPNES Board of Directors.

8. POSITION RE H.R. 1

The National Association for Practical Nurse Education and Service would like to make known its support of H.R. 1, Section 241, which directs the Secretary of Health, Education, and Welfare to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting the specific formal criteria now included in Medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the Medicare and Medicaid programs.

A large and important group of personnel in this category consists of licensed practical nurses for whom the usual formal education requirements for licensure have been waived. Many of these nurses have had years of experience during which they have been taught informally by the physicians and registered nurses under whom they have worked, have availed themselves of opportunities for continuing education, and have engaged in self-study. Over the past three decades NAPNES has assisted them in their efforts toward self-education by developing and arranging for the conduct of courses which incorporate pretests and proficiency tests. We are therefore in a position to testify that many "waivered" LPNs have competencies equivalent to those of LPNs who have completed the prescribed program of study. They are an important resource for alleviating the health manpower shortage which is depriving so many of our citizens of the care which they need.

Yet many of these LPNs are not being utilized to the full extent of their potential because of a federal regulation requiring that charge nurses in long-term care facilities accepting Medicare patients be graduates of state-approved schools of practical nursing or have equivalent *formal* training. As a result of this regulation thousands of LPNs who have had years of experience as charge nurses in long-term care facilities are barred from serving in this capacity. The regulation therefore not only constitutes a serious obstacle to the much-needed expansion of these facilities; it also threatens to close the doors of existing facilities. In consequence, many elderly patients and those suffering from chronic disease are being deprived of the care they need or are being forced to occupy space in the more expensive acute-care facilities.

In its concern for these patients, NAPNES has on several occasions pointed to the trend toward qualifying personnel on the basis of their abilities rather than the settings in which they developed these abilities and has offered its services in the development of an examination that could be used to evaluate the competence of waivered LPNs. At its 30th annual convention in April, 1971, the

NAPNES membership unanimously endorsed S. 892, which contains the same provisions as those in Section 241 of H.R. 1, and offered assistance to the Secretary of Health, Education, and Welfare in the development of such an examination (see attached copy of resolution). In line with this action by the membership, in August, 1971, the director of NAPNES' Department of Education participated in a meeting, called by the Division of Medical Care Standards of the Public Health Service, at which plans for developing such an examination were discussed.

We should like to point to an additional use to which such an examination might be put. State practical nursing licensing boards recognize formal education that is secured in another state, a fact which enables many LPNs to become licensed by endorsement when they move from one state to another. This mobility is denied waivered LPNs, since state boards do not recognize the licenses these nurses have received in other states. As a result, the public is deprived of the services of many competent LPNs. The development of an examination of the kind proposed in Section 241 might well be used for qualifying waivered nurses for service in other states.

In summary, the National Association for Practical Nurse Education and Service believes that the proposal contained in Section 241 of H.R. 1 would contribute substantially to the improvement and expansion of the health services available to the citizens of this country. It therefore urges that serious consideration be given to the passage of legislation embodying this section.

NATIONAL ASSOCIATION FOR PRACTICAL
NURSE EDUCATION AND SERVICE,
New York, N.Y.

RESOLUTION

ADOPTED BY THE NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE AT ITS 30TH ANNUAL CONVENTION, APRIL 29, 1971, IN CINCINNATI, OHIO

Whereas, William B. Saxbe, United States Senator from Ohio, in the interest of alleviating the critical shortage of health care personnel has introduced legislation that will direct the Secretary of Health, Education, and Welfare to develop and conduct a program designed to determine the proficiency of licensed practical nurses* who do not otherwise meet the formal educational requirements for the performance of the duties and functions of LPNs, and

Whereas, The National Association for Practical Nurse Education and Service supports the philosophy of continuing education and the full utilization of all levels of health care personnel and so stated in its position, approved by its Board of Directors in January, 1969, and

Whereas, The National Association for Practical Nurse Education and Service has channeled its efforts for more than three decades into the development of continuing education courses for which pre-testing and proficiency testing have been developed, for the upgrading of all LPNs; now therefore be it

Resolved, That this Association commend Senator Saxbe for his expressed concern for the health and welfare of the American people, and be it further

Resolved, That this organization extend its offer of assistance and the full extent of its resources in aiding the Secretary of HEW in achieving his assigned task.

BOSTON, MASS., *February 3, 1972.*

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.:

The East Boston Neighborhood Health Committee wishes to strongly support your legislation for a 5-year extension of the maternal and infant care and children and youth programs. These programs are essential in providing adequate health care to mothers and children of the city of Boston as well as other cities in the United States. The limited extension proposed by the Nixon administration would severely cripple these essential health programs.

Mrs. PAT BUONOPANE,
East Boston Neighborhood Health Committee.

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*This term also applies to the licensed vocational nurses of California and Texas.

STAFF, EAST BOSTON HEALTH CENTER,
Boston, Mass., February 3, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.:

The staff of the East Boston Neighborhood Health Center are seriously concerned by the administration's request for only a single year extension of the present MIC and CNY programs. These programs are presently providing essential services to mothers and children in Boston who would otherwise be without care. We strongly support the legislation introduced by you for a 3-year extension of these programs. Year-to-year authorizations of these programs have a crippling effect on health care delivery.

JAMES O. TAYLOR, M.D.,
Medical Director.

LABOURE CENTER VISITING NURSE SERVICE,
SISTERS OF CHARITY,
South Boston, Mass., February 1, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: Knowing the great importance of the continuance of the satellite clinic at the Laboure Center by the St. Margaret's Maternity Hospital, I ask you and count on you to fight for continued federal funding of Maternal and Infant Care, especially in S. Boston where I care for patients as a Public Health nurse and see the tremendous results of such programs.

And so I make a tremendously great plea that you will do all that you can to promote and finance this worthwhile cause.

Thank you for your consideration of this matter.

Sincerely,

Sister MARY CAROLINE HRICZLEV,
Staff Nurse, Registered Nurse.

SAINT MARGARET'S HOSPITAL,
Boston, Mass., February 2, 1972.

Hon. GAYLORD NELSON,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: We would like you to endorse the authorization of a continuation of moneys for the Maternal & Infant program for the next five years. This program enables many mothers to seek better prenatal care, thus decreasing maternal morbidity and infant mortality. The patients from this program are of the lower socio-economic group.

We look forward to a continuation of these funds.

Sincerely,

Sister MARY BERNADETTE,
Administrator.

BRIGHTON-ALLSTON COMMUNITY HEALTH CORPORATION,
Brighton, Mass., February 1, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: We have been informed that you are conducting hearings this week on the extension and refunding of the Children and Youth and Maternal and Infant Care programs of HEW.

Our community of Allston-Brighton in Boston is served by both these programs. Without them, many of our less advantaged families would not receive good preventive care for their children. They would be forced, because of the high cost of outpatient care, not usually covered by their insurance, to revert to seeking care only in crises in the overcrowded emergency rooms and clinics of our hospitals. Young mothers, in the hope of cutting down on the cost of maternity

care, would return to the practice the MIC program as tried so hard to change—that of going for pre-natal care late in pregnancy instead of early.

We strongly support your efforts to see that these valuable programs are continued, and continued until such time as a more satisfactory national system of helping people pay for health care has been instituted.

We look forward with deep concern to the outcome of your hearings and to the final action of Congress.

Sincerely yours,

ROBERT A. ENGLAND, *President.*

LABOURÉ CENTER,
SISTERS OF CHARITY,
South Boston, Mass., January 31, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: On behalf of the mothers and infants of South Boston, I make an earnest plea that you do all in your power to promote the extension of the Maternal and Infant Care and Children and Youth Programs.

South Boston is an O.E.O. poverty target area without hospital services or adequate physician services. In order to overcome this gap in medical care, St. Margaret's Maternity Hospital in nearby Dorchester has operated a satellite clinic at the Labouré Center for over four years. This clinic has provided much needed services to mothers and their infants with excellent back-up hospital services. Unless the federally funded M.I.C. and C. and Y. Programs are extended, there is little hope that these services can be continued. Numerically, this means that over one third of South Boston's prenatal mothers and their infants will be without adequate care.

Realizing the tremendous progress that has resulted from these two programs, I know that I do not have to belabor the point with further rhetoric. I count on your interest in the well-being of our mothers, infants and youth to fight for continued federal funding of M.I.C. and C. and Y. Programs.

Sincerely,

Sister EILEEN KINNARNEY,
Administrator.

LABOURÉ CENTER,
SISTERS OF CHARITY,
South Boston, Mass., February 1, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: It is reassuring to know that you are taking the initiative in the attempt to extend the Maternal and Infant Care and Children and Youth Project for five years.

From my years of working here in South Boston, I realize the importance of this program which provides prenatal maternal care and post natal care to mothers and children. Since there is no local hospital in the area and only limited physician care, it is fortunate that Saint Margaret's Hospital from nearby Dorchester has established a satellite clinic in our center to service the mothers in this vicinity. Over one-third of all the births in South Boston are connected with this Project. Without this care, I know that many families would be unable to have good care for the mothers and babies.

In our work with families, we have found that any help we can afford them is greatly appreciated and used to the best of the abilities of each one.

Be assured of our support and prayers for you and your associates in this important work. If there is anything further we can do, please do not hesitate to request it.

Sincerely,

SISTER SHEILA O'FRIEL,
Director, Home Management Department.

BRIGHTON, MASS., *February 1, 1972.*

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: I want to add my voice to the many you have heard from thus far in support of legislation extending the maternity and infant care and children and youth programs for 5 years. If these programs are only extended for 1 year, this program can stand a good chance of being killed the next year or the next. With short term funds, commitments can not be made to the community.

As a nutritionist in one of these programs in Boston, I can see the great need for the M&I, C&Y clinics. I work in Roxbury. Many of our patients would be without health care or overwhelm the city hospital if our clinic did not exist. Not only should funds bt extended for a long period of time but more health centers should be open since there are areas of Boston, indeed most of Massachusetts and all Indian reservations and Appalachia, without such facilities for children and pregnant women.

Sincerely,

MRS. DONNA GOTTLIEB.

MICHIGAN STATE EMPLOYEES ASSOCIATION,
Lansing, Mich., February 15, 1972.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Senate Office Biulding, Washington, D.C.

(Attention of Mr. Tom Vail, Chief Counsel).

DEAR MR. CHAIRMAN: This statement is in response to a telegram of February 2, 1972, from Mr. Vail, Chief Counsel to the Senate Committee on Finance, concerning our position on H.R. I which we wish to be considered by your distinguished committee.

STATEMENT

The Michigan State Employees Association, representing over 19,000 state employees and in excess of 4,000 members who are employed by the Michigan State Department of Social Services, recognizes the need for welfare reform, but is very concerned that the legislation presently before you does not contain provisions for the transfer of social service employees at the state level to the Federal level who are responsible for eligibility and cash assistance payment functions. H.R. 1, as reported by the House, makes no provision for these thousands of employees in Michigan, and indeed, many thousands who would be affected at the state and local level throughout the nation.

We, in Michigan, appreciate the Federal concern to assist the poor, disadvantaged people, and therefore, the concept of H.R. 1 is acceptable. However, our Michigan experiences these past few years dictates that we express to you a rather selfish concern for those employees who have been involved in the field of social service or social welfare through most of their work experience. Our concern is related to the inequities that come mostly through the implementation of "wide sweeping changes" or merger of governmental activities from city to county and county to state, and now, under H.R. 1, from state to Federal control.

Whenever there is a merger or take-over from one governmental agency to another it creates a genuine concern on the part of all the employees involved. I am certain that you have heard previously many of these concerns are stimulated because of lack of communication, definition and unanswered questions that could have a profound effect on all employees from the lowest to the highest level positions. Some of these questions are as follow:

1. Would the intent and purpose of H.R. 1 to help the unemployed conceivably have the reverse effect by removing employees from the payroll thereby having them become recipients under the new program rather than employees with great expertise who had administered assistance under existing programs?
2. What guarantee does one have for job security if and when the bill passes?

3. What salary rate will be set for the various classes of Michigan state employees? If the Federal classification that is comparable to a specific state is at a lower rate of pay would the state employee have to suffer a loss by being placed at a lower rate?

4. What will happen to the fringe benefits, such as annual leave, sick leave and retirement?

5. What happens to the employee with many years of seniority?

6. What happens to the Michigan Civil Service employees who are presently covered by social security?

7. Most importantly, will there be a provision for a merit promotion ladder, if these employees are federalized?

We feel that these are genuine, justifiable concerns, since to repeat, H.R. 1 as reported from the House does not make any provision for transfer for the affected employees at the state and local level.

We are very mindful of the fact that Congress has become aware of these anxieties because of the amendment that has been offered by Senator Ribicoff; amendment No. 559 to H.R. 1. With respect to this amendment we would like to make certain observations:

Reference is made specifically to Section 2173 of that amendment and which provides that; "fair and equitable arrangements shall be made, as determined by the Secretary of Labor, to protect the interests of all employees of any State or political subdivision thereof who presently perform such functions. Such arrangements shall include provisions, not inconsistent with law, necessary to protect individual employees against a worsening of their positions with respect to their employment and to assure compensation and benefits at levels not less than those applicable to such employees immediately prior to the effective date of this Act, or in the case of an agreement between the Secretary and any State, immediately prior to the effective date of the agreement, including provisions necessary to—

"(A) Preserve rights, privileges, and benefits (including continuation of pension rights, credits, and benefits) under collective-bargaining agreements, or otherwise, in effect on the effective date of this Act or such agreement;

"(B) Continue collective-bargaining rights;

"(C) To aid terminated employees in obtaining employment by the Secretary or the State or a political subdivision thereof of employees, including assurance of priority periods of employment by the State or reemployment for employees subsequently terminated or laid off and crediting periods of employment, and

"(D) Provide paid training or retraining programs to assist in carrying out the purposes of this Act."

Some may feel that the above provisions adequately protects the interests of State and local public employees who would be affected. We agree and support, the areas of employee concern outlined in the amendment and believe that similar provision should be incorporated in every program or plan where a transfer of administration takes place. However, we believe the proposal has fault in that it anticipates the termination of current state and local public employees, and limits the Federal concern to aiding terminated employees in obtaining employment thereafter. This, you will note is the substance of subparagraph (C) listed above.

The Michigan State Employees Association therefore urges the Congress to provide the pattern for proper employee protection by rewriting above subparagraph (C) to guarantee that no employee shall be terminated as the result of transfer to Federal administration of the functions now being administered by state and local jurisdictions and that any change in the work force shall be accomplished by attrition, voluntary employee decisions or new work assignments only after paid training or retraining programs have adequately fitted the affected employee.

We are also aware that the Department of Health, Education and Welfare, working with the United States Civil Service Commission, has proposed amendments to Section 507 of H.R. 1 in the Senate, which would provide for the orderly transfer of many employees of state and local public assistance programs. One very serious question remains unanswered that relates to the fact the proposed amendment offered by the Department of Health, Education and Welfare and the United States Civil Service Commission, indicates that the Federal government would expect to offer to *MANY* (emphasis supplied) employees of state and local public assistance programs the appropriate jobs in the administration

of Federal assistance programs which the pending bill would create. However, this still leaves us with the frustration that all of the affected employees would not be provided for.

Also, under the sick leave portion of the D.H.E.W. amendment a person going from state to Federal service can carry sick leave over but cannot use the carry-over until after Federal sick leave has been used. Prior state employees will not be allowed to pick up their accumulated state sick leave if they have been on an authorized leave of absence. The existing Federal employees can, after a leave of absence, pick up all of their sick leave. This, of course, creates dual standards. It is our position that state employees who become Federal employees should enjoy the same rights and privileges. Special consideration should be given in all areas to state employees because this is an involuntary transfer. After all, the state employees did not choose to become a Federal employee.

Continuing under the D.H.E.W. and U.S.C.S.C. amendment concerning retirement, the amendment provides for a $10.00 monthly increase in retirement. This will, of course, again, create dual standards. The retirement provision should provide that employees receive full retirement benefits computed on the highest annual compensation received during a period of 5 consecutive years. If this is not done it would be possible for a person to lose 50% of the retirement benefits he would have received if he had continued service with the state.

We, of course, again support the efforts of the Department of Health, Education and Welfare and the United States Civil Service Commission in attempting to provide protection for many of the employees that would be affected.

We would respectfully recommend that the Committee seriously consider the latest suggestion of Senator Ribicoff (as we understand it) that a vastly reduced pilot program be initiated to see just how this type of legislation would work. It is our feeling that through this approach, proper planning, staffing, cost and other experiences could be accumulated and analyzed on a small scale so that appropriate amendments might be made to correct any deficiencies before embarking on a large nationwide program of federalization.

We appreciate the concern that Congress has expressed over the years in providing for job protection in the public and private sector and we are confident that once the concerns of the state and local employees have been received by the Congress that they will not take action without giving the affected employees every consideration and protection that the Federal government should morally provide.

In closing, the Michigan State Employees Association has a responsibility and a well-deserved reputation for fighting for employee rights in a true merit system and we pledge our support to this distinguished committee and to the Congress in achieving equity for all affected employees and in particular for the four thousand plus members of the Michigan State Employees Association.

We wish to thank the committee for the opportunity to present our views on this most significant legislation.

Respectfully,

LAWRENCE A. PICHÉ,
President, Michigan State Employees Association.

ST. ELIZABETH'S HOSPITAL,
Brighton, Mass., February 1, 1972.

Senator GAYLORD NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: I am writing in support of your efforts to extend the authorization for the Maternal and Infant Care and the Children and Youth Programs. I think it is essential that this authorization be extended for at least five years. In our program we are providing care for mothers and children for whom there are no other medical esources in the community. We emphasize preventative care and feel we have resources particularly suitable for families with multiple problems. It is unrealistic to think that even if a national health plan were authorized within the next year that it could be quickly implemented to the extent necessary to provide the kind of care now being offered by our, and other, M.I.C. and C & Y Programs. Once again families in the communities served by these programs would be without adequate care.

Your efforts on behalf of these programs are appreciated both by our staffs and the community.

Sincerely yours,

JOHN H. GOULD, M.D.,
Coordinator, M.I.C.—C. & Y. Programs.

STATEMENT OF THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, IN REGARD TO ITS POSITION ON NATIONAL HEALTH CARE (INCLUDING S. 1376)

The National Association of Independent Insurers is a voluntary national trade association of some 533 insurers * of all types, both stock and non-stock, whose membership provides a representative cross-section of the casualty and fire insurance business in America. Our companies, which have long been recognized as the most competitive and progressive segment of the fire-casualty insurance business, have continued to expand the voluntary market availability of automobile insurance at a faster rate than the rate of increase in new vehicle registration, so that currently they are serving more than half the insured motorists in the country.

Despite our overriding interest in the property and casualty insurance field, we still view the matter of National Health legislation as crucial. There can be no doubt that any programs which deal with the delivery of health care will directly affect the manner in which automobile accident victims are compensated. Thus, the interest of the NAII is a most direct and profound one.

To be most acceptable to public demands and responsive to public needs, the NAII endorses a National Health program which:

Makes medical services available to all citizens regardless of financial status;

Controls the cost of medical care;

Produces the highest degree of utilization of medical facilities;

Retains the financing of health services to the maximum extent possible through the existing private insurance industry mechanisms, under regulation;

Eliminates wasteful duplication, inefficiencies, and inequitables;

Preserves automobile insurers as the primary carrier for the compensation of automobile accident victims.

This statement will address itself principally to the latter three objectives.

RETAIN FINANCING OF HEALTH SERVICES THROUGH EXISTING PRIVATE INSURANCE INDUSTRY MECHANISMS UNDER THE STATE REGULATORY SYSTEM

Consistent with our traditional position that the public is best served through private industry operating in a highly competitive market, we express the conviction that the private insurance segment has proved itself worthy and qualified to provide the basic financial protection required of those in need of medical care. In the final analysis the highest expertise, the available servicing and claims handling facilities, and the machinery to provide effective coordination between the provider of services and the consumer of these services reposes with the health insurance industry. Any National Health Insurance program should maximize its role and confine the role of government to responsibilities which the private insurance industry cannot assume, such as providing social welfare benefits for the medically indigent.

Also, consistent with our traditional position, we urge that responsibility for regulation of the private health insurance business should remain with the state insurance departments which possess both the staff resources and expertise to perform this function without superimposing an unnecessary and unwarranted level of federal control.

ELIMINATION OF WASTEFUL DUPLICATION, INEFFICIENCIES AND INEQUITIES

A study of the testimony before various congressional, state, and industry committtes will disclose that no one seriously questions the desirability of avoiding

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*354 members and 179 subscribers to our statistical services.

duplication of medical benefits. Health insurers have sought to achieve this objective among themselves through the incorporation of policy language providing for the "coordination of benefits". More importantly, in several jurisdictions in which local laws would permit, many accident and health insurers have provided for and successfully pursued a right of subrogation in those instances in which the injury for which benefits have been paid resulted from the negligent conduct of a third party. To the extent that this is accomplished, the cost of the loss has been properly shifted away from the innocent victim to the responsible party, and equity has been achieved.

The desirability of achieving this equity has not eluded the U.S. Congress in its past considerations of compensation programs. Various federally-legislated programs, including Title XIX of the Social Security Act (Medicaid) and the Federal Employees Liability Act, provide for recoupment from the negligent party causing the injury for which benefits have been paid.

In connection with National Health programs and their relationship to programs providing compensation for accident victims, it has on occasion been suggested that this loss shifting creates inefficiencies within the system. Perhaps this contention would be more persuasive if total compenation evolved from one program alone. But such is not the case:

Many health insurance plans provide inside limits, specified deductibles and/or co-insurance features, which ultimately will be lost to the accident victim unless he pursues a claim against an automobile insurer;

The disability features, i.e., wage loss (and in some programs intangible first party recoveries beyond wage loss) will only be compensated from another source or sources;

Under the prevailing automobile accident reparations system and many "no-fault" proposals, the recovery for pain and suffering is retained and must be pursued under a separate system;

Damage to property and to vehicles must also be pursued from a separate source.

Thus, less confusion and greater efficiency and convenience will be actually achieved by keeping the entire cost of compensating automobile accident victims within one benefit system. A fair analysis of the characteristics of both health and automobile insurance highly favors the auto system as the most viable and effective method by which to accomplish these objectives.

Equally important, the efficiencies and equities produced through non-duplication further highlight the desirability of preserving the automobile insurer as the primary source of benefits for auto accident victims.

PRESERVATION OF AUTOMOBILE INSURERS AS THE PRIMARY CARRIER FOR COMPENSATING ACCIDENT VICTIMS

The legislative experiences in Massachusetts, Delaware, Florida, and Illinois attests to the fact that "no-fault" insurance laws, regardless of how structured are upon us. A recent study by the NAII staff, which disclosed that no less than 29 state legislatures convening in 1972 will deliberate auto reparations reforms, further attests to the fact that the laws heretofore enacted are not the exceptions but the rule. Therefore, our continued concern for efficiency and convenience is necessary. Partially for the reasons heretofore stated, retaining the automobile insurer as the primary source of these benefits is essential. But there are other reasons equally important:

(1) The no-fault laws now enacted and virtually all proposals that are being seriously considered provide for the conditions of entitlement and amount of benefits that may be recovered beyond mere economic loss. These losses involve pain and suffering and inconvenience and the amount allowed is in relation to the medical expenses incurred. With this proprietary interest that the automobile insurer has, insurers would continue to provide effective and economical medical compensation.

(2) Motoring serves a utilitarian function or a pleasure-producing function, or both, for those who engage in it. But it likewise saddles serious hazards and burdens on our society in the form of deaths, injuries, noise, traffic congestion, air pollution, and consumption of natural resources. Sound public policy dictates that to the fullest extent possible those who engage in an inherently dangerous or socially burdensome pursuit should bear the full costs of that pursuit—including the costs of all attendant safeguards and measures neces-

sary to minimize or underwrite the damage it inflicts on others. It would be unfair and unwise to shift the costs away from those who engage in this pursuit and thereby subsidize it through either tax dollars or health insurance premiums paid by the non-motoring citizen.

(3) Keeping the full costs of motoring squarely on the shoulders of those participating in it also provides at least one form of disincentive against unreasonable over-use. Over-use of the automobile by some citizens already creates serious problems in America—such as the worsening congestion of our inner cities and arterial highways by the glut of commuter-driven cars, which could and should be replaced by mass transportation. To shift a major portion of auto accident losses from auto accident losses from auto insurance to national health insurance is a step in the wrong direction. This would compound both the traffic congestion problem and the safety problem.

In summary, therefore, the NAII respectfully urges the Committee to view with caution any suggestions that duplication can only be avoided through the relegation of automobile insurance to an excess or a secondary position. Not only is the avoidance of duplication possible, which retaining auto insurance as the primary source of benefit recovery, but for the reasons herein stated it is most desirable.

CONCLUSION

There are a few issues relating to social legislation exceeding the significance which Congressional action in the health care field will have on our nation. The fate of a pluralistic private financing system; the preservation of state regulation in some, if not all, insurance matters; the role of automobile insurance—its preservation or potential demise; the economic impact on the taxpayers and insurance buyers are all inexorably entwined with the final disposition of this vital question.

In the area of reparations reform we have constantly urged cautious deliberation and evaluation. With the same reasoning we urge this premise in the Committee's deliberations for a responsive and permanent health care program. Without exercising this caution, a rash decision might very well create a national crisis which is irrevocable. To safeguard against this potential, NAII respectfully urges a coordinated program preserving the private insurance industry which would assure the highest efficiency through retention of the automobile insurers in their traditional role as primary auto injury insurer.

LEHIGH VALLEY COMMITTEE AGAINST HEALTH FRAUD, INC.,
Allentown, Pa., February 15, 1972.

SENATE FINANCE COMMITTEE,
New Senate Office Building,
Washington, D.C.

DEAR SIRS: We are an independent, non-profit corporation with 35 lay and professional members. We oppose chiropractic inclusion in Medicare for the following reasons:

1. Chiropractic theory is false. When used as a basis for practice, it presents a public health hazard.
2. Chiropractic education is inadequate for the proper diagnosis of diseases.
3. Chiropractic full spinal x-rays ("spinographs") are used primarily for "window dressing" and are a radiation hazard.
4. Federal insurance programs which tried chiropractic coverage experience widespread claim abuse.
5. Prior chiropractic testimony to the Senate Finance Committee contained inaccurate statements.
6. Deception is an *integral* rather than an incidental part of the chiropractic system.
7. It is unfair to force taxpayers to subsidize this system until its flagrant deficiencies have been eliminated.

These are strong statements, but detailed evidence to support them is attached. We appreciate your kind consideration of our material.

Sincerely,

H. WILLIAM GROSS, D.D.S.,
President.

CONTENTS

EXHIBIT A

The Scope of Chiropractic

Most chiropractors are themselves confused about the nature of disease, healing, what they do and why some of their patients feel better.

Some chiropractors confine themselves to musculoskeletal disorders which can respond to massage and other techniques of physical therapy. Others treat everything from colds to cancer. In 1968, a U.S. Dept. of Health, Education and Welfare panel collected information from chiropractic schools and organizations. H.E.W. concluded that the majority of chiropractors were treating a wide variety of diseases, including ulcers, deficiency anemia, tonsillitis, impaired hearing, chronic heart condition and gall-bladder disease. Although this data came from official chiropractic sources, official chiropractic maintains that the H.E.W. study is invalid because the panel was "biased".

The Parker Chiropractic Research Foundation has charted more than 40 categories of diseases which it claims chiropractors are treating (Exhibit A–1). According to Parker (Exhibit A–2) these statistics are a "compilation" of data from the national chiropractic organizations plus *several thousand members* of the Parker foundation. This chart has been widely circulated by chiropractors. Some use it on their office cards. Local and state chiropractic organizations use it in newspaper advertisements.

Chiropractors and chiropractic organizations also advertise various forms of spinal pictures, claiming that they can treat almost the full gamut of disease (Exhibits A–3, D–1). Yet when questioned, many chiropractors claim that only "other chiropractors" do this, that they confine themselves only to legitimate chiropractic problems. Chiropractors also say that they "do not treat diseases, only spinal misalignments which cause certain disease processes". The two national chiropractic organizations also disagree as to the proper scope of chiropractic.

Out side investigators are thus confronted with a maze of contradiction and doubletalk. We believe that most chiropractors are themselves confused about the nature of disease and healing processes. Nor do they understand the relationship between what chiropractors do and why some of their patients feel better.

This chart is included only to illustrate claims as to the scope of chiropractic. Chiropractic "compilations" of this type are usually not reliable for statistical purposes.

A-1

CHIROPRACTIC RESEARCH CHART

All statistics used in this chart are based upon studies reported by the Chiropractic Research Foundation of the National Chiropractic Association, the Committee on Research of the International Chiropractors Association, and Parker Chiropractic Research Foundation. These reports represent the results obtained under chiropractic care for a large variety of chronic conditions. The vast majority of these cases had also been previously diagnosed and treated by practitioners other than chiropractors.

CONDITIONS	* Percent Accepted for Treatment	Percent Well or Much Improved	Percent Slightly Improved	Percent Same	Percent Worse
ALLERGIES	92.3%	87.2%	10.3%	2.5%	0%
ANEMIA	88.3%	81.5%	9.2%	7.7%	1.6%
ARTHRITIS	89.2%	73.3%	16.8%	9.4%	.5%
ASTHMA	92.3%	80.5%	12.1%	6.5%	.9%
BACK DISORDERS, GENERAL	98.2%	81.75%	17.3%	.95%	0%
BRONCHITIS	94.3%	84.2%	9.9%	3.9%	2.0%
BURSITIS	96.1%	89.3%	7.1%	3.6%	0%
CONSTIPATION	98.3%	79.2%	13.3%	6.7%	.8%
DIZZINESS	94.6%	86.3%	7.8%	5.9%	0%
EMOTIONAL DISORDERS	90.4%	85.5%	8.0%	5.5%	1%
GALL BLADDER DISORDERS	90.3%	80.9%	14.3%	4.8%	0%
GENERAL TENSION	86.4%	72.5%	16.5%	8.8%	2.2%
GENERAL WEAKNESS	89.2%	87.0%	8.7%	0%	4.3%
GOITER	82.3%	85.7%	10.7%	3.6%	0%
HAY FEVER	92.3%	81.6%	13.4%	5.0%	0%
HEADACHES, NONMIGRAINE	98.7%	83.2%	11.1%	5.1%	.6%
HERNIATED DISCS	87.3%	88.2%	7.9%	3.5%	.4%
HIGH BLOOD PRESSURE	88.6%	73.0%	19.3%	6.4%	1.3%
INDIGESTION	96.4%	89.4%	4.5%	5.3%	.8%
INSOMNIA	94.6%	81.8%	11.4%	5.1%	1.7%
KIDNEY DISORDERS	88.3%	81.9%	3.6%	9.7%	4.8%
LIVER DISORDERS	87.1%	80.5%	16.7%	2.8%	0%
LOW BLOOD PRESSURE	94.1%	73.6%	17.6%	8.8%	0%
LUMBAGO	96.7%	87.3%	8.0%	4.2%	.5%
MENOPAUSE DISORDERS	87.1%	73.4%	13.3%	13.3%	0%
MENSTRUAL DISORDERS	94.6%	81.8%	11.9%	5.9%	4%
MIGRAINE HEADACHES	93.6%	86.6%	8.1%	2.9%	2.4%
NAUSEA	84.2%	100.0%	0%	0%	0%
NERVOUSNESS	95.6%	80.8%	12.8%	5.3%	1.1%
NEURALGIA	97.3%	80.1%	14.2%	5.7%	0%
NEURITIS	98.2%	86.4%	6.4%	7.2%	0%
PARALYSIS	73.6%	68.8%	20.8%	8.3%	2.1%
PLEURISY	93.2%	95.0%	5.0%	0%	0%
RHEUMATISM	96.1%	77.2%	14.7%	8.1%	0%
SACRO-ILIAC DISORDERS	98.4%	81.8%	17.2%	1.0%	0%
SCIATICA	97.2%	85.0%	9.4%	5.1%	.5%
SINUSITIS	93.1%	83.2%	11.8%	4.7%	.3%
SLIPPED DISCS	94.2%	88.7%	7.9%	3.0%	.4%
SPINAL CURVATURES	97.1%	82.9%	5.7%	8.6%	2.8%
STIFF NECKS	92.6%	93.2%	4.4%	2.4%	0%
STOMACH DISORDERS	91.3%	82.5%	13.1%	3.7%	.7%
ULCERS	92.1%	80.2%	13.2%	6.0%	.6%

THE PARKER CHIROPRACTIC RESEARCH FOUNDATION, INC.,
Fort Worth, Tex., August 6, 1971.

DEAR ————: First, I want to apologize for the long delay in answering your letter, but just about the time that it arrived we were in stages of preparation for our Homecoming where we had nearly 1,700 people in attendance. I hope that we are not too late to contribute at least information to your project.

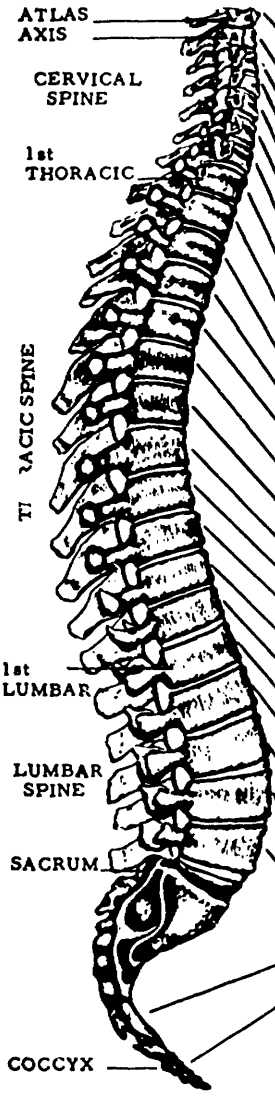
Second, I want to congratulate you on considering chiropractic as a career.

In answer to your several questions, I am going to refer you to the American Chiropractic Association, 2200 Grand Avenue, Des Moines, Iowa 50312 for information relative to the chiropractic research foundation of the national chiropractic association. The NCA is now known as the American Chiropractic Association. In answer to your second question relative to the ICA, I'll refer you to them. Their address is 741 Brady Street, Davenport, Iowa 52803.

The Parker Chiropractic Research Foundation is an organization which engages in research both on a technical and on a business basis and disseminates this information through Seminars conducted six times each year in Dallas, Texas.

CHART OF EFFECTS OF SPINAL MISALIGNMENTS A-3

Every area of the body is controlled by nerves. The normal function of these nerves can be disturbed by misalignments of the vertebrae causing the disease conditions shown below:



VERTEBRAE	AREAS	EFFECTS
	Blood supply to the head, the pituitary gland, the scalp, bones of the face, the brain itself, inner and middle ear, the sympathetic nervous system.	Headaches, nervousness, insomnia, head colds, high blood pressure, migraine headaches, mental conditions, nervous breakdowns, amnesia, sleeping sickness, chronic tiredness, dizziness or vertigo, St. Vitus dance.
	Eyes, optic nerve, auditory nerve, sinuses, mastoid bones, tongue, forehead.	Sinus trouble, allergies, crossed eyes, deafness, eye troubles, blindness, fainting spells, certain cases of blindness.
	Cheeks, outer ear, face bones, teeth, trifacial nerve.	Neuralgia, neuritis, acne or pimples, eczema.
	Nose, lips, mouth, eustachian tube.	Hay fever, catarrh, hard of hearing, adenoids.
	Vocal cords, neck glands, pharynx.	Laryngitis, hoarseness, throat conditions like a sore throat or quinsy.
	Neck muscles, shoulders, tonsils.	Stiff neck, pain in upper arm, tonsilitis, whooping cough, croup.
	Thyroid gland, bursae in the shoulders, the elbows.	Bursitis, colds, thyroid conditions.
	Arms from the elbows down, including the hands, wrists and fingers, also the esophagus and trachea.	Asthma, cough, difficult breathing, shortness of breath, pain in lower arms and hands.
	Heart including its valves and covering, also coronary arteries.	Functional heart conditions and certain chest pains.
	Lungs, bronchial tubes, pleura, chest, breast, nipples.	Bronchitis, pleurisy, pneumonia, congestion, influenza.
	Gall bladder and common duct.	Gall bladder conditions, jaundice, shingles.
	Liver, solar plexus, blood.	Liver conditions, fevers, low blood pressure, anemia, poor circulation, arthritis.
	Stomach.	Stomach troubles including nervous stomach, indigestion, heart burn, dyspepsia.
	Pancreas, islands of Langerhans, duodenum.	Diabetes, ulcers, gastritis.
	Spleen, diaphragm.	Hiccoughs, lowered resistance.
	Adrenals or supra-renals.	Allergies, hives.
	Kidneys.	Kidney troubles, hardening of the arteries, chronic tiredness, nephritis, pyelitis.
	Kidneys, ureters.	Skin conditions like acne, pimples, eczema, or boils.
	Small intestines, Fallopian tubes, lymph circulation.	Rheumatism, gas pains, certain types of sterility.
	Large intestines or colon, inguinal rings.	Constipation, colitis, dysentery, diarrhea, ruptures or hernias.
	Appendix, abdomen, upper leg, cecum.	Appendicitis, cramps, difficult breathing, acidosis, varicose veins.
	Sex organs, ovaries or testicles, uterus, bladder, knee.	Bladder troubles, menstrual troubles like painful or irregular periods, miscarriages, bed wetting, impotency, change of life symptoms, many knee pains.
	Prostate gland, muscles of the lower back, sciatic nerve.	Sciatica, lumbago, difficult, painful, or too frequent urination, backaches.
	Lower legs, ankles, feet, toes, arches.	Poor circulation in the legs, swollen ankles, weak ankles and arches, cold feet, weakness in the legs, leg cramps.
	Hip bones, buttocks.	Sacro-iliac conditions, spinal curvatures.
	Rectum, anus.	Hemorrhoids or piles, pruritus or itching, pain at end of spine on sitting.

For further explanation of the disease conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

In answer to your next question, I will have to be a little general. Our research has been going on for nearly twenty years and it is done throughout the United States and Canada, and in several foreign countries, with the help and cooperation of our members. I think this answers your fifth question as well.

As to the chart that you sent, the percentage figures on this chart are what you might call a *compilation of percentages gleaned from sources such as* eighteen chiropractic clinics in the State of Texas that were originally operated by Dr. Parker and added to by the findings of *both of the national associations* that you mentioned earlier, and brought up to date from reports from our *several thousand members.*

EXHIBIT B

Chiropractic Education

We agree with the 1968 H.E.W. report which concluded that "chiropractic education does not prepare its practitioners to make adequate diagnoses or to provide appropriate treatment".

In 1960, the Stanford Research Institute published a study which included inspection of two chiropractic schools. They noted that although certain scientific subjects were part of the academic program, the school libraries and laboratories did not appear to be in actual use.

In 1966, the A.M.A. Dept. of Investigation studies chiropractic school catalogues and found that less than half of their faculty members had recognized college degrees. Thus, teachers of basic science subjects did not appear to have proper expertise to teach these subjects. Our Committee's review of catalogues in 1970 found the faculty composition essentially unchanged.

Recently, most chiropractic schools have affiliated with other colleges for basic science classes. This will not cause a dramatic increase in the quality of chiropractic training, however, basic science courses merely prepare one for the *study* of disease. They do not prepare one to make diagnoses or prescribe treatment. Moreover, no presently practicing chiropractor went through such a program.

We agree with the H.E.W. that chiropractic education does not prepare its practitioners to make adequate diagnoses or provide appropriate treatment. Chiropractors should not be licensed to make diagnoses or provide primary health care. Rather, those who can adapt to scientific thinking should be retrained as physical therapists to work under the supervision of qualified physicians.

EXHIBIT C

Chiropractic Salesmanship

Chiropractic promotion includes dubious methods.

The Parker Chiropractic Research Foundation has developed a sales approach for chiropractors. Its founder, Dr. James Parker, estimates that more than 10,000 chiropractors and their assistants have attended his practice-building seminars. Journalist Ralph Lee Smith, who attended the course a few years ago, documented its nature in the June 1968 issue of Today's Health Magazine (Exhibit C–1).

Smith describes how the course is built around a 335-page *Textbook of Office Procedure and Practice Building for the Chiropractic Profession.* Parker's Summary of How to Conduct An Effective Consultation" on page 134 states:

. . . From the time the telephone rings until the time you start the examination, you are working toward one goal: "Mr. Jones, there is most definitely something wrong with your spine that could absolutely be causing almost all, if not every bit of your trouble."

Parker's techniques include:

1. Offer "free consultation" (pp. 61–63) but lead patient into "examination" which costs him money (p. 75).
2. The "yet disease" (Exhibit C–1, p. 3).
3. "Digging for chronicity" (Exhibit C–1, p. 3).
4. "One adjustment for each year of age of the average chronic patient is a rough thumbnail guide of what people will willingly accept and pay for." (p. 148–149).

5. "If in doubt about the payment or the return of the patient, take only the smaller X-rays on the first visit but ostensibly X-ray fully." (p. 127).

In spite of these dubious methods, Dr. Parker is a welcome lecturer at chiropractic schools. When one of us merely requested a catalogue from Texas Chiropractic College, the school gave his name to Dr. Parker. Parker's letter of encouragement mentions that chiropractors often reap incomes of "$50,000 to $75,000 and even $100,000 annually . . ." (Exhibit C–2).

Dr. Parker is thus not only sanctioned, but is highly respected by the chiropractic system.

[From Today's Health, June 1968]

A Golden Touch For Chiropractors

(By Ralph Lee Smith)

Our writer takes the world's leading "success course" for chiropractors. He learns to "open the trap door," initiate the "yet disease," and "dig for chronicity." Graduates may be proving the methods in your community.

"Give your patients the impression that you're busy and prosperous. When I was in practice I would sometimes go into another room, dial my own number, come back to my desk, answer the phone, and pretend to talk to another patient while a real patient sat there. Sometimes I would have relatives come and sit in my reception room—patients would think they were other patients. If a salesman showed up I would keep him waiting in the reception room for a while—same reason. Also, you can study a patient's records with a flashlight in an adjoining broom closet, then walk in with them as if you were coming in from Room 86 of your 'suite!'"

The speaker was James W. Parker, one of the most successful chiropractors in the United States—a shrewd, earthy man, a born story teller, and a person of tireless energy. He has the revivalist preacher's gift for holding an audience for hours, permitting his voice to gain in speed and rise in pitch and dramatic intensity, then suddenly lowering it to make a point, start another subject, or tell an unexpected deadpan joke. Also, like many a backwoods preacher of legend, he is perfectly at ease urging his audience to love their fellow men while slyly encouraging them to exploit these same fellow creatures from here to breakfast.

Parker has the King Midas touch. The creator of a chain of 18 thriving chiropractic clinics in Texas, he has grossed millions of dollars while spending over half a million on advertising and public relations. After making one fortune from ill persons he is making another from his fellow chiropractors. His project seems to be nothing less than turning the entire chiropractic profession into an army of smooth-talking merchants. I have seen James W. Parker in action; I have seen how chiropractors have responded; and I think he is likely to succeed.

Parker has set up a little enterprise called the Parker School of Professional Success. This, in turn, is a division of another Parker creation, the Parker Chiropractic Research Foundation. The scientific-sounding name of this latter organization looks good on diplomas, plaques, and the like.

Finally, there is a third organization, Share International, which uses the offices and personnel of the other two. Share International is the sales arm of the operation, providing chiropractors with materials for putting the Parker system into operation in their own practice. It issues a mail-order catalog, and also sets up shop and sells its wares during the three-day seminars in "practice building" that Parker holds six times a year, usually at the headquarters of the three enterprises in the Hotel Texas in Fort Worth. Six thousand chiropractors and their assistants have attended one or more of the seminars (the 1960 census showed only 14,360 chiropractors in the entire country), and more flock to Fort Worth as each new one is held.

The Parker seminars may represent a decision on the part of chiropractic to turn to super-salesmanship for survival in a scientific age that has revealed its theory about the cause and cure of disease to be a quaint medical fairy tale.

Chiropractic is the last unchanged, widely practiced survivor of numerous

therapy cults such as naturopathy and magnetic healing that sprang up in the 19th century. It was invented by an uneducated and partialy illiterate grocer of Davenport, Iowa, named Daniel David Palmer. Palmer seemed to think that the great secret of the ages—the cause and cure of human disease—had been vouchsafed to him and him alone.

Illness, he said, is caused by slight misalignments, called subluxations, in the vertebrae of the spine. These subluxations supposedly pinch the nerves that leave the spinal cord to various parts of the body, impairing the flow of "nerve force" on which health depends. To cure disease, he claimed, one simply forced the straying vertebrae back into place by a manual pressure on the backbone called a "chiropractic adjustment." After a series of such adjustments the malaise would disappear.

Of course, science now knows that the causes of most diseases and the correct methods for treating and curing them bear no resemblance to the Davenport grocer's naive dream. Modern research has failed to find any evidence for the kind of nerve impingements that chiropractors claim occur so frequently, and has failed to show any relationship between such alleged impingements and the cause or cure of most illness. (See "Chiropractic: Science or Swindle?" by Ralph Lee Smith, *Today's Health*, May 1965.) The vast majority of health problems are clearly unrelated to malfunction of the spinal nerves because they are so obviously caused by physical injuries like fractures, chemical injuries from poisons and drugs, infections and infestations, dietary deprivation, crowding, poor hygiene, tumors, degenerative diseases, and reproductive malfunctioning.

I was therefore fascinated to know what was being said and done at the Parker seminars, which have been widely advertised in chiropractic journals. The fee for attending the three-day course is $250. I sent it in, calling myself "Dr. Lee Smith, Chiropractor." There are directories of licensed chiropractors, and I am not listed in them since I am not a chiropractor but a journalist. But my registration was accepted without question.

When I checked in at the seminar registration desk in the Hotel Texas an attractive girl smiled and handed me a handsome split-cowhide briefcase with "Dr. Lee Smith" stamped on the side in gold. Inside was a sample packet of materials available from Share International, and a 336-page multigraphed soft-cover book called *Textbook of Office Procedure and Practice Building for the Chiropractic Profession*. The seminar, I soon learned, is built around this remarkable book.

More than 200 chiropractors and their assistants were in attendance when Parker, a man of medium height with black hair, a burr haircut, black horn-rimmed glasses, and a neat, small mustache, wearing a badge that said simply "Dr. Jim," stepped to the rostrum to begin the first session at one p.m.

"At these sessions," he said, "I intend to teach you all the gimmicks, gadgets, and gizmos that can be used to get new patients . . . Thinking, feeling, acting determine the amount of money you will take to the bank . . . Remember, enthusiasm is the yeast that raises the dough."

The afternoon and evening sessions were devoted to "Success Philosophy." It turned out that, when it comes to love, the hippies have nothing on Jim Parker. To succeed, the *Textbook* says, the chiropractor must "LLL: Lather Love Lavishly!!" "When you meet a new patient," Parker explained, "you can push a button. You can push the LLL button, the love button. It's like a light bulb that you switch on. When you meet a new patient, LLL him in. When you do this, you disarm a patient who has developed sales resistance."

However, like the hippies, Parker finds some people more lovable than others. An unlovable type from the chiropractor's point of view is a person with an acute illness. The course, says the *Textbook*, "is designed to make you a 'D.C.'—'Doctor of Chronics' rather than a Doctor of Acutes." "You'll make a lot more money," Parker explained.

But what if the patient comes in with acute, rather than chronic, symptoms? The chiropractor's task, Parker said, is to try to discover that the symptoms are "an acute flareup of a chronic condition," and to convince the patient that this is so.

During this and succeeding sessions many subjects were covered, including: how to advertise for patients (chiropractors can buy mats from Share Inter-

national for whole series of newspaper ads); how to get patients to refer other patients; how to answer the questions of people who doubt the validity of chiropractic treatment (a dual technique is used—frighten people away from scientific medical treatment by alleging that its methods are "deadly," and claim that such treatment, with all its dangers, deals only with "the symptoms" of disease, while chiropractic attacks and eliminates the "true cause"); when to give presents to patients and their children and what to give; how to maintain a mailing list and what literature to send; how to arrange the office suite ("Place Bible in reception room"); and how to "manage" patients who are in treatment.

Perhaps the most important topic, however, was the basic procedure for getting the patient into treatment. As the *Textbook* neatly summarized it: "From the time the telephone rings until the time you start the examination, you are working toward one goal · 'Mr. Jones, there is most definitely something wrong with your spine that could absolutely be causing almost all, if not every bit, of your trouble.'"

The *Textbook* kicks off the subject with a detailed discussion of telephone technique, including many sample conversations. "If possible," it says, "the assistant should handle calls since she can refuse requests for prices and can praise the doctor and chiropractic with an emphasis not possible for the doctor himself."

When the chiropractor does get on the line, his job is to get the prospect in. The bait on the hook is a "free consultation:"

"Q: 'How much do you charge?'

"A: 'There is no charge . . . (pause) . . . for the consultation of the first visit. This is to determine the cause of your trouble and what should be done about it.'"

"Tact and diplomacy are necessary," the *Textbook* notes. "Such sentences as the following OPEN THE TRAP DOOR:

". . . I certainly understand what you mean when you say you spent so much money without getting results. We will try hard not to let that happen when you come here.

". . . Your (nice/cultured) voice tells me you are an intelligent (woman/man) and I am sure once you have made up your mind to try something you will follow through."

Actually, the *Textbook* explains, the patient will *not* learn "the cause of your trouble and what should be done about it" in the free consultation. Its purpose is to get the caller into the doctor's office so he can make a complete selling pitch in person. "The consultation is without cost," says the book, "but the examination will cost them money."

When the patient comes in, the chiropractor's assistant first secures basic information including name and address. "Check the patient's address for income status," the *Textbook* tells the chiropractor (later on the chiropractor is also to "learn family occupation by developing interest in the family. This should be done subtly."). The patient is then ushered into the august presence, where the chiropractor deals with him in a 13-step procedure that leaves nothing to chance.

As the unsuspecting patient enters, the chiropractor pushes the love button and lathers him lavishly. While the lather flows the chiropractor seeks to "establish common bond" through such links as "fraternal jewelry, children, similar religious affiliations."

"What would you like me to do for you?" he then asks. His moves now, according to the *Textbook*, are:

"(1) Eye contact; (2) Lean forward; (3) Hands on desk, or one hand on edge of desk and other at side; (4) When patient begins to answer, you can lean back in chair and listen attentively with arms and legs uncrossed."

Now comes the nitty-gritty. First, the "Yet Disease." "If the patient has a pain in his left shoulder," Doctor Parker said, "Ask, 'Has the pain started in your right shoulder yet?' Use it when you must instill a sufficient amount of fear to get the patient to take chiropractic."

The next step is to "dig for chronocity." The chiropractor puts an elaborate

series of questions to the patient that suggest or imply that the condition is chronic. "How long has it been since you really felt good?" the practitioner murmurs gently. ("I make $10,000 a year on that one, easy," a chiropractor sitting next to me whispered in my ear.)

With the verbal digging completed and chronicity unearthed, the chiropractor moves on to "Connect up affected parts (pain) with the area of treatment (spin)"—that is, to tell the patient that his condition stems from spinal subluxations. Having done this, the chiropractor is then to "restate information (or acquire additional information) which may prove useful later on to explain limited results, or to excuse you from getting results expected." As a final step he releases some more lather to "establish LLL principle in patient's mind." At this point, says the *Textbook*, "most patients are ready to proceed."

With the fish on the line, the chiropractor is told to "lean back," make "eye contact," and reel him in with a speech that Parker calls "the assumptive close." It goes like this:

" 'Mr. Jones, at this point we can be sure of one thing—if you are not a chiropractic case, chiropractic will never help you. If you are a chiropractic case, nothing else will ever help you, so our first job is to determine whether or not you are a chiropractic case. We have had a number of similar cases in the past, and have found that the first thing to do is conduct a thorough (chiropractic) examination, including x-rays, laboratory tests, a physical examination, orthopedic and neurological tests, and whatever else might be indicated, depending upon what we find. If you are ready, we can begin your examination right now.' OR 'When would you like to start this examination?' OR 'Come with me.' "

If the fish wriggles, the chiropractor plays him carefully. The *Textbook* provides answers the chiropractor can give to every imaginable patient objection or reservation.

If the patient is still balky, the chiropractor offers a "preliminary examination." Beginning where the patient feels pain, he touches the afflicted parts, then says something like, "There doesn't seem to be anything wrong with the arm itself . . . let's trace the nerves back to the spine and check there." When this has been done, Doctor Parker suggested that the chiropractor can say, "Oh, here it is. Why didn't we look here first. I'm glad we found the trouble here, because this is my specialty." During the process, said Doctor Parker, the chiropractor can "ask leading questions" and "use little comments and innuendoes, such as 'Hmm. I don't like that.' "

Now the chiropractor pulls out all the stops. "Build fear of more serious trouble, if necessary," the book says. "Proceed to make a serious statement followed by a hopeful statement, which would cover the full scale of patient feeling and emotion, as follows: 'Mrs. Brown, it's possible this could be the beginning of something serious. Let's see if chiropractic can help. It wouldn't make you mad if we [stopped this pain/made a new back] for you, would it?' "

If Mrs. Brown still doesn't see what is good for her, she gets both barrels between the eyes. "Do you feel there could be a tumor or perhaps cancer causing these nerves to act up?" the chiropractor asks. Having raised such specters, the chiropractor sits back and lets Mrs. Brown's fears do the rest. "Put the problem of making decisions on the patient's shoulders," the book says.

No human extremity is out of bounds for the sales pitch. "In terminal cases," the book states, "mention 'a miracle of nature has often occurred.' "

While tightening the screws, the chiropractor simultaneously keeps a sharp eye peeled for "the green light." Sooner or later, the books says, it comes.

The netted fish is then examined and x-rayed. "If in doubt about the payment or the return of the patient," the *Textbook* suggests, "take only the smaller x-rays on the first visit but ostensibly x-ray fully."

When the examination is completed the doctor is told to collect for it on the spot. "That will be $27.50 for today," he is told to say. "Will that be cash or check?" "Begin writing receipt," the book continues. "Don't look up."

To take care of cases in which the chiropractor has unwisely extended credit, he can purchase from Share International a handsome wall certificate stating that he is a member of "State Credit Association," and a bookful of collection

forms of graduated degrees of severity and threat, all bearing the heading "State Credit Association." No address for this Association is given on either the wall certificate or the forms, and the forms all say "MAKE YOUR PAYMENTS DIRECT TO THE CREDITOR." It is, of course, the chiropractor himself who mails them out.

On the patient's next visit the chiropractor, who has relaxed and is back to lathering, hands the patient a document entitled "Confidential Report of Chiropractic Examination and Recommendations," which consists of six sheets and a blue cover. Chiropractors purchase them from Share International. "Our examination has now been completed," it says. "In your particular case, we have found definite misalignments in your SPINE resulting in a disturbed nervous system. Therefore, you are a case for chiropractic."

The "Report" explains the chiropractic theory of disease, and adds that "the nervous system is the master system which controls all other systems of the entire body, including the glandular, reproductive, digestive, eliminative, respiratory, and circulatory."

"They couldn't possible have a condition not covered here," Doctor Parker observed.

The "Report" sets for the chiropractor's "analysis of the patients illness ("analysis" was a word frequently used in the seminar: the laws of some states do not permit chiropractors to "diagnose" illness), together with a recommended number of visits for adjustments, a price for the series, and an offer of a discount if the patient pays the full sum in advance.

The *Textbook* adds some comments intended for the chiropractors eyes only. However, the book observes, there is no reason for the chiropractor to be unduly modest in his expectations: "Chiropractors should keep in mind that many truck drivers, carpenters, electricians, conductors, steel workers, and radio repairmen earn more than $12,000 annually."

After the final session, members of the seminar attended a farewell dinner. There Doctor Parker gave each of us a handsome diploma from the Parker Chiropractic Research Foundation, stating that we had "completed the prescribed course of study at the Parker Chiropractic Research Seminar." (Actually, not only did we do no research but no one was required to "complete" any course of study, since no attendance was taken at any of the sessions.) Those wishing to do so could also join the Foundation for $10 a year and receive a second item—an impressive black-and-silver membership plaque.

I talked to many chiropractors during the three days of lectures. Their response to the seminar was overwhelmingly enthusiastic. Over half those in attendance wore blue badges showing that they had attended previous seminars and had come back for more. A chiropractor from Ohio told me that he had been attending the seminars since 1959: by applying Parker's methods he had built his practice from $25,000 to $100,000 a year. Another said that this was his 18th seminar. "After the first one my income went up from $2000 to $4000 a month," he said. He is also now near the $100,000 mark. A third didn't give figures but summarized his situation with graphic simplicity. "We have gone," he said, "from rags to riches."

THE PARKER CHIROPRACTIC RESEARCH FOUNDATION,
Fort Worth, Tex.

DEAR "FUTURE" DOCTOR OF CHIROPRACTIC: You probably will be surprised to receive a letter from this Chiropractic Foundation addressing you as a "future" Doctor of Chiropractic. However, here is the way it happened and why it is happening:

Last May I delivered the graduation and banquet address at the Texas Chiropractic College, 5912 Spencer Highway, Pasadena, Texas. At that time I had an opportunity to talk at length with the college president, Dr. W. D. Harper. I explained to him that we in this Foundation, being in the midst of research and helping the field practitioners, have observed that there is a great shortage of chiropractors in the field. I asked Dr. Harper what we could do to help to encourage interested, dedicated and qualified men and women study to become Doctors of Chiropractic.

He advised me that he had a list of several hundred who had either inquired of the college about the possibilities of entering the Texas Chiropractic College, or whose name had been sent in to the college by some doctor who felt that you would make a fine professional man or woman. I asked for that list so that I might write to you to encourage you to seriously consider taking such a step.

Chiropractic is growing by leaps and bounds. The wide range of ailments and illnesses that are achieving results through chiropractic care is ever increasing. Sick people just get well through chiropractic, and that is a fact! As a result of this situation, most Doctors of Chiropractic have more than they can do. There is a great need for new doctors to enter this worthy profession.

Truly, there is no profession, no career, no vocation nor avocation that one could enter in the 1970's that could be nearly as rewarding as to become a Doctor of Chiropractic.

Because they get results, often times miraculous results, because they work with the natural healing power of the body, chiropractors are beseiged with patients from every walk of life seeking help. As a natural result, Doctors of Chiropractic reap compensations in income that often reach into $50,000 to $75,000 and even $100,000 annually, without much difficulty. We see this happening every day, with advanced and modern methods of achieving real and lasting results.

I am wondering if you are still interested in taking up chiropractic as a career? If you are, this Foundation would like to forward to you some additional material and suggestions for your consideration. Sick people need more chiropractors badly. If you are interested in becoming a Doctor of Chiropractic, I would be pleaded to have you use the enclosed postage-paid envelope and write me your present interests, your age, your educational background, and any questions that you might have in this regard. As soon as I hear from you, I will send you some material for your further consideration.

Thank you for your interest.

Sincerely,

JAMES W. PARKER, D.C., Ph. C.

EXHIBIT D

Chiropractors greately exaggerate what they can do.

ADVERTISING

More than 25% of chiropractors in our area advertise in violation of the rules of the Pennsylvania Board of Chiropractic Examiners. Some mislead and greatly exaggerate what chiropractors can do (Exhibit D–1). Non-advertising chiropractors also benefit from this publicity.

Advertising copy may be purchased from the Parker organization (Exhibit D–2). In one type, the chiropractor simply inserts his name, thus appearing to have treated a patient whose case history has been described in the ad.

Most health professionals feel it is unethical to advertise. Some non-advertising chiropractors agree, but do not take simply steps which we believe would discourage their colleagues' advertising. It is estimated that 10 to 20 percent of U.S. chiropractors advertise.

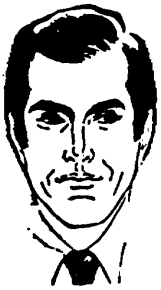
We believe that advertising, where it is legal, is an integral part of chiropractic practice. Unfortunately, many newspapers which accept these ads suppress news which is unfavorable to chiropractic.

WHAT HEALTH PROBLEMS DO CHIROPRACTORS TREAT?

D-1

In discussing the types of health problems that the Chiropractic profession handles, we must first state that there are very few diseases, as they are understood today, which are not treatable by Chiropractic methods. This doesn't mean that every case of sickness will yield to our method. It does mean that no matter what the disease may be, if it results from displaced spinal vertebrae interfering with normal nerve function, the only permanent relief to be hoped for must come from Chiropractic adjustments.

"There are very few diseases....which are not treatable by chiropractic methods."



When a person gets sick, although it may be the stomach, intestines, liver, gall bladder, kidneys, heart, lungs or any other part of the body, it is most likely that the first cause is mechanical displacements of segments of the spinal column. Gastritis, constipation, diabetes, etc., are failure of function and the chief cause lies in displaced spinal vertebrae interfering with normal nerve function.

"....diabetes .... the chief cause lies in displaced spinal vertebrae..."

Chiropractors do not prescribe medicine. In our opinion, it is far more important to trace the nerves affected, determine where the interference lies in the spine and then to adjust the spine, to correct the cause of the problem. Adjustments correct abnormal spines, restore body tone and posture and remove the cause of nerve interference. When it is remembered that your nerve energy is Nature's rejuvenating power and healing agent, it becomes obvious why Chiropractic gets such splendid results.

CHIROPRACTIC-A MODERN WAY TO HEALTH

Sponsored as a Public Service to Create a Better Understanding of the Science of Chiropractic.

LEHIGH VALLEY CHIROPRACTIC SOCIETY (1971)

(1971)

DIABETES

Dr. R. T. LaBARRE
CHIROPRACTOR

The most common immediate cause of diabetes mellitus, (the most common of about 40 forms), is insulin deficiency. The doctor must work to restore normal metabolic efficiency, thus assuring normal insulin secretion.

Doctors of Chiropractic are best able to carry out this care, because their work is based on the fact that all parts of the body require an uninterrupted normal nerve supply—and any condition that involves the nervous system will affect the involved area, and produce dis-ease.

Sponsored By...

LA BARRE CHIROPRACTIC CLINIC

Office Hours Mon.-Wed.-Fri. 9:30 to Noon—5 p.m. to 9 p.m.
Sat. 10 a.m. to 1 p.m.

No Appointment Necessary

711 W. Broad St., Bethlehem 691-8727

Normal living requires chiropractic care.

DON'T ROB YOUR HEALTH

Dr. LaBARRE

Falls, strenuous strains, sprains, slipping, scooping, stooping, shaking, jolts, jars, tension, poor posture, tugging, stretching, twisting, turning, pushing, jumping, sudden impacts, lifting, and exertion produce pressure and tension on delicate nerves. These nerves system "short circuits" impare normal nerve energy flow.

Chiropractic is the science specializing in restoration of normal nerve function. See your Chiropractor when the irritation occurs.

Don't let an acute condition become chronic!

Sponsored By

DR. RICHARD T. LaBARRE
711 W. Broad St., Bethlehem
HOURS BY APPOINTMENT
PHONE 691-8727

D-1

This Pennsylvania Chiropractor's ad matches that offered for sale (Exhibit D-2) by the Parker organization.

REDUCE SUSCEPTIBILITY . . .

INCREASE YOUR RESISTANCE TO FLU!

Some people are susceptible to illness because their resistance is low.

They should endeavor to raise their resistance and thus lower their susceptibility to illness.

Life force must be shut off before the body is susceptible, and resistance is lowered in proportion to the degree in which life force is shut off.

Chiropractic Principle

Chiropractic teaches that sub-normal resistance is due to lack of functional impulses sent out over nerves because a vertebra is out of alignment and pressing on nerves.

These impulses emanate from the brain, are transmitted down the main cable, called the spinal cord, and branch out to all parts of the body.

When these vertebrae get out of alignment, they interfere with nerves and impair function.

The severity of illness depends upon the degree to which the life force is shut off by a vertebra impairing nerves.

How Chiropractic Helps

Chiropractors help the body to increase resistance and reduce susceptibility by adjusting the misaligned vertebra, thereby releasing the imprisoned life impulse.

McKIM
CHIROPRACTIC CLINIC
1967 W. Union Blvd.
Bethlehem • 865-2010

1 block east of Almart. Daily 9 to 12 a.m. and 4 to 8 p.m. Thursday 9 to 12 a.m., Saturday 8 to 11 a.m.

YOU CAN'T WISH YOURSELF WELL!

By Dr. H. F. McKim

Dr. H. F. McKim
CHIROPRACTOR

Many people stay half sick and half well nearly all the time, grunting along and wishing for health.

If wishes were horses, beggars would ride," as the old saying goes. If you are sick you have to have hope, faith and above all, a desire to get well — a desire strong enough to make you investigate EVERY possibility.

On the other hand, many people stay sick because they are confused, or become disgusted when everything they try fails to help.

We find the average sufferer has been diagnosed, treated or operated, and steered from one specialist to another, only to find that as one ailment is patched up, trouble starts somewhere else.

It is discouraging when you spend your time and money in a sincere effort to get well and yet nothing seems to help. Things lose their importance and become miserable!

It is difficult to be a good wife, mother, father, husband, son, daughter or grandparent when sick and miserable.

While such chronic cases are always a challenge, it is a much greater thrill and gives us more confidence to watch these unfortunates take a new lease on life, once we untangle their scrambled nerve lines, allowing Nature to restore normal function and heal. Thousands of successful case histories are on file that are proof positive evidence that sick people get well under chiropractic care — many times after other methods fail.

Each week we offer a message of hope to discouraged sick folks by writing about how many regain their health at the McKim Chiropractic Center. But we can't help YOU unless you give us the opportunity.

Does it give you courage to learn that a retired registered nurse, past sixty, recovered from headaches, indigestion, constipation, shoulder bursitis and traces of arthritis that she had been suffering for years. No. 164. Perhaps the dramatic and grateful recovery of excruciating pain from a slipped disc and sciatic leg pains experienced by a father in his late thirties. Or, perhaps the rapid recovery of an infant brought to us suffering pitifully from an acute food rash practically all over her tiny body, or maybe the little six and seven year old brother and sister that recovered almost overnight from severe tonsilitis and high temperature will excite you into action.

Chiropractic may be your answer, too. But you can't just WISH for it — you must investigate! Do it today. Further delay may make it worse. Besides, what have you got to lose except your ill health?

One of a series of articles published in the public interest to explain and illustrate scientific chiropractic written by Dr. H. F. McKim, 1967 W. Union Blvd., Bethlehem — 1 block east of Almart. Daily 9 to 12 A.M. and 4 to 8 P.M. — Thurs. 9 to 12 A.M.; Sat. 8 to 11 A.M.

SPORTELLI

Chiropractic Clinic

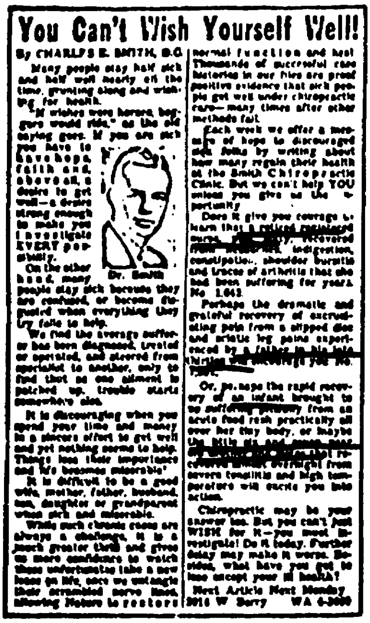
• Cold Feet
• Lowered Resistance

• Slipped Disc

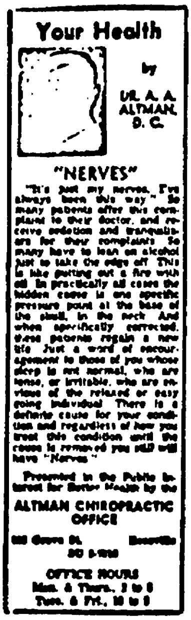
DR. R. A. KINSEY
1-27-70
CHIROPRACTOR
25th & Birch Sts., Easton
Dial 252-3449
• Headache • Female Disorders

Advertising Aids

D-2


You Can't Wish Yourself Well!

By CHARLES E. SMITH, D.C.


Your Health

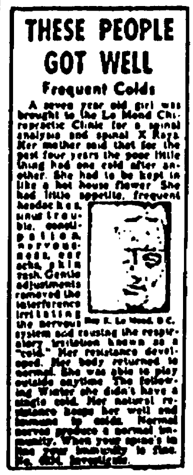
by

DR. A. A. ALTMAN, D. C.

"NERVES"

ALTMAN CHIROPRACTIC OFFICE

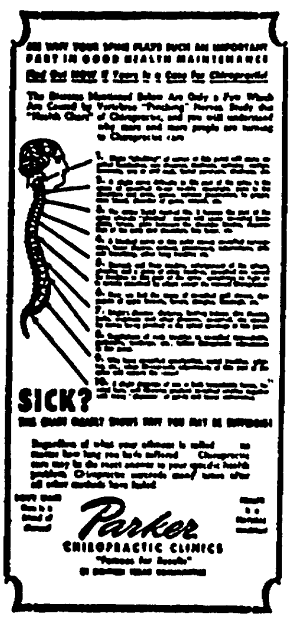
OFFICE HOURS


THESE PEOPLE GOT WELL

Frequent Colds

Newspaper Ads

Copies of health-column type ads, actually used by five different doctors, to guide you in preparing and personalizing your own copy for newspaper advertising. A total of 107 ads; more than a 2-year supply; several sizes and styles; cover many different conditions. Complete set, reduced, while they last .. Only $19.95.


SICK?

Parker

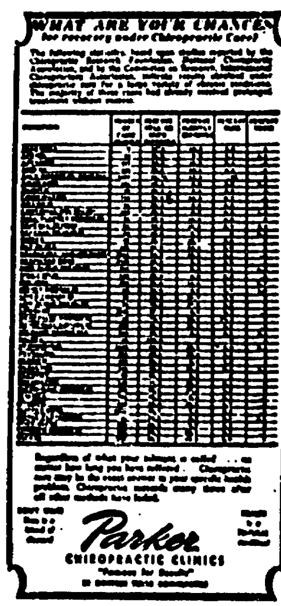
CHIROPRACTIC CLINICS

Newspaper Mats

Excellent for running alternately with health column ads shown above. The newspaper inserts your own signature cut affording you a big saving on art work and engraving.

Nerve Chart	$2.95
Research Chart	2.95
Both for	4.95

Size: 3-3/4" x 8-1/4"


WHAT ARE YOUR CHANCES

Parker

CHIROPRACTIC CLINICS

EXHIBIT E

"A nightmare of catastrophic proportions."

FEDERAL INSURANCE PLAN EXPERIENCES

Four federal employee groups included chiropractic coverage in their health plans in 1960 but dropped it in 1966 because of claim abuses:

(1) National Association of Letter Carriers (Exhibits E–1, E–2, E–3, E–4).
(2) Rural Carrier Benefit Plan (Exhibit E–5).
(3) Maintenance Employees Benefit Plan.
(4) Motor Vehicle Employees Plan.

Dr. Charles Homes, medical consultant to the Letter Carriers, described its experience as a "nightmare of catastrophic proportions . . . while supposed to limit . . . to conditions of the spine, they were treating every disease known to man (Exhibit E–2)." This included measles, mumps, ulcer, cancer, mental disease and bedwetting. All were supposed to be caused by displaced ("Subluxated") spinal bones. The radiologist who examined 300 sets of x-rays found most of them to be of inferior quality and "unfit for diagnostic purposes". He also raised the question of radiation hazard. Even chiropractic officials who reviewed these x-rays could not locate the subluxations reported by the chiropractors who had submitted them (Exhibit E–4).

In our opinion, the Letter Carrier experience demonstrates that the chiropractic spinograph has little or no diagnostic value and presents a radiation hazard.

John W. Emeigh, administrator of the other three plans, described their chiropractic experience as "very adverse" (Exhibit E–5). Many treatments and x-rays were judged to be unnecessary. In some cases, "treatments were provided on the same day for as many as five members of a family".

NATIONAL ASSOCIATION OF LETTER CARRIERS,
Washington, D.C., September 1, 1970.

Dr. STEPHEN BARRETT,
Allentown, Pa.

DEAR DOCTOR BARRETT: I am sending copies of some of the outlandish bills we have received from Chiropractors prior to our severing our coverage of them. It was a tremendous relief to get rid of them because the Presidents of the two chiropractor Associations were unable to keep their members in line even with the most stringent orders and other means within their power.

Our investigation was limited to our Plan alone.

I sincerely hope you can succeed in preventing their gaining recognition. Dr. Cole's report shows their inability to take diagnostic x-rays and to read them.

I hope the material I am sending will help.

Respectifully yours,

CHARLES K. HOLMES, M.D.
Medical Consultant.

APRIL 6, 1970.

The experience of The National Association of Letter Carriers while cov ring the services of Chiropractors was a nightmare of catastrophic proportions. The reasons were simple:

1. While supposed to limit Chiropractic to conditions of the spine, namely subluxations of the vertebrae with impingement of the nerves causing disfunction and therefore disease, were treating every disease known to man.

2. Their diagnoses included Measles, Mumps, Cardiac disease, Duodenal Ulcer, Tumors, Cancer of the Prostate, Mental Disease, Nocturnal Eneuresis, Gynecological conditions, Arthritis and a host of others, all supposed to result from claimed subluxations of a vertebra.

3. The x-rays submitted were of such inferior quality that Doctor Wallace Cole, a Roentgenolist from the Washington Clinic who reviewed our films found over fifty percent totally unfit for any diagnostic purpose. He reviewed over 300 sets of films and found only one subluxation. I am enclosing a copy of his report.

I am also enclosing copies of some of the more extravagent claims. In June 1965 we dis-allowed claims amounting to $1,412.00; in July $2,359.00 and August $2,619.00.

Doctor Louis O. Gearhart, D.C. was Director of Professional Affairs of the American Chiropractic Association and I found him most co-operative and can say the same for Doctor L. W. Rutherford, D.C. who was President of the International Chiropractic Association.

As a result we held conferences with both the American and International Associations and coverage of Chiropractors was cancelled.

Respectfully yours,

CHARLES K. HOLMES, M.D.,
Medical Consultant.

WASHINGTON CLINIC,
Washington, D.C., August 6, 1965.

Dr. CHARLES K. HOLMES,
Medical Consultant, National Association of Letter Carriers,
Washington, D.C.

DEAR DOCTOR HOLMES: I have reviewed two-hundred sets of x-ray films since August 27, 1964 and with two exceptions, the films were taken by chiropractors, chiropractic clinics or x-ray laboratories. The x-ray laboratories sent films from the New York City area.

A large majority of the submitted films were of poor quality and had limited diagnostic value. Some of the films, however, were of good technical quality. The defects in the film quality can be summarized as follows:

1. The positioning of the patient was not good, resulting in distortion. This was most common in films of the base of the skull and cervical spine.
2. A large number of films were over-exposed, resulting in a dark or black film. This type of error results in films of very limited diagnostic value.
3. The processing of the films has been poor, resulting in multiple artifacts.
4. A large number of films were not dated, lacked a number for identification and had no marking as to left or right.
5. In a large number of cases, insufficient films were taken. The lateral projection of the spine is absolutely essential to correctly evaluate the presence of any disease process. In the majority of cases such lateral films were not taken.
6. There were many full-length films of the spine taken on a long film in the A.P. projection only. This produces an impressive looking film but in my opinion has limited value.
7. The usual over-exposed film submitted raises the question of excessive radiation to the patient; this could be determined by a monitoring system.

In many cases I was completely unable to offer an opinion as to the presence or absence of disease. It is absolutely essential to have good films correctly positioned and processed to determine an abnormality of the skeletal system.

There were two cases in which a barium enema was done. Both of these examinations were unsatisfactory due to poor preparation of the patient for this difficult examination.

Sincerely yours,

WILLIAM S. COLE, M.D.,
Radiologist, Washington Clinic,
D.A.B.R.

REPORT OF DIRECTOR, HEALTH INSURANCE

(By James P. Deely)

To the Officers and Delegates of the Forty-Fifth National Convention held at Detroit, Mich., August 14-20, 1966. Greetings:

I take pride in submitting to you the financial reports of the N.A.L.C. Health Benefits Plan for the years ended December 31, 1964 and December 31, 1965.

The reports show that the Plan is *not* making tremendous profits. They also show that the Plan is *not* accumulating extremely large reserves which would tend to make a balance sheet look good. Above all, however, they *do* show that the Plan is financially keeping its head above water.

It has always been the intention of your Board of Officers to formulate premium rates at amounts within the budget of a Letter Carrier which would allow the payment of adequate comprehensive benefits and establish reserves. I firmly believe that we have done just that.

(This is a report of the experience of the National Association of Letter Carriers with chiropractic insurance coverage, explaining why it was discontinued because of abuses by chiropractors.)

CHIROPRACTORS

Our Actuaries opposed the inclusion of a "Chiropractor" in our definition of a "doctor" when the Plan was established in 1960. In an effort to make available as many practioners as possible, we persuaded our professional consultants to accept our point of view. Chiropractic was recognized.

Almost from the inception of the program we encountered trouble with chiropractic claims. Expenses were submitted for X-rays that could not be interpreted, due to the poor technical quality of the films; claims were made for treatment of measles, mumps, heart trouble, mental retardation, female disorders and sundry other ailments. None of these conditions has any medical relationship to vertebral subluxations or spinal misalignments.

For the contract term beginning November 1, 1964, clarifying language relating to chiropractic was put in our brochure. The new language was not a change in benefits; it simply clarified the benefits allowable. Recognition of chiropractic was never intended to cover any expenses beyond spinal adjustments by hands of vertebral subluxations or misalignments. As is the case in all other types of claims, the Plan reserved the right to require X-rays to demonstrate the presence of the diagnosis.

In the interim, the problem became worse instead of better.

Early in December of 1964, several other employee organizations suggested we join them in a meeting with the national officers of the two major Chiropractic groups. On December 8–9, 1964, we did participate in a conference with leaders of The American Chiropractic Association and the International Chiropractors Association.

This meeting developed the interesting and significant fact that our problems with chiropractic were identical to those of the other participating plans.

After a frank and complete review of the situation, both associations issued bulletins to their respective membership. It is doubtful if anyone of the employee representatives could express the problem more clearly or succinctly than did the two Chiropractic associations.

The bulletin of the American Chiropractic Association stated:

"We were invited to the meeting to impress upon us the urgency and the need for adequate cost control to counteract the many claims abuses by members of our profession. We are amazed at the number of fantastic claims and cases which were shown to us to justify the urgency of the situation."

The International Chiropractors Association reported:

"It is no secret that most insurance carrier complaints stem from three major abuses: (1) Excessive charges; (2) Practices beyond analysis, X-ray and spinal adjustment, and (3) Prolonged care and excessive office calls."

The leaders of both ACA and ICA made repeated efforts to impress upon their membership the gravity of the situation, and the need to halt and prevent further abuses of insurance benefits. For reasons I cannot explain, these efforts produced no discernible improvement.

By mid-1965, we were convinced that it would be a greater disservice to our member to continue recognition of chiropractors than to eliminate them from our contract. If recognition continued, and the abuses also continued, the inevitable result would be financial disaster for many of our members. That is to say, some chiropractors would continue to furnish treatment for services not covered under the contract which, in turn, would result in the member literally "holding the bag" for incurred expenses that were not insurable, although the chiropractor would have every right to expect payment from the patient.

In commenting on this subject, one fact should be emphasized. It is a matter of record that we not only engaged the professional services of disinterested medical consultants to interpret X-rays in dispute, but we also made the same X-rays (and related claim data) available to representatives of both chiropractic groups.

One incident will dramatize the problem confronting me as Director of our Plan.

At our invitation, representatives of both ACA and ICA met in our office with one of the most reputable radiologists in the area, whom we had engaged on a temporary consultant basis.

Our doctor (medical) presented 20 sets of X-rays that had been submitted by chiropractors. Each film was purported to show a subluxation; in several instances, four to six subluxations had been diagnosed in a single X-ray.

One after another, each film was placed in the view box. The chiropractic representatives including a radiologist of their own selection, were invited to point out the subluxations. Not a single one was identified. Nor did the chiropractic representatives offer a solitary comment.

Effective January 1, 1966, the brochure was amended to delete a "Chiropractor" in the Plan's definition of a "doctor."

RURAL CARRIER BENEFIT PLAN,
Washington, D.C., January 20, 1972.

STEPHEN BARRETT, M.D.,
Chairman, Board of Directors, Lehigh Valley Committee Against Health Fraud, Inc., Allentown, Pa.

DEAR DR. BARRETT: This is to comment relative to the providing of chiropractic coverage in the health plan sponsored by the National Rural Letter Carriers' Association. This plan—The Rural Carrier Benefit Plan—did provide chiropractic coverage during the period July 1960 through December 1966. Chiropractic coverage was dropped as of January 1, 1967 and is now specifically listed as one of the exclusions.

The following was the coverage provided for chiropractic services in the Plan:

"This Plan will pay benefits for services of a chiropractor only for spinal adjustments by hands and spinal x-rays to determine the presence or absence of vertebral subluxations or misalignments."

We had a very adverse experience in connection with the providing of chiropractic coverage in the Plan. The coverage was limited, as noted above, however this limitation was frequently not understood by our insureds. This resulted in numerous claims being submitted for treatment which did not fall within the coverage provided by the Plan and there were many expenses which involved treatment for medically diagnosed illnesses. There were many expenses for x-rays which we had to question in order to establish that they were necessary services. We alo experienced many cases of abuse where an individual received a treatment every day or every other day for extended periods of time. There were a number of cases where treatments were provided on the same day for as many as 5 members of a family.

Our insureds did not understand the limited coverage; and likewise, they did not understand the necessity for invoking the test of "reasonable and necessary" in determining benefits allowed for the coverage which was provided.

In discussing our administrative problems with other Federal health plans, it was learned that we were all experiencing the same type of difficulty. We attempted to utilize the services of the major chiropractic associations in an effort to minimize the problem areas involved. We received fine cooperation from the International Chiropractic Association; but, there was little meaningful assistance, in connection with our problem as we saw it, from the American Chiropractic Association.

A series of meetings were held during the calendar year 1965 which involved the participation of administrators from Federal Plans and officers and representatives of the Chiropractic Associations. It became quite obvious that our efforts were not going to result in a resolution of the problems we were experiencing. The difficulty we were having with our insured members because they thought they had coverage which the Plan could frequently not provide, coupled with the overall administrative problems involved, caused us to propose the deletion of chiropractic coverage in the Plan.

I trust this brief review of the problem will provide the information you are seeking.

Sincerely yours,

JOHN W. EMEIGH, *Director.*

EXHIBIT F

Chiropractic officials gave inaccurate testimony.

1970 SENATE FINANCE COMMITTEE HEARINGS

William S. Day, D.C., President of the International Chiropractors Association and State Senator from the State of Washington, represented his organization. Senate Finance Committee Chairman Russell B. Long questioned him closely about the scope of chiropractic. Dr. Day stated clearly (Exhibit F–1) that migraine headaches, ulcers, hepatitis, deficiency anemia and several other diseases were outside the legitimate scope of chiropractic.

Using an I.C.A. Directory, we sent letters to 222 members of his organization asking if they treated and would accept a new patient with migraine, ulcers and/or hepatitis. Almost all of the 182 who replied said yes. Two replies (Exhibits F–2 and F–3) provide an interesting contract. While one Kentucky chiropractor was saying that "Chiropractic offers the safest and best health care for hepatitis", another (one of the few who said "No.") indicated that Kentucky communicable disease laws would prevent him from accepting a pure hepatitis case.

Dr. Day was accompanied by John Q. Thaxton, D.C., a former President of the International Chiropractors Association, who was greeted as a "staunch friend" by Senator Clinton B. Anderson of New Mexico. Dr. Thaxton, who sat by silently while Dr. Day said chiropractors do not treat migraine, has advertised migraine treatment in a New Mexico newspaper (Exhibit F–4). Other chiropractors have advertised that "chiropractic is almost a specific for migraine . . ."

HEARINGS BEFORE THE COMMITTEE ON FINANCE, U.S. SENATE, NINETY-FIRST CONGRESS, SECOND SESSION ON H.R. 17550

AN ACT TO AMEND THE SOCIAL SECURITY ACT, SEPTEMBER 14, 15, 16, 17, AND 21, 1970

Page 574:

Chairman LONG. . . .

Now, the medical profession says that your profession claims that it can treat all sorts of things for which it can do no good whatever, that the time that is spent is wasted, and that in some cases there is a risk to the person's life.

Here is an HEW report on the things that they have severe doubts that a chiropractor can do much about, some of which I am sure you would contend he can do something about. Here is the percentage of chiropractors that they say are reporting to be treating these conditions: headaches. I take it that you contend that a chiropractor can help a headache.

Dr. DAY. First, let me state categorically that the chiropractor does not claim to be able to cure all conditions. Now as to certain types of headaches. In fact we are very successful on many types of headaches.

The CHAIRMAN. How about migraine?

Dr. DAY. Migraine?

The CHAIRMAN. Yes.

Dr. DAY. No.

Page 575:

The CHAIRMAN. You don't treat ulcers?

Dr. DAY. No, sir.

The CHAIRMAN. Well, this report says 76 percent of chiropractors report they are treating ulcers.

Now, this is Health, Education, and Welfare reporting to us. How about deficient——

Dr. DAY. I don't know where they got those figures, Senator.

Page 576:

The CHAIRMAN. What about hepatitis?

Dr. DAY. Hepatitis is an infectious disease. We would refer this to a physician.

The CHAIRMAN. According to this report, 32 percent of chiropractors reported treating hepatitis.

Dr. DAY. Senator, this particular report you referred to again had 22 or 23 people on the committee. Twenty-two of them were either medical doctors or medically oriented. There was no chiropractor on the study committee. The special technical committee was made up of eight people, five of whom were medical doctors. So the report, I say, is an erroneous report.

EXHIBIT G

Bowling Green, Ky., July 7, 1971.

DEAR SIR: Thank you for your letter dated July 3rd. Yes, I take care of cases like yours, and Chiropractic offers the safest and best health care for hepatitis, as well as many other conditions.

When you get to Bowling Green, please call me, and I will arrange an appointment for you.

Looking forward to having an opportunity to help you, I remain

Yours truly,

L. K. CAUSEY, D.C., Ph. C.

HUDSON CHIROPRACTIC OFFICES,
Madisonville, Ky., July 7, 1971.

DEAR: Thank you for your letter of inquiry concerning the future care of your condition.

The laws of the Commonwealth of Kentucky as pertaining to Chiropractic require that all infectious or communicable diseases be reported to the state or local departments of health for treatment.

As your condition may fall in this classification under state law I would be unable to accept your case solely on the basis of being able to treat hepatitis.

Sincerely,

ORRIN E. HUDSON, Jr., D.C.

WHICH IS RIGHT?

DR. DAY'S STATEMENT

Dr. DAY. First, let me state categorically that the chiropractor does not claim to be able to cure all conditions. Now as to certain types of headaches. In fact we are very successful on many types of headaches.

The CHAIRMAN. How about migraine?

Dr. DAY. Migraine?

The CHAIRMAN. Yes.

Dr. DAY. No.

Or Dr. Thaxton's ad

HEADACHE HAS A BASIC CAUSE

A headache is a nerve condition which usually results from pressure caused by abnormalities or misalignment in the neck part of the spinal cord. Many of the most severe headache conditions, including migraine, begin with a dull ache in the back of the neck, which proves that the basic cause of the headache is a nerve disturbance in this region.

In any headache condition, may we recommend that a careful examination be made of the patient's spine and nervous system to determine the basic underlying cause of the trouble so that correction can be made as early as possible.

Dr. Thaxton[1] and Dr. Crume, Chiropractors. Complete Chiropractic X-Ray Service, Raton Realty Bldg., Ph. 445-9262, Raton, N. Mex.

[1] Dr. Thaxton is past president of the International Chiropractors Association.

Or Dr. McKim's ad

"Chiropractic is almost a specific for migraine . . ."

IS YOUR HEADACHE MIGRAINE?

DR. H. F. MCKIM

Is Migraine or "Sick Headache" upsetting you? Frequently, you feel wonderful between those excruciating attacks. As time passes you may notice circulatory or digestive disturbances or a dull headache or a stage of extreme well-being preceding these attacks. You notice a severe pain of a sharp shooting character localizing mostly in either the frontal, temporal or occipital portion of one side of the head. Further attacks seem to be getting more frequent and more severe. You may notice intolerance to light and sound, incapability of mental exertion and nausea.

Chiropractic is almost a specific for migraine in that it searches for and removes the cause.

If your headache seems to be migraine consult your Chiropractor. Remove the cause and end those torturing pains.

CHIROPRACTORS DEMONSTRATE WHY CHIROPRACTIC COVERAGE CAN BE EXTREMELY COSTLY

"If you were to come into my office I wouldn't even want to know what's wrong with you".

Dr. Parker suggest that chiropractors recommend to patients only as many adjustments as they can afford (Exhibit C–1). We shudder at the prospect of his 10,000 disciples using the medicare allowance to determine the "necessary" number of adjustments. We are also alarmed at the chart which Dr. Parker claims is a summary of experience with more than 250,000 chiropractic patients (Exhibit G–1). Treatment for the "100 most common ailments" averaged more than 35 adjustments each!

It is not unusual for chiropractors to enter contracts whereby patients pay large sums in advance for 50 or more adjustments. A New Jersey chiropractor tried to use such a plan to finance the opening of his office (Exhibit G–2)!

Nor is it unusual for a patient to be x-rayed frequently. A 3-page bill submitted by a Nazareth, Pa. chiropractor to a local insurance company demonstrates seven sets of x-rays of the same region during a one year period (Exhibit G–3). This chiropractor was President of his local society in 1970.

On May 16, 1971, Chiropractor Reginald Gold gave a public talk (Exhibit G–4) which we recorded. He was introduced as "one of the country's leading authorities on chiropractic", as President of the Representative Assembly of the International Chiropractors Association and as a lecturer on the faculty of three chiropractice schools. Among his statements were the following:

"Chiropractors don't cure diseases. Now I'll tell you something else. They don't even treat diseases. If you were to come into my office, I wouldn't want to know what's wrong with you. I wouldn't want to know what your symptoms are. I would want to do one thing. I'd like to examine your spine—even if you feel healthy, I want to find every place within your body where some nerve is pinched off and correct that pinched off nerve . . .

". . . I would like to examine your spine now and regularly from this point on, fit or well, because there is no way you can tell when one of these bones is misaligned. I'm a chiropractor and *I* can't tell when I have a subluxation! So, you know what I do? Three times every single week of my life I have another chiropractor check my spine . . .

"Now I know it's not practical for you to see a chiropractor three times a week for the rest of your life. . . .

". . . *Talk to your chiropractor about family maintenance care meaning you, your spouse and all the kids, regularly, once a week for life.*"

TEN IMPORTANT CALCULATIONS on approximately ONE FOURTH MILLION CASES receiving over 10,000,000 CHIROPRACTIC ADJUSTMENTS for the most frequent ONE HUNDRED CONDITIONS. Prepared by the Parker Chiropractic Research Foundation.

CONDITION	Av. Age of Patient (Yrs.)	Av. Dur. of Cond. (Yrs.)	% Prev. Med. Care	% Cases Accepted	Av. No. of Adj.	Av. Adj. Req. for ea. Yr. Ex.	Av. Days Under Chiro. Care	Av. Days Req. for ea. Yr. Ex.	% Results X-ray & Other Exams	% Results No X-ray
Acne	17.4	4.2	88.2	92.1	28.2	6.8	76.3	18.9	85.4	58.6
Adenoids	11.2	6.1	87.2	90.3	26.0	4.3	74.0	12.1	85.8	56.9
Allergies	23.5	7.4	84.6	92.3	50.1	6.7	140.5	19.0	87.2	59.8
Anemia	38.0	9.4	93.8	88.3	55.2	5.9	156.8	16.6	81.5	56.2
Angina Pectoris	49.9	7.0	93.4	86.2	32.1	4.6	93.8	13.4	73.9	59.6
Anorexia	27.1	5.3	80.9	83.1	24.5	4.6	65.5	12.3	66.6	46.8
Appendicitis	34.1	6.6	84.6	94.6	22.3	3.4	62.5	9.4	88.5	57.9
Arthritis	51.0	8.5	92.2	89.2	49.0	5.8	111.7	13.1	73.3	49.7
Asthma	32.9	9.7	95.7	92.3	45.1	4.9	117.9	12.1	80.5	54.9
Bladder Trouble	41.6	6.3	91.2	88.4	31.6	5.1	91.3	14.5	78.2	54.8
Boils (chronic)	26.7	7.3	93.2	87.2	41.1	5.6	110.3	15.1	83.8	56.3
Bronchitis	39.9	10.4	88.1	94.3	28.7	2.8	86.9	8.3	84.2	57.3
Bursitis	46.1	2.8	64.2	96.1	19.5	6.9	49.6	17.7	89.3	61.5
Chorea	19.5	4.2	87.4	88.4	48.3	11.5	132.6	31.5	75.0	51.3
Colds	31.9	8.1	72.4	97.6	24.1	2.9	68.3	8.4	89.8	60.2
Constipation	42.4	9.8	88.2	98.3	30.2	3.1	95.0	9.6	89.1	62.4
Cystitis	43.9	8.0	73.3	91.7	50.2	6.3	140.6	17.5	83.4	56.5
Deafness	47.7	9.2	89.5	89.2	33.2	3.6	93.5	10.1	71.9	52.3
Dermatitis	33.8	7.5	85.8	87.1	36.1	5.1	112.0	15.0	76.2	51.3
Diabetes	51.1	8.1	95.1	86.2	51.3	6.3	145.8	18.0	77.5	53.2
Dysmenorrhea	27.2	5.5	73.3	94.7	19.1	3.5	48.6	8.8	86.6	59.2
Dyspnea	39.0	3.2	100.0	96.8	27.5	8.5	77.8	24.3	89.5	57.3
Ear Disorders	32.4	4.2	79.9	87.7	18.6	4.4	48.4	11.5	70.0	49.1
Eczema	26.2	6.8	92.3	84.3	42.3	6.2	110.0	14.7	84.6	57.7
Enuresis	9.6	6.0	79.3	92.3	40.6	6.7	107.2	17.9	75.4	52.2
Epilepsy	23.5	8.2	97.5	86.4	76.1	9.3	211.5	25.8	79.5	55.4
Eye Disorders	26.8	7.3	87.7	87.3	42.5	5.8	111.9	15.3	71.5	49.9
Fatigue	45.0	4.6	92.0	93.1	27.6	6.0	78.2	17.0	84.0	56.9
Flatulence	44.6	11.1	80.0	91.2	24.0	2.2	68.1	6.1	76.6	51.8
Febrile Dis.	14.3	4.3	33.3	94.6	6.0	1.4	15.8	3.6	97.0	65.8
Gall Bladder Dis.	40.9	5.1	90.5	90.3	32.6	6.4	100.5	19.7	80.9	56.7
Gastritis	36.7	6.0	100.0	93.4	32.9	5.5	101.2	16.8	90.3	62.1
General Weakness	47.9	5.2	73.9	88.6	46.3	8.9	126.3	24.2	89.0	60.0
Goitre	39.2	10.3	100.0	82.3	43.3	4.2	115.3	11.2	85.7	57.0
Hay Fever	30.7	10.0	92.2	92.3	41.2	4.1	111.0	11.1	81.6	57.8
Headaches	38.7	7.3	86.1	98.7	9.0	1.2	26.5	3.6	93.2	68.1
Heart Dis.	47.9	7.6	89.7	90.6	36.8	4.8	104.2	13.7	74.3	51.3
Hemorrhoids	43.1	9.6	87.0	86.1	50.9	4.8	141.4	14.7	85.4	58.8
Herniated Discs	32.6	4.5	83.2	87.3	27.2	6.5	76.4	17.0	88.2	59.3
Herpes Zoster	52.7	12.4	86.7	89.3	33.6	2.8	102.5	8.2	86.7	59.7
High Blood Pressure	54.4	7.8	90.7	88.6	32.1	4.1	96.0	12.3	82.6	58.0
Hives	21.9	5.2	87.5	88.2	32.5	6.2	96.1	10.8	83.3	57.3
Hyper-Thyroidism	23.9	7.5	100.0	89.1	68.3	9.1	190.7	25.4	93.8	65.1
Indigestion	42.2	7.9	87.1	96.4	29.2	3.7	89.1	11.3	89.4	62.3
Insomnia	42.6	6.8	90.9	94.6	27.2	4.0	83.3	12.2	81.8	57.5
Intercostal Neuralgia	46.1	5.7	60.0	95.3	11.0	1.9	29.7	5.2	96.7	65.3
Jaundice	34.8	2.9	86.7	84.1	18.1	6.3	42.2	14.5	93.3	64.7
Kidney Disorders	41.3	7.9	89.1	88.3	43.2	5.5	110.1	14.0	81.9	57.1
Laryngitis	39.8	5.7	73.3	93.2	17.1	3.0	48.5	8.5	96.3	66.3
Liver Disorders	46.7	8.3	97.2	87.1	43.9	5.3	113.2	13.6	80.5	53.9
Low Blood Pressure	42.2	8.5	83.4	94.1	32.3	3.8	95.4	11.2	73.6	52.7

CONDITION	Av. Age of Patient (Yrs.)	Av. Dur. of Cond. (Yrs.)	% Prev. Med. Care	% Cases Accepted	Av. No. of Adj.	Av. Adj. Req. for ea. Yr. Ex.	Av. Days Under Chiro. Care	Av. Days Req. for ea. Yr. Ex.	% Results: X-ray & Other Exams	% Results: No X-ray
Lumbago	40.7	6.5	74.0	96.7	23.9	3.7	67.2	13.4	87.3	63.5
Lumbo-Sacro-Iliac Strain	44.8	4.2	56.7	97.6	23.7	5.6	47.5	11.4	86.7	58.2
Menopause	43.4	4.5	86.7	87.1	24.9	5.5	69.9	15.5	73.4	50.9
Menstrual Disorders	29.9	6.6	89.6	94.6	33.1	5.0	98.2	14.9	81.8	55.4
Mental Disorders	35.1	7.2	88.9	91.3	47.1	6.5	149.3	20.7	72.5	51.3
Migraine	38.0	11.0	92.8	93.6	38.7	3.5	103.4	9.4	86.6	59.1
Muscular Incoordination	34.7	6.6	86.5	91.0	27.8	4.2	84.6	12.8	78.4	54.8
Mult. Sclerosis	41.1	6.5	97.6	87.2	60.1	9.1	169.9	26.1	47.7	15.9
Neuritis	34.3	8.1	80.0	84.2	22.8	2.8	61.1	7.5	97.1	66.2
Nephritis	38.7	5.6	86.5	89.2	34.1	6.1	88.5	15.8	83.8	57.9
Nervousness	38.3	7.6	89.9	95.6	35.1	4.1	104.6	13.7	80.8	54.6
Nervous Stomach	46.2	5.3	80.0	93.2	44.7	8.4	116.8	22.0	86.6	58.3
Neuralgia	45.3	6.2	71.1	97.3	21.1	3.4	58.0	9.3	80.1	54.8
Neuritis	48.0	5.6	77.7	98.2	25.2	4.5	71.5	12.8	86.4	59.2
Obesity	37.5	11.8	88.2	82.1	47.3	4.0	123.6	10.5	62.9	41.3
Pain Shoulder & Back	41.8	5.7	60.7	96.5	22.5	3.9	61.1	10.7	87.5	60.2
Pain Hips & Legs	43.1	4.0	76.9	94.2	19.1	4.8	55.7	13.9	82.1	55.9
Pain Shoulder-Arms	45.8	4.3	73.0	97.1	33.1	7.9	92.2	21.4	89.2	61.4
Parkinson's Dis.	58.6	7.9	95.6	74.1	57.6	7.3	158.2	20.0	52.2	35.1
Palsy	47.3	7.2	97.3	78.4	63.7	8.8	173.3	24.1	56.7	38.4
Paralysis	41.4	6.4	85.4	73.6	42.8	6.7	111.4	17.4	68.8	45.0
Pleurisy	39.4	4.1	80.0	93.2	24.6	6.0	68.2	16.6	95.0	65.1
Pneumonia	33.2	16.4*	93.8	94.1	28.6	1.8*	77.6	4.7*	93.8	64.9
Polio (acute)	11.3	22.5*	41.2	93.6	34.6	1.5*	45.5	2.0*	97.8	80.2
Polio (chronic)	14.8	7.0	86.4	77.2	51.3	7.3	142.7	20.4	71.2	49.5
Prostate Trouble	53.1	9.6	83.4	87.3	42.9	4.7	116.7	12.1	83.7	58.1
Rheumatic Fever	27.0	5.5	92.6	91.2	52.2	4.0	145.9	26.5	96.3	65.3
Rheumatism	49.9	8.5	85.3	96.1	33.5	3.9	95.4	11.2	77.2	51.7
Sciatica	50.7	6.1	78.7	97.2	26.7	4.4	71.3	11.7	85.0	59.1
Sinusitis	39.9	8.8	90.5	93.1	32.3	3.6	93.5	10.6	83.2	57.3
Spinal Curvature	34.2	6.5	62.9	97.1	30.3	4.6	91.8	14.1	82.9	57.4
Stomach Disorder	41.0	8.3	88.3	91.3	31.2	3.8	93.6	11.3	82.5	59.1
Strabismus	13.0	6.8	89.3	91.6	57.6	8.5	153.8	22.6	80.4	55.9
Tic Douloureaux	47.4	7.4	84.1	87.2	46.2	6.2	123.9	16.7	77.3	53.7
Tonsillitis	20.9	4.5	81.1	92.3	23.4	5.2	62.6	13.9	91.9	63.7
Torticollis	37.0	6.9	53.4	98.6	11.4	1.6	24.1	3.5	93.2	64.6
Ulcers	44.4	7.3	96.4	91.3	46.2	6.4	122.1	16.7	80.2	57.2
Varicose Veins	43.7	7.9	73.0	86.1	32.7	4.1	94.1	11.9	81.0	56.0
Vertigo	44.3	4.7	82.3	94.6	42.1	8.9	115.4	24.5	86.3	59.9
Vomiting	27.6	6.3	100.0	92.1	24.3	3.8	68.9	10.9	86.6	58.8
Children's Acute Diseases	8.0	6.0*	78.2	93.2	4.1	.7*	6.0	1.0*	97.3	82.6
GENERAL DISORDERS OF THE SIX SYSTEMS OF THE BODY										
Nervous	37.9	8.2	91.3	96.2	34.9	4.2	106.3	12.9	90.8	67.3
Circulatory	48.1	7.9	90.6	91.3	38.1	4.8	102.7	13.5	75.1	51.3
Glandular	37.8	9.8	92.1	87.3	43.2	4.4	112.2	11.4	86.3	61.9
Digestive	38.2	8.1	91.2	92.3	32.7	4.0	91.1	11.2	91.0	63.5
Eliminative	41.3	9.6	88.4	92.1	32.3	3.4	94.1	9.8	87.6	64.3
Muscular	32.1	5.3	82.3	94.6	23.5	4.3	59.0	11.1	91.3	70.1
Overall	37.4	6.8	85.2	89.9	35.2	5.2	97.6	14.4	82.3	55.9

*Days

ROBERT M. KRESTAN, D.C.,
North Bergen, N.J., May 19, 1971.

I am pleased that you are interested in my offer and hope the following will answer all of the questions you may have.

For the past two years, I have been working with chiropractors in New York and New Jersey, on internship if you will, to sharpen my professional ability. And now, for many reasons, not the least of which is the expense of a professional education, after six years of study to become a chiropractor, I must turn to my future patients for assistance.

I need monies to furnish and equip an office in the Allentown-Bethlehem area. To acquire these funds, I am willing to exchange my services at a reduced fee for a prepaid, lump sum. A small investment of $725.00 will bring you one full year of professional, chiropractic treatments. An even smaller amount of $150.00 will give you six months of competent chiropractic therapy. In other words, a year is based on 100 office visits ($2.75 per), and six months 50 office visits ($3.00 per). There really is no time limit of a year or six months. Your treatments will be counted as 50 or 100. If you are an invalid requiring strictly house calls, the cost of your investment will have to be $600.00 for a year or 100 house visits.

I am sure you already realize the value in health and dollar savings to you. And I am as anxious to start your health program as you are. You may send money if you wish but it is not necessary at present. However, I would like to know if you are interested in my offer. After I have located an office, I will require the fee, prepaid, in order to furnish and equip it.

Yours truly,

R. N. KRESTAN, D.C.

LOQUASTO CLINIC OF CHIROPRACTIC,
November 23, 1971.

TO WHOM THIS MAY CONCERN:

History: Patient involved in a car accident on October 4, 1970.

Diagnosis: Intervertebral disc syndrome—severe with sciatic neuritis and paresthesia affecting both lower extremities. With Cervical-brachial plexus radiculitis and associated paresthesia affecting left arm to hand.

Treatment: Chiropractic spinal adjustments with physical therapy as indicated.

Prognosis: Patient has progressed from the point of walking with crutches and a cervical collar to a back support and at the present time no support. She still has limited range of motion and weakness in the lower back, also limited range of motion in the shoulder and left arm. She is still presently totally disabled and unable to do her usual duties.

Office visits: 131 at $9	$1,179.00
Oct. 6, 7, 8, 9, 12, 14, 15, 16, 22, 26, 30, 1970.	
Nov. 6, 9, 16, 17, 18, 19, 20, 23, 25, 27, 30, 1970.	
Dec. 1, 3, 4, 7, 9, 11, 14, 16, 18, 21, 23, 28, 30, 31, 1970.	
Jan. 2, 4, 7, 8, 11, 13, 15, 18, 19, 20, 22, 25, 26, 27, 29, 1971.	
Feb. 1, 2, 3, 5, 8, 12, 16, 17, 19, 22, 23, 25, 1971.	
Mar. 1, 5, 8, 11, 16, 18, 22, 25, 29, 1971.	
Apr. 5, 9, 13, 19, 21, 28, 1971.	
May 4, 6, 7, 10, 12, 17, 18, 21, 24, 27, 31, 1971.	
June 3, 8, 11, 16, 21, 22, 23, 25, 28, 30, 1971.	
July 6, 8, 16, 20, 22, 26, 28, 1971.	
Aug. 4, 6, 17, 19, 23, 25, 28, 30, 1971.	
Sept. 3, 7, 10, 20, 22, 27, 29, 30, 1971.	
Oct. 1, 4, 14, 20, 22, 27, 28, 1971.	
Nov. 9, 17, 1971.	
Weekend calls: 4 at $15	60.00
Oct. 10, 1970, Dec. 26, 1970.	
Sept. 5, 1971, Oct. 24, 1971.	
Consulation, first aid treatment and examination: 1 at $15, Oct. 5, 1970	15.00
Neurological and orthopedic examination: 2 at $15, Jan. 25, 1971 and June 28, 1971	30.00
Ice therapy and tapeing: 3 at $3, Jan. 8, 1971, May 7, 1971 and June 28, 1971	9.00

X-rays: 4 at $10, Oct. 9, 1970	$40.00
1—A to P cervical dorsal	10.00
1—lateral cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
1—Lateral cervical dorsal: 1 at $7	7.00
X-rays: 4 at $10, Oct. 30, 1971	40.00
1—A to P cervical dorsal	10.00
1—lateral cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
X-rays; 3 at $10, Dec. 3, 1970	30.00
1—A to P cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
X-rays; 4 at 10, Mar. 16, 1971	40.00
1—A to P cervical dorsal	10.00
1—lateral cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
X-rays: 4 at $10, May 31, 1971	40.00
1—A to P cervical dorsal	10.00
1—lateral cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
X-rays: 4 at $10, July 22, 1971	40.00
1—A to P cervical dorsal	10.00
1—lateral cervical dorsal	10.00
1—A to P lumbosacral	10.00
1—lateral lumbosacral	10.00
X-rays: 2 at $10, Sept. 29, 1971	20.00
1—A to P cervical dorsal	10.00
1—A to P lumbosacral	10.00
Laboratory (Lehigh Valley Labs, in Allentown, Pa.):	
Urinalysis: 1 at $5	5.00
Blood test: 1 at $27.50	27.50
Report of injuries	15.00
Total	1,597.50

CARBON COUNTY CHIROPRACTIC ASSOCIATION,
Palmerton, Pa.

DEAR PATIENTS AND FRIENDS: We are happy to announce the forthcoming Public Forum on "Your Health and Chiropractic".

This Forum will be presented by Dr. Reginald Gold, *one of the country's leading authorities on Chiropractic.* Dr. Gold is chairman of the Representative Assembly of the International Chiropractic Association and is a lecturer on the faculty of three Chiropractic colleges.

Dr. Gold is an outspoken critic of *"the indiscriminate use of prescription drugs"* claiming that much of the drug abuse on our college and high school campuses, today, is a result of the ready acceptance by the American public of pain killers,

tranquilizers, weight reducing pills and many other commonly used medications. He says that as long as parents teach, by example, that drugs are a harmless and acceptable solution to problems, they can hardly be surprised when their youngsters accept drugs as an easy escape from unpleasant situations.

Such questions as:

1. What is chiropractic?
2. How does the spine and nervous system affect my health?
3. Do all conditions respond to chiropractic?
4. Can children be treated by a chiropractor?
5. How does chiropractic feel about drugs?

will be answered in everyday terms that you can readily understand.

Where—Palmerton Area High School Auditorium (Fireline Road) Palmerton, Penna.

When—Sunday, May 16, 1971.

Time—3:00–4:00 p.m. (Question and answer period following).

Don't miss this tremendous program. Everyone invited—No admission.

EXHIBIT H

The Legislative Dilemma

Chiropractors are licensed to treat conditions beyond the scope of their abilities.

On one hand, legislators are confronted with overwhelming evidence that chiropractic is without scientific validity. On the other hand, many are deluged with letters from constituents who believe that chiropractors have helped them.

Because most people recover spontaneously, it may be difficult for patients to judge whether recovery from symptoms was related to their treatment.

We believe that most chiropractors are sincere and personable individuals but are confused about what they are doing. We recognize that they help some people with a combination of physical therapy, friendly interest and suggestive reassurance. Licensing laws, enacted to curtail abuses, are now used as a shield: "Since we are duly licensed, we should be covered by Medicare and other insurance plans." Present licensing laws do not insure quality health care. Until this is corrected, it is unfair to make taxpayers subsidise the chiropractic system.

Some legislators have told us that they enjoy back massages from chiropractors on a regular basis. Some are prone to minimize the significance of the data we present, on the theory that such abuses are limited to a small minority of "other chiropractors" which has its counterpart in other health professions.

This report is an attempt to demonstrate that there are very few "other chiropractors", and that chiropractic statements to the contrary are little more than misleading propaganda. We hope that the United States Congress will not yield to the political pressure of the well-financed chiropractic lobby.

Department of Health,
Section of Hospitals & Medical Facilities,
Lincoln, Nebr., February 9, 1972.

Hon. Russell B. Long,
Chairman of the Finance Committee, Committee on Finance, U.S. Senate, New Senate Office Building, Washington, D.C.

Dear Senator Long: It is my intent to suggest changes in the Social Security Act which will make it possible for more small facilities in rural areas to participate in programs established under Titles XVIII and XIX and provide some control on charges for care by reducing the overhead costs of the facility. My comments cover two points of law:

1. A facility or "a distinct part" as defined in Section 1861 J.
2. The determination of reasonable cost as defined in Section 1861 (v) (1) (A) and (B).

These requirements place compliance with the technical details of the program, rather than the welfare of the patients, as the basis for establishing and maintaining staffing patterns for patient care. (See Attachment #1).

Experience indicates that a long-term care unit, either skilled nursing care, extended care facility, or intensive care facility, operates economically and at a satisfactory professional level when the unit has sixty or more beds. The information received from many operators in this State is that the sixty-bed capacity is the beginning point for a sound fiscal program for the institution.

It appears to me that H.R. 1 amendments to Section 229, beginning on page 99 of the House bill, emphasizes the "distinct part" requirement. I respectfully suggest that this action would further militate against a reasonable program of care in a rural state such as Nebraska. (See Maps Attachment #2)

I respectfully suggest that the requirements put the Government into the detailed supervision of the administration of these various facilities rather than stipulating the levels of care that the patients are to be provided and methods of paying for such care. Where many of our institutions in Nebraska have a total capacity of less than 100 beds to serve the community in either acute care, long-term care, or both, that the requirement for a "distinct part" is unrealistic, uneconomical, and is the main reason why many of the smaller institutions throughout the rural parts of our State have not been able to meet requirements for participation.

In reference to the determination of reasonable cost as defined in Section 1861 (v.), I respectfully call to your attention that the law provides "such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs". However, the requirements of sentences (A) and (B) restrict the choice provided in the above quoted part by stipulating the following: "Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect 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 in individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement introduced by the methods of determining costs proves to be either inadequate or excessvie." The effect of this stipulation is to establish a cost accounting for each "distinct part" and eliminates the possibility of a "per diem, per unit, per capita, or other basis . . . . .". This cost accounting requirement for each "distinct part" places the facility in hazard to subsequent audits which might question the distribution of costs for services rendered to any, or all, of the "distinct parts". This has occasioned a considerable financial burden on a facility providing such services when audits made subsequently take exceptions to such distribution of costs and require repayment of funds from the facility. For nonprofit institutions this poses an extreme hazard to their economic stability. In such instances, there has been no question of the facility providing the services for which it was paid, only the distribution of costs between the "distinct parts". (See Attachment #3 relating to St. Mary's Hispital in Nebraska City)

Added evidence of financial difficulty when cost accounting and charging for care on a "distinct part" is given in the auditor's report on Jefferson County Memorial Hospital, Fairbury, Nebraska. A news clipping indicates other communities are in similar circumstances. (See Attachment #4)

It is respectfully suggested that the elimination of sentences (A) and (B) Section 1861 (v) (1) would permit the establishment of costs for authorized services on an audited flat rate cost unit basis. This would make audits meaningful as to whether services were provided, as charged; not the administrative division of costs between "distinct parts."

Respectfully submitted.

VERNE A. PANGBORN., *Director.*

[Attachment 1]

COMMENTS ON H.R. 1 FROM VERNE A. PANGBORN

Friend, Warren Memorial Hospital

This hospital in a southeast Nebraska community of 1,069 is attempting to supply medical services to the community. The hospital has 47 beds all on one floor. Thirty-eight are in the new section and classified as acute. Nine beds in the old section could be chronic or convalescent and classified as "skilled" under Medicaid. All 47 beds are served from the same nurses' station.

If only acute level care is provided in all 47 beds, one R.N. on each shift of each twenty-four hour period will meet the regulation. However, when we classify the nine beds in the old unit as a "distinct part", another professional person (R.N. or L.P.N.) must be employed on each shift to meet the regulation.

The facility is now providing a lower level of care in nine of the 47 beds but must double the R. N. or L. P. N. coverage to meet requirements of Medicaid and which can only be reflected by increased cost without measurable increase in benefits to the patient.

There is another hospital in Saline County at Crete, about 18 miles distance, which has 66 acute beds.

Oxford, Fritzer Memorial Hospital

This hospital is located in southeast Nebraska, Furnas County, in a community of 1,090. The nearest hospital is about 20 miles distance at Alma. The Oxford hospital is licensed for 30 acute beds. The 66 bed nursing home in Oxford, which is operated by the same corporation as the Oxford hospital, is providing care under Medicaid.

If shared nursing were permitted, a skilled ICF level of care could be provided.

The *competition* for *professional* personnel in this community has caused the hospital to be deficient in supplying adequate R. N. coverage for many months, and they may be forced to drop the Medicare certification.

Oakland, Oakland Memorial Hospital

This hospital in northeast Nebraska, Burt County, is located in a community of 1,429. The closest hospital is 14 miles at West Point. This Oakland facility is licensed for 20 acute and 20 chronic beds.

Under program regulations, separate professional staffing would be required to be in compliance in each section. (Unless both areas are running a high rate of occupancy at the same time.) Some consideration should be made to permit both 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. shifts to be under the direction of an R. N. or L. P. N. with sufficient aides to meet patient care needs in both sections.

This report is prepared "with a concern for the care of the patients in mind".

By Joe Hageman, Director, Division of Standards, Nebraska State Department of Health; and Verne A. Pangborn, Director, Section of Hospital and Medical Facilities, Nebraska State Department of Health.

[Attachment 2]

TESTIMONY BY VERNE A. PANGBORN

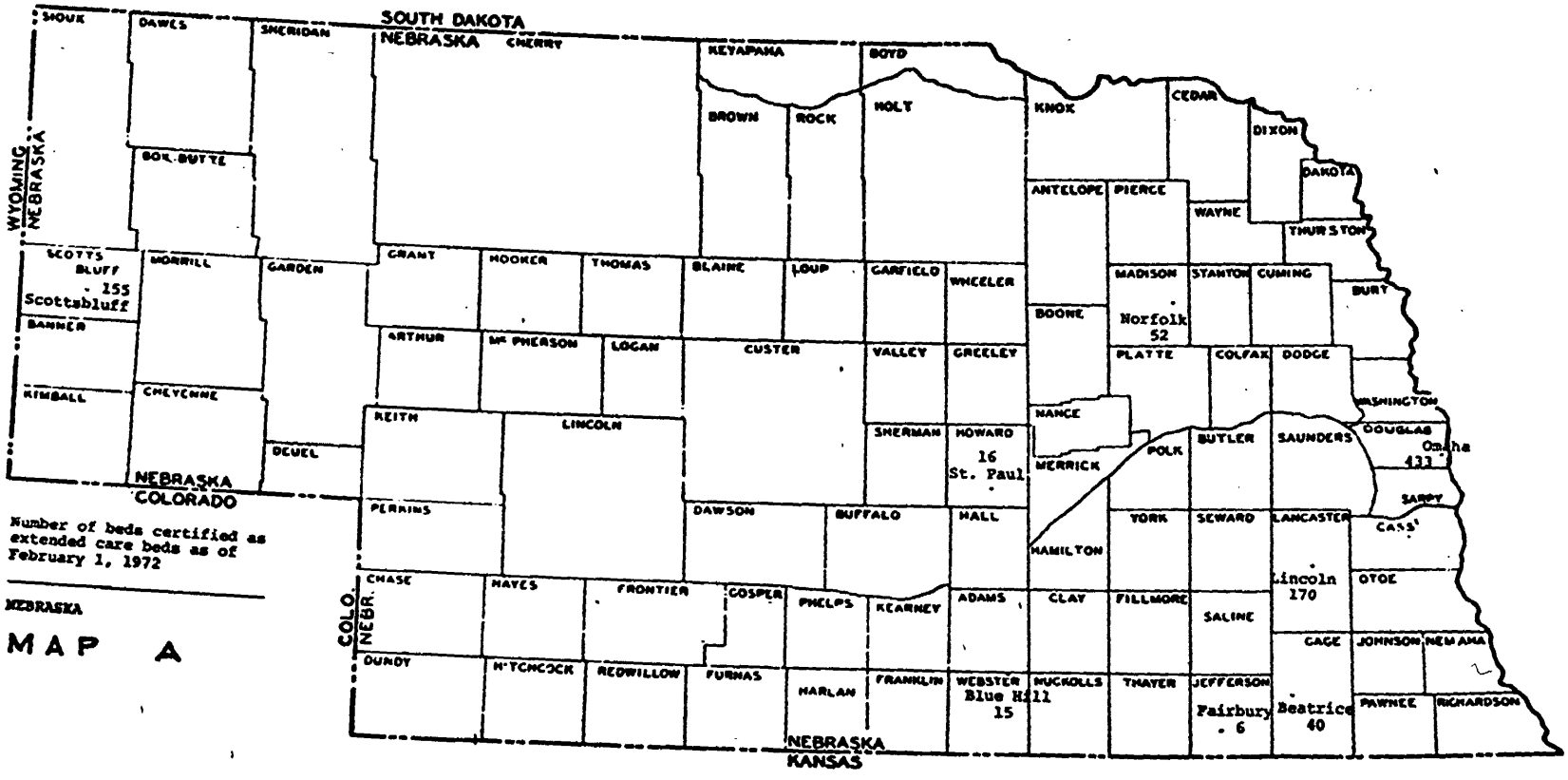
Map A shows the number and location of beds certified for extended care under Title XVIII,

Map B shows all licensed freestanding long-term care beds.

Map C shows long-term care beds as units of a community hospital, and

Map D shows acute care beds in general hospitals

All delineate resources available but not certified largely because of lack of financial feasibility of meeting Federal requirements.

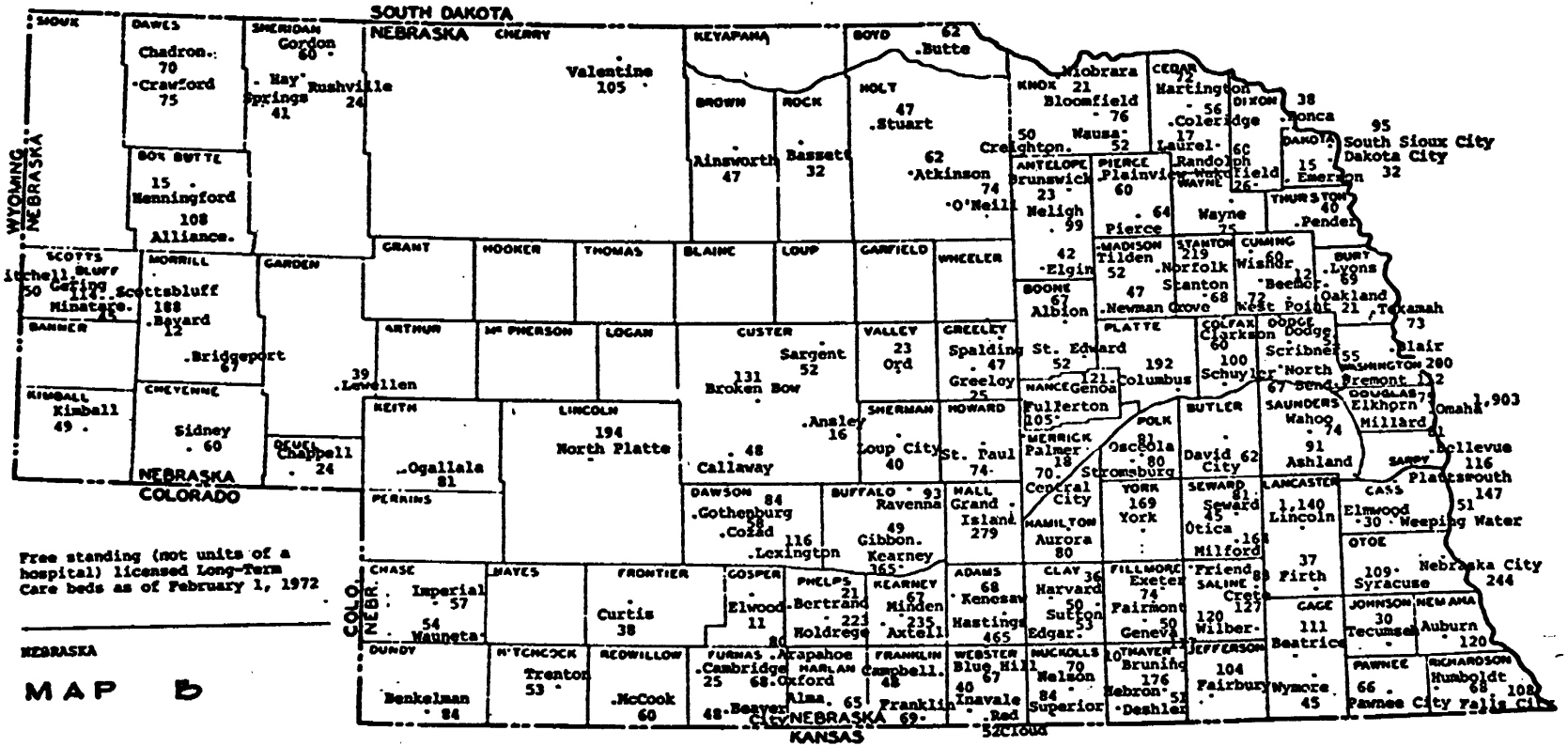


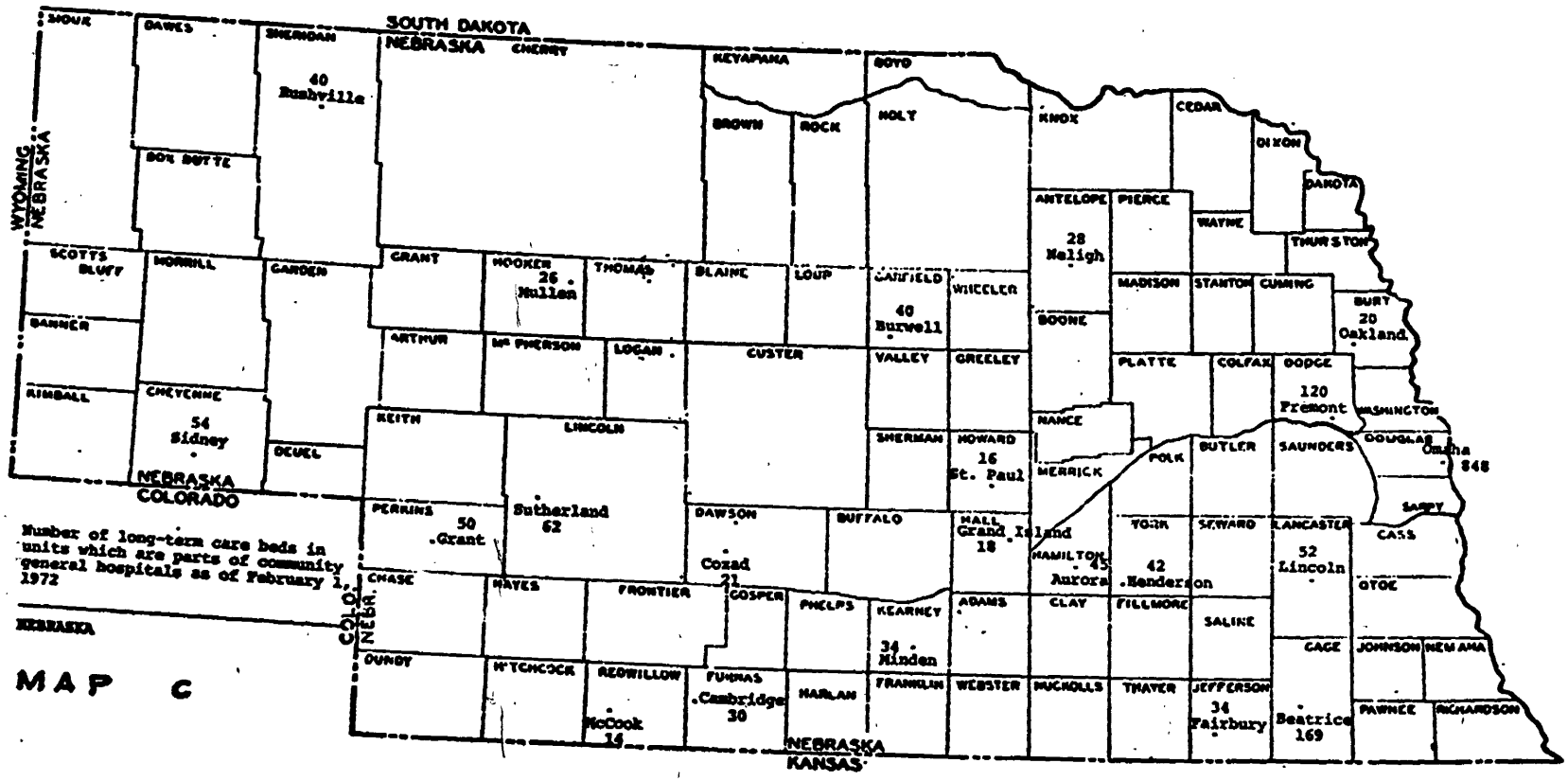
Number of beds certified as extended care beds as of February 1, 1972

NEBRASKA

MAP A

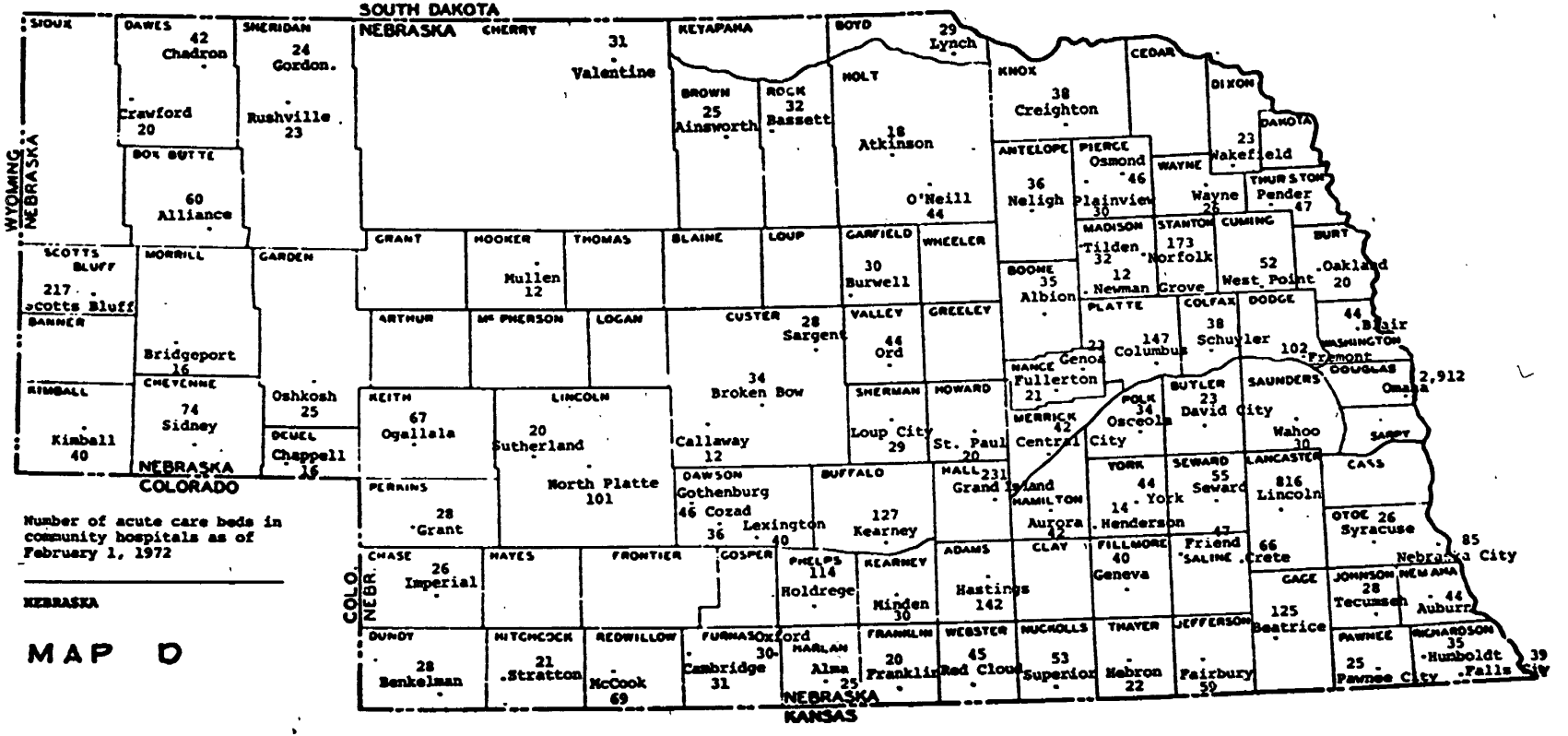
3133


SOUTH DAKOTA
NEBRASKA
WYOMING
COLORADO
KANSAS
Free standing (not units of a hospital) licensed Long-Term Care beds as of February 1, 1972
NEBRASKA
MAP B



Number of long-term care beds in units which are parts of community general hospitals as of February 1, 1972

MAP C



Number of acute care beds in community hospitals as of February 1, 1972

NEBRASKA

MAP D

3136

[Attachment 3]

ST. MARY'S HOSPITAL,
Nebraska City, Nebr., September 10, 1971.

Senator CARL T. CURTIS,
Washington, D.C.

DEAR SENATOR CURTIS: Greetings from Nebraska! Things at St. Mary's Hospital are not so rosy at present. We had our hospital accreditation survey August 10. The standards for accreditation for the Geriatrics department were so high that we are unable to meet them. For instance, they say we must have an R.N. or L.P.N. on duty 24 hours a day in that Department instead of the 56 hours a week required by the State.

This would make the costs so high that patients could not afford the cost. In other words we must operate this area the same as all other areas of the hospital. Therefore, the only thing we can do is follow the recommendations of the Lay Advisory Board and close the unit.

This is, indeed, a sad event at St. Mary's as we feel we are doing a good service to the people of Nebraska City in really helping to keep people from having to be admitted to the acute area of the hospital.

I am enclosing the news release that appeared in the local paper. I hope things are going well for you in Washington.

Respectfully,

Sister M. CLARA HEITMAN, O.S.F.,
Administrator.

(Enclosure.)

St. Mary's hospital announced today that effective November 1 the geriatrics department on Second floor will be closed. Patients and their families were notified a few days ago of this reluctant step.

Sister Clara Heitman, the administrator of St. Mary's, said the hospital is closing the department with the greatest of regret but that the move is necessary because the hospital is no longer in a position to absorb the increased expenses connected with such a division as we have done in the past.

The advice to close the Second floor to long-term nursing home-type patients came after long consideration by the lay advisory board. After reviewing the financial situation again the board unanimously adopted a resolution urging that the geriatrics department be eliminated from the hospital.

Two reasons were given for the move:

1. The hospital is being severely penalized by medicare because of the geriatrics department. Medicare reimburses the hospital for the bare cost of caring for medicare patients. The Medicare regulations require that allocated costs be applied on the same basis to our geriatric patients as to the patients in the acute care section of the hospital. This is wrong because there is a difference between these patients as they do not require the same care.

2. After a recent survey of St. Mary's hospital for accreditation purposes the hospital was notified that in order to meet the standards of accreditation a registered nurse or a licensed practical nurse must be on duty in the geriatrics department 24 hours each day. Present charges for patient care in this department would not cover this added, more expensive service. The hospital and physicians feel it is vital that St. Mary's continue to be an accredited hospital.

By closing the geriatric department at St. Mary's Hospital an estimated $30,000.00 net gain in revenue over expenses will be realized annually.

Attachment #4

VANBOSKIRK · FRY · TRUMBLE
AND ASSOCIATES
ESTABLISHED 1922
Certified Public Accountants

WILLIAM A. FRY, C.P.A.
LELAND B. VANBOSKIRK, C.P.A.
DONALD M. TRUMBLE, C.P.A.
ARNOLD H. WHITE, C.P.A.
W. FRED REESE, C.P.A.

NORVEL L. JACOBS

MEMBERS AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
806 WALTON BUILDING
816 NORTH ELEVENTH STREET
LINCOLN, NEBRASKA 68508

C. E. REMINGTON, C.P.A.
CONSULTANT

Branch Offices
FAIRBURY, NEBRASKA
W. FRED REESE, C.P.A., MGR.
NORFOLK, NEBRASKA
CHARLES HAASE, C.P.A., MGR.

January 7, 1972

JEFFERSON COUNTY MEMORIAL HOSPITAL

FAIRBURY, NEBRASKA

DEPARTMENTAL GAINS AND LOSSES
September 30, 1971

AB:my

JEFFERSON COUNTY MEMORIAL HOSPITAL
DEPARTMENTAL GAINS AND LOSSES COMPUTED
ON THE BASIS OF DEPARTMENTAL COST FINDING
For the Year Ended September 30, 1971

Department	Departmental Income	Direct Costs	Gross Margin	Allocated Overhead	Net Departmental Gains (Losses)
Routine patient care	405 896	179 867	226 029	193 102	32 927
Operating room	23 210	11 913	11 297	13 665	(2 368)
Delivery room	6 450	3 327	3 123	4 686	(1 563)
Nursery	15 910	612	15 298	13 065	2 233
Radiology	43 825	23 623	20 202	21 277	(1 075)
Laboratory	79 156	43 897	35 259	11 225	24 034
Anesthesiology	3 467	1 770	1 697	284	1 413
EKG	8 222	283	7 939	45	7 894
Pharmacy	65 749	26 193	39 556	7 587	31 969
Central supply	39 040	38 681	359	15 062	(14 703)
Inhalation therapy	7 636	1 190	6 446	190	6 256
Physical therapy	32 387	25 364	7 023	10 690	(3 667)
IV administration	11 517	6 841	4 676	1 094	3 582
Outpatient service	3 746	54	3 692	3 462	230
Nursing home	139 348	78 976	60 372	127 097	(66 725)
ECF unit	49 739	2 151	47 588	12 794	34 794
Totals	935 298	444 742	490 556	435 325	55 231
Deductions:					
Medicare adjustments - Inpatients				50 378	
- ECF				32 273	
County allowances - Hospital				1 188	
- Nursing home				4 551	
Blue Cross-Blue Shield discounts				639	
Employee discounts				132	89 161
Net Operating Loss for Year					(33 930)
Add interest income					3 062
Net Deduction from Surplus					(30 868)

JEFFERSON COUNTY MEMORIAL HOSPITAL
SUMMARY OF OPERATIONS
For the Year Ended September 30, 1971

Hospital Operations:				
Gross income		746 211		
Deduct:				
Medicare adjustments	50 378			
County allowance	1 188			
Other discounts	771	52 337		
Net Operating Income			693 874	
Expenses:				
Direct costs		363 615		
Overhead costs		295 434	659 049	
Net Operating Gain			34 825	
Add interest income			3 062	
Total Addition to Surplus Hospital Operation				37 887
Extended Care Facility:				
Gross income			49 739	
Deduct:				
Medicare adjustment			32 273	
Net Operating Income			17 466	
Expenses:				
Direct costs		2 151		
Overhead costs		12 794	14 945	
Net Operating Gain - Addition to Surplus Extended Care Facility				2 521
Nursing Home:				
Gross income		139 348		
Deduct:				
County allowances		4 551		
Net Operating Income			134 797	
Expenses:				
Nursing services		78 976		
Depreciation		12 770		
Administration		16 676		
Employee health and welfare		5 428		
Operation of plant		13 031		
Laundry		9 906		
Housekeeping		10 718		
Dietary		58 568	206 073	
Total Deduction from Surplus Nursing Home Operation				(71 276)
Total Reduction in Surplus				(30 868)

JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.

FAIRBURY, NEBRASKA

Report for the Year Ended
September 30, 1971

JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.

I N D E X

VANBOSKIRK · FRY · TRUMBLE
AND ASSOCIATES
ESTABLISHED 1933
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NORFOLK, NEBRASKA
CHARLES HAASE, C.P.A., MGR.

Board of Directors
Jefferson County Memorial Hospital, Inc.
Fairbury, Nebraska

Gentlemen:

We have made an examination of the records of your hospital for the year ended September 30, 1971, and have prepared a balance sheet as of that date and operating statements for the year ended September 30, 1971, and other supporting schedules.

Without making a detailed examination of transactions, we have examined or tested the accounting records to the extent considered necessary for the purpose of the report.

Since the scope of our examination at this time did not include all of the auditing procedures necessary to render an opinion, we do not express an opinion on the accompanying statements.

VanBoskirk Fry Trumble & Assoc.

December 18, 1971
WFR:AB:my

SCHEDULE 1
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
BALANCE SHEET
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

	September 30, 1971	September 30, 1970
ASSETS		
Current:		
Petty cash	200 00	200 00
Net bank account balance - Operating Account	13 746 83	32 560 10
Net bank account balance - Capital Account	2 791 13	2 306 69
Short-term U.S. Government obligation (at cost)		50 000 00
Certificates of deposit	35 000 00	
Savings Account	16 237 94	
Accounts receivable - Patients	152 122 86	129 316 96
Due from Medicare - September 30, 1970	11 892 00	41 892 00
Due from Medicare - September 30, 1971	32 080 00	
Inventories	54 322 56	46 400 28
Prepaid expenses	10 933 29	6 070 24
Total Current Assets	329 326 61	308 746 27
Fixed (Schedule 9):		
Intangible	52 162 01	52 162 01
Land	13 942 78	13 942 78
Building	651 841 37	651 841 37
Fixed equipment	399 873 85	399 873 85
Other equipment	272 552 61	266 700 88
Total	1 390 372 62	1 384 520 89
Accumulated depreciation	566 022 33	484 226 43
Net Book Value of Fixed Assets	824 350 29	900 294 46
Total Assets	1 153 676 90	1 209 040 73

SCHEDULE 1
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
BALANCE SHEET - Continued
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

	September 30, 1971	September 30, 1970
LIABILITIES AND EQUITY		
Current:		
Accounts payable - Trade	19 353 08	17 197 67
Accrued payroll taxes	6 041 50	9 802 70
Notes payable - Due within one year	12 307 59	34 307 59
Accrued interest	2 490 45	2 564 80
Accrued payroll	7 218 25	7 024 93
Due Medicare - September 30, 1967		6 839 00
Due Medicare - September 30, 1968	22 233 00	22 233 00
Due Medicare - September 30, 1969	5 522 00	5 522 00
Due Medicare E.C.F. - September 30, 1970	9 576 00	9 576 00
Due Medicare E.C.F. - September 30, 1971	9 480 00	
Total Current Liabilities	94 221 87	115 067 69
Long-Term Debt:		
Mortgage loan payable	412 209 43	424 517 02
Less amount due within one year	12 307 59	12 307 59
Total Long-Term Debt	399 901 84	412 209 43
Equity:		
Pledges	508 115 33	500 389 98
Less unpaid pledges	4 470 49	5 043 81
	503 644 84	495 346 17
Hill Burton contributions	483 645 03	483 645 03
Equity - Other	5 784 32	5 784 32
Retained earnings (deficit) - September 30 - (Schedule 1A)	(333 521 00)	(303 011 91)
Total Equity	659 553 19	681 763 61
Total Liabilities and Equity	1 153 676 90	1 209 040 73

SCHEDULE 1A
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
SCHEDULE OF CHANGES IN CURRENT YEAR RETAINED EARNINGS
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

	1971	1970
Retained Earnings - October 1 (deficit)	(303 011 91)	(212 870 77)
Add Medicare Adjustments:		
1967		(6 839 00)
1968		(22 233 00)
1969		(5 522 00)
Loss year ended September 30	(30 868 09)	(55 547 14)
Balance	(333 880 00)	(303 011 91)
Deduct adjustment for 1967 Medicare settlement	359 00	
Retained Earnings - September 30	(333 521 00)	(303 011 91)

SCHEDULE 1B
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
INVENTORY SCHEDULE
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

Supplies - Administrative	854 99
- Dietary	4 704 65
- Housekeeping	880 77
- Laundry and linen	3 421 33
- Plant	4 243 05
- Medical and drug - Nursery	49 50
- Pharmacy	20 939 83
- Radiology	1 110 87
- Lab	4 224 96
- Medical records	1 534 33
- Central supply	11 911 73
- Physical therapy	446 55
Total	54 322 56

SCHEDULE 2
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
SUMMARY INCOME STATEMENT
(UNAUDITED FINANCIAL STATEMENTS)

	Fiscal Year Ended September 30, 1971				Fiscal Year Ended September 30, 1970			
	Nursing Home	Extended Care	Hospital	Total	Nursing Home	Extended Care	Hospital	Total
Operating revenue (Schedule 4)	156 931 93	58 730 35	719 636 21	935 298 49	167 937 87	51 546 07	614 139 41	833 623 35
Adjustments to revenue (Schedule 8)	(4 551 39)	(32 273 21)	(52 336 40)	(89 161 00)	(8 389 12)	(25 899 23)	(16 226 17)	(50 514 52)
Net Operating Revenue	152 380 54	26 457 14	667 299 81	846 137 49	159 548 75	25 646 84	597 913 24	783 108 83
Less Operating Costs before Depreciation and Interest:								
Salaries (Schedule 6)				522 775 17				489 619 65
Supplies and other (Schedule 6)				258 558 97				244 496 01
				781 334 14				734 115 66
Operating Gain before Depreciation and Interest				64 803 35				48 993 17
Less: Interest				31 288 89				31 540 28
Depreciation				81 795 90				91 664 22
				113 084 79				123 204 50
Net Operating Gain (Loss)				(48 281 44)				(74 211 33)
Other income (Schedule 7)				14 351 31				13 225 82
Interest income				3 062 04				5 438 37
Reduction in Retained Earnings				(30 868 09)				(55 547 14)

SCHEDULE 3
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
STATEMENT OF SOURCES AND USES OF FUNDS
For the Year Ended September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

Fund Sources:		
From Operations:		
Net loss for the year (Schedule 2)	(30 868 09)	
Add depreciation which reduced net income but did not require a cash outlay	81 795 90	50 927 81
Disposal of investment securities		50 000 00
Net increase in pledges to hospital		8 298 67
Total Sources of Funds		109 226 48
Fund Uses:		
Increase in surplus - Prior year adjustment	(359 00)	
Acquisition of equipment	5 851 73	
Increase in receivables	24 885 90	
Increase in inventories	7 922 28	
Increase in prepaid expenses	4 863 05	
Purchase of other investments	51 237 94	
Payment on mortgage loan payable	12 307 59	
Decrease in current liabilities	20 845 82	
Total Uses of Funds		127 555 31
Decrease in Cash Funds		(18 328 83)
Cash on Hand - October 1, 1970:		
Operating Account	32 560 10	
Capital Account	2 306 69	34 866 79
Cash on Hand - September 30, 1971:		
Operating Account	13 746 83	
Capital Account	2 791 13	16 537 96

SCHEDULE 4
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
ANALYSIS OF REVENUE
For the Year Ended September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

	MEDICARE			WELFARE			REGULAR						
	In-Patients	Out-Patients	Total	In-Patients	Out-Patients	Total	In-Patients	Out-Patients	Total	Total Hospital	Nursing Home	Extended Care Facility	Total
Routine services	248 348 00		248 348 00	8 706 00		8 706 00	131 069 50		131 069 50	388 123 50	139 347 97	49 739 00	577 210 47
Routine service - Obst.				841 00		841 00	16 931 00		16 931 00	17 772 00			17 772 00
Routine service - Newborn				590 00		590 00	15 320 30		15 320 30	15 910 30			15 910 30
Operating room	4 950 00		4 950 00	470 00		470 00	16 050 00		16 050 00	21 470 00			21 470 00
Recovery room	340 00		340 00	40 00		40 00	1 360 00		1 360 00	1 740 00			1 740 00
Delivery room				250 00		250 00	6 200 00		6 200 00	6 450 00			6 450 00
Anesthesiology	549 50	15 00	564 50	87 75	1 50	89 25	2 647 25	166 50	2 813 75	3 467 50			3 467 50
Diagnostic radiology	19 024 00	2 233 50	21 257 50	647 00	192 00	839 00	15 357 50	6 243 50	21 601 00	43 697 50		127 00	43 824 50
Lab diagnostic	39 050 50	834 50	39 885 00	1 545 50	47 00	1 592 50	30 788 00	1 686 50	32 474 50	73 952 00		1 398 50	75 350 50
Electrocardiology	5 645 00	12 50	5 657 50	82 50		82 50	2 352 50	67 50	2 420 00	8 160 00		62 50	8 222 50
Physical therapy	8 970 50	11 020 00	19 990 50	131 00	1 488 00	1 619 00	3 592 00	4 557 50	8 149 50	29 759 00		2 627 50	32 386 50
Pharmacy	24 185 56	322 18	24 507 74	1 505 03	44 80	1 549 83	22 662 13	3 335 42	25 997 55	52 055 12	10 776 91	2 916 99	65 749 02
Inhalation therapy	5 566 00		5 566 00	399 50		399 50	1 486 00	2 00	1 488 00	7 453 50		183 00	7 636 50
Blood bank	2 280 00		2 280 00	60 00		60 00	1 260 00	166 00	1 426 00	3 766 00		40 00	3 806 00
Intravenous solutions	5 350 00		5 350 00	244 50		244 50	5 901 20	9 50	5 910 70	11 505 20		12 00	11 517 20
Central supply	11 840 14	226 81	12 066 95	768 92	12 50	781 42	14 459 54	1 114 23	15 573 77	28 422 14	6 807 05	1 602 86	36 832 05
Physical therapy equipment	100 75	1 560 30	1 661 05		39 52	39 52	240 42	246 01	486 43	2 187 00		21 00	2 208 00
Emergency room	35 00	252 50	287 50	12 50	54 50	67 00	202 50	3 188 45	3 390 95	3 745 45			3 745 45
Totals	376 234 95	16 477 29	392 712 24	16 381 20	1 879 82	18 261 02	287 879 84	20 783 11	308 662 95	719 636 21	156 931 93	58 736 35	935 298 49

SCHEDULE 5
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
COMPARISON OF REVENUE
(UNAUDITED FINANCIAL STATEMENTS)

	MEDICARE		WELFARE		REGULAR		NURSING HOME		EXTENDED CARE	
	10-1-70 to 9-30-71	10-1-69 to 9-30-70	10-1-70 to 9-30-71	10-1-69 to 9-30-70	10-1-70 to 9-30-71	10-1-69 to 9-30-70	10-1-70 to 9-30-71	10-1-69 to 9-30-70	10-1-70 to 9-30-71	10-1-69 to 9-30-70
Routine services	248 348 00	205 242 00	8 706 00	5 216 00	131 069 50	107 052 00	139 347 97	148 630 34	49 739 00	40 958 50
Routine service - Obstetrical			841 00	340 00	16 931 00	12 510 00				
Routine service - Newborn			590 00	618 00	15 320 30	8 915 20				
Operating room	4 950 00	5 495 00	470 00	462 50	16 050 00	15 330 00				
Recovery room	340 00	345 00	40 00	50 00	1 360 00	1 245 00				
Delivery room			250 00	100 00	6 200 00	4 525 00				
Anesthesiology	564 50	585 45	89 25	76 75	2 813 75	2 598 30				1 00
Diagnostic radiology	21 257 50	20 688 00	839 00	394 50	21 601 00	16 282 00			127 00	376 50
Lab diagnostic	39 885 00	33 147 50	1 592 50	1 025 85	32 474 50	25 564 00		3 00	1 398 50	876 00
Electrocardiology	5 657 50	4 097 50	82 50	187 50	2 420 00	2 130 00			62 50	35 00
Physical therapy	19 990 50	24 063 50	1 619 00	1 160 00	8 149 50	12 944 50		160 00	2 627 50	4 073 00
Pharmacy	24 507 74	27 809 68	1 549 83	833 11	25 997 55	23 587 75	10 776 91	12 626 58	2 916 99	3 073 33
Inhalation therapy	5 566 00	6 238 50	399 50	220 50	1 488 00	747 50			183 00	463 00
Blood bank	2 280 00	1 646 00	60 00		1 426 00	1 052 00			40 00	54 00
Intravenous solutions	5 350 00	4 952 01	244 50	141 50	5 910 70	4 398 00			12 00	45 50
Central supply	12 066 95	12 796 02	781 42	375 66	15 573 77	12 556 07	6 807 05	6 517 95	1 602 86	1 503 74
Physical therapy equipment	1 661 05	686 31	39 52	18 92	486 43	129 13			21 00	86 50
Emergency room	287 50	377 30	67 00	20 00	3 390 95	3 162 40				
Totals	392 712 24	348 169 77	18 261 02	11 240 79	308 662 95	254 728 85	156 931 93	167 937 87	58 730 35	51 546 07

SCHEDULE 6

JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.

SCHEDULE OF SALARIES, SUPPLIES AND OTHER EXPENSE

(UNAUDITED FINANCIAL STATEMENTS)

	September 30, 1971			September 30, 1970		
	Salaries	Supplies and Other Expense	Total	Salaries	Supplies and Other Expense	Total
Administrative and general	32 131 63	31 765 29	63 896 92	32 458 17	24 301 98	56 760 15
Dietary	56 224 70		56 224 70	55 915 54		55 915 54
Dietary - Raw food		35 717 77	35 717 77		38 160 53	38 160 53
- Other		4 565 35	4 565 35		5 218 34	5 218 34
- Nursery		230 11	230 11		207 62	207 62
Housekeeping	29 774 75	7 392 80	37 167 55	29 587 47	6 963 55	36 551 02
Laundry	18 389 78	263 15	18 652 93	16 303 74	3 013 43	19 317 17
Linen		2 462 65	2 462 65		6 623 61	6 623 61
Operation of plant	12 096 79	18 060 40	30 157 19	9 939 95	15 381 60	25 321 55
Medical and surgical		1 209 68	1 209 68		4 918 45	4 918 45
Medical and surgical - Nursery		382 01	382 01		312 34	312 34
Motor service		502 74	502 74		515 73	515 73
Nursing	260 804 38	191 50	260 995 88	238 180 23	207 73	238 387 96
Intravenous solutions		6 841 44	6 841 44		5 334 40	5 334 40
Pharmacy	7 411 76	18 788 54	26 200 30	7 140 58	21 276 05	28 416 63
Medical records and library	12 410 63	1 942 53	14 353 16	9 803 21	2 318 71	12 121 92
Operating room	9 482 63	2 430 33	11 912 96	9 414 88	2 867 86	12 282 74
Delivery room	3 303 95	23 50	3 327 45	3 247 52	285 08	3 532 60
Anesthesiology		1 769 57	1 769 57		1 595 01	1 595 01
Radiology	14 907 09	22 740 27	37 647 36	14 656 13	20 499 09	35 155 22
Laboratory	24 606 31	16 180 92	40 787 23	20 698 89	16 816 65	37 515 54
Electrocardiology		283 15	283 15		322 75	322 75
Physical therapy	23 534 25	1 830 15	25 364 40	27 051 37	565 53	27 616 90
Inhalation therapy		1 190 06	1 190 06		1 422 30	1 422 30
Blood bank		3 110 00	3 110 00		3 222 00	3 222 00
Central supply	17 696 52	22 042 50	39 739 02	15 221 97	15 924 65	31 146 62
Telephone and telegraph		4 002 69	4 002 69		3 380 75	3 380 75
Employee benefits and social security		29 066 01	29 066 01		27 889 79	27 889 79
Insurance		4 452 57	4 452 57		2 329 76	2 329 76
Repairs and maintenance		14 739 17	14 739 17		8 260 26	8 260 26
Emergency room		54 30	54 30		300 22	300 22
Sales tax		172 15	172 15		-0-	
Accounting services		3 727 82	3 727 82		3 588 67	3 588 67
Legal services		427 85	427 85		471 57	471 57
Totals	522 775 17	258 558 97	781 334 14	489 619 65	244 496 01	734 115 66

SCHEDULE 7
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
OTHER INCOME
(UNAUDITED FINANCIAL STATEMENTS)

	For the Year Ended 9-30-71	9-30-70
Recovery of accounts charged off	170 60	306 14
General contributions		1 383 00
Meals sold	9 198 49	8 340 36
T.V. rental - Hospital	1 722 00	1 300 00
- Nursing Home	352 00	610 00
Telephone and telegraph	108 88	113 92
Medical records - Transcripts	291 00	313 00
Supplies sold	296 12	291 08
Drugs sold	8 00	295 44
Sales taxes collected on supplies sold	221 50	81 02
Finance charges	1 972 12	191 86
Laundry	10 60	
Totals - Other Income	14 351 31	13 225 82

SCHEDULE 8
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
ADJUSTMENTS TO REVENUE
(UNAUDITED FINANCIAL STATEMENTS)

	For the Year Ended 9-30-71	9-30-70
Uncollectible accounts		(8 425 82)
Adjustments - Blue Cross-Blue Shield - In-patient	(627 22)	(486 07)
- Blue Cross-Blue Shield - Out-patient	(11 65)	(8 30)
- Welfare - In-patient	(1 678 95)	(2 025 25)
- Welfare - Out-patient	490 66	100 27
- Welfare - Nursing Home	(4 551 39)	(8 389 12)
- Employees	(131 60)	(41 75)
Medicare adjustment	(50 377 64)	(5 339 25)
Extended care Medicare adjustment	(32 273 21)	(25 899 23)
Total Deductions from Revenue	(89 161 00)	(50 514 52)

SCHEDULE 9
JEFFERSON COUNTY MEMORIAL HOSPITAL
STATEMENT OF FIXED ASSETS AND DEPRECIATION
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

	Meth.	Rate or Life	Cost	Accum. Deprec. 10-1-70	Deprec. for Year	Accum. Deprec. 9-30-71
Hospital:						
Intangible (Sch. 10)	SL	20%	40 415 31	32 975 30	7 440 01	40 415 31
Land			9 062 81			
Building	DB	40 yrs.	499 781 90	100 819 97	19 948 10	120 768 07
Fixed equipment	DB	18 yrs.	312 863 82	118 341 27	21 613 40	139 954 67
Movable equipment	DB	12 yrs.	232 731 66	114 986 54	19 628 11	134 614 65
Total Hospital			1 094 855 50	367 123 08	68 629 62	435 752 70
Nursing Home:						
Intangible (Sch. 10)	SL	20%	11 746 70	11 746 70		11 746 70
Land			4 879 97			
Building	DB	40 yrs.	152 059 47	39 104 83	5 647 73	44 752 56
Fixed equipment	DB	18 yrs.	87 010 03	40 598 75	5 156 76	45 755 51
Movable equipment	DB	12 yrs.	39 820 95	25 653 07	2 361 79	28 014 86
Total Nursing Home			295 517 12	117 103 35	13 166 28	130 269 63
Grand Total			1 390 372 62	484 226 43	81 795 90	566 022 33

Note: Interest during initial construction and architect fee allocated between building and fixed equipment on basis of ratio of general contract to electrical and mechanical contracts.

Allocation between hospital and nursing home are on the basis of square footage.

SCHEDULE 10
JEFFERSON COUNTY MEMORIAL HOSPITAL, INC.
INTANGIBLE PLANT
September 30, 1971
(UNAUDITED FINANCIAL STATEMENTS)

Fund raising	12 500 00
Consultation and organization	610 99
Bonds and insurance	2 912 66
Office and miscellaneous	5 478 11
Administrative salary prior to opening	10 833 00
Other salaries prior to opening	1 227 25
Appraisal of plant	600 00
Loan brokerage fee	18 000 00
Total	52 162 01

Cozad City TRIBUNE
"The ... County"
Vol. VII No. 17 Thursday, January 11, 1972 Second Class Postage Paid at Cozad, Nebraska 69130

Thursday meeting

Cozad council asked for help on nursing question

Cozad City Council granted raises to all city employees Thursday night at a council meeting dominated by presentations by Jack Barnett of Robert C. Raymond & Co. and William LaCroix, administrator of Cozad Community Hospital.

LaCroix appeared before the council to discuss the local effect of several established nursing home regulations, particularly one requiring a professional nurse on duty for a minimum of 56 hours a week.

That regulation put into effect at Cozad Community Hospital Nursing Home, LaCroix told the council, would generate even more expense in an operation that was over $30,000 in the red in 1971.

The administrator asked the council to help he and his hospital board make a decision regarding the regulation.

He said he felt there were three options:

-Adhere to the regulation and lose more money in the operation.

-Phase out the nursing home and convert its facilities to hospital use, including additional offices, patient rooms and storage.

-Increase the size of the nursing home to make adherence to Health, Education and Welfare (HEW) regulations more profitable.

No decision was made Thursday, but the council is studying the question.

In an interview later with the TRIB, LaCroix said the professional nurse regulation is not now being observed. He said the nursing home could continue to operate without meeting the requirement fully, but it would be at a cost of lower welfare reimbursements, loss of approval for care of bedfast patients and other penalties.

Putting professional nurses on duty for 56 hours weekly would mean heavy additional expenses.

"Last year," he said, "the hospital just about broke even. But the nursing home was about $34,000 in the red, meaning the hospital is carrying the home. I don't know how much further it can be carried by the hospital."

"If we had 40 beds instead of 29 we could operate it more profitably," he added, "but that would mean a substantial building expense."

LaCroix told the TRIB a decision one way or another would be necessary soon. He said he hoped the council and hospital board would help in the decision-making process and that the public would make itself heard in the matter.

Barnett met with the council to discuss the city audit prepared by Raymond Co. certified public accountants.

Monthly raises of $25 were granted to street, sanitation and police department personnel and the resident engineer. Police dispatchers were granted $10 raises. All are retroactive to Jan. 1.

THE COUNCIL OF STATE GOVERNMENTS,
New York, N.Y., February 10, 1972.

Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: We are writing to you on behalf of the National Conference on Uniform Reciprocal Enforcement of Support to express the concern of the Conference about various provisions of H.R. 1 now under consideration by your Committee. The Conference is composed of state and local officials responsible for the enforcement of interstate family support. Each year millions of dollars are collected for deserted wives and children under this program and to a large extent these collections represent money which otherwise would be paid by the taxpayer as additional welfare costs. The Conference is vitally concerned that H.R. 1 or other amendments to the Social Security Act not hamper this successful program for obtaining support for dependents.

Enclosed is a memorandum and four resolutions expressing the views of the Conference with respect to this legislation. We hope that they will receive consideration in the preparation of the Committee's bill.

Sincerely,

WILLIAM L. FREDERICK,
Director, Eastern Office.

(Enclosures.)

COMMENTS CONCERNING H.R. 1 AND RELATED AMENDMENTS TO THE SOCIAL SECURITY ACT BY THE NATIONAL CONFERENCE ON UNIFORM RECIPROCAL ENFORCEMENT OF SUPPORT

The National Conference on Uniform Reciprocal Enforcement of Support is composed of judges, masters, referees, clerks, probation officers, prosecutors, welfare administrators, caseworkers and other officials of state and local government who are involved in enforcing the duty of support for dependents. In particular, the Conference is concerned with interstate enforcement of family support under the provisions of the Uniform Reciprocal Enforcement of Support Act which has been adopted by all fifty states, the District of Columbia, Puerto Rico and three territories.

At its 1971 Annual Meeting the Conference adopted four resolutions relating to H.R. 1 and other proposed amendments to the Social Security Act. Copies of the resolutions are attached.

RESOLUTION I

The Conference is of the opinion that principal responsibility for support and fraud prosecution should be left with the various states under existing laws and collection procedures. Under present federal and state law, there is appropriate sharing of the proceeds of on-going support money, reimbursement of assistance granted, or money obtained by fraud prosecution.

However, more equitable and definite arrangements for sharing of the proceeds of support and fraud action needs to be established under H.R. 1 and other Social Security Act amendments. States supplementing the federal minimum income allowance should share on a proportionate basis.

In the event S. 3019 is adopted by the Congress, Attorney General actions likely will be relatively few in number since most absent parents reside in the state where assistance is granted. Sharing of any recovery with the state, however, should not be conditioned upon a prior state court order. Personal service for ordering support normally is required and not possible when the whereabouts of the absent parent is unknown.

RESOLUTION II

The Conference urges Congress to make funds more readily available for the law enforcement process for obtaining support. Although funds are currently available for welfare department support activity, salaries and fees for prosecuting attorneys, courts, clerks, sheriffs, and the like, are furnished from state and local funds, though the federal government shares in the proceeds of any recovery of support.

Matching funds are available currently for selected demonstration projects involving arrangements with local courts and law enforcement officials supply-

ing other than usual service to the welfare agencies. Reported projects seem to be limited to assumption of welfare agency responsibilities for which funds were already available with little, if any, net increase in money to the states.

RESOLUTION III

Lastly, the Conference believes information should be available to state locator services in welfare cases from all federal agencies, including the Veterans' Administration from which no information may be obtained at this time. Address information from Internal Revenue Service should be available without the necessity of a prior court order, as in the case of the Social Security Administration. If we are serious about locating deserting parents so as to obtain support for their dependents, particularly those on welfare, it should be possible to obtain address information from the records of all public agencies.

RESOLUTION IV

Of utmost concern are the several federal district court decisions holding the granting of AFDC benefits may not be conditioned upon the co-operation of the mother, or other custodial relative, with welfare department or law enforcement officials in obtaining support for the child(ren) from an absent parent. These decisions have been affirmed by the United States Supreme Court in *Juras* v. *Meyers*, No. 71–63 (Oregon) and *Weaver* v. *Doe*, No. 71–478 (Illinois) and apply whether the child is born in or out-of-wedlock.

Congress has expressed its concern on several occasions that every effort be made to obtain support from the parents of deserted children rather than merely rely upon public assistance. Examples of this Congressional intent are the so-called "NOLEO" provisions of the early '50s requiring that prompt notice be given local law enforcement officials of the furnishing of aid to a child who has been deserted or abandoned by a parent; the requirement in the early 60's that each state establish a central unit for location purposes; the 1967 Social Security Amendments requiring a single unit for obtaining support from an absent parent, including establishing paternity when necessary, and federal participation in the special funding of these efforts. Congressional intent, seems clear but under the recent court decisions the mother is excluded from this cooperative effort.

In order to implement the Congressional requirements effectively, many if not most, states have required the cooperation of the mother, or other custodial relative, as a condition of eligibility for the child(ren) for whom a duty of support is owed. For a child born out-of wedlock, the mother is the only person who can name the father, sign the paternity complaint, and testify to material facts.

While some states have statutes enabling the welfare department to bring an action in its own name to obtain support from the absent parent of a child born in wedlock or whose paternity has been established, usually the only evidence it can present from case files regarding desertion and non-support is self serving and second hand. Law enforcement officials and courts customarily require testimony of a witness having first-hand knowledge of the circumstances and the action, being civil in nature, does not carry the usual sanctions of the non-support misdemeanor. Moreover, we believe that the principal duty of support rests with the absent parent and not with the taxpayer. This requires cooperation in obtaining the address of absent parents or leads upon which to base location efforts.

Although the proposed disregard of a portion of the income from support payments in arriving at need will serve as an incentive in some cases, there seems to be little justification for not taking appropriate support action in all cases where possible.

The Conference urges strong federal sanctions be enacted as soon as possible by amendment of the Social Security Act to require full recipient cooperation in every material aspect of the support enforcement process as a condition of initial or continuing eligibility for AFDC. Without such sanctions, Conference members feel cooperation will be minimal, rising caseloads with decreasing support contributions will result, and an effective test of whether or not there is a bona fide desertion under current federal law will be lost.

Self-incrimination, right to privacy, equal protection and the imposition of an additional eligibility requirement by the states not required by the Social Security Act have been the issues raised in the federal court cases. The courts have not reached the constitutional objections in their decisions.

Sanctions contained in the Social Security Act amendment could be waived in the event criminal prosecution for adultery or fornication were possible under state or local law. Those few states having such laws could then grant immunity from prosecution by legislative amendment where such information was obtained for support purposes in welfare cases or abolish the criminal statutes altogether in accordance with current trends. There seems to be some favorable precedent with regard to the privacy issue, leaving only a possible attack on grounds of equal protection.

TWENTIETH NATIONAL CONFERENCE ON UNIFORM RECIPROCAL ENFORCEMENT OF SUPPORT, OKLAHOMA CITY, OKLAHOMA, OCTOBER 10–14, 1971

RESOLUTION I

Whereas, delegates to the Twentieth National Uniform Reciprocal Enforcement of Support Conference have studied and been advised of those provisions of H.R. 1 concerning parental responsibility, establishment of paternity and the penalty for fraud; and

Whereas, it appears that all child support collected is to be collected at the expense of the state; and

Whereas, prosecution for fraud would seem to become the responsibility of U.S. Attorneys despite the presently existing apparatus at state and county levels; and

Whereas, the above provisions would seem to impede the orderly collection of child support and prosecution for fraud;

Be it resolved, that the Executive Committee draft a statement on behalf of this Conference to present to appropriate members of the Senate Finance Committee expressing opposition to the support and fraud provisions of H.R. 1.

RESOLUTION II

Whereas, the number of children requiring support from absent parents has greatly increased; and

Whereas, the chief benefit from the payment of child support accrues to the federal government; and

Whereas, the state agency charged with the administration of the AFDC program is prohibited from engaging in law enforcement; and

Whereas, the duty to enforce support from absent parents is placed upon local law enforcement agencies most of which are not funded for such activity;

Be it resolved, that the Executive Committee of the National Conference on Uniform Reciprocal Enforcement of Support express to the Senate Finance Committee the strong feeling of this Conference that federal funds be more readily available to state and local law enforcement agencies and that the maintenance of effort provision contained in current social and rehabilitative services regulations be eliminated.

RESOLUTION III

Whereas, it is essential to effective enforcement to have all sources of information available for locator services; and

Whereas, information from various federal agencies, notably the Veterans Administration, is not now generally available to state law enforcement or locator services;

Be it resolved, that the Executive Committee of the National Conference on Uniform Reciprocal Enforcement of Support be instructed to actively seek enactment of federal legislation to make available to state locator services, information possessed by federal agencies.

RESOLUTION IV

Whereas, the parents of minor children are primarily responsible for their support; and

Whereas, the 50 states and the territories have provided legal procedures to enforce support for minor children by financially able parents; and

Whereas, this principle and legal enforcement thereof is being attacked on the technical ground that the Social Security Act does not require the mother of a

dependent child to take action against the father to secure support as a condition of eligibility for public assistance; and

Whereas, it is argued that the mother of an illegitimate child does not have to name the father of the child as a condition of eligibility for public aid;

Be it resolved, that this Twentieth National Conference on Uniform Reciprocal Enforcement of Support request that the Social Security Act be amended to enable states and territories to enforce support as in the past and that the Conference's position on this issue be made a matter of record with the appropriate House and Senate Committees.

STATE OF CALIFORNIA,
DEPARTMENT OF JUSTICE,
San Francisco, February 18, 1972.

Hon. RUSSELL B. LONG,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: As I am sure you are aware the provisions of H.R. 1 relating to the enforcement of child support obligations and to the detection and prosecution of fraud have been the subject of interest and discussion among law enforcement and welfare officials with responsibilities in these areas. Both the National and Western Regional Reciprocal Conferences have discussed and passed resolutions on these subjects and they have been discussed at length in meetings of the California Family Support Council, a group composed of District Attorney's deputies and investigators, and welfare and probation department staff.

In response to a resolution of the Western Regional Conference on Uniform Reciprocal Enforcement of Support, a committee from that conference, chaired by the President of the California Family Support Council, has drafted a report on H.R. 1 containing a number of recommendations. This resolution and report have been forwarded to your committee. I have reviewed the report and am in general agreement with it. I urge your serious consideration of it, and wish to take this opportunity of adding a few comments of my own.

The provisions for the detection, prosecution and punishment of fraud contained in sections 2031(e)(3) and 2171(b), (e)(3), are at best inadequate and possibly unconstitutional in their uncertain and arbitrary application. Although "fraud" is adequately defined in substance, sections 2032 and 2172, it is inadequate in its failure to differentiate on the basis of the amount involved. Further, inadequate provision for investigation, preemption of state fraud statutes, and, apparently, placing the entire duty of prosecution on the United States Attorney's Offices, ill-equipped or staffed to deal with the problems, practically guarantees rampant fraud. In California, a very conservative estimate of 15 per cent fraud was developed from a State Welfare Board survey in 1969. We have enclosed a copy of the report for your information.

Although the act wisely retains the child support enforcement provisions of the present Social Security Act, and even increases the federal funding available to the states, problems are apparent in the new provisions of H.R. 1 set forth in sections 2175 and 2176. Both sections are of questionable constitutionality.

Section 2175 provides that a parent who has "deserted or abandoned" his spouse or children is obligated to the United States in defined amounts which may be collected from amounts due from the United States. In view of the decision in *Sniadach* v. *Family Financial Corp.*, 395 U.S. 337 (1969), such prejudgment garnishment is almost certainly unconstitutional. A better solution would be the enactment of legislation permitting assignment and attachment of federal wages and other obligations (such as income tax refunds) where a support order or judgment exists. Such a provision should be applicable to nonwelfare cases as well.

Section 2176 by creating a federal crime defined in part by "crossing state

lines" and applicable only to welfare cases, has obvious constitutional problems. Moreover, even if constitutional, the proof problems of intent are virtually insurmountable, and it seems very doubtful that the Offices of the U.S. Attorney are going to use their resources attempting such prosecutions. Finally, there is the possible problem that the prosecution preempts state statutes and thus prosecution by a State of men who have left the State would be impossible.

In the matter of funding state enforcement efforts, it is strongly recommended that the percentage of cost formula for enforcement agencies should be changed to a percentage of dollars collected formula. The latter formula would encourage efficiency and if the percentage return to the agency gave some return in addition to actual cost, would encourage expanded effort. A figure of about 20 per cent is suggested. A percentage of cost formula could be retained as an alternative for those auxiliary services, either local or state, such as locator services, which do not actively participate in actual collection.

Finally, your attention is invited to recent decisions of the United States Supreme Court affirming various three-judge federal court decisions, the effect of which is to enormously weaken the ability of the states to follow the direction of Congress in the vigorous enforcement of child support obligations and the determination of paternity. In order to carry out the mandate of Congress contained in section 402(a)(17) of the present Social Security Act (42 U.S.C. § 602(a)(17)), most, if not all, of the states enacted provisions which conditioned eligibility or continued receipt of aid on the caretaker parent's cooperation with the district attorney. *See, e.g.*, Calif. Welf. & Inst. Code § 11477. The Court has ruled that such provisions are inconsistent with the Social Security Act. *Juras* v. *Meyers*, No. 71-63, 30 L.Ed.2d 39 (1971), re-hearing denied 30 L.Ed. 280 (1971) (signing a complaint and naming the putative father); *Carleson* v. *Tayler*, No. 17-306, 30 L.Ed.2d 364 (1971), (signing a complaint); *Weaver* v. *Doe*, No. 7-478, 30 L.Ed.2d (1971), (naming the putative father). It is obvious that effective enforcement is difficult if not impossible if there is no way to force the mother to cooperate.[1] It is urged that the Congress make it clear that such conditions are permissible.

I do not take any position at all on the merits of this welfare reform bill in its granting of aid aspects. I do wish to call your attention to weaknesses in the enforcement aspects. As stated earlier, I am in agreement with the analysis made by the Committee for the Western Regional Conference in general, and have added my own comments for emphasis, and to add to those already made. In regard to the suggestions on funding and on overcoming the effect of the recent Supreme Court decisions, it is recommended that they be considered as immediate amendments to the present Social Security Act, whether or not H.R. 1 is ultimately adopted. It is particularly important to make it clear that the states may condition receipt of aid on cooperation because without such an amendment, enforcement efforts will be greatly reduced.

Finally, if you would consider it helpful, members of my staff are available to testify before your Committee, or provide you with any other information which may be of assistance to you.

Very truly yours,

EVELLE J. YOUNGER,
Attorney General.
By CHARLES A. BARRETT,
Chief Deputy.

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[1] We include for your information a copy of the Petition for Rehearing filed in *Juras* v. *Meyers*, setting forth in detail the problems and justifications for such a condition.

The Recipient Fraud Incidence Study

Conducted by

THE FRAUD REVIEW PANEL

for the

STATE OF CALIFORNIA – HUMAN RELATIONS AGENCY

DEPARTMENT OF SOCIAL WELFARE

PART I

Study and Findings

JANUARY 1970

REPORT ON A STUDY TO DETERMINE THE EXTENT OF RECIPIENT FRAUD IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN WELFARE PROGRAM

January, 1970

January 7, 1970

Mr. Robert Martin, Director
State Department of Social Welfare
744 P Street
Sacramento, CA 95814

Dear Mr. Martin:

Enclosed is our report covering a special study made for the purpose of identifying the extent recipient fraud is present in the Aid to Families With Dependent Children (AFDC) welfare program and more specifically, the Family Group and Unemployed Parent components of that program. This study was requested following a preliminary survey, the results of which were published in a report dated July, 1968.

The report is presented in six sections:

1. Study Background
2. Selection of a Sample of AFDC Cases
3. Guidelines Established for the Investigation
4. Conduct of the Investigation
5. Review by the Regional Teams and Fraud Review Panel
6. Study Findings and Projections

In performing the study the Fraud Review Panel used the services of District Attorneys and, in some counties, welfare departments to investigate in excess of 1,200 AFDC cases selected at random from all such cases in the State. In addition, contributing efforts were received from a number of other state and federal departments and agencies. We wish to thank and express our gratitude to the hundreds of people who gave so much effort to assure that this study was effective in determining the extent of recipient fraud.

Findings developed by the investigators were first screened for completeness and accuracy by one of three Regional Review Teams established to provide study coordination and supervision. Following that screening, cases were reviewed in detail by a Fraud Review Panel composed of five attorneys familiar with the AFDC welfare program. In its review of cases the Panel designated those as containing fraud only if there was clear evidence that the case fell within the definition of fraud set forth on page 7 of the accompanying report.

Study results reveal that 15.75% of the sample cases contained fraud. Of the dollar amount paid in June, 1969 to all sample cases, 10.00% was determined to have been received fraudulently by recipients.

The estimate of fraud developed by this study as applicable to June, 1969 can be used to project the amounts fraudulently obtained during the total year 1969. The Research and Statistics Division, California Department of Social Welfare, has indicated that welfare payments have continued to increase since June and that considering June as an average 1969 month would lead to a realistic, but slightly conservative, estimate of the annual amounts. Multiplying the estimate of fraud dollars in June by twelve, we estimate that during 1969 payments totaling $59,109,744 were received fraudulently by recipients included in these components of the AFDC program.

It is the sincere hope of the Fraud Review Panel that the findings in this report and the comments and observations that have been made a part of the study will be viewed in a positive context. It has been the Panel's goal not only to establish the extent of AFDC recipient fraud, but also to indicate

areas in which this fraud is most prevalent, all to the end that those truly in need may be most benefited.

Very truly yours,

FRAUD REVIEW PANEL MEMBERS

Keith C. Sorenson, District Attorney
San Mateo County

John M. Price, District Attorney
Sacramento County

Richard N. Parslow, Jr., Deputy District Attorney, Orange County

Ray T. Sullivan, Jr., County Counsel
Riverside County

Rudolf H. Michaels, Chief, Legal Office
State Department of Social Welfare

REPORT ON A STUDY OF WELFARE FRAUD IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN WELFARE PROGRAM

STUDY BACKGROUND

In the spring of 1969, the State Department of Social Welfare was directed to form a Fraud Review Panel to conduct a statewide study of the incidence of recipient fraud in the Aid to Families with Dependent Children (AFDC) program in California. This study was a follow on to an earlier survey of welfare fraud which was reported in July, 1968. That study had failed to produce definitive results relative to the extent of undetected recipient fraud in the AFDC program. The requirement for such a review evolves from the continued controversy over the extent of improper payments to recipients aided under this program, how much is improperly paid, and in what manner such improper payments are obtained.

To determine the extent, if any, that improper payments had been made to recipients, this study began with the selection of a sample from the State AFDC caseload. It is important to note that the sample was a statewide sample, not a sample of particular counties. Every effort was made to complete the study promptly to make it possible for useful and effective legislation to be enacted, should any be appropriate from the findings and conclusions developed. Accordingly, once the decision had been made to go ahead with the study, the work tasks were expedited as much as possible. The investigation focussed on two AFDC cash grant assistance programs: the Family Group and the Unemployed Parent. The Boarding Home and Institutions component of the AFDC program was not covered by the study.

The legal and administrative framework within which the investigation was conducted includes the provisions of the laws and regulations related to welfare administration as contained in the federal Social Security Act, the State Welfare and Institutions Code, and the Operations Manual of the State Department of Social Welfare.

In addition to developing a plan for scientific sampling of the statewide AFDC caseload, a carefully structured investigative plan for the conduct of the investigation was also established. A description of the extent to which security was maintained and the efforts which went into the selection of an independent and statistically reliable sample follow.

SELECTION OF A SAMPLE OF AFDC CASES

The investigations made in this study relate to payments made to recipients in the month of June, 1969. In that month, approximately 1,000,000 people, representing approximately 270,000 families, were participating as recipients of the Family Group and Unemployed Parent components of the AFDC program. Since the unit of measure was to be the family, it was from these two sub-groups that the sample was selected.

The State of California engaged the international accounting and management consulting firm of Ernst & Ernst to assist the Fraud Review Panel in obtaining an appropriate, unbiased sample for investigation, as well as to assist in coordinating the study. The firm provided an operations research and statistical sampling specialist to work with representatives of the State Department of Social Welfare's Research and Statistics Division to develop a proper method of selecting the statewide sample to be used.

After study, a general plan was developed which conformed to the essential criteria for unstratified random sampling. This type of sampling was chosen because the purpose of the study was to measure the level of undetected fraud among family welfare recipients as a whole, rather than any segment of these recipients (age, ethnic group) or any one county or other geographical area.

To meet the accuracy criteria established for the study, it was determined that a sample of 1,219 cases should be examined. To make allowance for the fact that cases would inevitably be included in the final sample which could not be investigated because they were closed at the time of the investigation, investigators were provided with a larger number of cases than was actually required so that sufficient cases might be investigated to provide the degree of confidence and accuracy desired. Thus, an appropriate amount of over-sampling was built into the random sample design.

After determining the number of cases which would have to be investigated in order that the desired level of reliability might be achieved, the next question to be answered was: From what source might the cases be selected?

The State Department Social Welfare maintains a Master Persons File which was established for purposes of medical claims clearance. This file includes the names of recipients in the Family Group and Unemployed Parent components of the AFDC program, as supplied by the county welfare departments. As a prelude to its use, appropriate tests were made of the file before any investigations began to determine that it was reasonably reflective of payments actually being made by the counties. Where it was found that this was not the case, appropriate supplemental statistical sampling techniques were applied to augment the sample so that it would be representative.

Ernst & Ernst provided independent guidance in the sample selection process. That firm selected and maintained complete control over the random number table used and directed the entire selection process as the random numbers were applied against the Master Persons File. The random numbers used were destroyed by Ernst & Ernst to prevent any possibility of disclosure of the sample case numbers prior to the time they were given to the investigators.

To achieve study reliability and insure an unbiased sample, the cases selected were scrambled before the order of investigation was designated. Thus, assurance was given that the order of listing in the Master Persons File would not be determinative of the cases selected for investigation. The cases were then listed and all copies of the listing retained by Ernst & Ernst until such time as the investigative process began. No representatives of the State of California, the Fraud Review Panel, or any other body other than the firm of Ernst & Ernst had any access to the list of cases selected for investigation until the time that the investigation process began.

All of the steps taken were fully in line with meeting the most rigorous requirements of unrestricted random sampling. Cases were examined sequentially until the desired number of investigations was made. The field investigation conformed well to the sampling plan. The actual number of cases investigated was 1,213 compared with a planned investigation of 1,219 cases.

GUIDELINES ESTABLISHED FOR THE INVESTIGATION

ORGANIZATION AND RESPONSIBILITIES FOR THE INVESTIGATION

As previously noted, a Fraud Review Panel was formed to direct the study. The functions of the Panel were:

1. To establish the guidelines for the conduct of the study, including agreements on the nature and extent of the investigation, and to adopt an appropriate definition of recipient fraud.
2. To review in detail, each of the sample cases selected, for the purpose of determining the existence of fraud based on a predetermined definition thereof.

To support the Fraud Review Panel in its efforts, a group of four consultants was named. They included experts in the welfare field representing county and state agencies.

To further aid the Panel, and as noted previously, the services of an outside management consulting organization were requested. Ernst & Ernst was selected from a number of firms invited to submit qualifications to assist with such a study. It was the function of this firm to:

1. Provide guidance to insure the objectivity of the study at all levels.
2. Provide guidance to insure adherence to the guidelines established by the Fraud Review Panel.
3. Tabulate the results of the investigation.
4. Aid the Fraud Review Panel in the preparation of the final study report.

The actual investigation was performed by welfare and District Attorney investigators throughout the state. From the sample case names provided, these representatives developed case findings and conclusions with sufficient documentation to enable the Fraud Review Panel to determine the existence of fraud.

DEVELOPMENT OF THE GUIDELINES

After preliminary planning, the Panel began meeting in May, 1969, to formulate the basic structure for the conduct of the investigation, as well as the manner in which the study should be controlled until its completion. It became obvious early in this organizational phase that investigation of over 1,200 welfare cases could not be properly supervised by a small group of people coordinating the study from Sacramento. Accordingly, it was deemed advisable that three area or Regional Review Teams be formed to assist the Panel in coordinating and supervising the study. Each Team included a representative from a District Attorney's office, a representative from a county welfare department, a representative from the State Department of Social Welfare, and a representative from the firm of Ernst & Ernst who acted as regional team leader.

So that findings might be related to total State payments, the study concerned itself only with payments received by AFDC recipients in June, 1969, and the case sample was drawn from the statewide AFDC caseload. Thus, the incidence of fraud identified at the conclusion of the study was to be a statewide figure which would in no way reflect the situation in a particular county.

A major factor in establishing the investigation guidelines was the definition of fraud which was to be applied. The Panel was in agreement that the definition of fraud contained in Section 20-003 of the State Department of Social Welfare regulations represented a valid definition for the purpose of this study. That definition reads:

> Fraud by applicants for or recipients of public assistance exists when the applicant or recipient has:
>
> 1. Knowingly and with intent to deceive or defraud made a false statement or representation to obtain aid, obtain a continuance or increase of aid, or avoid a reduction of aid.
>
> 2. Knowingly and with intent to defraud failed to disclose a fact which, if disclosed, could have resulted in denial, reduction or discontinuance of aid.

3. Accepted aid knowing he is not entitled thereto, or accepted any amount of aid knowing it is greater than the amount to which he is entitled.

4. For the purpose of obtaining, continuing, or avoiding a reduction or denial of aid, made statements which he did not know to be true with reckless disregard of the truth.

Other guidelines prescribed by the Fraud Review Panel included the following:

1. That the study would begin as soon as a statistically reliable sample was developed.

2. That the random sample drawn at the beginning of the study would be sufficiently large to satisfy the requirements of the statewide sample needed, allowing for cases that would have to be rejected because they were inactive at the time the investigation began.

3. That requirements for minimum investigative efforts be established. By establishing these requirements it was not the intention of the Panel to limit an investigator's effort but only to suggest the minimum efforts for investigating each case. It was determined that each step in the investigative process would be completed in spite of the fact that evidence of fraud might be obtained at some point early in the investigation.

4. That an orientation program be developed to insure that investigations would be conducted uniformly throughout the State, and that the program be presented by each of three regional teams to the investigators in their area who would be involved in the study. As developed, the program included the following:

   A. Necessary instruction which provided the investigator with an overview of the general approach and purpose of the study, as well as the individual steps of the investigative and review process with which he would be involved.

B. An explanation of the sampling process.

C. An explanation of the organisational structure of the study and the specific responsibilities of each person involved in the study.

D. Instruction on the definition of fraud to be applied.

E. A review of the investigative guidelines prepared for use by the investigators.

5. That the Panel develop appropriate forms and procedures to assist each investigator in his gathering of data, and developing conclusions on each individual case. The checklists so developed, as well as appropriate summary and conclusion forms, were distributed to each county investigative unit for inclusion in each individual case file. The checklists essentially covered the review steps suggested for a minimum investigation effort as previously prescribed by the Panel.

CONDUCT OF THE INVESTIGATION

ORIENTATION AND INITIATION OF THE INVESTIGATION

The orientation programs were conducted in each of the three regions in mid-July, 1969. At these meetings the investigation checklists as well as the master list of cases selected for each region were distributed to representatives of county investigative units. This was the first time the cases selected for investigation had become known to anyone other than the consultant firm of Ernst & Ernst.

At each of these meetings, the Executive Secretary of the State Social Welfare Board, the project coordinator from Ernst & Ernst, the Regional Review Team leader and members, took part in describing the study and its approach. Special attention was given to the role of the investigator and the requirements he was to satisfy. A portion of the meeting was set aside for investigators to ask questions relating to any facet of the study.

In the course of these meetings, certain qualifications were stressed. For instance, the fraud to be investigated was explained to be solely that which pertained to the welfare payments made in June, 1969. If, during the course of the investigation, fraud was believed to have occurred, either before or after the month of June, the investigator was asked to provide supplemental information in the file and mention this fact in his report. It was made clear that local District Attorneys' prosecution of suspected fraud cases should not be deferred until the study was completed. It was made clear that any amounts of fraud discovered which related to payments made in months other than June were not going to be included in the results of this study. As noted, the study related only to payments made in June, 1969. Administrative errors which came to the attention of the investigator in the normal process of conducting his investigation were also

to be noted. The investigators were invited to accumulate information which could be useful to the Fraud Review Panel in developing recommendations for improvement of the AFDC program.

The procedures to be followed in processing the cases were explained. Upon completing his investigation and preparing his report, each investigator was to transmit the file of documents developed in the investigation to the regional team for review. If the Regional Review Team found that all requirements were satisfied in terms of the criteria and guidelines earlier established, it would then transmit the case file to the Fraud Review Panel. If it was found the case file did not indicate the investigative requirements had been met, it was to be returned to the investigator for further work and completion.

Owing to the variation in size of the participating counties, the number of investigators involved and attending this meeting in each region varied from one to approximately sixteen per county. The county representatives were primarily District Attorneys' personnel. In most counties, the District Attorney's investigative unit was responsible for performing the investigations. In several of the larger counties, the District Attorney's office was assisted by the local county welfare department in performing the investigations.

THE COMPILATION OF FINDINGS AND DEVELOPMENT OF CONCLUSIONS

Documentation and findings were compiled in accordance with a standard checklist for the conduct of each investigation. Even though fraud or administrative error was found in a particular case prior to completing all of the investigative tasks, the investigator completed the collection and analysis of all items required in the checklist. Where documentation or information could not be included in the case file, the investigator was asked to provide justification for its absence from the file.

The primary responsibility for developing the case information necessary to enable the Fraud Review Panel to reach a conclusion rested with the investigator assigned the case. This placed a responsibility on each investigator to prepare a report on his investigation which conveyed to the Regional Review Team and the Fraud Review Panel as complete and accurate a presentation of the case as possible. He was required to show that his findings in each case flowed logically from the evidence he developed, as shown by the documents included in his case file.

REVIEW BY THE REGIONAL TEAMS AND FRAUD REVIEW PANEL

The review of cases was divided into two phases. The first phase was a preliminary review performed by one of the three Regional Review Teams. The second and final review was made and conclusions were reached by the Fraud Review Panel in Sacramento.

THE REGIONAL REVIEW TEAM

The three Regional Review Teams were in existence for the duration of the study. The scope of their involvement included the following:

1. Development and presentation of the orientation for investigators.
2. Providing assistance to the investigators in initiating the investigations.
3. Conducting periodic reviews of the investigation progress and coordinating as required.
4. Controlling cases and information about the study within their region.
5. Reviewing submitted cases.
6. Transmitting completed cases to the Fraud Review Panel, or returning incomplete cases to the investigative unit.
7. Providing general assistance to the Fraud Review Panel as required.

The first two tasks in this list have been discussed briefly in previous sections of this report. Highlights of the other tasks are discussed below.

Periodic reviews of the investigation progress and investigative coordination were performed in each region. This was necessary to assure that the study deadlines would be met and to alleviate problems, particularly with agencies not directly involved in the study, whose assistance had been requested. Individual members of each regional team assumed special coordination assignments. In one region, the county welfare department representative was instrumental in acquiring many additional services from the welfare agencies in support of the study.

For two of the Regional Teams, this coordinating task was especially time consuming owing to the extensive geographical area included in their regions.

Based on the need for reliable study results, the scientific design of the study, and the techniques applied in the selection of sample cases, control of the cases in each region was imperative. Master lists of case names and numbers were maintained by each Regional Review Team for control over the systematic and sequential allocation and investigation of cases. Each case reviewed by the Teams was checked against the master list to insure it was properly includable in the study. In addition to control for statistical purposes, each Team was responsible for maintaining the confidentiality of each case and the information evolving from the investigations.

The scope of review of individual cases also included the measuring of the quantity and quality of the investigative work as presented against the guidelines set forth for the investigation; determination of the completeness of the documentation and its orderly compilation; assurance that the findings and reporting were accurately and completely presented; and the correcting of any clerical errors.

The screening process at the Regional Review Team level called for individual members of each Team to review individual cases. For particularly complex cases or cases in which the investigator's reporting raised questions, the entire Team participated in the review. Team members making the individual case reviews used the expertise of other members of the Team for support in assuring that a proper investigation had been made and the findings were properly presented.

From this screening, cases were either forwarded to the Fraud Review Panel with appropriate comments, or returned to the investigative unit for further work. In a few instances cases were rejected from the study by the Regional Team inasmuch as the case was not active at the time the investigation began.

72-573 O - 72 - pt. 6 -- 29

THE FRAUD REVIEW PANEL

The Fraud Review Panel held meetings in Sacramento as the number of cases received merited such meetings. An Ernst & Ernst representative, serving as coordinator, attended each of these meetings as a non-voting participant and as a Regional Review Team coordinator. Great care was taken by the Panel in this review to ascertain that there was clear evidence of recipient fraud in a case before it was so designated. Each case of recipient fraud, as determined by review of the case, was discussed at length by the entire Panel. All of the Panel members were attorneys familiar with the AFDC program. As such, they were familiar with the implications of the definition of recipient fraud. Further, they were aware of the evidence needed to establish the existence of fraud.

In addition to compiling information on the extent of fraud in the sample cases investigated, the Panel also gathered information on administrative errors that had come to the attention of the investigator at the time of his review. The frequency and extent of the incidence of administrative errors are included in the final section of this report. However, it should be emphasized that the study was not aimed at determining the extent of administrative error. This information, as a by-product of the study, is submitted in this report in the expectation that it will be useful in reducing the extent of such errors in the future.

STUDY FINDINGS AND PROJECTIONS

Investigation of the AFDC cases selected for review from the statewide Master Persons File indicated a significant number contained recipient fraud. It was also noted that a significant number contained administrative error which resulted in an incorrect payment to the recipient.

Cases investigated totaled 1,213. Of these, 191 or 15.75% were found to contain recipient fraud. The most common type of identified fraud was found to be 'Unreported Income' which was present in 8.74% of the cases investigated. The second most common was the presence of an 'Unreported Man Assuming the Role of Spouse' which was found to be present in 4.21% of the cases investigated. Recipient fraud of some other type was found to be present in 2.80% of the cases investigated.

Although the study's aim was to determine the amount of recipient fraud present in the program, examples of administrative error also came to the attention of the investigators as they performed their review tasks. Administrative errors were found to be present in 5.36% of the cases investigated. The study was not aimed at determining the extent of administrative error. Accordingly, the amount of such error quoted here, and in the accompanying tables, is not to be considered as properly reflective of all such error in the sample or the AFDC program.

A tabulation of the findings developed by the study is outlined in Table I accompanying this report.

The statistics outlined above deal with the frequency recipient fraud and administrative errors were found to be present in the cases investigated. When the findings relating to the dollars fraudulently received by recipients are examined, a better understanding of the effect of these fraudulent activities

is obtained because mere determination that fraud existed in a given case does not necessarily mean that the entire grant was fraudulently obtained. In instances of outright ineligibility, the entire amount paid would be due to fraud but in other cases, such as those of unreported income or the failure to report the ineligibility of one of several children, only a part of the grant would be attributable to the fraud while the balance would be characterized as "properly paid." Of the total amount paid to recipients covered by the cases included in the sample, 10.00% was found to have been received fraudulently. Further, 1.76% was found to have been paid as a result of administrative error.

The total amount paid in June, 1969 to all recipients included in the Family Group and Unemployed Parent components of the AFDC program amounted to $49,258,124 according to Welfare Department records. Relating the study findings to these total payments, and considering the reliability which can be given to the results developed from the sample used, there is a 95% reliability that, plus or minus 1.61%, $4,925,812 of the total amount paid in June, 1969 to the families covered by these components were received fraudulently. Table II further outlines these findings.

The estimate of the dollar amount of fraud in June, 1969, can be used to project the fraudulent amounts for all of 1969. The Research and Statistics Division, California Department of Social Welfare, has indicated that welfare payments have continued to increase since June and that considering June as an average 1969 month would lead to a realistic, but slightly conservative estimate of the annual amounts.

By multiplying the June estimates by twelve, it is estimated that payments totaling $59,109,744 were received fraudulently and payments of at least $10,403,316 were received as a result of administrative error in 1969.

Payments received fraudulently are estimated to have been made as a result of the following fraudulent acts in the amounts indicated:

	Estimated 1969 Amount
Type of fraud:	
Unreported Income	$27,958,908
Unreported Man Assuming Role of Spouse	20,688,408
Other	10,462,428
	$59,109,744

RECIPIENT FRAUD INCIDENCE STUDY

June, 1969

NUMBER OF CASES, TOTAL PAYMENTS, AND FRAUD PAYMENTS IN AFDC SAMPLE CASES, BY TYPE OF FRAUD

TYPE OF CASE	CASES		TOTAL PAYMENTS			FRAUDULENT PAYMENTS		
	NUMBER	PERCENT	AMOUNT	PERCENT	AVERAGE PER CASE	AMOUNT	PERCENT ALL PMTS.	AVERAGE PER CASE
Cases Determined to Contain Fraud:								
Unreported Income	106	8.74%	$ 20,947	9.30%	$197.61	$10,649	4.73%	$100.46
Unreported Man Assuming Role of Spouse	51	4.21	10,626	4.71	208.35	7,890	3.50	154.71
Other:								
Unreported Change in Family Composition	7	.58	1,561	.69	223.00	779	.34	111.29
Misstatement of Material Fact	9	.74	1,519	.67	168.78	746	.33	82.89
Unreported Ineligible Child	3	.25	664	.30	221.33	116	.05	38.67
Unreported Excess Personal Property	5	.41	936	.42	187.20	936	.42	187.20
Unreported Ineligible Recipient	4	.33	557	.25	139.25	557	.25	139.25
Failure to Disassociate	5	.41	1,165	.52	233.00	684	.30	136.80
Misrepresentation of Availability for Employment	1	.08	166	.07	166.00	166	.08	166.00
Total Other	34	2.80	6,568	2.92	193.18	3,984	1.77	117.18
Total Cases Determined to Contain Fraud	191	15.75	38,141	16.93	199.69	$22,523	10.00%	$117.92
Balance of Cases	1,022	84.25	187,133	83.07	183.10			
TOTAL IN SAMPLE	1,213	100.00%	$225,274	100.00%	$185.72			

NUMBER OF CASES, TOTAL PAYMENTS, AND PAYMENTS INVOLVING ADMINISTRATIVE ERROR IN AFDC SAMPLE CASES

TYPE OF CASE	CASES		TOTAL PAYMENTS			ADMINISTRATIVE ERROR		
	NUMBER	PERCENT	AMOUNT	PERCENT	AVERAGE PER CASE	AMOUNT	PERCENT ALL PMTS.	AVERAGE PER CASE
Cases With Administrative Error	65	5.36%	$ 11,161	4.95%	$171.71	$3,956	1.76%	$ 60.86
Balance of Cases	1,148	94.64	214,113	95.05	186.51			
TOTAL IN SAMPLE	1,213	100.00%	$225,274	100.00%	$185.72			

Note: It can be accepted with 95% reliability that the sample percentages above which relate to recipient fraud are accurate to within better than ± 2.2%. Information relating to administrative error was noted incidental to the investigation of recipient fraud and the review tasks were not designed to determine the extent of such error. Accordingly, no accurate projections of such error can be made from the cases investigated.

TABLE I

RECIPIENT FRAUD INCIDENCE STUDY

June, 1969

ESTIMATED TOTAL NUMBER OF CASES AND AMOUNT OF PAYMENTS INVOLVING FRAUD

TYPE OF CASE	CASES		PAYMENTS	
	SAMPLE PERCENT	ESTIMATED NUMBER	SAMPLE PERCENT	ESTIMATED AMOUNT
Type of Fraud:				
Unreported Income	8.74%	23,170	4.73%	$ 2,329,909
Unreported Man Assuming Role of Spouse	4.21	11,162	3.50	1,724,034
Other	2.80	7,423	1.77	871,869
Payments With Fraud	15.75	41,755	10.00	4,925,812
Balance of Payments	84.25	223,353	90.00	44,332,312
TOTAL PAID IN JUNE, 1969	100.00%	265,108	100.00%	$49,258,124

ESTIMATED TOTAL NUMBER OF CASES AND
AMOUNT OF PAYMENTS INVOLVING ADMINISTRATIVE ERROR

TYPE OF CASE	CASES		PAYMENTS	
	SAMPLE PERCENT	ESTIMATED NUMBER	SAMPLE PERCENT	ESTIMATED AMOUNT
Cases With Administrative Error	5.36%	14,210	1.76%	$ 866,943
Balance of Cases	94.64	250,898	98.24	48,391,181
TOTAL PAID IN JUNE, 1969	100.00%	265,108	100.00%	$49,258.124

Source: Total June, 1969 cases and payments from California Department of Social Welfare, Research and Statistics Division.

Note: It can be accepted with 95% reliability that the sample percentages and derived amounts above which relate to recipient fraud are accurate to within better than ± 2.2%. Information relating to administrative error was noted incidental to the investigation of recipient fraud and the review tasks were not designed to determine the extent of such error. Accordingly, no accurate projections of such error can be made from the cases investigated.

TABLE II

The Recipient Fraud Incidence Study

Conducted by

THE FRAUD REVIEW PANEL
for the
STATE OF CALIFORNIA – HUMAN RELATIONS AGENCY
DEPARTMENT OF SOCIAL WELFARE

PART II

Recommendations

JANUARY 1970

January 7, 1970

Mr. Robert Martin, Director
State Department of Social Welfare
744 P Street
Sacramento, CA 95814

Dear Mr. Martin:

The results of the study to determine the incidence of undetected recipient fraud in the Aid to Families With Dependent Children (AFDC) caseload have been reported to you under separate cover on this date.

In conducting this study new benchmarks have been established in cooperative relations between county and state government. The major part of the study work has been performed by District Attorneys and members of their staffs. In spite of the extreme pressure of other responsibilities, these individuals and agencies have given generously of their time, sometimes at personal sacrifice. In addition, a number of county welfare departments have also contributed investigative and other valuable staff services.

The taxpaying public which has the responsibility of caring for those who are truly in need deserves to have confidence that the regulations governing the welfare program are scrupulously adhered to. For the same reason, those who are in any way involved in the administration of the system have the absolute duty to insure that such is the case. Only in this way can the proper concept of public support of welfare programs be realized.

In conducting this study the Fraud Review Panel was given a unique opportunity to survey and critically examine many of the procedures and problems related to the program.

Our observations and the study findings clearly indicate a serious problem is present which will require continuing attention. It appears most advisable that a program be developed which will constantly assess the level of administrator and recipient compliance with the law and regulatory requirements. We recommend that a program be adopted which will provide for continuing review and monitoring of that compliance.

Accompanying this letter are further recommendations developed during the conduct of the study. Many are not new. Many have been discussed elsewhere. The Panel believes, however, that the study findings add a new note of urgency, and it is for this reason that they are restated here. The findings in the report, the comments and observations above, and the accompanying recommendations should be viewed in a positive context. It has been the Panel's goal to establish the extent of fraud and to suggest ways in which waste can be curtailed to the end that those truly in need may be most benefited.

Very truly yours,

FRAUD REVIEW PANEL MEMBERS

Keith C. Sorenson, District Attorney
San Mateo County

John M. Price, District Attorney
Sacramento County

Richard N. Parslow, Jr., Deputy District Attorney
Orange County

Ray T. Sullivan, Jr., County Counsel
Riverside County

Rudolf H. Michaels, Chief, Legal Office
State Department of Social Welfare

RECOMMENDATIONS DEVELOPED FROM A STUDY TO DETERMINE THE EXTENT OF RECIPIENT FRAUD IN THE AID TO FAMILIES WITH DEPENDENT CHILDREN WELFARE PROGRAM

January, 1970

RECOMMENDATIONS

State and County Administration

A significant portion of welfare fraud losses result from the failure to report changes in family composition and income; either earned income, income in-kind, or income received from other sources. Related to this is the need for a clearer understanding on the part of the recipient of his responsibility to report such circumstances, and improvement in the system by which such reports and status changes are received and processed by the counties.

It is clear there is room for improvement in all of these areas. The recipient-oriented caseworker must realize the serious implications for the recipient as a result of his (the caseworker's) failure to insure the recipient's understanding of these requirements. The consequence of such a failure can lead to prosecution. While this fact should be impressed on the recipient, the caseworker must also understand that failure to adequately cover this subject in his discussions with the recipient may be exposing both to needless difficulty.

A significant portion of the fraudulent conduct and many of the errors identified in this study commenced or were permitted to continue unabated because some caseworkers were not sufficiently aware of the danger signals. The apparent lack of training and/or interest on the part of some caseworkers may be viewed as a significant factor associated with the incidence of fraud and error.

There is a serious lack of uniformity between the counties as to (1) when during the month such reports of changes in family composition and income are due, (2) the manner of processing the reports, and (3) the ease with which the information contained in the reports can be applied to the grant. In connection with these problems the Panel recommends that:

1. Regulations provide for a mandatory, timely, simplified and uniform system for reporting income and changes in family composition by recipients throughout the State.
2. Regulations and forms on this and other subjects be written in a clear and concise manner to the end that ambiguity is eliminated. For example, the word "prompt" would be better understood if a specific period of time were substituted; the words "Income" and "Family Composition" would be better understood if they were clearly defined and their definitions impressed on recipients.
3. Monthly detailed status and income reports be required as a pre-requisite of paying aid.
4. The recipient be instructed, before being asked to complete any document relating to eligibility for aid, that any false statement will subject him to criminal penalties.
5. Regulations regarding signatories on affirmations and reaffirmations require that all adults in the home who affect the grant must sign these documents, as well as any and all adults responsible for the child.
6. Greater attention be given to those cases in which there is variable income or income from self-employment, as well as during those periods in which there are five weekly pay periods.
7. Consideration be given to pressing disciplinary and/or legal action against caseworkers and others who deliberately or negligently overlook illegal situations or who aid and abet in the commission of welfare fraud.
8. It be required that each applicant for aid receive a pictorial pamphlet outlining his responsibilities; and this document be followed up with

mailings at intervals in the future. An example of such a brochure accompanies this report as Appendix A.

9. Efforts to simplify AFDC program regulations be continued. The extensive detail involved in policy, regulations and calculation of the need and the grant, results in confusion and misunderstanding of the program requirements.

In the course of the study the Fraud Review Panel was exposed to some of the administrative complexities of the internal system at both the state and county level. The vastness and costs of these systems would seem to justify close and continuing scrutiny to insure that the internal mechanism functions as efficiently and economically as possible. While payment documentation is a necessity, attention should be given to simplifying the steps, eliminating unnecessary steps and providing some tracking system in order to determine without delay the number and amounts of grants received in a particular case in a given period. Reports of all kinds should be carefully evaluated to insure they are still justified in terms of their usefulness and purpose and, if so, that they are both accurate and timely. Although these comments are of a general nature, the Panel recommends that:

10. Continuing attention be given by the State Department of Social Welfare to updating the Master Persons File and developing procedures which will assure that it remains current. In this connection it is important that the counties continually provide current information for input into the file.

11. Regulations concerning the final payment of aid in the month of discontinuance be improved. At this point substantial overpayments can be made which are difficult or impossible to recover due to the inability of the system to respond promptly to change.

12. Notices advising recipients of discontinuance contain in bold print that there is no further entitlement; that any warrants received should not be cashed but returned to the welfare department. Further, that such notice recite the penalty for non-compliance with this requirement.

13. As an aid to maintaining better controls, support contributions received by the probation or other departments of county government in all cases be uniformly transmitted to the welfare department to offset the grant instead of being paid directly to the recipient.

In their review of sample cases in this study, members of the Panel have identified a number of problem areas associated with the payment of aid and the policies and regulations related thereto. As a means of resolving these problems, the Panel recommends that:

14. A system of closer followup be established to insure that extra sums paid recipients to meet specific special needs are actually used for the purpose intended.

15. A policy be adopted which will provide for the discontinuance of aid when a recipient absents himself from the state for thirty days for whatever reason.

16. Regulations require the listing of parent social security numbers as well as other potential employable family members on the application for aid, and a greater effort made to obtain these numbers on current cases. Applicants for aid who do not have social security cards can be assisted in completing the simple application at the time the application for aid is taken.

17. In cases involving fraud, the guilty party not have the benefit of deductions for work-related expenses and/or other exemptions in computing the amount of the overpayment.

18. Caseworkers alone not have the authority of declaring individuals incapacitated. Supervisory staff should participate in this decision after appropriate evaluation and verification.

The Panel makes two observations with regard to existing statutes and the need for legislative action. First, the wording in Section 10500, Welfare and Institutions Code is such that it is being used for purposes contrary to its intent. Secondly, Section 11482 of the Welfare and Institutions Code, as related to Section 487.1 of the Penal Code causes a distinction to be made between welfare recipients and non-welfare recipients.

The Panel recommends that legislation be introduced for the purpose of amending:

19. Section 10500, Welfare and Institutions Code reads as follows:

> "Every person administering aid under any public assistance program shall conduct himself with courtesy, consideration, and respect toward applicants for and recipients of aid under that program, and shall endeavor at all times to perform his duties in such manner as to secure for every person the maximum amount of aid to which he is entitled, without attempting to elicit any information not necessary to carry out the provisions of law applicable to the program, and without comment or criticism of any fact concerning applicants or recipients not directly related to the administration of the program."

This section should contain language which speaks to the recipients' responsibility and, further, sets forth the requirement that welfare benefits are to apply as a supplement to all other benefits to which the recipient may be entitled, and after property which exceeds the limitations has been utilized.

20. Section 11482, Welfare and Institutions Code reads as follows:

> "Any person other than a needy child, who willfully and knowingly, with the intent to deceive, makes a false statement or representation or knowingly fails to disclose a material fact to obtain aid, or who, knowing he is not entitled thereto, attempts to obtain aid or to continue to receive aid to which he is not entitled, or a larger amount than that to which he is legally entitled, is guilty of a misdemeanor."

This section should be amended so it is consistent with Section 487.1 of the Penal Code; that is welfare fraud resulting in an overpayment of less than $200 should be considered a misdemeanor and in excess of $200 should be defined as a felony. Such a change would clarify the present law.

Caseworker-Recipient Relationships

Efforts of caseworkers, both eligibility and social workers, are directed toward assisting the recipient in obtaining financial independence and self-determination, as well as improving his self-image and his physical and emotional environment as well as that of his family. The tools used by the caseworker in achieving these objectives are the various financial aid and service programs supported by the public or private organizations within certain limits and guidelines. The caseworkers' responsibility to render aid in a humane and understanding manner is obvious. Their responsibility in administering public funds and the public trust involved is just as obvious.

There appears to be however, a minority of caseworkers who overlook and encourage acts by recipients which are contrary to the letter and intent of the prescribed limits and guidelines. Aside from fostering greater dependency in the recipient, these few caseworkers should realize that welfare cheating is a morally degrading act. Unlawful acts are just as degrading when committed by a welfare recipient as when committed by an individual who is financially independent. For these caseworkers to fail to shoulder their responsibility in this area - to deliberately overlook or in other ways to encourage this behavior in recipients is directly contrary to basic social work philosophy. An indication of this adverse and negative attitude manifested itself recently when some caseworkers advised their co-workers and recipients not to cooperate in this study, a study

72-573 O - 72 - pt. 6 -- 30

which was instituted and conducted within the jurisdiction of welfare administration. Public employees have the same obligation to taxpayers, as employees of private organizations have to their employers, and such activities should be dealt with accordingly.

Welfare recipients specifically and the public in general have a right to expect that caseworkers will be trained and knowledgeable in their areas of responsibility. Although recognizing there is a great amount of detail involved in this work, the Panel believes that a significant part of the administrative error and fraud identified in its report could have been avoided with improved caseworker training.

On the general subject of caseworker-recipient relationships, the Panel recommends that:

21. Greater emphasis be placed on developing in caseworkers, a sophisticated awareness of the possibility that they may be deceived. This subject is discussed at greater length below.

22. Increased emphasis be placed on supervision and review of case record material by caseworkers and supervisory staff. More than isolated instances were noted where glaring errors and omissions requiring follow-up did not receive necessary attention or were subject to unnecessary delay.

Detection and Prevention of Fraud

In general terms, one of the most pressing needs in connection with preventive programs is a systematic training program for caseworkers and eligibility workers. Such training should be included in the initial caseworker orientation and furthered by the use of in-service training programs. Involvement should be mandatory. A suggested plan for developing such a comprehensive program is contained in Appendix B.

In the area of detection and prevention, the Panel recommends that:

23. In consideration of the extent of welfare fraud and administrative error revealed by the fraud study, county governments carefully review the present level of fraud investigation and staffing to determine whether they are adequate to cope with the size of the existent problem.

24. A method be developed for identifying, for closer follow-up, those cases in which the recipient has previously been suspected of welfare fraud or has, in fact, been convicted of welfare fraud.

25. The State utilize information developed by state and federal agencies as aids to administering the program. Systematic obtaining of information on recipients earnings, benefits and property would be of significant benefit in this regard.

26. Cases involving large monthly totals of aid payments and other income, and cases involving unemployed or incapacitated parents, be scheduled for special and more frequent follow-up.

27. In instances where recipients are not furnished caseworker services, provision be made for frequent review of eligibility.

28. County governments be encouraged to expand their investigative staffs to meet the problems identified by the study. Smaller counties should receive assistance in developing investigative staffs in the areas of child support and welfare fraud, perhaps through a county pooling arrangement.

29. Where school attendance is a condition of receipt of welfare the caseworker contact the school with sufficient frequency to insure that eligibility continues to exist.

30. The policy of non-scheduled home visits by caseworkers during normal business hours be adopted by all counties.

DOES YOUR SOCIAL WORKER KNOW ?

ABOUT MONEY YOU GET FOR YOURSELF OR YOUR CHILDREN

[_] from your job
[_] from a child's job
[_] from your family
[_] from your friends
[_] from a child's father
[_] from rent
[_] from social security
[_] from workmens' compensation
[_] from disability
[_] from unemployment
[_] from any other source

ABOUT PEOPLE IN YOUR HOME - WHEN ANYONE MOVES IN, MOVES OUT, OR VISITS

[_] a family member
[_] another adult or child
[_] your child
[_] a friend

ABOUT YOUR PROPERTY - THINGS YOU OWN OR BUY

if you are buying or selling:
[_] a home
[_] other property
[_] a car
[_] appliances
[_] furniture
[_] if you are buying life insurance

HAVE YOU MOVED LATELY? ARE YOU PLANNING TO MOVE?

Does your social worker know your new address? [_]

SCHOOL

Do you have a child over 15 who does not go to school? [_]

IF YOUR SOCIAL WORKER DOES NOT KNOW THE THINGS YOU HAVE CHECKED ABOVE, call him and tell him now - this is for your PROTECTION !

3198

PROTECT YOURSELF — TELL YOUR SOCIAL WORKER

For your child to get the right amount of aid, your social worker must know about:

MONEY you or your child get - no matter who or where it is from.

THINGS you own or are buying.

PEOPLE who live with you - no matter who they are.

Have you told your social worker ALL he must know to pay aid for your child?

Don't wait for him to ask. Tell your social worker ALL THE FACTS now !

WHAT IS FRAUD ?

A few people do not tell their social worker all the facts.

These people can be arrested for fraud.

What is FRAUD?

Fraud is a crime. A person may have to pay a fine and he may be put in jail for fraud.

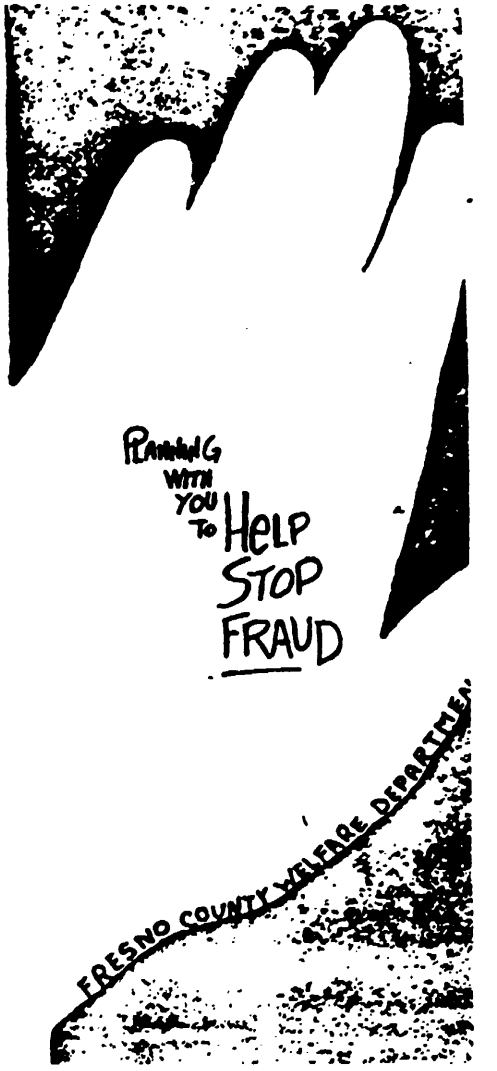
When a person gets aid that he should not get, he may be guilty of fraud...

IF the aid was paid because he lied.

IF the aid was paid because he told only part of the truth.

IF the aid was paid because he did not tell all the facts right away.

You can help stop fraud. Check the list inside this folder. If your social worker does not know all these facts about you and your family - tell him NOW !



3199

SUGGESTIONS FOR DEVELOPING A

FRAUD PREVENTION AND DETECTION TRAINING PROGRAM

1. The Director of the State Department of Social Welfare would have responsibility for mandating this program in all counties.
2. The curriculum would be developed by a group consisting of representatives of the County Welfare Directors' Association and the District Attorneys' Association who have demonstrated an interest in this area. Included would be a Deputy District Attorney with experience in welfare fraud and child support, an experienced casework and eligibility supervisor, a county welfare investigator and district attorney investigator as well as selected executive staff of the State Department of Social Welfare.
3. Each new caseworker and eligibility worker would receive fraud detection and prevention training as a part of his orientation.
4. Within the first six months the new staff member would participate in a full days fraud prevention and detection training activity.
5. Advanced courses would be provided for supervising staff at regular intervals and participation would be mandatory. Subject matter would be varied.
6. Programs would include a heavy emphasis on prevention, as well as:
    a. Identification of clues and leads
    b. Actions to be taken
    c. Referral procedures
    d. Recipient responsibility
    e. Staff member responsibility
    f. Case examples to illustrate

APPENDIX B

In the Supreme Court of the United States

OCTOBER TERM, 1971

No. 71-63

ANDREW JURAS, individually and in his capacity as Administrator of the Oregon Public Welfare Division,
Appellant,

vs.

SHARON LEE MEYERS, et al.,
Appellees.

On Appeal from the United States District Court for the District of Oregon

Petition for Rehearing

Joined in by the States of Arizona, California, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Nebraska, Nevada, New Mexico, Oklahoma

LEE JOHNSON
Attorney General of Oregon
JOHN W. OSBURN
Solicitor General
AL J. LAUE
THOMAS H. DENNEY
Assistant Attorneys General
State Office Building
Salem, Oregon 97310
Telephone: (503) 378-4402
Counsel for Appellant

On the Petition for Rehearing
EVELLE J. YOUNGER
Attorney General of California
GLORIA F. DEHART
JAY S. LINDERMAN
Deputy Attorneys General
6000 State Building
San Francisco, California 94102
Telephone: (415) 557-0420

[Continued on Inside Front Cover]

SORG PRINTING COMPANY OF CALIFORNIA, 340 FIRST STREET, SAN FRANCISCO 94105

Attorneys for the States Joining in Petition for Rehearing

GARY K. NELSON
Attorney General of Arizona

JAMES B. FEELEY
Assistant Attorney General
1624 Adams Street
Phoenix, Arizona 85007

EVELLE J. YOUNGER
Attorney General of California

GLORIA F. DEHART
JAY S. LINDERMAN
Deputy Attorneys General
6000 State Building
San Francisco, California 94102

ROBERT L. SHEVIN
Attorney General of Florida

DANIEL S. DEARING
Chief Trial Counsel
State Capitol
Tallahassee, Florida 32304

WILLIAM J. SCOTT
Attorney General of Illinois

FRANCIS T. CROWE
Assistant Attorney General
160 North LaSalle Street, Room 900
Chicago, Illinois 60601

THEODORE L. SENDAK
Attorney General of Indiana

RICHARD C. JOHNSON
Chief Deputy Attorney General
219 State House
Indianapolis, Indiana 46204

RICHARD C. TURNER
Attorney General of Iowa

LORNA LAWHEAD WILLIAMS
Special Assistant Attorney General
Lucas State Office Building
Des Moines, Iowa 50319

VERN MILLER
Attorney General of Kansas

EDWARD G. COLLISTER, JR.
Assistant Attorney General
State Capitol Building
Topeka, Kansas 66612

JOHN B. BRECKINRIDGE
Attorney General of Kentucky

GEORGE F. RABE
Assistant Attorney General
State Capitol
Frankfort, Kentucky 40601

ROBERT H. QUINN
Attorney General of Massachusetts

WALTER H. MAYO III
Assistant Attorney General
State House
Boston, Massachusetts 02233

CLARENCE A. H. MEYER
Attorney General of Nebraska

GERALD S. VITAMVAS
Deputy Attorney General
1526 K Street, 4th Floor
Lincoln, Nebraska 68509

ROBERT LIST
Attorney General of Nevada

MARGIE ANN RICHARDS
Deputy Attorney General
Nye Building
201 S. Fall Street
Carson City, Nevada 89701

DAVID L. NORVELL
Attorney General of New Mexico

JULIA C. SOUTHERLAND
Special Assistant Attorney General
Post Office Box 2348
Santa Fe, New Mexico 87501

LARRY DERRYBERRY
Attorney General of Oklahoma

PAUL C. DUNCAN
Assistant Attorney General
112 State Capitol
Oklahoma City, Oklahoma 73105

SUBJECT INDEX

TABLE OF AUTHORITIES CITED

In the Supreme Court of the United States

No. 71-63

ANDREW JURAS, individually and in his capacity as Administrator of the Oregon Public Welfare Division,
Appellant,

vs.

SHARON LEE MEYERS, et al.,
Appellees.

On Appeal from the United States District Court for the District of Oregon

Petition for Rehearing

Appellant, Andrew Juras, Administrator of the Oregon Public Welfare Division, respectfully petitions this Court for a rehearing in the above-captioned case. The States of Arizona, California, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Nebraska, Nevada, New Mexico and Oklahoma, through their respective Attorneys General, respectfully join in this petition. Without having had the benefit of full briefing and oral argument, this Court, on October 12, 1971, summarily affirmed the judgment of the three-judge District Court below, invalidating the provisions of Oregon law which predicate continued receipt of benefits under the Aid to Families With Dependent Children (AFDC) program upon cooperation by the

custodial parent in identifying, locating, establishing paternity (if necessary) and obtaining support from a "needy, dependent" child's absent parent.

REASONS FOR GRANTING A REHEARING

This Court has decided a question of broad public importance and has affirmed a judgment which has sweeping nationwide impact, without having had the benefit of full briefing and argument. The decision affects not only the State of Oregon and the thirteen states which have joined in this petition, but the remainder of the fifty states as well, all of which, in the exercise of legislative judgment, have implemented in a fashion similar to Oregon, the Congressional directives of the "NOLEO" provisions of the Social Security Act [42 U.S.C. §§ 602(a) (11), (17), (21), and (22)] requiring notification of law enforcement officials and subsequent action to establish paternity and secure support from absent parents for the benefit of needy AFDC children.

The Oregon regulations at issue implement the federal "NOLEO" provisions by providing for a denial or termination of assistance if the mother "refuses to cooperate" with law enforcement officials in seeking child support. In the instant case, appellee Meyers refused to sign a non-support complaint against her husband, while appellee Young refused to reveal the identify of the putative father of her illegitimate child. However, "failure to cooperate" may also include a refusal to be interviewed by law enforcement officials or a concealment of the identity or whereabouts of the father.[1] All of these aspects of "cooperation" are encom-

1. *E.g.*, California Welfare and Institutions Code section 11477 provides for disqualification from continued AFDC eligibility if the custodial parent refuses to offer reasonable assistance to law enforcement officers and defines specific acts which shall be deemed to constitute such refusal as: (a) "A refusal to be interviewed by the district attorney," (b) "A refusal to sign a complaint against the absent parent," (c) "A request to dismiss the complaint," or (d) "The concealment of the identity or whereabouts of the absent parent."

passed within the Oregon regulations, yet have differing impact and justification. Cases from other jurisdictions raising these different aspects are currently pending before this Court [*Carleson v. Taylor*, No. 71-306, Oct. Term 1971 (California—refusal to sign a complaint); *Weaver v. Doe*, No. 71-478, Oct. Term 1971 (Illinois—refusal to name the putative father of an illegitimate child)] and before three-judge District Courts in at least two states [*Chee v. Graham*, D. Ariz. No. CIV 70-532 PHX WEC (refusal to identify putative father of illegitimate child and refusal to sign complaint); *Doe v. Carleson*, N.D. Cal. No. C-71 864 RFP (refusal to be interviewed by district attorney)], and before the Court of Appeals for the Tenth Circuit (No. 71-1180) in the appeal from *Saiz v. Goodwin*, 325 F.Supp. 23 (D. N. Mex. 1971) (refusal to identify putative father of illegitimate child).

The NOLEO provisions of the Social Security Act, as well as regulations of the United States Department of Health, Education and Welfare, impose stringent requirements upon states to establish paternity and to secure support from natural parents for needy, abandoned children, in lieu of continued, self-perpetuating welfare subsistence. In many instances, the cooperation of the mother is absolutely essential to the successful collection of child support. Providing the mother with the option, as does the Oregon law in question, of cooperating in this regard or of not continuing to receive welfare "is a reasonable administrative tool . . . [which] serves a valid and proper administrative purpose for the dispensation of the AFDC program." *Wyman v. James*, 400 U.S. 309, 326 (1971). Moreover, particularly in cases of illegitimate children, cooperation by the mother *at least* in terms of identifying the father may well be the *only* method by which the process of judicial

establishment of paternity and the sought-after securing of support, may even be commenced.

This Court's decision, touching on all of the various factors comprising parental "cooperation with law enforcement officials", as it appears to do, will have a devastating effect on the states' ability to give meaningful effectuation to the NOLEO provisions of the Social Security Act. These adverse results will occur most significantly in the area of attempting to secure support for illegitimate children—the very area in which, appellant believes, Congress was most concerned in the enactment of the NOLEO provisions.

Appellant urges this Court to grant a rehearing in this case to permit full briefing and argument, with the participation of other concerned states, before any final decision is reached. Simultaneously, it is respectfully urged that probable jurisdiction be noted in *Carleson v. Taylor,* No. 71-306, and *Weaver v. Doe,* No. 71-478, to permit full exploration and plenary consideration of the very important interrelated issues raised here and there.

ARGUMENT

The Oregon Regulations in Issue Are a Reasonable Administrative Tool Which Serve a Valid and Necessary Purpose in the Dispensation of Benefits Under the "Aid to Families with Needy Children" Program.

Appellees have urged, and the District Court has held, that the Oregon regulations, providing for a termination of AFDC benefits upon a mother's refusal to "cooperate with law enforcement officials" in seeking parental support from absent fathers, are invalid because in conflict with the Social Security Act. Appellant respectfully submits that a thorough analysis of the Social Security Act, as construed by this Court in *King v. Smith,* 392 U.S. 309 (1968), and *Wyman v. James,* 400 U.S. 309 (1971), compels the conclusion that the challenged provisions of Oregon law are valid.

In *King v. Smith, supra,* this Court appropriately noted that the "protection of . . . [dependent] children is the paramount goal of AFDC," 392 U.S. at 325, and held that the State of Alabama could not subvert that objective by means of the "transparent fiction that . . . [dependent children] have a substitute father," *id.* at 334, simply because their mother had had an occasional rendezvous with a paramour.

In that case, however, this Court, in discussing the "NOLEO" provisions which are at issue herein, noted that the Congressional intent was clear that those "provisions seek *to secure parental support in lieu of AFDC support* for dependent children." *Id.* at 332 (Emphasis added). The NOLEO provisions are directed at the participating states—requiring the state "welfare" and "law enforcement" officials to establish procedures to determine paternity (if necessary) and to secure support for abandoned children from legally responsible parents. 42 U.S.C. § 602(a)(17). And, as noted by the District Court below (see Jurisdictional Statement at 8-9), the Social Security Amendments of 1968 (81 Stat. 878) gave to the states additional federal aid and agency-assistance in pursuing this important goal. See 42 U.S.C. §§ 602(a)(21), (22).

Thus, all concerned must cooperate in striving toward the goal of obtaining parental support in lieu of AFDC—all except the mother, at least so say appellees. The mother is exempted from this cooperative scheme, in appellees' view, because of her asserted overriding "right of privacy" (her desire to avoid discussing any details of her sexual activities which have resulted in the conception, and birth, of the now "needy" child)—notwithstanding the Congressionally-mandated goal of obtaining parental, rather than public, support for the child. Appellant submits that this

Court has already definitively rejected the same assertion in a virtually identical context:

> "The focus is on the *child* and, further, it is on the child who is *dependent*. There is no more worthy object of the public's concern. The dependent child's needs are paramount, and only with hesitancy would we relegate those needs, in the scale of comparative values, *to a position secondary to what the mother claims as her rights.*" *Wyman v. James, supra,* 400 U.S. at 318 (Last emphasis added).

Appellees correctly pointed out in their Motion to Dismiss or Affirm (at page 6 and footnote 2) that the Oregon Public Welfare Division has been provided with "legal tools to recover child support from absent fathers on its own motion."[2] However, appellees' argument presupposes that the state officials know the *identity* and the *whereabouts* of the absent father. Appellant submits that knowledge in these regards can be obtained by state officials—at least, and particularly, with regard to illegitimate children —most easily, and often exclusively, from the mother. "[I]t is obvious that any program to enforce a support obligation for an illegitimate child is useless if the mother refuses to reveal the identity of the child's father. . . ." *Saiz v. Goodwin, supra,* 325 F.Supp. at 25.

Yet appellee Young herein, like appellee Doe in *Weaver v. Doe,* No. 71-478, *supra,* and like appellant Saiz in the appeal in *Saiz v. Goodwin, supra,* and like plaintiff Chee in *Chee v. Graham, supra,* argues that she need not "cooperate"—not even to provide the name of a man whom

2. Unquestionably Oregon, and other states [see, *e.g.,* Cal. Welf. & Inst. Code §§ 11350, 11353, 11476 as amended effective October 1, 1971, the text of which is set forth in Appendix B to the Motion to Dismiss or Affirm in *Carleson v. Taylor,* No. 71-306] possess "legal tools" to proceed "on their own," *in certain instances,* against absent fathers to obtain child support.

the state may contemplate suing for the benefit of her illegitimate child—but that she and her child must nonetheless continue to receive AFDC benefits. Appellant submits that neither the Social Security Act nor the Constitution compels such a result—yet the decision of the District Court which has been summarily affirmed herein leads inexorably to such a state of affairs.

In our view the issue in this case is substantially identical to that in *Wyman v. James,* and, insofar as differences exist, the regulation here presents an even stronger case for a determination that it is a "reasonable administrative tool; that it serves a valid and proper administrative purpose for the dispensation of the AFDC program; [and] that it is not an unwarranted invasion of personal privacy . . . ." *Wyman, supra,* 400 U.S. at 326.

In *Wyman,* this Court stated the issue before it to be "whether a beneficiary of the program for Aid to Families With Dependent Children (AFDC) may refuse a home visit by the caseworker without risking the termination of benefits." 400 U.S. at 310 (Footnote omitted). In the instant case, the issue is whether a recipient may refuse to cooperate with law enforcement officials by refusing to sign a complaint, by refusing to be interviewed, or by concealing the identity of the putative father of the child—again without risking the termination of benefits.

In *Wyman* (400 U.S. at 315-16), this Court discussed federal aspects of the AFDC program provided for in Subchapter IV, Part A, of the Social Security Act of 1935, 49 Stat. 620, as amended, 42 U.S.C. §§ 601-610. The Court noted that the purpose was to encourage the care of children in their own homes by enabling the states to furnish financial assistance and other services to needy dependent children to strengthen family life, and recited from the Act

72-573 O - 72 - pt. 6 -- 31

that a state must, in determining need, take into consideration any other income or resources, must provide for bringing the conditions to the attention of an appropriate court or law enforcement agency where the state agency had reason to believe the child's home was unsuitable, and that where there is reason to believe the aid is not being used in the best interests of the children, the state agency may provide counseling or guidance or advise the recipient that protective payment or the appointment of a guardian or criminal penalties might result. The Court noted that home visits were not required by federal statute or regulation, *id.* at 319, but that the home visit required by New York served the appropriately important purpose of enabling the state to determine whether there were changes affecting the family's eligibility or the amount of assistance and whether there were any social services needed. *Id.* at 314.

As relevant to the instant case, the Social Security Act also requires that the state plan must provide for prompt notice to law enforcement officials in respect of a child who has been deserted or abandoned by a parent [42 U.S.C. § 602(a) (11)], and must provide for the *development and implementation* of a program to establish the paternity of a child born out of wedlock and to secure support from the abandoning parent for any child receiving aid. 42 U.S.C. § 602(a) (17). Thus, the establishment of paternity and the obtaining of support here, in contrast to the home visits of *Wyman,* are *required* by the Act. The Oregon regulation at issue here implements, rather than conflicts with, this requirement.

In *Wyman,* after noting the hesitancy with which the Court would relegate the dependent child's paramount needs to a status inferior to any claimed rights of the mother (400 U.S. at 318) the Court approvingly acknowl-

edged the state's interest in seeing that the primary objects of its concern (needy children) in fact benefit from its grants of aid. A sanction against the mother (of termination of assistance) was held to be an appropriate "gentle means . . . of achieving that assurance." 400 U.S. at 319. Here, if maternal cooperation is refused, assistance simply does not begin or is terminated.[3]

The application of these considerations to the instant case are apparent. The obtaining of support from an absent parent is perhaps *the* critical factor in allowing the recipient child to become freed of dependence on public assistance. The potential benefit to the child, itself, is patently obvious. Moreover, where the child is illegitimate, the determination of paternity provides him with a "name" and a heritage. For all children, the obtaining of support from the absent parent provides a responsible parent, and encourages contact and the strengthening of the family ties in furtherance of the Congressional objective. *See* 42 U.S.C. § 601.

Within the context here of implementing the NOLEO provisions, in instances where paternity of a needy child is in question and where the mother "refuses to cooperate" but where the identity of the putative father is known or suspected, alternatives to aid termination are "not without . . . seriously objectionable features," *Wyman, supra,* 400 U.S. at 323, just as were the sought-after search warrant procedures in *Wyman.* See 400 U.S. at 323-4. Where the identity of the putative father is known or suspected, the state may appoint a guardian ad litem for the child and file a civil suit in its name against the alleged father. The mother is then a potential witness and subject to civil discovery both by the state, representing the child, and by the

3. Compare *Wyman,* 400 U.S. at 317-18: "If consent to the visitation is withheld, no visitation takes place. The aid never begins or merely ceases, as the case may be."

See also, HEW's regulation [45 C.F.R. § 235.70 (c), 36 Fed. Reg. 3869 (Feb. 27, 1971)] which reflects a similar option: the mother may receive aid and thereby become subject to NOLEO requirements, or she may withdraw her application for assistance.

alleged father. Her answers are then a matter of public record. Where the responsible state agency has been unable to carry out an interview and preliminary investigation, these answers may reveal that the named or suspected father is not the likely father whether due to the mother's lack of candor of ignorance of biological facts; and thus, may unnecessarily reveal embarrassing personal facts. There is also obvious and unnecessary loss of privacy and embarrassment to the improperly named man. In any event, such personal facts will be a matter of public record in all cases, whereas a private and confidential interview with enforcement officials might have determined that there was no possibility of succeeding in an action. Clogging of the judicial system with unnecessary and fruitless lawsuits also would thereby be avoided. Minimum interference with the "privacy" of all concerned—*man, woman,* and *child*—would be insured.

We submit that the question at issue here is indistinguishable from that in *Wyman,* except that it presents a stronger case in favor of validity. The Oregon regulation is "a reasonable administrative tool" that "serves a valid and proper administrative purpose for the dispensation of the AFDC program" and is clearly within the holding and rationale of *Wyman.* As this Court aptly observed there:

> "What Mrs. James appears to want from the agency which provides her and her infant son with the necessities of life is the right to receive these necessities upon her own informational terms, to utilize the Fourth Amendment as a wedge for imposing those terms, and to avoid questions of any kind." 400 U.S. at 321-22.

Here, each of the appellees attempted to insert a "Ninth Amendment Wedge," when in fact all that is involved is a

matter of simple choice—either to cooperate in securing support for her child while receiving public assistance, or not to cooperate and suffer the consequence of loss of aid. "The choice is entirely hers, and nothing of constitutional magnitude is involved." *Wyman v. James, supra,* 400 U.S. at 324.

CONCLUSION

For the above reasons, it is respectfully requested that this Court grant a rehearing in this case and note probable jurisdiction in *Carleson v. Taylor, supra,* and *Weaver v. Doe, supra,* to permit full exploration and plenary consideration of the very important interrelated issues raised.

LEE JOHNSON
Attorney General of Oregon
JOHN W. OSBURN
Solicitor General
AL J. LAUE
THOMAS H. DENNEY
Assistant Attorneys General
State Office Building
Salem, Oregon 97310
Telephone: (503) 378-4402
Counsel for Appellant

On the Petition for Rehearing

EVELLE J. YOUNGER
Attorney General of California
GLORIA F. DEHART
JAY S. LINDERMAN
Deputy Attorneys General
6000 State Building
San Francisco, California 94102
Telephone: (415) 557-0420

CERTIFICATE OF COUNSEL

I, JAY S. LINDERMAN, hereby certify that:

I am a member of the Bar of the Supreme Court of the United States.

I am a Deputy Attorney General of the State of California and as such, I have been associated by/and with Lee Johnson, the Attorney General of the State of Oregon, as counsel for appellant on the foregoing Petition for Rehearing.

The foregoing Petition for Rehearing is presented in good faith and not for purposes of delay and I so certify on my own behalf and on behalf of the Attorney General of the State of Oregon.

Dated: November 3, 1971

JAY S. LINDERMAN

NORTH DAKOTA MEDICAL ASSOCIATION,
Bismark, N. Dak., February 3, 1972.

Hon. QUENTIN N. BURDICK,
U.S. Senate,
Washington, D.C.

DEAR MR. BURDICK: Current State Health Department Regulations require that patients in nursing homes are seen by a physician once every thirty days. Title XVIII, and by reference Title XIX, have similar regulations as a condition for participation.

The Council of the North Dakota Medical Association reiterated a previous position that patients should be seen when medically necessary, and not on a time interval basis. The Council endorsed the enclosed resolution passed by the American Medical Association and directed that a copy be forwarded to you.

Thank you for your cooperation.

Sincerely,

VERNON E. WAGNER.

(Enclosure.)

RESOLUTION 1—PHYSICIAN VISITS TO EXTENDED CARE FACILITIES

Resolution 1 requested that the AMA urge the Social Security Administration to amend its regulations so that a physician may exercise his medical judgment and visit Medicare and Medicaid patients only as frequently as medically necessitated, rather than at least once every thirty days.

The House considered the following Substitute Resolution:

"*Resolved*, That the House of Delegates of the American Medical Association affirm that, in the interest of the best patient care, the frequency with which patients are seen is properly the decision and responsibility of the physician, subject to proper and recognized review by his peers and be it further

"*Resolved*, That this policy be transmitted to all public and private third party payment agencies and to the Joint Commission and Accreditation of Hospitals."

Substitute Resolution 1 *adopted.*

NEW YORK, N.Y.

TOM VAIL,
Chief Counsel, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

The following statement is for insertion in formal hearing record on HR1.

We are opposed to H.R. 1 It is based on false premise that cause of poverty lies within poor. It is punitive. Its passage, even with Ribicoff amendments does not advance true welfare reform.

But the position of the poor retrogresses, state by state. We urge immediate emergency relief to the states until Congress can develop a more adequate welfare reform program. Using fiscal 1970 as the base year, assure each state of 100-0/0 federal funding of all welfare costs over this base providing they do not retreat from current standards.

WALTER L. SMART,
Executive Director,
National Federation of Settlements and Neighborhood Centers.

STATEMENT OF WILLIAM A. DIMMICK, PRESIDENT OF THE HEALTH AND WELFARE PLANNING COUNCIL OF MEMPHIS-SHELBY COUNTY, TENN.; ACCOMPANIED BY PAUL SCHWARTZ, DIRECTOR, DIVISION OF SOCIAL WELFARE, MEMPHIS STATE UNIVERSITY; AND MOSE PLEASURE, JR., ASSOCIATE EXECUTIVE DIRECTOR OF THE HEALTH AND WELFARE PLANNING COUNCIL, BEFORE THE COMMITTEE ON FINANCE, AUG. 26, 1970, ON H.R. 16311

Mr. DIMMICK. Honorable members of the Senate Committee on Finance, I am William A. Dimmick, president of the Health and Welfare Planning Council of Memphis-Shelby County, Tenn. With me are Paul Schwartz, director, Division of Social Welfare, Memphis State University and Mose Pleasure, Jr., associate executive director of the health and welfare planning council. Mr. Schwartz is on my left, Mr. Pleasure is on my right.

A brief historical statement is in order to place this testimony in proper perspective. A welfare subcommittee of the planning council's division of community development began work on an alternative to the present welfare system in response to President Nixon's announced intention to introduce welfare reform legislation. Subsequent study and debate included all segments of the population of Memphis adopted the results of this study and debate as the Council's official and Shelby County. The planning council's board of directors adopted the results of this study and debate as the council's official position on welfare reform. This official position is bound under the title "Concepts for Dignity", copies of which we are pleased to leave for the further consideration of the committee. "Concepts for Dignity" goes into great detail in pointing out 40 points which we consider basic to welfare reform.

The Health and Welfare Planning Council was then encouraged by Shelby United Neighbors, our local United Fund, to seek a statewide base for study and debate. At the request of the United Funds and Community Councils of the four major urban areas in Tennessee, Brigadier Luther A. Smith, president of the Tennessee Conference on Social Welfare, commissioned Paul Schwartz of Memphis State University to prepare a statement for study which was mailed to over 6,000 health and welfare professionals and volunteers. At its annual meeting in Nashville the TCSW voted to appoint a representative to join The Health and Welfare Planning Council of Memphis in testimony before this committee. Mr. Schwartz is that appointee. I take pride in pointing out, therefore, that in addition to the kind invitation of the Senate Committee on Finance, our testimony here today is the result of the hard work and warm support of a significant cross section of the people of the State of Tennessee.

We take great pride in the fact that through the efforts of Mr. Cliff Tuck, director of Coordination for Shelby County, our welfare positions received warm recognition and consideration by the National Association of Counties. A number of position points in our presentation were incorporated in the NACO welfare positions. In this way the efforts of Tennesseans have gone quite beyond our borders.

We are present, also, because it is a privilege and a duty to lend assistance, as small as it may be, to you who shoulder the ultimate responsibility for reforming the presently inadequate system of public welfare. We share with you this moment of tremendous opportunity and challenge in our Nation's history. We share with you this moment during which our glorious national dream can begin to become reality indeed for more of our people. We stand with you at the threshold of a new American era—an era ushered in by the establishment of a minimum income floor guaranteed as a right to those for whom our opportunity structure does not function properly.

This revolutionary new concept has the potential for becoming the basis of genuine reform in public welfare. We salute our administrative and congressional leaders, past and present, whose commitment to social justice and human welfare has brought us to this day of great promise. Our presence here is based on the real hope that the family assistance plan will produce the welfare reform which we all seek. We applaud this body for leading the Nation to the realization that public welfare is a national issue. As partners with our esteemed administrative and congressional leaders we come to present recommendations which we hope will assist in achieving our common goal. The basic premise upon which our position is built is that welfare reform is needed to help people get off the welfare merry-go-round. There is a brief paragraph not included in the text before you which I would like to add to our text.

The paragraph is this.

The reason for welfare reform in the first place is that we must now make it operate to get people out of poverty rather than perpetuate the cycle of poverty. In order to achieve this reform, we must guarantee two basic things. First, a basic minimum income floor guaranteed as a right to those in need, and second, a comprehensive array of social services to serve as bridges out of poverty.

While the two basic guarantees are inseparable in our judgment, we tend to stress bridges out of poverty as a very essential element.

This is the end of the paragraph and I will be glad to provide the reporter with a copy of it.

I would like now to address ourselves, then, to the adequate income floor. By adequate income floor we mean a level at or above some reasonably established

mark of basic impoverishment. Our recommendations, which we view as basic to the achievement of an adequate income floor, are:

1. That the minimum income floor should be set at $3,600 for a family of four. This basic level can be flanked by two subsequent measures which tend to progressively reduce the overall cost of financial assistance.

2. The national food stamp program should be eliminated and supporting appropriations reallocated to provide for the high-income floor. Food stamps might be used for individual emergency situations instead of an ongoing solution to impoverishment.

3. Congress and State legislative bodies should raise the minimum wage to $1.75 per hour in order to place approximately 10 million jobholders above the threshold of impoverishment.

4. Both the basic income floor for welfare recipients and the minimum wage rate should be adjusted annually based on any significant increase in the consumer index.

5. The working poor without children should be covered (with the understanding that jobs covered by the minimum wage law is the best solution to this particular poverty problem). Single adults who work or are unemployed also be included.

6. Old-age assistance, aid to the blind, and aid to the disabled legislation should provide the same eligibility requirements as social security, with a minimum floor of $200 per month for a single person (over 62 years of age; any age person for blind or disabled), and $350 per month for a married couple.

7. Benefits for the aged, blind and disabled should have an automatic cost-of-living increase based on the consumer index as suggested for welfare recipients.

Now, to address ourselves to bridges out of poverty. The success or failure of an adequate income floor, in achieving the goal of the elimination of poverty, will depend on the strength and effectiveness of the bridges out of poverty built into the welfare program. A comprehensive array of social services must be provided for all recipients who need them if this goal is to be accomplished. Only adequate, effective and forthright services, of broad scope, can produce the orderly translation of the status of poverty into the status of productivity. We strongly urge the creation of these bridges out of poverty as an integral part of, and not divorced from, the welfare package.

1. Of highest priority, in this regard, will be the availability of free day care services for working mothers. Day care should be expanded, provided on a 24-hour basis, and enriched by the incorporation of Headstart concepts. Organized groups, religious, and otherwise, could make giant steps toward providing these services if the proper incentives were offered.

2. If mandatory job and training requirements are retained in the family assistance plan the public sector, including private public contractors, should be made "employers of last resort," with training and salary support financed from Federal funds.

3. To assist in controlling the population explosion, additional financial incentives should be provided for recipients who voluntarily decide not to have more than one child per parent (perhaps $250 additional per year; a family of four would receive the minimum floor of $3,600 plus $250, or $3,850 per year). This provision should be included only if through income tax reform an equal tax credit were made available in the same manner to nonrecipients.

4. Of crucial importance to building and maintaining bridges out of poverty is the participation of local citizens, especially the recipients themselves, at all levels of planning and administration of the welfare program. This item cannot and must not be given short shrift.

5. The family assistance plan should have a scheduled phasing out of State funds until there is a complete Federal takeover of the cost of welfare in 10 years.

Such a plan will redeem the American dream for many who can have little or no hope without it. Such a plan will give those of us who are more fortunate even more reasons to be proud that we are Americans.

We have with purpose in regard for your time made a brief statement. We thank you for your time with us, your efforts in behalf of all the people of our land and the world, and we respectfully request your further consideration of the "concepts for dignity." We offer ourselves for any service to which you may call us.

Thank you.

Senator ANDERSON. Any questions?

Senator JORDAN. No questions, thank you.

Senator ANDERSON. Senator Harris?

Senator HARRIS. Father Dimmick and Mr. Schwartz and Mr. Pleasure, I am immensely impressed with your statement, but, more than that, with how it was prepared. Is there anything like this going on anywhere else in the country, where there has been some attempt to get the local people together to concentrate on coming up with some ideas on welfare?

Mr. PLEASURE. We do not know anything like it.

Senator HARRIS. It is the first I have heard of it.

Mr. SCHWARTZ. I understand something like this took place in California but whether that was only limited to Government functionaries or the broad citizen phase I do not know.

Senator HARRIS. I wish that same sort of process could go on all over the country. As you know, having just been in the process of developing these recommendations—and it goes without saying that I think they are right on target; I think what is said, Father Dimmick, about a minimum income floor guaranteed as a right are very important words; I think what you say about the level of income and recommending, instead of food stamps, except in emergency situations, raising the level, is good; Senator McGovern was here yesterday before this committee and said he would be quite happy with that kind of suggestion.

I am very pleased with what you say with regard to participation of local citizens in the program and with your recommendations about federalization of the welfare system so that it will be taken over as a Federal program. I think that must be done for a lot of reasons.

There are so many myths about welfare. You and I know we would not like to, as they say, "be on relief," but, somehow people assume that poor people do or that they just do not have the ambition that the rest of us have.

How can we dispel a lot of these myths about welfare, do you think? Is there a better way than what we have done?

Mr. DIMMICK. Maybe my colleagues would like to——

Senator HARRIS. Mr. Pleasure, do you have any ideas?

Mr. PLEASURE. The process that we took this through over a full year and a half—this was not done overnight—the process we took this through, we think, is a valid process and when the well motivated volunteers that you can find in any community are given an opportunity to take part in this, they may begin by being turned over, but they are exposed to something that becomes an educational process for them. The community becomes educated. This kind of education process——

Mr. SCHWARTZ. This includes welfare recipients.

Mr. PLEASURE. The Memphis Welfare Rights Organization was right in the middle of this. Sometimes it becomes abrasive but it was good experience for everybody and out of it came what you heard. This is theirs. This is no professional job. This is the result of the process we took this thing through. It is a beautiful thing. It is time consuming, it can be frustrating, but it is fundamental to how a democracy works.

Senator HARRIS. From the standpoint of those who are not themselves recipients of welfare assistance, did you find in this process some of them changed some of their ideas about welfare?

Mr. PLEASURE. Absolutely; yes, sir.

Mr. DIMMICK. We were utterly amazed, we should say, maybe utterly is too strong a word to use, but when our "Concepts for dignity", when we were working this out and finally had the paper ready to present, there was no major opposition to its adoption. There were some questions and I would say minor modifications on part of the wording of it but because the people involved had been through the process of thinking about these, I think, therefore, they were ready—well, these were their ideas, shall we say—they were not ready to accept somebody else's ideas but they had grown along with these.

Mr. SCHWARTZ. May I say this essentially was how we attacked the stereotype of happy dependents on welfare, the person who would rather sit there than get out.

I think there are two points I would like to add to what was said. One is I am under the impression—I may not be accurate—that a services package attached to this bill involves development of service areas programs in various States in order to create various service packaging including adoptions and family counseling, and so on. If the process whereby these service area programs were

developed went through a similar kind of process, I think we could literally involve hundreds of thousands of citizens from various walks of life in the process of getting acquainted and undergoing the various attitudes changes referred to.

The second point, the effect of an adequate welfare program surrounded by work opportunities and work incentives and surrounded by adequate services would produce a situation in which thousands of people would be leaving welfare for the productive area and that would be the best public relations for all of us in the world and the best interpretation.

I think everyone is touched sitting here and hearing a Senator tell about when he was on relief and touched by the fact that he is now a Senator. A program of moving people out of welfare is the best thing we can ever achieve and I think we join all America in this thing.

Senator HARRIS. I agree with that. The thing that struck me some years ago in talking about welfare is that, though they do not realize it, people receiving welfare assistance and those who are taxpayers are saying the same thing about welfare. They do not hear each other say it, but they both say it is a failure, that it traps people in poverty, that it perpetuates dependence. If we could somehow listen to each other, we would find out we are on the same side. More people now realize that welfare as it now exists is not working.

Mr. SCHWARTZ. The opportunity for this process, however, exists in so many segments of this bill. The creation of day care facilities on local level has to be supported by boards and groups of citizens. And it is this kind of involvement, I think, that would parallel this and really produce a changing view and I would feel, we all would agree, having lived through this year and a half, that involvement is the best way.

Senator HARRIS. I appreciate that very much, Mr. Schwartz and Father Dimmick and Mr. Pleasure. You have helped not only with your testimony but with the idea of how it came up.

Senator ANDERSON. It has been a fine statement. Thank you very much.

Mr. DIMMICK. Thank you very much. We are indeed grateful to you.

(The document referred to previously "Concepts for Dignity," follows:)

CONCEPTS FOR DIGNITY

RECOMMENDATIONS OF THE HEALTH AND WELFARE PLANNING COUNCIL OF MEMPHIS AND SHELBY COUNTY, TENN. FOR REFORMING THE U.S. PUBLIC ASSISTANCE SYSTEM

> We, the people of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and to our posterity, do ordain and establish this Constitution for the United States of America.

The Preamble to our Constitution is still the most cogent statement of goals ever formulated for a nation. That we are in yet another cycle of ferment toward achieving these goals is testimony to their continuing dynamism and relevance. It is this dynamism and relevance which brings the United States to the very point of making the "goals of America" relevant to *all Americans*.

To this end the Health and Welfare Planning Council of Memphis and Shelby County, Tennessee has sought to be and to become one of the major *places* where Mid-Southerners can voluntarily formulate plans for social policies and programs. "Concepts For Dignity" is a result of that process. A *Welfare Task Force*, appointed as an *ad hoc* sub-committee of the Community Development Steering Committee, has been at work for more than six months on these proposals. The Board of Directors of the Health and Welfare Planning Council adopted the forty Welfare Reform Positions as Council policy for testimony before the Senate Finance Committee and inclusion in the record of the committee hearings.

It is our belief that the involvement of people at the local level, people from all strata and all segments of the population, in the process of identifying and defining major social issues and problems and the development and initiation of proposals and plans intended to contribute to their solution is the only practical means for making the "American Dream" a national reality—for making the "goals of America" the goals of every *American*. The Welfare Task Force has given documentation to the utility of this concept. For spurring our faith and inspiring further exploration and innovation we give profound thanks to the

dedicated volunteers—The Welfare Task Force, The Community Development Steering Committee, and the Board of Directors—who are the authors of "Concepts for Dignity".

MOSE PLEASURE, Jr.,
Associate Executive Director.

Community Development Steering Committee:
Dr. Granville Davis, *Chairman*
John T. Fisher
Elias Goldsmith
Miss Elizabeth Jones
Reverend James M. Lawson
Leon Lynch
Dr. Joseph H. Riggs
Mrs. A. R. Scharff, Jr.
Clifford L. Tuck

Welfare Task Force:
Clifford L. Tuck, *Chairman*
Mrs. Joseph H. Miller
Mrs. Patricia Vander Schaaf

Staff:
Mose Pleasure, Jr.

INTRODUCTION

Much of the current debate about "Welfare" is confusing. It is difficult to determine whose welfare is at stake or exactly who is "on" welfare at any given time. Are the recipients of "Public Welfare" the true beneficiaries of the American general social welfare system? Or, do the majority of Americans enjoy a propitious general social welfare system at the expense of a minority for whom this system does not work? Up to now the answer to these questions have depended on the prejudicles of the respondents. Now that such prejudices have become unconscionably costly luxuries we should be able to "tell it like it is". Let the following "item" serve as introductory to the story which must be told.

As a teenager, Roger Atkinson lived with his parents in a Public Housing Development. Roger attended Public School and participated in the "reduced price" lunch program. After graduation he entered the Army. Upon discharge Roger retained his National Service Life Insurance. He enrolled in the State University, working part-time to supplement his GI Bill Stipend. Roger married a Public Health Nurse, bought a home with a GI Loan, and obtained an RFC Loan to go into business.

When Roger, Jr. was born in City Hospital the Atkinsons purchased a small ranch through the Veteran's Land Program. Payments on land placed in the Soil Bank speeded up the payoff of the mortgage. Roger's father and Mother retired to the ranch in real comfort on their Social Security Checks. REA lines supplied electricity for the ranch, the Federal Government gave assistance in clearing the land and supplying emergency feed, the County Agent showed him how to terrace the land, and the Federal Government built him a fish pond.

Roger, Jr. read books borrowed from the Public Library. The money saved for Roger, Jr. by his parents and Grandparents was insured by a Federal Agency. In Public School Roger, Jr. paid the less than cost price charged by the school for the federally subsidized lunch program. Roger, Jr. rode the school bus, played in municipal park, swam in the public pool, and became a member of Future Farmers of America. Roger, Sr. owned an automobile, so he favored State and Federal Highway Programs. He was one of the signers on a petition seeking Federal assistance in developing an industrial project to "help the economy of his area", was a leader in a move to get a new Federal Building, and went to Washington with a group to ask the Federal Government to build a great dam costing millions so that the area could get "cheap" electricity. He was also a leader in a move to get his specific type of business special tax write-offs and exemptions. Then one day, when he heard that it would require a larger share of taxes to provide substitute, supportive and supplemental goods and services for persons who live below the poverty index, Roger Atkinson, Sr. wrote to his Congressman: "I protest these excessive governmental expenditures and the attendant high taxes. I believe in rugged individualism; I think that people should stand on their own feet without expecting handouts. I am opposed to all socialistic trends and I demand a return to the principles of our Constitution and the restoration of States' Rights."

The picture is overdrawn and an extremely complex reality has been oversimplified, but the point is valid: like Roger Atkinson, Sr., the majority of Americans both accept and actively promote Public Assistance Programs. Welfare Controversy and opposition develop when "welfare" is narrowly construed to mean the scant few Public Assistance Programs other than the Local, State and Federal subsidies which benefit the majority and which are known by more acceptable names.

A recent poll indicates that the citizens of the United States are increasingly concerned about the conditions of their fellow citizens:

There is a marked increase in concern for the plight of America's disadvantaged over the past four years, according to a recently released Lou Harris Poll. The Harris Organization, which polled a cross section of 1,542 Americans last May, found Americans "increasingly conscience-stricken over the plight to the poor, the elderly and those subject to various forms of discrimination." A similar survey was conducted in 1965. Results of the two surveys were:

CONCERN FOR DISADVANTAGED

[In percent]

	1969	1965
Say they "often feel bad" over the way—		
Some people in the United States still go hungry	63	50
Older people have been neglected	52	35
American Indian has been treated	42	24
Some people in big cities still live in slums	37	31
Negroes have been treated	35	32
Some Jews have been treated	21	19
Some Catholics have been treated	15	14

Harris said the results "rather convincingly indicate that the rank and file of Americans are not without both guilt and compassion for the condition of the less privileged. If anything such sentiments have been on the rise." He said that current notions that the American public is "going sharply to the right" is a misconception in light of his findings.

The Health and Welfare Planning Council therefore determines that all Public Assistance Programs, under whatever name, must be structured to: 1) Assure individual dignity, 2) Provide individual economic security, and 3) Provide motivational inducements for individual improvement and advancement.

In September, 1969, the Nixon Administration introduced a surprising and bold welfare reform measure to the U.S. Congress entitled "The Family Assistance Plan". The measure is surprising in that it seeks to establish a national standard for welfare and it is bold in that it introduces the concept of a minimum level of subsistence for Americans as national policy for the first time in American History. A "Welfare Task Force" was appointed by the Planning Council and authorized to study the developing welfare reform legislation and recommend a policy position for reforming the National Welfare System.

Nationally, the characteristics of the victimized poor can be statistically described:

1. At the end of 1968 there were 25 million Americans below the poverty index ($2.43 per day per person as indicated in the Heineman Report Recommendations).

2. Thirty-three percent of the poor are employed full-time, but earn annually approximately $1,000 below the poverty index line.

3. Sixty-seven percent of the poor are white.

4. Thirty-three percent of the poor are black (includes Mexican-Americans, Puerto Ricans, Indians, etc.)

5. Forty percent of the poor are children under 18 years of age.

6. Twenty percent of the poor are over 65 years of age.

Statistics cannot adequately convey the abject hopelessness of existence in poverty. Poverty is best understood when fortunate Americans try to live for a week or two on a "welfare diet" or for longer periods with other types of privation typical of poverty existence. The tradegy of being in poverty can be strikingly summarized in a statistical statement, however: "Seventy percent of the nonaged

heads of poor families worked for at least part of the year and most of those who did not work were ill, disabled, women with young children, or children."

In Memphis and Shelby County there were about 47,000 persons on some form of Public Welfare (narrowly construed) at the end of 1969, or approximately 6% of the total County population. Memphis and Shelby County, on the other hand, have 160,000 persons living on incomes below the poverty index line, or approximately 25% of the total County population. Memphis and Shelby County are second only to San Antonio, Texas as the worst metropolitan area in the United States in poverty density.

CONCEPTS FOR DIGNITY—HEALTH AND WELFARE PLANNING COUNCIL OF MEMPHIS AND SHELBY COUNTY, TENN.

WELFARE REFORM POSITIONS

(Positions not necessarily listed in order of importance)

1. Name of legislation should be "Life Assistance Plan," rather than "Family Assistance Plan".

2. Since 10,000,000 jobs in the United States are paying less than $1.60 per hour (less than poverty level), State and national legislative bodies should raise the minimum wage law to not less than $1.75 per hour and extend law's coverage to all job classifications not presently covered.

3. Welfare should provide assistance of $3,600.00 to a family of four and continue support payments until the family has reached a total unsupported income of $5,500.00 per year (decreasing Federal support fifty-cents for every dollar earned to that point). Base allowance should be $1,300.00 per adult and $500.00 per child. Applicant income gained from irregular or infrequent sources should be exempt as a criteria for eligibility.

4. Must have a yearly adjustment based on consumer index (cost of living) increase. This increase should be figured from the previous year's 12-mo. average, and a separate check issued for the total amount of annual increase on December 1st, with percentage to be added to next year's monthly benefits.

5. Federal Government plan should require at least ninety-percent of State expenditures for welfare to continue as supplement to Federal guarantee floor during first two years, but provide for eventual funding totally by Federal Government. Example:

	Percent State share to continue	Percent State share to be picked up by Federal
Fiscal 1971-72	90	10
Fiscal 1973 (July 1, 1972)	80	20
Fiscal 1974 (July 1, 1973)	70	30
Fiscal 1975 (July 1, 1974)	60	40
Fiscal 1976 (July 1, 1975)	50	50
Fiscal 1977 (July 1, 1976)	40	60
Fiscal 1978 (July 1, 1977)	30	70
Fiscal 1979 (July 1, 1978)	20	80
Fiscal 1980 (July 1, 1979)	0	100

6. The Federal Government will absorb State share costs as indicated in item 5 formula if the State agrees to reallocate "saved" appropriations to education and manpower programs, especially for the poor (previous State increases in education and manpower budgets would be averaged for last three years to insure welfare dollars are not being used to take place of normal increases).

7. Working poor without children must also receive benefits, including single adults who are working or unemployed.

8. Mothers who are also heads of families should be aware of benefits, but not be required to work or register for training except at her own option, but should be encouraged to attend family planning, home management, and where needed, basic education courses established within this plan while children are attending school.

9. Persons required to register for jobs or job training should be placed in positions which have opportunity for advancement and to which they are satisfactorily motivated.

10. Minor members of families must be provided tutoring or other extra educational help where this need is identified.

11. Free day care provisions should be provided in the life assistance legislation and day care should be expanded to a 24-hour schedule and provide Head Start educational concepts; incentives should be provided to organized religion for providing these services. Quality educational standards should regulate all day care facilities.

12. Monitoring policy of life assistance legislation should provide incentive to train assistance recipients as para-professional monitors to provide income checks on an optional semi-annual and mandatory annual basis.

13. Supportive service within life assistance plan, such as employment and training, must be periodically reviewed and monitored by local and State citizen review committees consisting of substantial recipient participation and representation from other social-welfare and manpower organizations. Citizen review committees shall be responsible for determining suitable job criteria.

14. Some provision is needed to insure that students living away from family will receive direct payment under assistance.

15. Assistance plan must not be restrictive in the definition of family and be flexible, based on need.

16. Assistance plan should provide for orientation and continuing family planning education of local, State, and National welfare administrators, case workers, and counselors within the program. Welfare recipients should assist in conducting the orientation sessions.

17. Handicapped children should be eligible for additional benefits above normal welfare provisions.

18. The Federal Government should pay full benefit with a Federal check and the State should reimburse the Federal Government for its share of the benefit, rather than pay benefits in two separate checks.

19. Welfare services administration should be a county government responsibility with the local administrative costs being supported by Federal funds. Citizen review boards should review and recommend all administration personnel applications.

20. If mandatory job and training requirements are retained in the "family assistance plan," then the public sector, including private public contractors, will have to become "employers of last resort," with training and salary support financed from Federal funds.

21. Each county must have a centralized general assistance office, as a division of its welfare service administration office, to provide "emergency assistance" when applications are being processed for welfare benefits, or an applicant is not eligible for benefits under welfare reform legislation.

22. Special emphasis will be placed on manpower programs for the rural poor.

23. Welfare legislation must include provisions that provide for job development and training planning programs that anticipate projected changes in the job market.

24. Legislation must include provisions that will adequately staff, provide regulatory and review authority to cooperative area manpower planning committees for the purpose of effecting maximum coordination between State employment and security offices and local private and public academic, employment and training offices and institutions.

25. When a welfare recipient is eligible for benefits from more than one agency, the agency providing the larger benefit will also provide the benefits due from the other agency(s) in the same check, subsequently receiving reimbursement from the other benefit agency(s).

26. Welfare eligibility should be determined by: (a) Number of children (proof of dependency), (b) sources and amount of regular income (see item 3—sources and amount must be substantiated), (c) personal or real property should not be a criteria for determining eligibility only if not considered a "necessity of life."

27. Applicant eligibility can be verified by telephone (home visits should not be necessary).

28. A person residing in a non-welfare residence should be eligible for benefits

if the applicant is not a legal dependent of a member of the household (verification through Internal Revenue Service).

29. Recipients of one form of welfare should be eligible to receive other forms of assistance equal to the amount of additional expenses encumbered by the recipient in meeting their required needs about and beyond those that would normally be provided by only one form of welfare (i.e.—handicapped, mentally retarded, etc.).

30. Additional "seasonal" benefits should be provided to recipients if the minimum level for a family of four is below $3,600.00 per year.

31. Welfare legislation should establish a "special reserve fund" at the local level to meet immediate needs resulting from lost or stolen benefit checks (reserve funds should be Federal cost).

32. A National Citizen Review Committee should be established and structured the same as local and State review committees. This committee should establish what personal and real property should be classified as "necessities of life" and therefore exempt from consideration as assets in determining applicant eligibility for all welfare classifications. Legislation should require citizen review of this criteria at least once every three years.

33. Elderly retired citizens drawing welfare benefits and who are over 62 years of age should be exempt from taxation.

34. Elderly citizens should plan and regulate senior citizen benefit programs by serving as at least a majority of the membership of a citizen review committee whose decisions shall be considered mandatory upon unanimous vote, and advisory upon majority vote.

35. Old age assistance, aid to the blind, and aid to the disabled legislation should provide same eligibility requirements as social security with a minimum floor of $200.00 per month for a single person (over 62 years of age for aged; any age for blind or disabled), and $350.00 per month per married couple (couples marrying after receiving benefits should retain original benefits). The amount of assistance should be reduced in proportion to other income (i.e.—social security benefits, other retirement income, income from bonds, stocks, rental property, etc.). Seventy-five dollars per month per single person and one hundred dollars per month per married couple should be exempted from other income in this formula.

36. Aged, blind and disabled benefits should have a provision which provides the same type of automatic cost of living increase as suggested in item 4 of the welfare reform positions.

37. Real property value should be exempt unless property produces an income for any welfare recipient regardless of classification.

38. To assist in controlling the population explosion, additional life assistance "incentive" benefits should be made to recipients who voluntarily decide not to have more than one child per parent (perhaps $250.00 additional per year incentive; family of four would then receive basic floor of $3,600.00 plus $250.00 incentive for a total of $3,850.00 per year). This provision should be included only if income tax reform provides an equal tax credit in the same manner to persons who are not welfare recipients.

39. Welfare recipients of all classifications should be provided official identification cards.

40. The national food stamp program should be eliminated for welfare recipients and supporting appropriations reallocated to basic floors of new welfare legislation, either to increase the minimum floors or to absorb a portion of the increased welfare costs created by these higher floor positions. The food stamp program should be retained to assist needy persons who have emergency needs or are otherwise not eligible for welfare benefits.

RESOLUTION OF THE TENNESSEE CONFERENCE ON SOCIAL WELFARE, APRIL 24, 1970

Based on a careful examination of the Family Assistance Plan, the Tennessee Conference on Social Welfare finds it unacceptable. We further believe that it is irreparable by amendment. We therefore do not support it. We actively support positive alternative legislation which endorses the following seven principles:

1. Structural reform is no substitute for adequacy of financing sufficient to improve the situation of all those who depend upon it.

2. The level of minimum income assurance should be adequate in relationship to cost of living estimates.

3. The federal floor should be raised to the level of poverty through a series of transitional stages such as to (a) strengthen Federal standards, (b) protect the higher level of payment while raising the lower, and (c) maintain the level of state expenditures necessary to achieve these ends.

4. Benefits in kind and services extended to those aided by the plan should not be used to reduce assistance levels.

5. Welfare reform should be such as to move toward greater inclusiveness and away from categorical distinctions.

6. The legal and constitutional rights of recipients should be fully protected.

7. No improvements in the public welfare system should be such as to reduce the effectiveness of measures to prevent need or obscure the urgency of steps for improvement.

STATEMENT OF WILLIAM E. WOODS, WASHINGTON REPRESENTATIVE AND ASSOCIATE GENERAL COUNSEL, THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. Chairman: This past decade can be characterized as a period of intensive national attention to health, distribution of health resources, and accessibility of health services. The enactment of Medicare and Medicaid in the mid-1960's certainly sets the high water mark of health legislation in the United States.

Pharmacies and the pharmacists who practice in them are an integral part of the total health network in this country. The National Association of Retail Druggists represents the owners of approximately 38,000 independent pharmacies in the United States in which some 75,000 pharmacists practice their profession. These pharmacies dispense about 75 percent of the out-of-hospital prescription drug requirements of the nation.

NARD, therefore, has substantial concern with the proposals pending before the committee, particularly as these proposals affect the provisions of prescribed drugs.

We believe that H.R. 1 takes the wrong approach when it permits State Medicaid plans to eliminate the scope and extent of optional health care services insofar as this permits the curtailment or elimination of vitally needed prescribed drugs. Our objective, over the years, has been to have comprehensive prescribed drug coverage included as one of the mandatory health services required of State Medicaid plans. H.R. 1, as passed by the House of Representatives, seeks to effect a false economy which we urge the Senate Finance Committee to reject.

Congress cannot assume, as it has in the past, that elimination of drug coverage from Medicaid or the withholding of drug coverage from Medicare reduces the overall costs of these programs. We fail to understand the logic of providing hospital, diagnostic, and physician services in either Medicaid or Medicare but denying the patient coverage for the prescribed drugs indicated. The mistake the Congress made in failing to include prescribed drugs in Medicare is now being proposed for Medicaid. With Medicaid, the potential loss of drug coverage could be even more devastating because younger persons and children are more often bothered with acute infectious diseases for which the only therapy, particularly for children, is frequently drug therapy. Elimination of the drug provisions of a Medicaid program could effectively turn the clock back to the pre-wonder drug era when children died of relatively simple ailments currently controlled only with antibiotics.

Experience reveals that one of the major shortcomings of Medicare, in our view, is its continuing failure to make any provision for prescribed drugs for beneficiaries who are not confined in an institution—hospital or extended care facility. A Medicare patient can obtain a multitude of services—physician care, hospitalization, diagnostic services—but Medicare drug coverage is limited to drugs furnished during confinement in an institution.

Particularly with elderly patients, care at the earliest opportunity may avoid more serious illnesses and complications and the need for hospitalization. While a Medicare patient has coverage for physician office visits in most cases, there is no coverage of any drug therapy that generally is the key to the patient's recovery.

Since enactment of Medicare, both the Johnson and Nixon Administrations

have appointed special task forces to study the advisability of adding home drugs to the Medicare program and both task forces have recommended including such drug coverage. Further support for including drug coverage for the Medicare home patient came in a report by the 1971 Advisory Council on Social Security which stated "Medicare should be expanded to include coverage of out-of-hospital drugs requiring a prescription."

Most frequently, illnesses require a physician visit and some form of drug therapy. Because this is not the most expensive segment of care, our thinking usually rapidly shifts to the higher costs of hospitalization or nursing home care. There is no question that the substantial costs of extended institutional stays concern every citizen. And coverage for these costs, either through public programs or through health insurance, is necessary and reassuring. But the focus here is on the health care items of greatest cost affecting the smallest segment of the population.

Unquestionably, more people visit physicians, need laboratory services for diagnostic purposes, and have drugs prescribed for their illnesses than are hospitalized or need institutional care. The physician and pharmacist are actually the first line of defense in our health care system. Unfortunately, both in government programs and in private health insurance programs, coverage for prescribed drugs is given too low a priority or excluded altogether.

In the consideration of the proposals before the committee, we ask that prescribed drugs be considered as an integral part of a basic health care package which would also include medical and diagnostic services. What good is there in making the services of a physician available to diagnose an illness, and making diagnostic laboratory services available to assist the physician, if after these procedures and services are completed, the necessary drug therapy indicated to properly treat the illness is not also available. It just doesn't make sense to expend the time and resources on a diagnosis for which therapy cannot be provided. And it does not make any more sense to institutionalize a patient to assure that drug therapy indicated will be provided. However, this is the posture of the current Medicare program, most private health insurance programs, and some Medicaid programs.

If H.R. 1 causes prescribed drugs to be removed from the State Medicaid programs—and most state programs do include these drugs—then the lack of drugs for Medicare home patients will be emphasized throughout the land and may even become a national crisis. Many of the Medicare home patients in the needy category are now receiving some drugs under State Medicaid drug programs.

To further augment our position supporting mandatory drug coverage, the following resolution was adopted October 14, 1971, at the NARD Annual Convention in New Orleans, Louisiana:

"Whereas, there are currently pending in the Congress of the United States a number of diverse proposals for improving the availability of health care services to all citizens; and

"Whereas, most pending proposals either exclude or make inadequate provisions for home drug needs; and

"Whereas, in both Medicare and Medicaid the Congress failed to recognize the vital and essential role of pharmaceutical services in any health program that attempts to provide even rudimentary medical care; and

"Whereas, it is self-defeating for any program to pay for diagnostic and physician services without also assuring that indicated pharmaceutical services will be adequately provided when and as needed;

"Resolved: That the National Association of Retail Druggists, in Convention assembled, urges the Congress to include pharmaceutical services as a priority and mandatory benefit in any revisions of current plans for National Health Insurance or any future federally-funded health care program; and

"Further Resolved, That Congress should consider hospital, diagnostic, physician, and pharmaceutical services as comprising a single, coordinated, and interrelated unit of health care; and

"Further Resolved: That Congress be urged not to restrict drug coverage to those drugs provided in or by hospitals or similar institutions or in any other manner which discriminates against independent pharmacy participation.

Pending before the committee are S. 936 by Senator Montoya and S. 1847 by Senator Humphrey to add a prescribed drug benefit to Medicare for patients not confined to an institution. However, S. 1847 contains several provisions which make it more appealing, in our view.

Both bills require a co-payment amount. Experience in private programs suggests that the co-payment feature, ostensibly incorporated as an economic control on utilization, becomes nothing more than a competitive weapon. NARD urges that neither co-payment nor co-insurance be incorporated in a Medicare drug program design: first, because economic controls are not the appropriate vehicle for controlling utilization, and second, because erecting economic barriers may bar access to needed drug care.

Utilization controls and review are necessary to maintain the integrity of the program but these controls should be related to medical necessity and take the form of peer review and utilization review.

NARD prefers the reimbursement concept advanced by S. 1847 where the participating pharmacies would receive reimbursement reasonably related to their individual operational costs. We especially concur in the recommendation that cost data justification only be required for reimbursement amounts which exceed the 80th or 90th percentile of all fees requested by all participating pharmacies. We do not concur, however, with the application of the cost justification provisions to pharmacies by volume where their charges fall within the 80th percentile.

NARD members have been particularly vocal in their opposition to the requirement embodied in S. 936 which would limit the pharmacy reimbursement to the formula established in the bill or the "actual, usual, or customary charge" to the public, whichever is the lesser. We believe that this provision embodies an inherent unfairness.

If a flat sum representing total reimbursement (except for product costs) is deemed necessary or desirable for administrative and other purposes, such a "fixed fee" should be variable and individually determined for each pharmacy. No two pharmacies have the same volume or product mix, labor costs, services provided, and other similar factors. That sum ought to be an amount that is fair and reasonable and should be applied without exception in calculating reimbursement.

We would urge that government programs adopt any reasonable method of determining charges employed by the individual pharmacy. However, where some different method of reimbursement is mandated by the program, it should be uniformly applied. In this connection we submit for the record as an appendix to this submission a copy of a report NARD sponsored which is the most extensive analysis and study of variability in pharmacy charges for prescription drugs conducted by the R.A. Gosselin Company.*

The purpose of the study was to collect and present objective and pertinent statistical data which could be used by third party reimbursement administrators and planners and others to aid in the design of fair and equitable reimbursement policies for all pharmacies commensurate with the public interest.

This study was undertaken to assist the Senate Finance Committee in considering drug coverage in any medical care program.

NARD strongly supports the provision of S. 1847 which requires the government to pay six percent interest on all drug claims which remain unpaid for more than 60 days after they have been filed. Experience with the state Medicaid programs has shown that capital can be quickly tied up in unpaid claims and may require the pharmacy to seek huge loans to stay in business. The Congress should consider shortening the 60 day period to 30 days, which is more consistent with normal commercial practices. If the claim has been on file with the government for longer than 30 days, the interest payments should begin.

A comparable interest on unpaid claims provision should be considered for for insertion in the Medicaid legislation. These state plans have been the biggest and most frequent offenders of prompt payment deadlines. Providing for an interest cost on unreasonably delayed payments would encourage modernization of claims processing and payment procedures in the states to the eventual benefit of all.

NARD believes that the "cost" basis employed in S. 936 is more workable than the "actual acquisition cost" incorporated in S. 1847. Under S. 936, "cost" would be an established figure which is determined to be the level at which the drug is generally available to pharmacies. The approach has a desirable certainty and ease of use. Determinations of "actual" acquisition cost, while perhaps more theoretically sound and logical to employ, are costly to administer.

*The report referred to was made a part of the official files of the committee.

We support the inclusion of essential non-prescription drugs in any drug benefit for either Medicare or Medicaid. Many non-prescription drugs, such as antacids, are material factors in the continued well-being of patients and should be included. Exclusion of these simple and less expensive items can only have an overall adverse effect on the entire drug program. Reimbursement plans included in either S. 936 or S. 1847 are acceptable.

One of the chief complaints about third-party drug programs, sponsored by either private groups or government, is that none of them permit or assure the providers of services an adequate role or voice in the design, operation, and administrative aspects of the program. At our instigation and request, a subcommittee of the House Select Committee on Small Business held three days of hearings during the summer of 1971 on the impact of third-party payment programs and the record of those valuable hearings details the problems and issues of greatest concern to independent pharmacists. Basically, however, the problems and contentions arise because all parties interested in the drug program, except the pharmacists who must economically and professionally operate and survive under them, have a role and voice in the planning and implementation.

Therefore, we support the provision in S. 1847 which would establish an Advisory Council on Drug Coverage to advise the Secretary of Health, Education, and Welfare on matters of general policy in the administration of the drug program.

However, we would go further than the proposed Advisory Council on Drug Coverage in S. 1847 and earnestly solicit consideration of a panel of providers which would be charged with the primary task of implementation of the drug benefit in Medicare. What we envision here is a panel of distinguished pharmacists (who would not be full time government employees) to act as a board of directors responsible for pharmaceutical benefits.

The provider panel would be charged with the principal responsibility for developing the design, operation and supervision of the administration of the benefits furnished. We submit that this would vest operational and administrative responsibility where it rightfully belongs and maximize the expertise and resources of the profession of pharmacy in developing and operating a successful drug benefit program.

Plans recommended by such a panel should be adopted and implemented unless the advisory council or the responsible governmental agency can demonstrate that the proposed plan is unreasonable or that the proposed plan is incompatible with other phases of the benefit package or program goals. NARD recognizes that the drug coverage program must be coordinated with other phases of the Medicare coverage in that ultimate control and supervision must be vested in the government. But such control and supervision by the government should be exercised only if the profession itself either cannot or will not supervise its own practitioners.

NARD believes that "provider panels" for each benefit area covered would result in an improvement in the Medicare program and a greater sharing of responsibility for the effects and results of the program by the providers. If the program is abused, or fails to achieve the desired results, or experiences other difficulties, the providers would have to first look to themselves for the answers rather than waiting for the government to act. In effect, the government and the providers would be partners in the provision of the benefits and share equally the credit and the blame for successes and failures.

Too often, social benefit programs appear to be designed by a governmental bureaucracy without regard to existing practices and procedures in general use and without an appreciation or understanding for the details involved in the actual administration and implementation of the plan. This tends to create a near adversary relationship between the government, the providers, and the beneficiaries which may interfere with the objectives of the program. A current example of such a situation appears to exist in the State of Maryland where press reports indicate that welfare recipients find a number of pharmacists unwilling to participate in the Medicaid program.

This is the type of result the "provider panel" concept we have proposed seeks to avoid.

NARD believes that one of the major weaknesses and deficiencies in current health care programs, both public and private, is the absence of, or inadequate provisions for, pharmaceutical services. We believe that one of the major strengths in the health care system is the thousands of independent community

pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare and Medicaid health care programs should seek to correct this deficiency and capitalize on the strengths of the existing retail distribution network for drugs.

The vendor program for provding drugs has proved acceptable in Medicaid. In fact, the change to the vendor program concept in health care was established in the last decade by the Kerr-Mills program. While NARD members have had many complaints about the actual administration by individual states of the vendor program under first the Kerr-Mills legislation and later under the modifications made by Medicaid, the strength of the vendor concept is as valid today as it was in 1960.

Another important, indeed essential, concept that has stood the test of time in Medicare and Medicaid is the "freedom of choice" guaranteed to patients to select any qualified provider of services to furnish needed health care services. We believe that freedom to choose the health care practitioner is a strength of the current federal programs and should be retained in any future program.

Combined, these two concepts—vendor program and freedom of choice—permit and preserve an opportunity for the traditional forces in our competitive enterprise system to assure that the quality of care and services will not deteriorate merely because the government may be paying all or part of the costs.

It should not go unmentioned that the addition of a drug benefit to Medicare should, in part, relieve part of the strain on state Medicaid budgets. Under the present health care plan for the aged Social Security recipients, hospitalization benefits and extended care facility benefits are guaranteed Payment of the Part B Medicare premium assures coverage for physician services. However, those who cannot afford prescribed drugs must resort to the Medicaid program in their state of residence. Under the current provisions of H.R. 1, the continuance of prescribed drug programs in the states is tenuous at best.

Realists will speak of costs, as they have in the past. And the costs of the program must certainly be considered.

First, all of the leading proposals incorporate some limitation on eligible drugs which may be paid for under the program. Where necessary to conserve funds or to permit the establishment of the program, we would support some limitations on the drugs which could be prescribed and dispensed where economically necessary and professionally justified.

Second, suggested elimination of the Part B premium payments is estimated to add approximately $1.5 billion to the Part A costs of Medicare—an amount that some believe would finance a fairly comprehensive Medicare drug program. It might well be that the Medicare beneficiaries would prefer to have drug coverage added rather than the elimination of the Part B premium—some of which is paid by state Medicaid programs. Perhaps a poll of the Social Security recipients would be decisive.

Third, costs of the program might be curtailed by selective enrollment. Under this alternative, coverage would be initiated under Part B of Medicare and the premium established at a level that would assure that only those with substantial drug expenditures would find election of the coverage economically attractive. Gradually, as funds and experience become available, the premium level could be consistently lowered until virtually all Social Security beneficiaries were enrolled for drug coverage. When near universal coverage was achieved, the premium payment could be eliminated and the program incorporated into Part A as has now been suggested for the Supplementary Medical Insurance program.

This gradual introduction of the benefit would assure that the aged would have access to drug coverage (which is not now available to them, generally) and could budget their drug expenditures with some precision. The actual cost to the government treasury, under such circumstances ought to be contained to manageable proportions. For example, the Task Force on Prescription Drugs cites figures which suggests that at a premium level of $100 annually, only 20 percent of the aged population would be expected to find enrollment economically beneficial.

And lastly, not all of the costs of the addition of a drug benefit to Medicare would represent actual additional cash outlays. Some of the expenditure will be recouped in reduced Medicaid expenditures and some savings will undoubtedly be realized from reduced utilization of other services covered under Medicare such as hospitalization.

NARD believes that Congress has the means and ability to initiate a Medicare Home Drug benefit, appropriately limited as to scope so as to contain costs at an

acceptable and affordable level. We urge the Congress to do so. At the same time, we ask Congress to incorporate prescribed drugs as a mandatory service in State Medicaid programs. The officers and staff of the NARD are most anxious to provide any information or assistance in achieving these goals.

FEBRUARY 15, 1972.

Senator RUSSELL B. LONG,
Chairman, Finance Committee, U.S. Senate, Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: Enclosed is testimony which we would like to offer to your committee regarding H.R. 1. We have been informed by Senator Griffin's office that you are accepting written testimony until February 18 for inclusion in the record. While we regret that it was not possible to appear personally before your committee, we are pleased to have this opportunity to present our views.

We are aware that there is some consideration of implementing certain welfare reform programs on a pilot basis. If that should be the decision of the Congress we would be very pleased if they were tried in Michigan since we are eager to move toward a more adequate and effective system of income assistance to the poor,

Sincerely,

LYNN A. TOWNSEND,
Chairman.
LAWRENCE P. DOSS,
President.

TESTIMONY SUBMITTED BY NEW DETROIT, INC.

New Detroit, Inc., was born in August 1967, when then Governor Romney and Mayor Cavanagh called upon leaders of the private sector and the community to consider how they could contribute to solving the major urban problems. There was a sincere response to this call from many walks of life. The Trustees of New Detroit are a broad cross section of leadership in the Detroit area—from business and industry, labor, government, educational institutions and the community at large.

While we have made significant progress in certain respects, New Detroit, Inc. is still in existence because the conditions which gave rise to the 1967 conflagration are still very much evident. One of the most persistent problems certainly is the existence of poverty on a large scale; which in turn intensifies a host of other problems. We soon learned that one of the principal means of responding to poverty, the welfare system, was working poorly.

In October 1968, New Detroit therefore called upon Governor Milliken to set up a Study Commission to develop alternative means of delivering public assistance, because the existing system was not accomplishing its stated goals.

The Michigan Welfare Study Commission, which the Governor subsequently established, completed its work a year ago and in May, 1971 we responded to its report with a broad position statement on welfare issues. I might say that in preparing our statement we received the reports of other welfare study commissions as well, and were particularly interested in those such as The Committee for Economic Development, the Arden House Conference on Public Welfare, and the President's Commission on Income Maintenance, which had strong representation from business and industry. We were struck by the similarity of conclusions reached in such studies, and ours are in a similar vein. When H.R. 1 was passed by the House of Representatives, our Board of Trustees evaluated Title IV of H.R. 1 in the light of New Detroit's own position. I am therefore submitting this testimony as the current Chairman of New Detroit officially reflecting its views on this subject.

I am aware that you are receiving a great deal of testimony and are well versed on the issues before you. I will, therefore, convey our main comments briefly.

We support the general thrust of H.R. 1 in two basic respects. First, because it establishes the principle of a national floor of income for Americans, including the working poor as well as those who cannot work.

Second, it significantly increases the federal share in benefit payments and the federal role in welfare administration. These represent much-needed directions for change, and our further comments are mainly directed toward strengthening H.R. 1 so that it will more effectively move in these directions.

If a floor of income is to be established, we believe it should be at least minimally adequate and it should be fairly applied to all Americans who are in need. The present level of family benefits ($2400 for a family of four) does not meet the adequacy test, as evidenced by the fact that it is only at sixty percent of the poverty level. While it is true that a family which has earned income can combine wages and H.R. 1 benefits to attain income slightly above the poverty line, those families which cannot work or cannot find work will suffer severe hardship.

While it may not be feasible to eliminate sub-poverty income levels at one stroke, we would like to see a plan to move toward this very minimal level of adequacy, with a higher benefit level than $2400 at the start, and a phased progression to at least the poverty line. We note that H.R. 1 freezes the $2400 benefit level for five years and does not even provide for changes in the cost of living from one year to another.

We realize that the family benefit levels of H.R. 1 are lower than those being paid to the great majority of present recipients under the current state-federal plan. Since it would be most unfortunate if welfare reform were to result in reducing present benefits, we urge you to include in H.R. 1 a requirement for mandatory supplementation by the states to maintain existing grant levels.

The concept of a floor of income for all Americans should also pass the fairness test. In this sense, we believe H.R. 1 should be strengthened in three respects. In the second year of H.R. 1's implementation, an elderly couple would receive $2400 a year, and so would a family of four. If our previous recommendation to increase family benefit levels were adopted, the unfairness which is evident in the above comparison would be diminished. Second, we believe need should be the criterion for eligibility, rather than family status. We would, therefore, hope to see the automatic exclusion of childless couples and single persons eliminated from H.R. 1. Third, fairness would be served if benefit levels were to take into account regional differences in the cost of living. While we realize the administrative complexity of adjusting for this factor, we ask you to consider ways in which this could be accomplished.

As previously stated, New Detroit warmly supports H.R. 1's movement toward federalization of public assistance, but we would like to see it move more fully in this direction. Otherwise, great variations will continue to exist in grant levels from one state to another, unjustly penalizing residents of certain states; and the crushing burden of welfare costs on state budgets will be only slightly diminished in those states which are currently paying benefits at relatively higher levels. (For example, Michigan would only save an estimated $45 million under H.R. 1, while the projected state Social Services budget for the next fiscal year is close to $600 million.)

To the extent the federal benefit floor is raised above $2400, there will obviously be greater savings to the forty-five states now providing grants at higher levels. We also recommend that there be federal matching for state supplemental payments, perhaps up to a ceiling amount, which might be the poverty line.

There are two additional provisions in H.R. 1 upon which we would like to comment very briefly. We are pleased that H.R. 1 authorizes the Secretary of Labor to provide 200,000 public service jobs for recipients. This is a positive recognition of the fact that there are not enough jobs available to fully meet the needs of poor people today. While there are wage safeguards built into the public service employment provisions, they are very inadequate in respect to private employment. It seems poor public policy to require recipients to accept employment below the minimum wage, which H.R. 1 now does.

We are pleased to see provision for child day care to enable mothers to pursue work or training. We hope sufficient funds will be allocated for this purpose, and that the care will not be simpy custodial but will provide educational, nutritional, and medical benefits as well. If we hope to enable the new generation to escape cyclical poverty, good quality programs should be provided.

We appreciate the opportunity to present our views to you. While we are not advocating any particular set of amendments to H.R. 1, we note with interest that Michigan Governor Milliken has endorsed the Ribicoff Amendents, which seem to take into account many of the ways in which New Detroit too would like to see H.R. 1 strengthened.

I believe you will be interested in knowing the broad representation which exists in New Detroit and I am, therefore, attaching a list of our Board of Trustees with their principal occupation.

NEW DETROIT, INC.

BOARD OF TRUSTEES.

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Roger Richards, President, Metropolitan Federal Savings & Loan Assoc., Chairman, Michigan State Housing Authority.
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Howard Sims, President, Howard Sims & Associates.
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Thomas Turner, President, Metropolitan Detroit AFL–CIO Council.
Miss Lenora Vernon, Student, Cass Tech.
Mrs. Jean Washington, Police-Community Relations.
Reginald Wilson, President, Wayne County Community College.
Stanley J. Winkelman, President, Winkelman Stores, Inc.
Jack Wood, Secretary-Manager, Detroit & Wayne County Building Trades Council.
Floyd Wylie, Administrative Director, Highland Park Mental Health Center.
Senator Coleman A. Young, Michigan State Senate.

THE ASSOCIATED GENERAL CONTRACTORS OF AMERICA,
Washington, D.C., February 18, 1972.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the 9,000 construction firms throughout the United States that comprise the membership of the Associated General Contractors of America, we submit our views on H.R. 1 for the record.

The construction industry is the largest single industry in the country. Therefore, the legislation now being considered by your Committee will have far reaching impact to our membership.

The implications of the welfare program as proposed warrant careful scrutiny. If we consider cost alone, the economy cannot afford such a burden. Conversely, it could be of little benefit to society for taxpayers to subsidize a guaranteed annual income at well above the poverty level, regardless of, and in many cases in spite of, ability or disposition to work.

The concept of enacting a plan to go into effect in two years, with a "test" period between now and then is no test at all. If enacted, the legislation would have more difficulty being repealed than it had becoming law, regardless of the results of the "test". If the years of 1972 and 1973 are to be a real test, why provide for automatic permanization of 1974?

There are several avenues we feel would do much to reduce the cost of a realistic welfare program, as well as to distribute equitably the responsibility therefor:

A sound trial period could include several concurrent testing programs in pilot form, with regular reports from the Comptroller General as to practical alternatives, and which should not be implemented automatically into a permanent plan;

Low-priority items which generate marginal benefits but which represent substantial portions of the cost could be initially eliminated from the plan, such as additional "dropout years", delayed retirement increment, and special minimum benefits;

Provisions for computing retroactively taxable wage base from $9,000 to $10,200 should be deleted; most contracts in our industry are obtained by fixed-price bids, and any such added expense not anticipated by an employer must be borne by him without contract adjustment;

Tax rate increases could be scheduled to maintain trust fund balances roughly at one year's benefit payments; and

Automatic benefit and wage base escalators could be eliminated to be determined by review at regular intervals.

The increasing numbers of people on welfare indicate an alarming acceptance of dependency on the state for sustenance with no effort on the part of the recipient in return. No incentive to produce is likely to be successful in the long run without some sort of requirement for participation for those who *can* work but choose not to.

It is conceivable that welfare rolls could be reduced through a combination of training and public service programs, benefits which are monitored by the donor, and more careful investigation of applicants.

It is to the benefit of every citizen that an equitable and effective program be enacted. It is to the same degree detrimental to all if we fail to do so.

Sincerely,

WILLIAM E. DUNN,
Executive Director.

Statement by William G. Reitzer

WHAT THE HOLY SCRIPTURE TEACHES ABOUT WELFARE

Because the Holy Scripture is what it is, it is sensible to consult its teachings whenever legislation on a particular subject is under consideration. The Holy Scripture, being the Word of God to God's creatures, not only holds out instruction but also implores compliance therewith.

Certain principles of Holy Scripture are germane to the Social Security and Welfare Proposals under consideration by the 92nd Congress. I am moved to set forth these principles, as a servant of God, in the interest of glorifying God's

gracious and good provisions for His creatures and at the same time seeking the general welfare of my countrymen.

Although I have degrees in law and theology from nationally accredited educational institutions, I reply upon the blessed Holy Spirit not only to direct me to make a truthful and helpful presentation, but also to apply the credibility thereof to the hearts of all who may have been directed this way.

The first principles of importance concern the exalted nature and destiny of man. The Bible states that God not only created man and woman, but He created them in His image. In essence they are spirits who will live forever. God endowed His creatures with a wonderfully complex brain, a spendid moral nature, a free will, the power of reproduction, and a large realm of sovereignty (the earth). They were given a sublime rule of life: to love God with all their hearts and their neighbor as themselves.

This requirement to love one's neighbor is set forth by some as the rationale behind social welfare legislation. It is asserted that the government has a duty to help persons with certain needs which they have not been able to provide for themselves, due, primarily, to low income.

The Bible does urge—and in the strongest terms—that the poor and needy should be taken care of. But does the Bible lay this obligation on the shoulders of the government and at the door of the public treasury?

THE GOVERNMENT IGNORES SPIRITUAL PRIORITIES

If the teachings of the Bible are taken as a whole, it becomes evident that any government activity in the area of welfare, unless fully committed to Biblical principles, will be working at cross-purposes with God and God's best intentions for needy individuals. The reason is that God is primarily interested in His creatures' spiritual welfare, and therefore, material considerations are of secondary importance.

The Bible teaches that every person that is born is in a state of alienation to God (because of sin) until he has been "born again" by the Holy Spirit. By this devine influence the human spirit is regenerated—somewhat like a dead storage battery is charged by an external influence—so that it takes on a new life wherewith it can have good fellowship with God. The condition for this new birth are repentance of one's sins and acceptance by faith in the forgiveness of one's sins because of the sufferings and death of Jesus Christ, the Son of God, whose undeserved sufferings and death, by God's justice, constituted an atonement for the sins of the world.

The entire import of the Bible is that a soul who has not been reconciled to God through regeneration cannot except lasting peace of mind and prosperity. As the Psalmist points out in Psalm 146, God helps those who trust in Him, but those who disregard Him, He eventually brings to ruin.

This bringing to ruin has a twofold purpose. On the one hand, God must uphold justice. It would be unjust for God to let the ungodly prosper. On the other hand, God also has reformation in view. As He said to a wicked people on one occasion: "I will go and return to my place, till they acknowledge their offense, and seek my face: in their affliction they will seek me early" (Hosea 5:15).

If therefore the government steps in and offers aid to those who are being chastened by God, the government becomes guilty of intermeddling in God's dealings with His creatures, usurping God's sovereignty, discounting God's wisdom and justice, and detracting from people's spiritual welfare. In addition, the government compounds the problem of undeserving individuals by bestowing upon them benefits to which, by God's justice, they are not entitled. This puts them under an obligation to be willing to make restitution before full reconciliation with God can take place.

Some will assert that much poverty and need are not due to personal sin, but to outside factors, such as economic exploitation or unforeseen circumstances brought about by the industrial age. Such an assertion has a ring of plausibility, but when examined more carefully, is found to lack substance in fact.

The whole tenor of the Bible is that a person who does what God commands will be taken care of by Him. As the 23rd Psalm states: "The Lord is my sheperd, I shall not want." The implication is that if we follow God's guidance, we will not get into situations where we will be exploited or surprised by unforeseen circumstances.

Moreover, the Bible urges us to be so concerned about the things of God that even the necessities of life concern us only on a day by day basis. For Jesus said in the Sermon on the Mount: "Take no thought, saying, What shall we eat? or, What shall we drink? or, Wherewithal shall we be clothed? . . . for your heavenly Father knoweth that ye have need of all these things. But seek ye first the Kingdom of God, and his righteousness, and all these things shall be added unto you. Take therefore no thought for the morrow: for the morrow shall take thought for the things of itself. Sufficient unto the day is the evil thereof" (Matt. 6:31–34).

THE GOVERNMENT ILL-DEFINES MATERIAL WELL-BEING

Not only does the government overlook these spiritual priorities, but it also works at cross purposes with God by holding forth and sustaining a different concept of material well-being. God's standard of living does not permit anything that is harmful to health, personal safety or morals, nor anything that is foolish or trival. Consequently, He would not approve of welfare payments that would be spent for cigarettes, unhealthy foods, excessive eating, indecent literature, or many other things the government allows. The government allows them because of weakness. The government is weak because it has only limited and ill-defined standards, only a limited interest in enforcing them, and is further handicapped by pressure groups whose standards are even lower than its own.

THE GOVERNMENT LACKS THE FACTS TO ADMINISTER PROPERLY

Another reason the government is not qualified to engage in social welfare is that it does not possess the facts to administer aid fairly. Each case of need has its separate requirements. To be fair, each case should be thoroughly investigated. But it is handicapped by rules against invasion of certain private rights. Even if these did not exist, it would still be very difficult for the government to establish the actual need because there are ways of concealing assets, of feigning inability, of faking accidents, of colluding with others, of magnifying needs.

Because of a lack of facts, the government is forced (also by other pressures) to assume the honesty of welfare applicants. As indicated earlier, the Bible indicates that something is seriously wrong if a person becomes a welfare case, for right living people do not get into the position of needing welfare, under any circumstances, no matter how exploitive the society or community they live in. As David said: "They that seek the Lord shall not want any good thing" (Psalm 34:10). And as Proverbs says: "He that giveth unto the poor shall not lack" (28:27).

Beceause of expediency, government aid is addressed to large groups, such as the aged, the blind, the disabled. Yet within such groups are widely varying needs because of wide differences in personal wealth, enterprise, health, surroundings, and the like. To offer all within a class certain aid creates a temptation for some to accept it although they do not particularly need it. Consequently, government welfare in this form brings with it a certain amount of loss of initiative, dignity, honesty and self-reliance, whether consciously or subconsciously. At the same time it makes private welfare less interested in offering assistance to persons within these classes.

It also may be noted that there is something inherently unjust about establishing national minimum income levels with little regard for the welfare of the peoples outside of the United States. If every individual is entitled to a certain standard of living by natural right, as it is asserted, why is that confined to our national boundaries?

ONLY CHRISTIANS AND CHURCHES ARE AUTHORIZED

Because the government is not qualified to legislate welfare, the government has no authority in this area. All the Biblical injunctions to help the poor and needy are directed at individual Christians and the Christian church. Nowhere does Jesus, nowhere do the Apostles appeal to a pagan government to help the poor of the land. Nor do they tell the poor to look to the government.

God alone knows how best to deal with those in need. He has all the facts. And He must direct welfare aid. This He does through His people.

God's people are better qualified to do welfare work because they do it voluntarily and out of love. They are also better qualified to receive, understand, and carry out God's instructions.

God has certain rules of life which He has set forth as good. It is His concern to impress His creatures with the goodness of these rules. They are contained in the Ten Commandments, and expounded in the Sermon on the Mount, the Book of Proverbs, the Psalms and throughout Holy Writ. They uphold, as we all know, such attitudes and conduct as reverence, piety, humility, honesty, temperance, industry, justice, mercy, kindness, benevolence.

It must be acknowledged that not only unbelievers but also too many of God's people fail fully to understand either the importance or the scope of these good rules. Consequently there exist considerable ignorance and rationalization about the causes and cure of social ills. Therefore it must be added that Christians and churches engaging in social welfare need to be sure they are receiving God's instructions correctly, or else they also will be interfering with God's best intentions for needy individuals.

The Scripture passage "if any would not work, neither should he eat" (2 Tes. 3:10) serves as a good illustration. In this connection one needs to remember that the Bible presents man's obligation to work as hard, and justifiably so (Gen. 3:17-19). Further, the more one lives an ungodly life, the harder one's work is apt to become. Obviously, this creates a live temptation for a man to try to escape his hard lot by various devices, either consciously or subconsciously, honestly or dishonestly, by some pretext or no pretext. But if a man does this, God will make him all the more miserable, for God wants a man to work, albeit menial or rigorous, than not to work at all. And this applies to the aged, the blind, and the handicapped, although, of course, allowances would be made depending upon the circumstances of each case. And, of course, work takes many different forms. For example, prayer can be classified as work, when it concentrates on intercession for others.

As a result, God's intent for individuals not gainfully employed is to find gainful employment as quickly as possible. And anything, no matter how well intentioned it may be, that prevents this is detrimental to the best interests of those individuals.

Further, employment must be good employment: it must provide a good service or develop a good product, and it must allow for the Sabbath rest. For the Bible teaches that the greatest happiness this life affords belongs to the person who is gainfully occupied as divinely directed six days a week and who keeps all of God's commandants seven days a week.

Consequently, help to the needy must direct itself to the well-being of the whole man. This brings into consideration all of his beliefs, thoughts, feelings, and actions. Otherwise all that is accomplished is stop-gap aid and a false sense of security that postpones, and compounds, the agony, and also tends to make an effective remedy for the initial need more difficult.

GOD IS THE HOPE OF THE NEEDY

The question now arises: What if Christians and the Church do not adequately supply the needs of the poor? It is unquestionably true that Christians and the Church fail, have failed, and will fail. But God never fails. The Bible presents God as the God of the needy, the oppressed, the helpless, the widows, and the orphans. "When my father and my mother forsake me, then the Lord will take me up," says the Psalmist (Ps. 27:10).

God has His ways of helping the needy. It is not through the government. There is always someone God can find to fulfill a specific need. As in the case of the Good Samaritan, although the unfortunate robbery victim was ignored by one religious man, and then by a priest, there came along then a good man of God to help. And God, not the government, will get the credit.

The difficulty is that we are inclined not to understand nor to appreciate how God is dealing in a situation. Therefore it is incumbent upon us to entertain more faith that the God of all the earth is doing right, and only offer aid when we know for sure that God wants us to.

If a government notwithstanding does act in the area of welfare, it should not compound the error by taking money out of the general treasury. For strict justice requires that money for welfare purposes be obtained only from those who specifically permit the government to engage in such activity. I honestly

feel I should not be forced to contribute tax money in support of government welfare programs, but to be left free to help the needy as God directs me.

That does not mean I object to paying taxes in support of the government, because the governments of the world are divinely ordained. According to the Bible, governments have a divinely-given sphere of operations. This sphere is to maintain peace and order by restraining evildoing (see Romans 13:1–7). This is accomplished by passing appropriate laws, with appropriate penalties, and strictly enforcing them.

WHAT THE GOVERNMENT MAY DO

Under its rightful authority the government may do, and should do, what is necessary to eliminate conditions that contribute to social welfare situations. In some cases persons should be forced to be responsible even if they are not so inclined.

For example, the Bible states "If any provide not for his own, and specially for those of his own house, he hath denied the faith, and is worse than an infidel" (1 Tim. 5:8). The government may hold a man responsible for the support of his wife, his children, or pregnant girl friend. And procedures, such as work-detention laws, should exist to make him fulfill this obligation. And if he manages to escape justice, financial responsibility should be shared by the parents of the father and the parents of the mother.

Also, the government would be authorized to make necessary laws to prevent exploitation of the worker and of the economy by industry and labor unions, or any power block. The government would be authorized to prevent exorbitant profits and salaries, manipulation of markets and prices, unfair competition, working employees at too fast a pace, and the like.

However, it is well to reemphasize that the promulgation of laws must proceed from the Bible as a basis. If the government is to eliminate evil, it must do so according to God's directives. The difficulty is that people do not want to impose on themselves the strictness of Biblical laws and penalties. Consequently the codes of laws that exist in the various states and in the nation at large fall considerably short of Biblical standards.

WHAT THE GOVERNMENT DOES IT MUST DO WELL

How closely a jurisdiction approximates its laws to Biblical standards has a great bearing on its well-being. For the Bible teaches that God blesses not only individuals in proportion to their diligence in observing the divine laws, but also each grouping of people in society, as the family, the neighborhood, the community, the city, the state, the region, and the nation as a whole. Therefore it is incumbent upon each grouping of society to have the best possible laws and the best possible conduct if it is to enjoy the greatest possible blessings of God.

Thus, if a legislative unit of society does not use its powers properly, either by failing to fully restrain evil or by perpetrating injustice through its laws (as by authorizing unjust welfare aid), all the people in that unit will suffer in some way under divine retribution. This has definite implications when one is confronted with the question whether the state or the federal government should legislate in a certain area. As a general rule, the smaller unit of society is better equipped to make good laws because it has a greater interest, a greater concern presumably, and better access to the facts. However, the opposite could be true. The difficutly with national legislation is, nevertheless, that it tends to establish a mean, and thereby adversely affect, even though it may be a minority, those jurisdictions which have better legislation than the national mean.

Legislation that is not guided by the whole Word of God will only create confusion, lawlessness, and ultimate discontent. This is evident in the history of welfare legislation. The more legislation, the more the welfare needs. Further proof appears from the Report of the House Committee on Ways and Means on H.R. 1 dated May 26, 1971. It refers to the "exploding number of broken families" that welfare legislation has to some extent produced. The Report openly admits that the "welfare system in the United States is moving toward a state of crisis and chaos."

This makes it all the more important to bring the impending welfare legislation into harmony with Biblical principles. My hope is the honorable members of the Senate may be disposed to make the necessary amendment to H.R. 1 to accomplish this.

AMERICAN NURSES' ASSOCIATION, INC.,
New York, N.Y., February 18, 1972.

Hon. RUSSELL B. LONG
Chairman, Senate Finance Committee, New Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The American Nurses' Association strongly urges that the Senate Finance Committee not report favorably on proposed Amendment No. 870 (Social Security Amendments of 1971) to permit reimbursement for services provided by assistance to physicians, introduced by Senator Gaylord Nelson.

The subject is one that has many implications both for the quality and the cost of health care. We would ask, instead, that the committee hold open hearings on this topic and that thorough study be done. Action at this time seems premature because of the great variety in types of programs, confusion as to who assistants to physicians are, and as to the dependent and independent roles of health professionals, and concern about inequities in care provided to those in rural areas, the aged population and the indigent, particularly those in minority groups.

We would like to have the opportunity to thoroughly explore these questions on the record, and we know that many other groups that provide health care would also like to participate in such discussions. We agree that reimbursement formulas need to be realistic, that costs of care must be covered, as we pointed out in our testimony of February 7 in which we also noted the difficulty experienced by home health agencies in receiving reimbursement for the skilled nursing care provided.

Attached for information of the committee are two documents: "The American Nurses' Association Views the Emerging Physician's Assistant," and the New York State Nurses Association's statement on Physician's Associate and Specialist's Assistant.

We ask that this letter and attachments be placed in the Record of the hearings on H.R. 1.

We will send copies of this letter and attachments to all members of the Senate Finance Committee.

Sincerely yours,

EILEEN M. JACOBI, R.N., Ed.D.,
Executive Director.

Attachments.

THE AMERICAN NURSES' ASSOCIATION VIEWS—THE EMERGING PHYSICIAN'S ASSISTANT

Demands for health care services are rising sharply. At the same time, manpower needs in industry and agriculture are decreasing, so that employment must be found for more people in the service fields. The search for means to meet the health care demands and the need for new areas of employment are creating pressures for new careers in the health field.

One of the most significant among the emerging occupations is the "physician's assistant." A variety of training programs are being developed to prepare individuals to assist the physician. *The term "physician's assistant" should not be applied to any of the nurse practitioners being prepared to function in an extension of the nursing role.* However, the term appropriately can be applied in the training and utilization of persons who under medical direction assist physicians by performing specific delegated medical activities. Some of these individuals are now organizing and seeking recognition as a distant group of practitioners in health care.

The American Nurses' Association views all nurse practitioners as members of the nursing profession. ANA assumes responsibility for defining the scope of their practice, for determining standards and educational requirements, and for interpreting their ethical and legal relationships, with physicians.

The practice of nursing is authorized by the nursing practice acts of the states. A Joint Practice Commission composed of representatives of ANA and the American Medical Association has been established to consider the congruent roles of nurses and physicians. This development holds promise for more effective and efficient utilization of the two major health professions in future health care services.

Several types of assistants are being prepared and utilized to function under the medical direction to extend physician's services. None of these assistants

are prepared to be substitutes for nurses, since nursing practice is more than performance of delegated medical nursing activities. Neither are these assistants acceptable substitutes for physicians. This development is of concern to the nursing profession. Physician's assistants working in a setting where nursing practice is an essential element of health care present problems that flow from the legal and ethical relationships between physicians and nurses. Therefore, nurses and physicians together must clarify the situation.

As yet there are no generally accepted guidelines for the preparation of all of these assistants. Further, there are as yet no universally accepted guidelines for the utilization of physician's assistants within the delivery system. Because of the vast differences in current programs, it is essential that efforts be made to bring about some uniformity of educational requirements.

As other groups have done in the past, physician's assistants are becoming organized in an effort to secure licensure, certification and other forms of recognition as a distinct health occupation. Until the functions of the physician's assistant are more clearly identified, and generally acceptable standards for training and practice are evident, licensure for their practice by the states should not be attempted.

The American Nurses' Association supports the call for a moratorium on the licensure of new categories of health workers until studies have been conducted to determine the need for licensure reform. Prior to such reform, it is imperative that the medical profession retain responsibility for delegation of medical acts to physician's assistants.

In licensing law, it first should be possible to define an independent area of practice which must be regulated in the interest of public health and safety. The definition of any health profession's practice should be stated in terms that are broad enough to permit flexibility in the utilization of assisting personnel within the bounds of safety for the client. The definition should also permit changes in practice consistent with desirable trends in health care practices.

Because the economic status of each group involved in health care is part of the economic environment of every other group, the American Nurses' Association has a stake in the economic status of the emerging physician's assistant. The ANA re-emphasizes that in establishing salary ssytems, recognition must be given to the character of responsibilities carried, and to requirements for education, experience and clinical expertise. In establishing the relationships between salaries of nurses and those of physician's assistants the differences in their responsibilities, preparation and experience should be taken into account.

The development of new health workers has provided impetus for long overdue examination of the health care system including the responsibility of each health worker for providing service to the patient. The focus must become people, their health needs, and meeting these needs through high quality care and in the most efficient and economic manner feasible.

AMERICAN NURSES' BOARD OF DIRECTORS.

December 17, 1971.

NEW YORK STATE NURSES ASSOCIATION,
Albany, N.Y.

THE NEW YORK STATE NURSES ASSOCIATION'S STATEMENT ON THE PHYSICIAN'S ASSOCIATE AND SPECIALIST'S ASSISTANT

(Approved by the Board of Directors, January 31, 1972)

The emergence of two new categories of health workers in New York State, the physician's associate and specialist's assistant, is unquestionably a tribute to the medical profession's concern and vision regarding the increasing demand for medical care services. This development documents clearly that profession's recognition of the deleterious consequences of the unavailability of such services to the people of this state. Further, it reflects the medical profession's commitment and determination to improve the present unsatisfactory situation.

The New York State Nurses Association has long supported the concept of a clearly identified assistant to the physician.[1] The Association wishes to reaffirm that support and to welcome these new members of the health care team.

[1] Hereafter in this statement the term "physician's assistant" shall refer to the physician's associate and specialist's assistant.

Obviously, implementation of these roles will not only enhance medical practice, but more importantly will provide for more effective utilization of the unique talents and services of nursing practitioners. Therefore, the Association pledges every cooperation in the orderly and efficient integration of these workers into the health care delivery system. In order to augment such integration the Association wishes to clarify its position on this development as it relates to the nursing profession.

The Association's position is as follows:

1. The role of the nursing practitioner is not synonymous with that of the physician's associate or the specialist's assistant.

The Association is compelled to emphasize this distinction in light of the persistent lack of understanding and recognition of the nature of nursing practice. Nursing practitioners, physicians and physician's associates—indeed, all health care workers—must necessarily share common bodies of knowledge and overlapping areas of functional expertise. However, to assume "interchangeability" of roles is to deny the uniqueness of each, thus diminishing the capability for meeting society's complex health care needs.

2. The physician's associate or specialist's assistant is not a substitute for the physician.

The Association recognizes the right of the medical profession to determine those medical acts which may be safely delegated to physician's assistants. Similarly, as an independent profession, nursing reserves the right to determine from whom it shall accept "delegation". Hence, nursing practitioners shall continue to execute those medical regimens prescribed only by a licensed or otherwise legally authorized physician or dentist.

In view of the original intent of the physician's assistant role, i.e., to increase the availability of medical care services to the public, the Association questions the rationale for consideration of assigning the assistant to write medical orders. It would appear that such utilization unnecessarily limits the assistant's involvement in direct services to patients. However, if the medical profession deems it appropriate to assign to the physician's assistant the task of writing medical orders, then the Association believes it appropriate for the physician's assistant to also carry out those orders.

3. The salary schedules for physician's assistants should reflect not only health care costs in general and the particular skills and competencies required for these positions, but also equitable relationships with the salaries and fees of other health workers.

In keeping with its long standing policy the Association will continue to insure appropriate financial compensation for services rendered by nursing practitioners and maintain an appropriate relationship between nurses' salary and fees and those of other members of the health care team. The Association will scrutinize very carefully the impact of salary schedules of the physician's assistant on the recruitment and retention of other members of the health care team.

The New York State Nurses Association endorses the view of the American Nurses' Association relative to the physician's assistant.[2] This Association also supports the American Nurses' Association's attempt to maintain dialogue on this matter with the American Medical Association and the American Hospital Association. Consistent with this, the New York State Nurses Association shall continue its effort toward comparable collaboration with the Medical Society of the State of New York, and the Hospital Association of New York State and those state governmental agencies charges with implementation of physician's assistant legislation.

Statement of the American Medical Association

Mr. Chairman and members of the committee: This statement will present the views of the American Medical Association on many of the provisions of H.R. 1, amending the Medicare and Medicaid programs, including our suggestions for modifications. In addition, comments are directed to an amendment before the Committee to establish Professional Standards Review Organizations. We also include our views on a program for catastrophic insurance coverage. While H.R.

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[2] American Nurses' Association, *The American Nurses Association Views the Emerging Physician's Assistant*. The Association, New York, December 1971.

1 does not now contain any provision to extend programs for maternal and child care which will expire on June 30, 1972, we strongly urge that this Committee take early action to do so, and recommend that H.R. 1 be so amended.

AMENDMENTS TO MEDICARE AND MEDICAID AND MATERNAL AND CHILD HEALTH UNDER H.R. 1

Many of the provisions of the bill relate merely to procedural or benefit changes, while others have a potential far-reaching effect on the future of these programs and upon the provision of health care for the recipients of care under these programs.

We will limit our remarks to those sections which we deem to be most significant.

Payments to Health Maintenance Organizations (Sec. 226)

Under this section, authorization is provided for a single Medicare payment to a "Health Maintenance Organization," under contract with the Secretary, to be made on a prospective, per capita basis covering services provided under both Parts A and B. Such organizations could provide comprehensive health services, either directly or through arrangements with others, but would have to include all of the Medicare benefits. Payment is not to exceed 95% of the amount which the Secretary estimates would be payable for both Part A and B benefits normally furnished. Beneficiaries would have the option of seeking to have Medicare benefits furnished through such an organization, or could continue to receive benefits as at present. While payments for these services would come from both Part A and Part B Trust Funds, it is to be noted that the Part B Fund would pay its full premium share on behalf of the beneficiary, and any reduction in costs arising from the 95% payment would accrue to the Part A Hospital Trust Fund.

We want to make clear at the outset that the American Medical Association supports a pluralistic approach to the delivery of medical services, whether they be furnished by group practice, or by individual practitioners or otherwise. The furnishing of comprehensive health services through prepaid group practice has existed for a number of years, but their development has been comparatively limited and is more pronounced in limited geographical areas. On the other hand, the "health maintenance organization" referred to here, is a prepaid group practice under contract with the government to provide certain required services. While it is partly based on certain existing prototype prepaid group practices, such existing groups are not "HMO's" in the sense discussed here under federal contract. Thus, we are lacking experience with this type of contract medicine (HMO's). We are concerned also that under additional legislation an effort is underway to bring "HMO's" into existence without evidence of the economic justification or their viability without continuing federal subsidy after being established. On its face, negotiation for comprehensive services at a figure which appears to show a savings to the program is patently salutary. However, before any such program is initiated nationwide and held out as a realistic benefit available to beneficiaries under the Medicare program, it is our recommendation that cost and utilization data should first be developed. Acceptable controlled demonstrations should test the capability of such a program to accomplish its purpose and to be implemented nationwide. Such experimentation would also demonstrate the degree of acceptability by physicians and patients of this type of health care delivery.

If such a determination is to be valid, it is necessary, of course, that the costs of the A and B programs be compared with an HMO cost for across-the-board Medicare beneficiaries in open enrollment, and not for a group which may be selected for this purpose. Interestingly, there appears to be some question concerning the cost benefits of HMO. While it appears that one of the main purposes is to achieve a financial saving in the program, in the Report of the Committee on Ways and Means in the last Congress it is stated that under this new approach there is expected to be a small increase in the first year or two in the amount of payment by the program, but that if additional beneficiaries enroll in either existing or newly established health maintenance organizations, there is likelihood of cost savings to the group.

Besides the consideration of whether the HMO provision will in fact result in cost savings to the program, there is the paramount consideration of the health care which will be provided to the beneficiary. We are alone in the serious concern about a program which provides incentives to providers for lower utiliza-

tion of benefits, and this aspect of the program—under-utilization—must be watched very closely so that the beneficiaries receive the best quality care. There are many additional questions to be resolved concerning the efficacy of this form of contract medicine. Moreover, it is important that the control and operation of the HMO be under the direction and supervision of physicians so that high quality care is provided. Operation of the health maintenance organizations under the direction of individuals or groups not competent in the health field should not be sanctioned.

In addition, if this section is adopted, provision should be made so that the public is properly informed concerning the degree of access to services. Such organizations are limited in number; and this benefit, if adopted nationwide, will not be available to most beneficiaries Much disappointment has already ensued where present benefits, such as home health services, are not locally available to beneficiaries of the program. There could be considerable dissatisfaction, to say the least, where an optional program service might not be available. Resulting public pressure could encourage the development of hastily organized groups capable of providing only substandard care.

Establishment of Incentives for States to Emphasize Comprehensive Health Care under Medicaid (Sec. 207)

Under this section, Federal Medicaid matching for certain comprehensive services would be increased and the federal matching with respect to long-term institutional care would be decreased and certain other limitations would be imposed. Specifically: (a) the Federal matching percentage for services furnished under a contract with (1) a health maintenance organization or (2) a community health center or similar facility providing comprehensive health care would be increased by 25%; (b) the Federal percentage after the first 60 days during a year for care in a general or TB hospital would be reduced by one-third; (c) the Federal percentage after the first 60 days of care in a skilled nursing home would be reduced by one-third unless certain conditions were met; (d) the Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after 365 days of such care during an individual's lifetime; and (e) the Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

We recognize that in a program with a limited amount of funding the government may wish to allocate the available monies among certain services. The Association supports the use of least costly services, and accordingly, where feasible, ambulatory services should be used instead of institutional care.

We believe, however, that the prevention of unnecessary use of institutional care should be effected without the reduction of federal matching for continued institutional care, which reduction may result in the unavailability of benefits for *needed* institutional care. Utilization review requirements under Medicaid should eliminate unnecessary institutionalization of patients.

Recognizing that the present design of the Medicaid program may be reviewed, as indicated by increasing interest in a new approach in providing care for the Medicaid recipient, we believe it would be well not to reduce, for the present time, the current levels of Federal support.

In any event, we strongly object to the provision which increases federal financial support only where services are provided in an HMO or community health center. (It is interesting to note, here, that where the patient is institutionalized through an HMO, there is no limit on such care, and there is no decreased support for such long term care.) This unwarranted, lopsided support could result in state programs requiring that medical care under its Medicaid program be furnished only in the favored settings in order for the States to take advantage of the additional Federal funding. This increased financial support in favor of one method of health care delivery is clearly discriminatory. Furthermore, there is not satisfactory evidence, either as to costs or quality of care, indicating a proper justification for this discrmination.

Any such "weighting" of payment to the states against services furnished outside the HMO or community health center tends to destroy the patient's choice of sources of care and, as a result, to again force care for the poor into a separate channel from that for other systems. Further, the present scarcity of such forms of health care organizations means that pressure is put on the state to discourage Medicaid patients from using more readily accessible forms in favor

of one generally much less available. State governments where such forms exist could receive Federal matching, in comparison with other states, out of proportion to the quantity and quality of care they render or their need for financial aid.

We urge the deletion of that portion of Section 207 which adds subsection (g) to Section 1903(a) (1) of Title 19.

Limits on Prevailing Charge Levels (Sec. 224)

With reference to payments made after December 31, 1970, for physician's services, this section provides that a "reasonable" charge could not exceed the higher of: (a) the prevailing charge level existing on December 31, 1970; or (b) the prevailing charge level covering 75% of the customary charges made for similar services in the same locality during the calendar year elapsing prior to the start of the fiscal year in which the request for payment is made. For fiscal 1973 and later years, the prevailing charge levels could only be increased "(in the aggregate)" above the fiscal 1972 levels to the extent that the Secretary finds, "on the basis of appropriate econmoic index data," that such adjustments are justified by economic changes.

We are aware of the great concern of the Congress and the public concerning rising health care costs. We as physicians share this concern. Nevertheless, we oppose this section, which establishes an arbitrary statutory limitation on physicians' charges under Medicare. While the factors underlying increased costs are complex, the proposed remedy is strikingly simple; merely pay a percentage of the customary charges. Even in this highly inflationary period, we know of no such direct stautory limitations on prices, wages or charges in other private sectors of the economy. The proposed limitation may attain a measure of cost control to the program; however, it should be kept in mind that a corresponding effect of this provision would be to shift this part of the burden of the program to the beneficiary.

Under this section, the Secretary is given additional new authority. For medical services, supplies and equipment which in his judgment do not generally vary significantly in quality from one supplier to another, the charges he determines to be reasonable for payment may exceed the lowest charge levels at which such services, supplies and equipment are widely available only to the extent and under the circumstances specified by him. While this provision may have application to supplies and equipment, we do not believe that medical services, which lack the uniformity of supplies and equipment, should be included. We strongly recommend that medical services be deleted from this new provision.

The Health Insurance Benefits Advisory Council is required to conduct a study of methods of reimbursement for physician services under Medicare and is to report the results of such study to the Congress together with a presentation of alternatives to the present methods of reimbursement and the Council's recommendations as to the preferred method. Because of the potential significance of this study on the Medicare program, the HIBAC Report should contain a presentation of factual bases for any recommendations and certainly adequate opportunity should be accorded to interested persons for review of the study before any implementation is undertaken.

Authority of Secretary To Terminate Payments to Suppliers of Services (Sec. 229)

The Secretary would be authorized to terminate or suspend payments for services under Medicare (with resulting prohibition of payments under Titles 5 and 19) where a person: (a) has made false representations; (b) has submitted bills in excess of the person's customary charge; or (c) has furnished services determined to be substantially in excess of the needs of the patient or to be harmful to him or of a grossly inferior quality.

The Secretary, after consulting with appropriate State and local professional societies, as well as with others, would appoint program review teams composed of physicians, other professional personnel in the health care field, and consumer representatives. The Secretary's determination as to (b) above would require the concurrence of the Program Review Team, and, as to (c) above, would require the concurrence of the professional members of the reviewing team.

The Association has many times stated that abuses in the program should be eliminated. The most effective way to review the services of physicians is

through the medium of other physicians. Professional services, whether they be legal, medical, or otherwise, should be evaluated by professional peers. Only physicians should be called upon to review the services of other physicians. This is the essence of peer review. And it should be kept in mind that this process, while it has disciplinary aspects, is essentially an educational process which forms a primary base for the continuing education of the practicing physician. The bill does not provide for appropriate peer review. We urge you to reject Section 220.

Section 222 provides for peer review experimentation in the various communities and our support for this provision is set out below.

Report on Plan for Prospective Reimbursement; Experiments and Demonstration Projects to Develop Incentives for Economy in the Provision of Health Services (Sec. 222)

This section requires the Secretary to develop expirements and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under Titles 18, 19, and 5, as contrasted with the present system of retroactive reimbursement. He would report to the Congress by July 1, 1973, the results of the experiment programs, and include recommendations with respect to the specific methods which could be used in a full implementation of a system of prospective payment. In addition to various other experiments, the Secretary is authorized to conduct experiments to determine whether peer review, utilization review and medical review mechanisms established on an areawide or community-wide basis would assure that services conform to appropriate professional standards of health care and that payment for these services would be made (1) only when, and to the extent, medically necessary, and (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only for the period these services cannot effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

We have supported provisions which are designed to test mechanisms, on an experimental basis, and which are introduced to improve government supported programs. While continuing in such support, we believe that these experiments must be carefully evaluated before they become an integral part of any of the programs—particularly those which have the potential for substantial change in the character of the program. Most important, of course, is the consideration that the quality of care should not be compromised for the sake of achieving some economy.

We support in particular the provision for experiments in various peer review mechanisms, and we will discuss this more fully later in relation to the amendment to create Professional Standards Review Organizations.

Limitations on Coverage of Costs under Medicare (Sec. 223)

Under this section the Secretary would be authorized to exclude as a reimbursable part of an institutional provider's "reasonable cost" any incurred cost which he found to be unnecessary "in the efficient delivery of needed health services." For those services deemed to be unnecessary, the provider could make a direct charge to the beneficiary if (a) the Secretary has provided notice to the public of such excess charges and (b) the provider identifies the charges to the individual.

This section has a potential for substantial changes, not only in the Medicare program, but also in the provision of health care to the public generally. While the intent of this section may be to reduce costs and standardize services among comparable providers, we view with concern the authority of the Secretary to determine the costs necessary for efficient delivery of needed health services under Title 18. Will this section, for instance, create different classes of services based upon the ability or desire of patients to pay for additional services?

One of the original goals of the Medicare program was to make accessible to the over 65 persons the same level of health care available to other individuals. We believe this section, with this unprecedented authority in the Secretary, would tend to do otherwise. On the other hand, we understand the concern about rising institutional costs in the Medicare program. Accordingly, we recommend that the Congress and all health organizations maintain careful surveillance over implementation of this section so that benefits to the patient are not arbitrarily reduced, in relation to those furnished other patients.

Study of Chiropractic Coverage (Sec. 273)

Under this section, the Secretary would be authorized to conduct a study of the coverage of services performed by chiropractors under Title 19, in order to determine whether and to what extent these services should be covered under Part B, Title 18. He would be required to report to Congress within two years his findings and recommendations.

Three important and reliable government studies of chiropractic already have been made and have all reached the same basic conclusion: Chiropractic services are not quality medical care.

These studies are:

(1) 1967 report by the National Advisory Commission on Health Manpower;

(2) Independent practitioners under Medicare—a 1968 report to Congress by former Secretary Wilbur J. Cohen; and

(3) The 1970 Report of the Task Force on Medicaid and Related Programs.

The first report found chiropractic to be a significant hazard to the public. The second report, after a study ordered by Congress, recommended unequivocally that chiropractic service should not be covered in the Medicare program. The third report and one, incidentally, upon which it appears that many of the modifications to the Medicare and Medicaid programs are predicated in H.R. 1, does not contain any recommendation for the proposed study but, *on the contrary*, states:

"A legislative amendment should be enacted denying financial participation in Medicaid payments to chiropractors and naturopaths."

The conclusions reached independently by these three studies have the full support of the medical profession—of the scientific community as a whole. In addition, they are supported by many organizations *outside* medicine.

For example, numerous organizations interested in health care for the elderly have strongly supported the findings on chiropractic of the HEW study. Included are the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW), the National Council of Senior Citizens, the nation's largest organization of Medicare recipients, and the Consumer Federation of America, representing 184 local, state, and national consumer-oriented organizations with millions of members throughout the country.

Among the many other organizations which have supported these findings are the American Hospital Association, the Association of American Medical Colleges and the American Public Health Association, to single out just three. At the APHA convention in November, 1969, its Governing Council formally adopted a resolution calling upon Congress to continue to exclude chiropractic and naturopathy from covered Medicare services and also recommended that Congress amend Title 19 so federal funds would "not be used to match State Medicaid expenditures for chiropractic or naturopathic services."

In the light of all this, we believe that another study would be unjustifiably repetitive, involving the already scarce time of professional people and unnecessary expenditure of funds. We believe the facts on chiropractic are all in, and a proper conclusion reached. Section 273 should be deleted.

Advance Approval of Extended Care and Home Health Coverage under Medicare (Sec. 228)

In order to overcome the situation where patients, after being admitted under an extended care or home health program, were later denied coverage, this section provides for automatic coverage for certain physical conditions and for limited periods as designated by the Secretary. We support this provision, which alleviates any financial hardship which otherwise would fall upon the patient. One part of this section should be modified, however. It would deny the benefit of advance approval to an individual where the Secretary had determined that the physician has submitted "with some frequency" erroneous certifications or inappropriate plans for services. This provision places an inappropriate burden on the patient for allegations against the physician. The conduct of the physician should be referred for peer review action. An opportunity should be provided to the physician for a hearing before the Secretary makes his determination.

Termination of Payment for Unnecessary Hospital Admissions (Sec. 237)

Under this section, if the utilization review committee of a hospital or extended care facility, in its review of admissions, finds a case where institutionalization was unnecessary, the payment would be cut off after three additional days. This provision is similar to the one in present law which terminates payment after three days' notice where services are found to be no longer necessary. We support this provision.

Limitation on Federal Payment for Capital Expenditures (Sec. 221)

This section provides that reimbursement amounts to providers of health services under Medicaid, Medicare, and Maternal and Child Health Care for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures (in excess of $100,000) which are determined to be inconsistent with State or local health facility plans.

The Association recognizes the need for effective planning of health care facilities and the need to prevent unnecessary duplication of facilities. We believe, however, that if this section is adopted, the exercise of the authority granted should be carefully scrutinized so that the development of desirable facilities is not impeded. In any event, facilities should have open to them the right of judicial review of the Secretary's decision. The language prohibiting such review should be eliminated and such right should be clearly expressed.

Payment under Medicare for Services of Physicians Rendered at a Teaching Hospital (Sec. 227)

Section 227 changes the thrust of the Medicare law, which currently provides that teaching physicians' services are physicians' services reimbursable under Part B (providing they meet the requirements set forth in regulations and Intermediary Letters). Under the new section, the services of teaching physicians are to be included in the definition of "Inpatient Hospital Services," and thus reimbursable from Part A, under reasonable cost formula. Only the services qualifying under two exceptions would be reimbursed on a fee-for-service basis under Part B.

The first exception would be for services provided by physicians to private patients (to be defined in regulations), and the second would be for those provided to inpatients of hospitals where during the 2-year period ending December 31, 1967, and for each year thereafter, all inpatients were regularly billed for professional services (and reasonable efforts were made to collect the billed charges and a majority of all patients actually paid the charges in whole or in substantial part).

With respect to non-private patients, reimbursement for services of teaching physicians would be included under Part A, on an actual cost or "equivalent cost" basis.

One of the objectives of Medicare was to eliminate distinctions in patient care. We believe that this change will create such distinctions. Moreover, we do not see the justification in determining the method of payment for services rendered in the teaching setting, in going back to 1965 and providing payment on fee-for-service basis only where the hospital meets certain conditions for payment since 1965. If the conditions are themselves valid to establish fee-for-service payments, then any hospital which is currently meeting such conditions ought to qualify and the section should be so amended.

We believe that as basic proposition, all patient services performed by teaching physicians should be compensated under Part B. While we recognize that difficulties have existed in administering the existing provision, we do not believe that the proposed approach will notably improve administration or that any such improvement would be sufficiently great to warrant possible diminution of high quality teaching programs and patient care programs in teaching hospitals. We should not diminish, in any way, our support of medical education programs.

Again, we strongly urge that continuation of payment be made under Part B for services of the teaching physicians.

Coverage for Disability Beneficiaries under Medicare (Sec. 201)

This section expands the Medicare program to include those individuals under age 65 who have been entitled for at least 24 months to receive benefits under the disability provisions of the Social Security Act and the Railroad Retirement

Act. Certain spouses and dependents would also be eligible. A similar provision was included and subsequently deleted, in the legislation which became P.L. 90-248, the Social Security Act Amendments of 1967.

At the time of the hearings before this Committee on the 1967 Amendments, we then urged that the expansion of Medicare not be adopted. The provision was deleted and in its place a provision was enacted calling for the appointment by the Secretary of HEW of an Advisory Council to study the need for coverage of the disabled under Medicare. This Council made its report to Secretary Cohen on December 31, 1968.

While the report recommended that the disabled be included it should be noted that the minority Report made the following observation: "The Council found no definitive data on the extent to which the medical needs of the disabled were currently unmet..... The Council found essentially no data on how the disabled are currently financing the substantial medical care the data show they do receive. It was noted, however, that private health insurance plays a significant role in the early months of disability for most of the disabled, and, for some, continues to play an important role even after disability has lasted several years." The report also noted that extension of Medicare to the disabled would result in a substantial duplication of existing private medical expense insurance.

We are well aware of the special problems of the disabled in the financing of their medical care. We do not question the need of some of the currently disabled persons for financial assistance to meet health care costs. However, Title 18 was enacted to provide assistance to one particular population segment, the over 65, in the financing of their health care. Other groups such as children, the disabled, the blind, and persons under age 65 who otherwise qualified for assistance, are included in Title 19.

We believe that Title 19 is the proper mechanism for assisting those groups whose needs require special attention. We would urge that you continue to preserve the integrity of the original intent and purpose of Title 18 by not expanding it to include groups now accommodated by Title 19. Special needs of the disabled in meeting the costs of medical care should be provided under Title 19.

Payment to States under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems (Sec. 235)

This section provides that Federal matching at a 90% rate would be available for the States to set up mechanized claims processing and information retrieval systems. Continuing operation of such systems would be supported at a 75% level. We understand that some states at the present time rely on carriers for this information. Under this section, a question is raised whether a state which might contract with carriers or other private enterprise to provide this information system would be eligible for increased federal support. We recommend this section should be made clear to provide that States wishing to use private facilities, such as insurance carriers, could do so.

Elimination of Requirement that States Move Toward Comprehensive Medicaid Programs (Sec. 230)

This section would remove the mandate, presently in Title 19, which requires the States to broaden the services and liberalize eligibility with a view towards furnishing by July 1, 1977, comprehensive care and services to all individuals and persons who meet the eligibility standards. Our policy has continuously supported a goal of making comprehensive health care available for all persons. We are aware, however, of the financial problems of the State and Federal governments with respect to current Medicaid programs, and accordingly it is recognized that a desire on the part of Congress to eliminate the 1977 requirement is now realistic.

Physical Therapy Services Under Medicare (Sec. 251)

Under Part B this amendment would provide coverage to beneficiaries for up to $100 per calendar year for physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. We also support this modification.

Use of State Health Agency to Perform Certain Functions Under Medicaid and Under Maternal and Child Health Programs (Sec. 239)

This section provides that in addition to the responsibility for establishing health standards for institutions in which recipients of medical assistance may receive care or services, the State Health Agency or other state medical agency shall be responsible for review, by appropriate health personnel, of the appropriateness and quality of care and services furnished. The section adds a new dimension to the role of a State Health Agency in reviewing services provided. While we support the purposes sought to be achieved in this section, we submit that review of physicians' services as to quality and appropriateness should be accomplished through peer review, providing for the review of physicians' services by other practicing physicians.

Utilization Review Requirements for Hospitals and Skilled Nursing Homes —Under Medicaid and Under Maternal and Child Health Programs (Sec. 237)

This section would require hospitals and skilled nursing homes under Titles 19 and 5 to have in effect a utilization review plan which meets the requirements for such review under Medicare. We also support this section.

Cost Sharing Requirements under Medicaid (Sec. 208)

The proposed section would now require the States participating in the Medicaid program to impose on the medically indigent (those not eligible for cash assistance) under the program a premium or enrollment fee graduated by income in accordance with standards prescribed by the Secretary. In the case of cash assistance recipients, nominal deductible and cost-sharing charges (prohibited with respect to mandatory services required under the plan), would be permitted with respect to optinal services. The Association supports the concept of an individual contributing towards his medical obligations where he is financially able to do so. Accordingly, we recommend that this section be adopted, but that its implementation be watched closely so that any charges will not operate to preclude necessary care.

We have a further suggestion to offer which we feel is aligned with this section. In the Report of the House Ways and Means Committee, it is stated that the "Committee has been concerned that costs of the Medicaid program have been escalating much more rapidly than anticipated and believes that an element of cost consciousness on the part of patients and their physicians should be introduced into the program primarily as a cost control device." In its report last year the Committee said: "Even a small charge gives the recipient (of services) a sense of participation and can reduce tendency to excessive use of services." We agree with these statements, and it was to further instill this sense of responsibility and participation, and to place the recipients in the mainstream of care, that we had requested the provision be made permitting payment to recipients of services under Medicaid. While the Congress did provide an option to the States for direct billing as to recipients who were not receiving cash benefits, we believe that the provision should be extended to include all Title 19 recipients, and we urge the Committee to provide for such an amendment to the program.

Hospital Insurance Benefits for Uninsured Individuals Not Eligible Under Transitional Provision (Sec. 202)

This section provides that persons not eligible for Part A benefits could voluntarily enroll for such benefits upon paying a monthly premium of $31 (to be adjusted if costs increase). We do not have sufficient information as to whether a monthly premium of $31 adequately covers the cost of the Part A program, but, in considering that much of the insurance coverage which is available to persons 65 and over is only supplemental to Medicare, we believe that the extension of Part A benefits to ineligible individuals 65 years and over is salutary.

Amount of Supplementary Medical Insurance Premium (Sec. 203)

This section would require the Secretary of HEW to establish annually the monthly actuarial rate and premium for enrollees under Part B of Medicare while limiting Part B premium rate increases. The premium rate could rise

only in direct relation to increases in social security cash benefits. Any gap between Part B income and expense would have to be covered from general revenues.

We view as salutary the purpose of this provision, to prevent increasing premium costs from becoming an unreasonable burden on the elderly, and accordingly, recommend support of this provision.

Program for Determining Qualifications for Certain Health Care Personnel (Sec. 241)

Under this provision the Secretary would develop a program designed to determine the proficiency of individuals who do not otherwise meet the formal education, professional membership, or other criteria established to determine the qualifications of various allied health personnel. Payment for services of individuals found to meet such proficiency standards could not be denied under Medicare or Medicaid.

We express concern for the establishment of standards for qualifications potentially at variance with current local requirements, and for the effect of such a provision on quality and administration of care. Such services, for example, might be furnished in an institution and be recognized for payment under a government program, but the services for general patients might be at variance with local health requirements. We believe that this proposed authority should be studied along with the general questions currently under review relating to licensure, certification and registration.

Penalties for Fraudulent Acts and False Reporting under Medicare and Medicaid (Sec. 242)

This provision would authorize penalties for certain acts relating to reimbursement under Medicare or Medicaid. The penalties would be (1) $10,000 fine or one year in prison, or both, for anyone knowingly and willfully making false statements relating to a right to benefits or payment under Medicare or Medicaid, or for any provider of services, supplier, or physician who solicits, offers, or received a kickback, bribe, or rebate of payment under Medicare or Medicaid, and (2) $2,000 fine or 6 months in prison, or both, for anyone who knowingly and willfully makes any false statement relating to the conditions of any health institution or facility to enable it to qualify for payments under Medicare or Medicaid.

Certainly persons committing fraudulent acts should be subject to punitive measures; however, we feel that the penalties provided are unduly severe. The penalties provided are not in relationship to the seriousness of the offense, wherein, for example, false statements affecting eligibility of institutional providers for certification incur a substantially less penalty than a statement relating to a right of payment for an individual's benefit. We recommend that this penalty provision not be adopted.

Amount of Payments Where Customary Charges for Services Furnished are Less than Reasonable Cost (Sec. 233)

Under this section, payments for services by institutional providers under Titles 18, 19, and 5 could not be higher than the charge regularly made by them for those services. We support this provision.

Institutional Planning under Medicare (Sec. 234)

This section would require providers of services under Medicare (hospitals, extended care facilities and home health agencies) to have in effect a regular plan including an operating budget and capital expenditures budget. While beneficial aspects are apparent in such a requirement, we are concerned whether all such providers will be able to meet these requirements, and whether as a consequence some providers might lose their eligibility for continued participation in the program.

Prosthetic Lenses Furnished by Optometrists under Supplementary Medical Insurance Program (Sec. 264)

This provision would redefine "physician" so as to include optometrists as physicians for the special purpose of establishing need for prosthetic lenses. The objective of this provision should not be accomplished under the language proposed. We object to the broadening of the term "physician" to include non-physicians.

National Drug Formulary

At this point we would like to reiterate our concern for any proposal to restrict the availability of drugs under government supported health care programs. This Committee has considered amendments to establish a National Formulary in the past and the Committee also has before it S. 936, which provides for such a formulary and for the provision of outpatient drugs under Medicare under Part A. This Committee is aware of our position on this subject, most recently referred to in our testimony on H.R. 17550 in the last Congress and also detailed in our letter to the Chairman on August 14, 1970. We are opposed to such proposals that would interfere with the professional judgment and responsibility of physicians. The creation of a formulary committee, with authority to exclude from the formulary (and therefore from payment) any drug which the Formulary considers unnecessary is, in our opinion, an infringement upon the professional judgment of practicing physicians. The creation of a Formulary with prescribing information about each drug listed is unnecessary. Adequate prescribing information to assist physicians in selecting the most appropriate course of therapy is available through a variety of acceptable sources. This Association has recently made available to all practicing physicians the AMA's Drug Evaluations. Additional provisions limiting the ability of the physician to prescribe the drug of his choice, through limitation on reimbursement or otherwise, are equally objectionable.

In summary, we will restate the essence of our position: In the best interests of the patient's welfare, the physician, in prescribing for his patient, should not be denied the availability of the full range of drugs, regardless of whether the patient's care is supported by payments from federal programs.

Amendment No. 823—Professional Standards Review Organization

This Committee has before it Amendment No. 823, entitled "Professional Standards Review Organization" (PSRO). This Amendment would establish a broad program for review of all health care services provided under Social Security programs, including Titles 5, 18, and 19.

When we testified in 1970, we stated that there were many differing views concerning various proposals for peer review and that accordingly it would not be wise to cast peer review into one statutory program. We are convinced that the caution expressed was valid, and that it should be reiterated at this time.

PSRO would affect not only Social Security programs, but once adopted, would affect all health care services in this country. It is generally recognized that the PSRO program carries a potential for cast changes in the provision of health care, and it is therefore important that we be sure that embarking on this course is in the best interests of patient care. The mechanism of PSRO has the capability—whether the reason be economic or otherwise—for molding health care services and structuring health care treatment for the nation. We need mention only the provision requiring the establishment of regional norms of care prepared by a national council, and to be applied by local PSROs, to illustrate this point.

It is also recognized that the creation and operation of PSRO's throughout the country, with their development, maintenance and review of profiles and records of all program beneficiaries and providers, will be a massive and extremely costly undertaking, and will result in duplication of many existing peer review resources.

Expansion of peer review activity has been taking place throughout the country, independent of any special peer review legislation. Many ongoing peer review and utilization review programs of medical societies, foundations, carriers, and health care institutions are now operating, and we can expect new innovative programs to be established. Concurrently, HEW is experimenting with additional programs for peer review (EMCRO).

If enacted, PSRO would lock peer review into one single, untested, nationwide program, with upredictable consequences. On the other hand, many valuable benefits can be gained through appropriate experimentation. H.R. 1, in Section 222, provides authority to the Secretary of HEW to conduct such experiments in community wide peer review programs, and we believe it would be wise to implement this authority before any single overriding plan is adopted.

We strongly recommend that the PSRO Amendment not be adopted, and that under Section 222 the Secretary conduct experiments with various forms of peer review, including programs with PSRO features.

Catastrophic Coverage

In the last Congress, this Committee recommended a program for catastrophic coverage for virtually all persons under the age of 65, including it as a part of H.R. 17550 later passed by the Senate. We recommend in its place the basic and catastrophic coverage as included in our Medicredit program.

During your hearings on national health insurance held in March last year, we presented our Medicredit program (S. 987, the Health Care Insurance Act of 1971), which provides both comprehensive basic and catastrophic coverage for the health needs of our people. Consequently, this Committee knows of the desire of this Association to provide a broad range of benefits, through insurance coverage, to protect all persons against the costs of illness, including the long term catastrophic cases. We urge that you not adopt a free standing program such as S. 1376. We believe that this type of free standing catastrophic coverage does not adequately recognize the extensive coverage which many individuals presently have. Individuals will have no incentive to maintain insurance programs presently providing benefits greater than the deductible under the catastrophic program. Even more importantly, for others without basic coverage, the "catastrophe" would occur before the benefits would be available. The program makes no allowance for the differing needs of individuals.

We believe that catastrophic coverage, to achieve its purpose, must be tied in with adequate basic coverage in order to afford the best range of protection. Such a program, as contained in Medicredit, using the mechanism of private insurance, would best meet the needs of our people.

MATERNAL AND CHILD HEALTH CARE

The maternal and child health care programs under Title 5 of the Social Security Act provide for certain formula and project grants. The formula grant programs are the major sources of care for mothers and children who do not have access to private care for preventive services and treatment of sickness. The maternal and infant care projects now in operation have substantially reduced infant mortality rates in areas where they have traditionally been highest by providing early and comprehensive medical care to high risk women and follow-up treatment for mothers and infants. More importantly, these projects, in reducing the number of neurologically damaged children, have improved the quality of life for many. In addition, the children and youth programs have provided preventive health services, diagnosis, treatment, and after-care, as well as early identification of defects which are correctable.

The legislative authority for carrying on the project grants is scheduled to expire on June 30, 1972. The program should be extended for another five years.

Notwithstanding the progress being made, the unmet health needs of infants, children and youth require a continuation of existing programs. Failure to do this would be a giant step backward. Many communities endeavoring to create new maternal and child health programs or to expand present services are unable to do so because sufficient funds are not available. The Title 5 legislation provides the means for financial assistance. We believe it is imperative that the present programs be extended, and we urge your consideration of the most expeditious means of accomplishing this.

STATEMENT BY JOHN H. BALLARD ON BEHALF OF THE WELFARE COUNCIL OF METROPOLITAN CHICAGO

My name is John H. Ballard and I submit this statement on behalf of the Welfare Council of Metropolitan Chicago of which I am Executive Director. The Council, a voluntary association of 253 health and social agencies, conducts planning, research and demonstration project activities in the health and welfare field. Since 1914, the Welfare Council has been a focus for social welfare agencies in their common concerns and has served as a center for community planning and action to strengthen health and social services and advance human welfare.

The Board of Directors of the Welfare Council has a long history of concern for our welfare system. We have adopted policy statements on a significant number of issues pertaining to public assistance. Recently, we have examined the present public aid system, found it obsolete, inefficient and inadequate and adopted a statement of policy on necessary welfare reform. In that statement which is attached, we propose seven principles as guidelines and criteria for a new program. They are as follows:

1. A guaranteed floor of income to poor families
2. The inclusion of the working poor
3. A requirement that recipients accept appropriate work or training when they are capable of doing so.
4. The inclusion of work incentives
5. Uniform eligibility standards, uniform federal administration of the family and adult programs, and elimination of the assistance categories
6. Expanded programs for work training and placement in private sector and public service jobs
7. Expanded developmental day care programs for low income families

When Title IV of H.R. 1 is measured in the light of these principles, it does represent a step forward in building a more adequate welfare system, however, the Welfare Council opposes Title IV in its present form and suggest major revisions or its exclusion from the bill until more adequate provisions can be agreed upon. The Title is built on some relatively sound principles carried over from the original administration proposal, but it includes far too many provisions which would be a reversal towards a more repressive and inhumane system and damaging both to our national fabric and more important, to those families and children who would be its purported beneficiaries. It is for the reasons as outlined below (and dealt with more at length in our position statement on Federal Welfare Reform attached to this statement) that we find H.R. 1 unacceptable. The Ribicoff amendments represent an effort to strengthen Title IV, however, we find that they are not comprehensive enough to alleviate an acceptable number of its inadequacies. Further, we do not agree with those who would propose that the weaknesses in Title IV can be justified in the light of a beginning step towards "reform".

1. The Resource Limitation should be raised to at least $2,000 and exempt an auto and educational savings in certain cases in addition to those exemptions in the bill.

2. Unlike the current practice, H.R. 1 proposes that budgets are not computed according to current need. It is unrealistic to assume that past family income has not been expended and that a family will save all income in excess of the payment levels in anticipation of going on welfare. It would be an extreme hardship to those who hold temporary jobs and piecemeal employment and to those who are abruptly thrown out of the labor force due to economic fluctuations. It would eliminate the migrant worker from assistance entirely.

3. H.R. 1 does not include family units of individuals and childless couples who are not aged, blind or disabled. These individuals should be included thereby eliminating the general assistance programs administered by the various states' and localities. Generally speaking, the general assistance programs are much more in need of improvement that the present federal programs. By extending the federal public assistance program to these individuals, it would include many able-bodied employable adults who have exhausted unemployment benefits and need every aid in returning to the work force.

4. Under H.R. 1, extensive investigations to determine eligibility are authorized. Such investigations are not only wasteful of administrative resources but also demeaning. At the present time, 20 states are using a simplified declaration method under directives from H.E.W. and experience to date indicates no increases in fraud or inaccurate grant payments. It would be unfortunate to revert to a system which has been improved upon.

5. The proposed benefit levels are inadequate. Most of the country's recipients would suffer a reduction in benefits under H.R. 1. In Illinois, for example, the combination of the grant and food stamps averages about $3,200 as opposed to the proposed $2,400 for a family of four. In addition, families of eight or more would be penalized due to a maximum $3,600 grant. In our position statement, we suggest a benefit system which would begin with "poverty level" grant and move towards a more responsible grant over a ten-year period.

6. The proposed penalty for failure to register for work and training is unduly punitive and harmful because it deducts a disproportionate amount of the grant.

7. We are opposed to the provisions in H.R. 1 which eliminate emergency assistance available under the present program. Not only is $100 inadequate, but such grants should not be recovered from the regular payments and should be available at any time.

8. Under H.R. 1, all payments will cease after two years, despite continued need, unless a family goes through the entire application process again. We oppose such a provision on the grounds that it will not only place undue hardship upon the recipient and cause large numbers to lose their benefits but it will also create a superfluous administrative burden and expense—especially in the light of resource limitation provisions.

9. The work requirement in H.R. 1 is far too broad and should not be applicable to mothers or other individuals caring for a child under 16 years of age and an individual whose spouse has registered.

10. H.R. 1 lacks adequate protections pertaining to the work requirement including adequate definitions of the suitability of work and rate of pay, assurances of work opportunities, and public service jobs.

11. The mandatory registration for vocational drug and alcohol rehabilitation should be removed. It would be extremely difficult to force individuals to accept treatment which is based upon a desire to change one's physical or behavioral patterns. In addition, the services are not available and such provisions would detract from adequately serving those who voluntarily seek such services.

12. Protections to the recipient are lacking in the dual administrative system of H.E.W. and Department of Labor.

13. The bill also lacks adequate protections pertaining to fair hearings including payment of recipients expense and free choice of representation.

14. Allowing imposition of a residency requirement would be a step backwards and in conflict with the major justification for a national program.

15. The child care provisions are inadequate. They lack refernce to even existing federal standards and provide for a level of financial support which, in fact, authorizes low quality custodial care with the primary goal to enable the mother to enter the work force rather than meeting the needs of the children.

It is upon these concerns that we have based much of our opposition to Title IV and refer you to a more detailed statement.

In summary, we support the needs for major structural welfare reform. Such a conviction is based on years of concern about the impact of the public aid system on the poor and a very careful study of bills before the Finance Committee. It is our conviction that neither H.R. 1 or various amendments which have been proposed adequately deal with the problem and bring actual practice closer to our intentions.

We recognize that it may be an extended period before the resolution of these problems is completely in Congress. In the meantime, it is urged that Congress and administration move to provide emergency aid to the states so that we do not create additional human suffering and unduly aggravate the fiscal problems of the states.

Statement of the National Association for Retarded Children

INTRODUCTION

Severely mentally retarded persons constitute about two-thirds of all adults severly disabled in childhood, and at least 15 per cent of adults who receive public assistance because of disability. H.R. 1 contains a number of provisions which will benefit these most handicapped people. NARC favors federalization of the adult categories, with inclusion of disabled children, equalization of entitlements as between the disabled and the blind, and inclusion of disabled social security beneficiaries under medicare. We are grateful to the committee for its recognition of rehabilitative intermediate care in the recently signed amendments.

Nevertheless, as we watch the parade of prestigious witnesses before this committee, the governors, and spokesmen for powerful national organizations, the National Association for Retarded Children, concerned as it is with the well being of all mentally retarded persons, both children or adults, must raise serious questions as to whether the board provisions of the Act as proposed will be fair in all respects to the mentally retarded.

We have great confidence in members of the Senate Finance Committee. We believe no member of this committee intends to discriminate against any citizen of this country because of his mental retardation; indeed we recognize that the committee has, on several occasions in the recent past, addressed itself specifically to problems created by the condition of mental retardation. If discrimination occurs, we are sure it will be by inadvertence, and by failure to recognize how some broad general provision can be adversely interpreted by administrative agency.

For this reason, we seek to point out to the committee several significant areas in which we believe such discrimination is likely to occur as a result of enactment of proposals presently before the committee. We hope the committee itself will take steps to amend the language accordingly.

1. Referral of Disabled Children

Disabled children in low income families will become entitled to disability assistance under the proposed new Title XX; Sections 2015 and 2033 of the House bill in effect require referral of all disabled applicants to the same state agency for disability determination regardless of age. It is clearly intended that the determination of disability among assistance applicants be handled by the same state unit as now handles these determinations with respect to disabled adults for SSA. In all but half a dozen states this is done within the State Vocational Rehabilitation Agency. The major criterion in such determinations heretofore has been ability to work. Such referral may be appropriate for persons over 15, but not for infants and young children.

The problems of identification of child clients are quite different than those of adults. We recommend that the Secretary be required to use the options open to him under Section 221 of the Act to refer children under 15 to an appropriate agency in each State, to be designated because of its special competence in evaluating and habilitating mentally and physically handicapped children, and to contract with such agency to evaluate children referred, both as to eligibility (with respect to disability) and as to need for habilitation.

Experience in the administration of the adult disabled child program under OASDI indicates that the vast majority of children who will be found disabled under the new legislation (H.R. 1) will be "developmentally disabled" within the meaning of the Developmental Disabilities Services and Facilities Construction Act (P.L. 91-517). All but one state have now designated a state agency to administer service programs (including diagnosis and evaluation) under this Act. Utilization of these state agencies in implementing the disabled child assistance program is strongly recommended. If, however, it is preferred to consolidate disability determination in State Rehabilitation Agencies, we strongly urge that a new sub unit be created with new staff especially oriented to the characteristics of disabled children.

2. Services for Disabled Children and Adults not Eligible for Vocational Rehabilitation

We recognize that the thrust of Section 2015 is to build on the experience in rehabilitating adult social security beneficiaries in order to get disabled adults back into the work force. Nevertheless, we believe it is also in the public interest to reduce personal, social and economic dependency among disabled people, and especially children, even when they are not eligible for vocational services. We therefore recommend that Section 2015 be amended as follows.

Amend (1) to read:

"(1) is over the age of 15 but has not attained the age of 65, and"

After Sec. 2015 (c), add:

"(d) For the purpose of assisting each blind or disabled individual to attain and maintain his optimal level of personal and social independence and to prevent exploitation or unnecessary institutionalization of such individual, the Secretary is authorized to pay any appropriate State agency the costs incurred in the provision of such services as he may specify to any disabled recipient who, because of age or severity of disability, is ineligible for vocational rehabilitation services under subsection (a).

3. Information and Referral Services for Federal Beneficiaries

In order to make sure that persons receiving income maintenance are able to obtain answers to their related questions while in contact with the social security district offices, we recommend that these offices be encouraged to

strengthen their information and referral and follow-up as well as their protective functions. (See Haber, Schmulowitz and Cormier, *Information and Referral Services in SSA District Offices: A Pilot Study* SSA Office of Research and Statistics, 1971)

4. Medicare for the Disabled

We recommend that the proposed two-year waiting period be waived specifically for disabled social security beneficiaries who are entitled as adult disabled children. It is estimated that this might increase the overall costs at most by three per cent. As we understand it, the rationale for the waiting period is twofold: (1) to avoid initially burdening the system with the early and relatively heavier costs attributable to the illness or accident that created the disability, and (2) to ensure that the beneficiary makes full use of the prior coverage to which he was entitled as a member of the labor force. Neither of these arguments apply to adults disabled in childhood, almost all of whom will have been disabled for more than ten years at the time they become entitled to social security benefits. Moreover, their private coverage (which will usually have been derived from their coverage under a family plan) will cease in most cases with the death or retirement of the parent on whom they have been dependent, i.e., at the time of their entitlement. Therefore a very awkward gap in their health coverage will be created unless the two-year gap is closed.

We recommend that the proposed amendments to Section 1811 of the Act (Section 201 of H.R. 1) be modified accordingly.

5. Disqualification of otherwise eligible individuals in public institutions from eligibility for public assstance and medical assistance

The Committee made a very important contribution to the well being of the mentally retarded through its amendments of last December affecting intermediate care in general and in public institutions for the retarded in particular. The phrase "public institution" tends to conjure up a picture of a large congregate care facility, such as Willobrook, or Forest Haven, or Rosewood, or Pennhurst, to name a few which happen to be in the news. Most of the residents in these facilities are multiply handicapped and certainly in need of care in a "medical institution", for which federal cost sharing will be available under Title XIX, subject to the standards wisely specified by the committee. The larger institutions will surely move under the Committee's incentives to qualify themselves and their residents for federal aid.

In our opinion, the continued exclusion, from public assistance, of otherwise eligible persons in "a public institution other than medical institutions" is not only anachronistic, but can actually be detrimental. The proper development of systems of well distributed community residence such as are needed to move the more able residents out of the present larger institutions should be encouraged. These individuals frequently need a supervised living situation which does not in itself provide "active treatment" but is specialized in its functons.

If appropriate facilities of this type are to be developed, both public and private resources should be applied. A person who is appropriately placed at a facility which could be called a boarding home should not be disbarred from receiving public assistance or from receiving reimbursement for the cost of his medical care merely because the boarding home is publicly owned or operated. Public and private facilities should meet the same standards, and when the same standards of operation and utilization are applied, such discrimination should be eliminated. Specifically we recommend that proposed Section 2011(e)(1)(A) be amended so that the last line reads "such month as he is an inmate of a public medical or penal institution."

At the same time the language of Section 1905 of the Act should be amended by deleting entirely the phrase that excludes inmates of public institutions from receiving covered medical services. Obviously care given in an institution which is not itself a medical institution is not itself covered inpatient care; however, a person who is appropriately placed in a publicly owned boarding home, sheltered home, personal care home, group home of half way house should have as much coverage for his intercurrent illnesses as he would have if he were in a similar facility under private sponsorship. To provide otherwise creates a disincentive to public agencies (state, municipal, county and other) to provide much needed facilities, especially in those geographical areas with acute shortages.

6. Protection against catastrophic costs of illness or disability

We applaud the chairman for his championship of the principle of providing catastrophic coverage as the most urgently needed aspect of national health insurance. However, to be true to its name, catastrophic coverage must protect against

all excessive costs related to illness or disability, not merely selected types of expense. Language which covers only "illness" or "medical and surgical care" may prove a cruel hoax, if families of mentally retarded or other chronically disabled children are left to bear other necessary heavy costs which may be the consequence of the mental or physical disorder. To protect the family against catastrophic costs, "catastrophic" coverage must absorb the cost of any kind of necessary remedial or other extraordinary care, occasioned by mental or physical disability where the cost *would otherwise become the personal liability of the individual or his family*. It is better to increase the threshold or deductible than to tax the family for catastrophic coverage and then leave them with residual catastrophic costs.

We recognize that impartial determination of what is "necessary" is crucial to the success of this system.

We also believe that all groups in the population must be covered for catastrophic costs either by insurance or under medicaid, and that coverage only for those in the labor force may discriminate against people who are intermittently employed, or disabled with modest unearned incomes.

7. Continued support of Maternity and Infant Care Projects

We foresee that these important projects must become a part of the new system of health care delivery and as such will eventually lose their present federal project grant status. A sudden cessation of project support with the expiration of this authority under Title V of the Act next June would be disastrous, however. The provisions of S. 2434 would cover continued support through the states. We urge the Committee to act immediately ~~(i.e. in H.R. 1)~~ to include either a three-year extension of present authority or an ample funding provision using state channels as proposed by Senator Magnuson.

STATEMENT OF ALICE BOYNTON, FORMER PRESIDENT, UNITED LOW INCOME, INC.

My name is Alice Boyton. I am presently a consultant for United Low Income, Inc., Maine's statewide organization of poor people, and an instructor at the University of Maine, South Campus, under a special Title I HEA grant. I am a welfare mother and fromer President of ULI. I have just received a Ford Fellowship Grant and along with my new status as a working mother will presently be off the welfare program, Aid to Families with Dependent Children. I have worked for OEO in their Community Action Program, I have finished a year of service in VISTA, working with Legal Services. It has been my job to establish good working relationships with officials in the Department of Health and Welfare and to work with other State committee's and task forces for the purpose of communicating the needs of poor people to them and the limitations of their resources to poor people. I have worked with local officials and community groups to enhance the existing local welfare system. I have been involved in training programs for the poor and programs for agencies. I spent two weeks last summer in Washington, D.C. learning about HR 1 and I have spent time in other states with low-income organizations and other groups dedicated to making changes that will better the lot of the poor.

I am familiar with the Commodity Food program and not just because I lived on them for months. I am familiar with the Food Stamp program, we have a pilot project. I a familiar with Head Start. One of my daughters attended while I was busy organizing the parents. I am familiar with Family Planning, Day Care facilities and lack of them. I am familiar with Housing problems and not just because I was forced by nature of my welfare status into sub-standard housing but also because of my participation in drafting and supporting legislation which passed the last Maine legislative session with intent to improve landlord relationships. I am also aware of towns that have rejected "Dirty" Federal money which could have been used to subsidize low-cost housing for the needy.

Throughout all the hours of work, suffering and sacrificing, the only thing that has truly impressed me is the ignorance that I have encountered. IGNORANCE!! The lack of truth and the overwhelming power of bodies such as your committee, the lack of understanding at every level within every agency is almost impossible to comprehend.

I will not be specific about HR 1. The bill is despicable. It appears untouched by human hands. I can not conceive of a nation as potentially great as ours with our tradition of protecting our honor stooping so low with their own people at

their mercy. I have reviewed Senator Muskie's remarks on HR 1. I have reviewed Governor Kenneth M. Curtis' remarks and no where do I read acceptance of HR 1. I read that something must be done but HR 1 is not the way to do it. I quote Mr. Paul A. LeVecque, Manager, Income Maintenance Unit, Department of Health and Welfare here in Maine: "The administration has claimed that this bill will federalize, standardize and simplfy the variety of welfare programs in existence. While some of the objectives of the program such as providing a minimum floor of income and more job opportunities are admirable, it seems to me that the details of the bill only create another maze of frustration and red tape plus an addel level of structure to go through in an already complicated and frustrating system that is supposed to help meet people's economic needs." If I personally must support any position I wholeheartedly support the Black Caucus. By virtue of their race and their willingness to make change within the system they have everything to gain and nothing to lose. Theirs is the most honorable and decent proposal to change that I can accept.

My recommendation is to burn HR 1 and try to forget that it was almost too late. Abstain from making undocumented charges about cheating, lazy, poor people. Stop courting a national social disaster. What the taxpayers *deserve* is the truth. What this country needs is a good dose of it. The truth that is. You throw crumbs to the poor via OEO and other various and sundry organizations. Because of it they are divided and eventually conquered. Millions of dollars are going to the moon and to Vietnam and I know . . . you've heard it all before. Have you ever litsened? Listened to the anguished cries whether they be provoked by bombs or by a system that destroys men just as effectively as racism has accounted for millions of broken spirits.

I am in awe of men who assume God's power . . . but sadly, I am not impressed.

STATEMENT OF THE AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS

The American Society of Medical Technologists is composed of approximately 21 thousand members engaged in the supervision and the performance of clinical laboratory tests. Included in the membership are supervisors with graduate degrees, technologists with baccalaureate degrees, and technicians with education ranging from two years of college to on-the-job training. Our organization believes it has major responsibilities for increasing technical knowledge, providing means for members to evaluate and improve their performance, and education of students entering the various levels of clinical laboratory practice. The ultimate goal of our Society is the provision of the best possible care to the patient at economically sound levels. I wish to thank you for allowing me to present our views on pertinent issues involved in the concept of national laboratory standards to improve clinical laboratory services. My comments are limited to the provisions of HR 1 that would amend Medicare and Medicaid.

Dr. M. M. Brooke, of the Laboratory Division, National Center for Disease Control, in a paper published in "Public Health Reports" (attached), states: "With assurance of payment of laboratory bills through health programs, the development of automated laboratory procedures, the establishment of mass screening programs, and the growth of comprehensive health insurance plans, the number of laboratory tests in this country may increase from an estimated 1,300 million now, to more than 3 billion by 1975." Obviously, payment for such vast numbers of laboratory procedures will constitute a significant amount of the cost of any health program.

Dr. Brooke, in the above cited report, also states: (. . . tests from . . .) "All types of medical laboratories—independent, hospital, and public health—are now generally recognized as subject to error, and we can therefore proceed with the task of improving laboratory services."

Already, the increased number of tests being performed under Medicare and Medicaid has required the use of automated screening techniques. The results of screening tests are examined; those producing abnormal results are then repeated and further tests ordered to evaluate the patient's condition. In actuality, when automated equipment is used, test values are spewed out very rapidly, but proper supervision is essential to insure that these values are correct. The instruments utilized should be constantly supervised by persons who have the educational background to fully understand the theoretical concepts upon which these instruments are based, their standardization or the limits of their capabilities.

If these "machines" are operated by individuals who do not adequately understand the operation, the test values may be erroneous and may be abnormal—meaning the patient will be studied further. Equally possible is for the results to appear normal, when in fact, they should have been abnormal. In this case, the patient is not followed up as soon as might have occurred with accurate test values. He thus can suffer irreparable harm, and the unnecessary additional costs of more lab tests, and extended hospital stay.

Programs in proficiency testing to improve the quality of laboratory tests have been developed by the American Society of Clinical Pathologists, the College of American Pathologists (CAP), the American Association of Bioanalysts, Proficiency Testing Service, Inc., and several commercial companies. In addition, CAP has developed a program which includes not only proficiency testing, but inspection of the laboratory equipment, staffing, and performance. While the quality of these programs is continually improving, participation is voluntary, thus limiting the potential benefits to laboratories which recognize the need for evaluation and improvement. With voluntary participation, there is no mandate for improvement if defects or performance is encountered. Even more discouraging is the fact that those who do not voluntarily participate are often those who need it most.

The Joint Commission on Accreditation of Hospitals (JCAH) conducts surveys of hospital laboratories in conjunction with their general inspection and review program. Usually the surveyor has limited knowledge in laboratory operation. He collects data which includes the number and type of personnel, procedures performed, methods of record keeping, and visible records of a quality control program. The only specific requirement for laboratory personnel under JCAH is that procedures be carried out by "competent" personnel with at least one qualified medical technologist on duty or available at all times. Laboratories receiving approval from the Joint Commission are automatically exempt from the need to comply with standards established in the Medicare regulations.

A laboratory not located in an accredited hospital must meet federal standards in order to receive payment for tests under Medicare. These standards are largely concerned with qualifications for clinical laboratory personnel. Hospital laboratories, therefore, may receive payment for Medicare covered procedures, while complying with JCAH regulations, a different and far less stringent set of standards.

The Clinical Laboratory Improvement Act of 1967 provides federal licensure of clinical laboratories engaged in inter-state commerce. This act emphasizes proficiency testing and internal quality control in an effort to insure the accuracy of test results. Again, most hospital laboratories are not covered by these regulations, since they do not engage in inter-state commerce.

More than half of the states in the country have some form of licensure regulations affecting clinical laboratory personnel or procedures. There is no currently accepted standard observed in state licensing regulations, and as a result, great variation exists from state to state. Some regulate the training or evaluate the performance of laboratory personnel; others attempt to test and evaluate the quality of work performed, while still others are largely ineffectual and merely maintain the status quo.

In some states, laboratories which qualify for JCAH, Medicare, and/or CLIA are exempt from the state law—thus, only a small portion of laboratories are covered by these laws.

In all states, laboratories operated by federal or local government are exempt as are the laboratories maintained in a physician's office for his own patients.

Federal regulations have sometimes tended to compound confusion by attempting to achieve similar goals by widely differing methods. For example: Medicare regulations attempt to insure quality by evaluating personnel, while Clinical Laboratory Improvement Act regulations control quality by evaluating the product, and the technical performance. As pointed out in the Auerbach report, there is an urgent need for the various government agencies to bring their criteria into one set of standards.

"Proficiency testing", as required under Medicare and the Clinical Laboratory Improvement Act, is either conducted under a state Health Department or, in the latter, through the Center for Disease Control (CDC) of HEW. In this context, proficiency testing is the evaluation of test accuracy by providing a substance which the laboratory analyzes. Results are then measured against the known value—a standard quality control process.

In several bills before this Congress, demonstration of proficiency is cited as a means of qualifying personnel—especially those who have not met specific educational and/or certification criteria. In some circles, this is meant to be a paper and pencil examination. How successful such an examination will be, remains to be seen. It should be noted that paper and pencil tests have definite limitations in the ability to measure attitudes and psychomotor skills, as well as limitations in the ability to adjust to technological change. In some states, proficiency means a challenge exam a student takes to receive academic credit for knowledge he has gained by other means. The American Society of Medical Technologists urges that those persons considering laboratory standards of performance and personnel be very careful to designate the exact meaning assigned to the term "proficiency testing". Further, we believe that all appropriate professional societies should be utilized to help develop and evaluate any proficiency testing examination prior to its adoption.

The government, organized medicine and the public have created a sudden surge of interest and action devoted to improvement of laboratory services. Resulting is a complicated array of confusing and often conflicting standards, rules, and regulations. The Second Annual Report of the Health Insurance Benefits Advisory Council of HEW states—"The Council is also concerned that the emphasis on the development of mechanisms for cost control may deflect interest and effort from an even more important goal—the need to relate the cost of a given health service to the substance and quality of the service rendered. The determination of the relationship of cost to quality requires the development of more precise measurements of quality. The Council, therefore, urges that the highest priority be given to the development of such measurements."

Many concerned allied health professions are seeking to protect the patient through better definition of performance standards for practitioners while also evaluating ways to delegate tasks to lesser trained individuals. This plan could reduce health costs while maintaining quality care. Personnel standards are best enforced by effective licensure regulations. Licensure efforts have been hampered this year by the national moratorium on licensure declared by the American Medical Association and the American Hospital Association. It is indicated that a comprehensive study of the problem will be made. A mechanism for this study is under consideration, but we have not seen an acceptable means for evaluating the results of the study, nor have we seen the development of the plan for implementing recommendations. We believe the following statements summarize the present situation:

1. There is a continuing need to assure the public the highest quality laboratory performance possible.
2. Due consideration must be given to cutting the costs of laboratory service without sacrificing quality.
3. There are too many fragmented and conflicting regulations now in effect to guarantee any level of consistent performance from one laboratory to another.
4. There is a need for national standards in order to insure consistent high quality in laboratory performance.
5. National uniform standards would provide adeqate control if the following factors were included:
   - (*a*) minimum standards for education of personnel
   - (*b*) institution of valid quality control requirements
   - (*c*) standards for equipment and technical methodology
   - (*d*) development of effective evaluation of laboratory performance

The provision of national personnel regulations could serve to set minimum standards for education, and could serve to enforce performance standards. As pointed out in the recent HEW Conference on Personnel Licensure and Certification (May 12 & 13, 1971), the responsibility for developing these standards should rest with the respective professional associations.

The public's interest lies solely in the receipt of accurate laboratory services. To this end, we believe uniform standards controlling both personnel and procedures are urgently required. Such standards, based on a program of careful study and evaluation, could ultimately guarantee the public reliable, low-cost laboratory service.

ADDENDUM

New Section 1123 (as added by Section 211A) under Section 241, title "XI of HR–1", contains the mechanisms for use of proficiency and equivalency examinations in qualifying personnel for many of the allied health professions.

Attached to this testimony is a statement of position of the American Society of Medical Technologists in regard to the use of equivalency and proficiency examinations which are currently being developed to determine personnel qualications in the clinical laboratory. We would like for this document to be entered in the record as a part of our testimony.

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NATIONAL MINIMUM STANDARDS FOR CLINICAL LABORATORIES

Clinical laboratories provide essential service to the medical practitioner, and through him, to the patient by furnishing vital information for the diagnosis, prevention, or treatment of any disease, or the assessment of the health of man. The Secretary shall require that all clinical laboratories be conducted, maintained, and operated without injury to the public health.

The establishment of minimum standards for clinical laboratories is vital in the public interest in order to reduce the hazard of inadequate performance. Adherence to minimum standards does not preclude the establishment of higher standards in a laboratory or participation in any voluntary or governmental accrediting program with standards equal to, or greater than, those herein presented.

RESPONSIBLE AGENCY

These standards shall be administered through the Center for Disease Control and under the direction of the Secretary of the Department of Health, Education and Welfare. Annually, a Laboratory Standards Advisory Committee (hereafter referred to as the LSAC) composed of appropriate representatives of the Department shall meet with a designated representative from each of the professional organizations involved in clinical laboratory service and representatives of the public to review, advise, and make recommendations relative to the administration and enforcement of these standards. A method of appeal for laboratories receiving adverse decisions shall be developed and administered by the committee.

APPLICABILITY

These standards shall apply to all clinical laboratories except:

(*a*) those operated by an individual licensed physician for laboratory work performed on his own patients.

(*b*) a laboratory operated for teaching or research purposes only, provided that the results of any examination performed in such laboratories are not used in the health maintenance, diagnosis, or treatment of disease.

DEFINITIONS

Clinical laboratory as used in these standards means any place, establishment or institution organized or operated for the practical application of one or more of the fundamental sciences by the use of specialized apparatus, equipment and methods for the purpose of obtaining information which may be used in the diagnosis, prevention or treatment of any disease or impairment or assessment of the health of man.

Specimen means any material derived from the human body for examination or other procedure for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, impairment or assessment of the health of man.

Structured training means a program planned to provide a predetermined amount of experience and in-service education in all areas of the clinical laboratory.

Acceptable laboratory means a laboratory that maintains standards equal to or greater than those set forth in this document.

Direct supervision as used in these standards shall mean the supervisor is on the premises and available immediately for consultation.

Adequacy shall be determined by authorized inspectors through the review of a quality control program, questionnaire, on-site inspection, including consultation with members of the laboratory staff.

INSPECTION

Laboratories shall have two years in which to apply for approval under these standards. Within one year following application, an initial on-site inspection shall be made by an authorized representative of the administering agency. Thereafter, an inspection will be made at least bi-annually, with a comprehensive questionnaire being answered and submitted to the administering agency in the intervening years. If a laboratory is placed on probation or services are suspended in one or more areas, a request for re-inspection must be made within a six-month period to determine if deficiencies have been corrected.

COMPLIANCE

Failure to apply for approval or failure to comply with these standards shall result in appropriate action to be taken by the Secretary.

EXAMINATION AND REPORTS

Standard: General

The laboratory examines specimens only at the request of a licensed physician, dentist, or other person authorized by law to receive such results. The factors explaining the standard are as follows:

1. Orders or requisitions for service must clearly identify the patient, the doctor, the tests requested, special handling required, e.g., "emergency", the date and where appropriate, should specify the time when the specimen was collected. Minimum patient identification data shall include at least the name of the patient, hospital number, room number or address, age, sex, and attending physician. Requests for examination of surgical specimens should contain a concise statement of the reason for the examination.

2. A clinical laboratory may accept requests for tests and make reports only to persons authorized by law or to their representatives.

3. If the laboratory receives reference specimens from another laboratory, it reports back to the laboratory submitting the specimens. The referring laboratory must maintain a record of the name of the laboratory performing the test and the laboratory performing the test must be identified on the patient's report by name and address or by code number.

4. Reports shall contain the identification of the person responsible for performing the procedure. Records of observation are made, concurrently with the performance, of each step in the examination of specimens. Records reflect the actual results of all control procedures. A copy of each laboratory report shall be retained for a period of at least six months.

5. Authenticated and dated laboratory reports are filed with the patient's medical record.

6. Tissue pathology reports must utilize acceptable terminology of a recognized system of disease nomenclature, and shall be cross indexed, using a system that is adequate for the hospital.

7. The pathologist shall prepare a descriptive diagnostic report of gross specimens received, which shall be a part of the patient's medical record.

8. The method of reporting should enable the physician to interpret easily the results of the test with reference to the range of usual values in health utilized by the laboratory, and with reference to the results of sequential and related tests. Reports of quantitative analyses shall include the units of concentration or activity.

9. A list or manual of analytical methods employed by the laboratory and a basis for the listed "normal" range is maintained in the laboratory. The list shall be available to the physicians.

10. If the laboratory refers specimens to another laboratory, the laboratory receiving the speciments must meet the applicable conditions under these stand-

ards. When tests are performed in a reference laboratory, the name of the laboratory submitting the test must be maintained as part of the record.

Standard: Collection of specimens

No person other than a licensed physician or one otherwise authorized by law may manipulate a patient for collection of specimens except that qualified technical personnel of the laboratory may collect blood or remove stomach contents and collect material for smears and culture under the direction or upon the written or verbal request of a licensed physician, dentist or other person authorized by law to use the findings of laboratory examinations.

Standard: Specimen records

The laboratory should maintain for at least one month a record of the daily accession of specimens each of which is numbered or otherwise appropriately identified. The factor explaining the standard is as follows:

Records must contain the following information:

1. The laboratory number or other identification of the specimen.
2. The name or other identification of the person from whom the specimen was taken.
3. Name of the physician or other person or laboratory that submitted the specimen.
4. The date and time (if appropriate) the specimen was collected.
5. The date and time (if appropriate) the specimen was received in the laboratory.
6. The condition of any unsatisfactory specimen.
7. The type of test performed.
8. The date test was performed.
9. The result of the laboratory test or cross-reference to results and the date of reporting.
10. Cytology slides and Histology slides and blocks must be adequately identified, indexed, and stored.

LABORATORY SAFETY, PHYSICAL FACILITIES

Standard: Safety—general

There shall be adequate space, facilities, equipment and supplies within this area to perform the services offered with optimal accuracy, precision, efficiency, and safety. The factors explaining these standards are as follows:

1. There shall be a detailed laboratory safety program in operation which includes written and practical instruction for all employees in all basic areas of safety. Technical personnel shall receive special instruction in the proper use of safety equipment appropriate to their specific area of assignment.
2. Waste from all laboratory areas shall be disposed of with the closest adherence to current pollution control policies.
3. In areas where radioactive materials are used, all federal and state regulations concerning safety must be closely followed.
4. There shall be specially marked containers for disposal of broken glassware.
5. All drugs and narcotics shall be kept in locked cabinets.
6. Syringes, needles, lancets or other blood letting devices capable of transmitting infection from one person to another must not be re-used unless they are sterilized prior to each use after first having been wrapped or covered in a manner which will insure that they remain sterile until the next use.
7. All specimens suspected or known to be contaminated, icteric, or infectious shall be clearly identified and handled with due caution.
8. All contaminated glassware shall be placed in an appropriate disinfectant prior to washing.
9. Surgical and autopsy material shall be handled and disposed of so as to prevent infection.

Standard: Safety—fire

1. Emergency fire instructions, which include the number of the fire department, instructions for evacuation of patients and personnel, location of fire fighting equipment, and the date of the last fire drill shall be prominently posted.
2. A current report of inspection by the Fire Marshall shall be on file.
3. Fire extinguishers of the proper type, showing a recent date of inspection, fire blankets, and other necessary fire fighting equipment shall be readily available in all areas of the laboratory.

4. Automatic sprinkler systems should be installed in all appropriate areas of the laboratory.

5. Smoking shall be prohibited in any areas with flammable material and preferably confined to rest areas.

6. Flammable material shall be stored in unbreakable safety containers in well ventilated storage areas equipped with explosion proof switches and fixtures.

7. If refrigeration is required, inflammable material shall be stored only in explosion proof refrigerators.

Standard: Safety—chemical

1. All chemical containers must be clearly and permanently labeled.

2. Overhead showers, step-on eye washers, safety goggles and other necessary equipment must be readily available.

3. Mechanical pipetting equipment shall be used for pipetting all dangerous materials.

4. Containers of acid and other highly caustic materials shall be stored at floor level as much as possible to minimize damage in the event of earthquake, storm, or other catastrophic event.

5. There shall be an adequate air control system including the use of fume hoods, ventilators, etc., to protect workers and work material from toxic and noxious fumes.

Standard: Safety-Bacteriological

1. All culture materials shall be sterilized before washing or discarding. Appropriate indicators shall be included in each batch of sterilized material.

2. All refuse, including specimens and other waste, shall be free from contamination by pathogenic organisms.

3. Bacteriological safety hoods shall be available which provide an adequate flow of air and a filter system which will remove all bacteria from the exhaust flow.

4. All laboratory areas affording any possibility of contamination shall be washed daily with an appropriate disinfectant. Immediate attention shall be given to spillage of contaminants.

5. Any employee with an infectious disease shall be excluded from patient contact.

6. Disposable syringes, needles and lancets should be used wherever possible and after use be rendered useless and placed in a special, clearly identified container before destroying.

Standard: Safety-Electrical

There must be a sufficient number of electrical outlets of proper voltage, adequately stabilized and all electrical equipment must be safely grounded.

PHYSICAL FACILITIES

Standard: Blood bank

1. The hospital maintains, as a minimum, proper blood storage facilities under adequate control and supervision of the qualified physician.

2. For emergency situations the hospital maintains at least a minimum blood supply in the hospital at all times, can obtain blood quickly from community blood banks or institutions, or has an up-to-date list of donors and equipment necessary to bleed them.

Standard: Clinical laboratory

1. Out-patient areas shall be so arranged as to provide an adequate, clean area with sufficient space to draw blood or collect other specimens. In addition, there shall be an enclosed area with bed facilities for faint or ill outpatients and for patients undergoing extensive diagnostic testing.

2. Adequate, well lighted, bench top space shall be available in each work area for the performance of tests and for location of instruments. Surface areas shall be covered with material appropriate for the type of testing performed.

3. There shall be adequate space throughout the laboratory for the particular volume and type of services offered. The overall design, arrangement of equipment, and assignment of personnel shall be so carried out as to minimize transportation and communication problems.

4. There shall be adequate rest rooms and locker space for all personnel.

5. There shall be adequate library and conference room facilities located in or near the laboratory.

6. Adequate storage space shall be provided for:

(*a*) reagents, glassware and other supplies needed for regular operations in each area.

(*b*) easy retrieval of current and inactive records, microscope slides, paraffin blocks and wet tissue specimens.

7. There shall be an adequate forced air ventilation system providing fresh air and removing toxic fumes.

8. Adequate refrigeration space shall be provided for materials requiring refrigeration.

DIRECTION AND PERSONNEL

Standard: Laboratory director—Responsibilities

The laboratory has a qualified director who is responsible for the organizational and administrative operation of the laboratory.

1. The director serves the laboratory full-time, or on a part-time regular basis. If he serves on a regular part-time basis, he does not serve more than three laboratories or he may serve up to five laboratories providing he has a qualified associate to serve as an assistant director in not more than three of these laboratories.

2. Commensurate with the laboratory workload, the director or assistant director spends time in the clinical laboratory which is sufficient to fulfill his duties as a director or assistant director and is readily available for consultation at all other times.

3. The director is responsible for the employment of qualified laboratory personnel and the provision for a program of in-service education.

4. Appropriate delegation of responsibilities of the director shall be made in his absence.

Standard: Laboratory director—Qualifications

The laboratory director must meet one of the following qualifications:

1. He is a physician certified by the American Board of Pathology or American Board of Osteopathic Pathology. This requirement is mandatory in the area of anatomic pathology.

2. He is a physician certified by an acceptable specialty board and he must have had at least two years of experience in his area of specialty in a laboratory acceptable under these standards. He will only be considered qualified to direct a laboratory performing those tests for which he is qualified by reason of certification or experience.

3. He is a person holding an earned doctoral degree from an accredited institution with a chemical, physical, or biological science or clinical pathology as his major subject, and is certified by an acceptable specialty board and he must have had at least two years of experience in his area of specialty in a laboratory acceptable under these standards. He will only be considered qualified to direct a laboratory performing those tests for which he is qualified by reason of certification or experience.

4. He is a person holding a masters degree from an accredited institution with a chemical, physical, or biological science or clinical pathology as his major subject and is certified by an acceptable specialty board, and he must have had at least four years of experience in his area of specialty in a laboratory acceptable under these standards. He will only be considered qualified to direct a laboratory performing those tests for which he is qualified by reason of certification or experience.

Standard: Blood bank director—Qualifications

A blood transfusion service must be maintained and directed by a pathologist or a physician qualified in immunohematology and blood banking.

He may also be the laboratory director providing he meets the stated qualifications.

Standard: Supervision

The clinical laboratory is supervised by qualified personnel.

Standard: Supervisor—Duties

1. The laboratory has one or more supervisors who, under the general direction of the laboratory director, supervise technical personnel and reporting of findings, perform tests requiring special scientific skills, and with the director is jointly responsible for the proper performance of all procedures.

2. There are two categories of supervisors. The general supervisor may have responsibilities in both technical and administrative functions in all areas of the laboratory, a general supervisor may also be a technical supervisor. A technical supervisor supervises the technical performance of the staff in his specialty and is readily available for personal or telephone consultation.

Standard: General Supervisor—Qualifications

He holds at least a baccalaureate degree in one of the chemical, physical, or biological sciences or medical technology and has met minimum requirements for certification in medical technology and has had two full years of experience in a laboratory acceptable under these standards.

Standard: Technical Supervisor—Qualifications

He holds at least a baccalaureate degree in one of the chemical, physical, or biological sciences or medical technology and has had a minmium of one year of structured training and one year of experience in his area of specialty in a laboratory acceptable under these standards.

Standard: Technical Personnel

The clinical laboratory has a sufficient number of properly qualified technical personnel to accurately perform the tests required of the laboratory and to participate in educational programs to establish or maintain competence of all personnel.

Standard: Technologist—Duties

The laboratory employs a sufficient number of clinical laboratory technologists to accurately perform under general supervision the clinical laboratory tests which require the exercise of independent judgment.

1. The clinical laboratory technologists perform tests which require the exercise of independent judgment and responsibility, with minimal supervision by the director or supervisors, in only those specialties or subspecialties in which they are qualified by education, training, and experience.

2. Clinical laboratory technologists are in sufficient number to adequately supervise the work of technicians, assistants and trainees.

Standard: Technologist—Qualifications

A clinical laboratory technologist must meet one of the following requirements.

1. He holds a baccalaureate degree in medical technology from an accredited college or university.

2. He holds a baccalaureate degree in the chemical, physical, or biological sciences, and, in addition, at least one year of structured training in a laboratory acceptable under these standards.

3. He holds an associate degree in a chemical or biological science or medical laboratory technique plus two years experience, with not less than one year of structured training, in a laboratory acceptable under these standards, and has achieved a degree of knowledge and skill commensurate with the baccalaureate degree level as demonstrated through the mechanism of educational equivalency and work proficiency examinations.

Standard: Technician—Duties

Clinical laboratory technicians are employed in sufficient number to meet the workload demands of the laboratory and they function only under direct supervision of a clinical laboratory technologist, supervisor or director.

1. Each clinical laboratory technician performs laboratory procedures which require technical skill and a minimal exercise of independent judgment.

2. No clinical laboratory technician reports test results in the absence of a clinical laboratory technologist, supervisor or director. This requirement shall not be applicable to the performance of procedures required for emergency purposes provided that the person performing the test is qualified to perform such tests, and the results of his work are reviewed by the clinical laboratory technologist, supervisor or director during his next duty period.

3. A student or trainee may perform tests only under the personal and direct supervision of a technical supervisor or clinical laboratory technologist.

Standard: Technician—Qualifications

A clinical laboratory technician must meet one of the following requirements:

1. He holds an associate degree in medical laboratory technique from an accredited institution and meets the minimal requirements for certification.

2. He holds an associate degree in a chemical or biological science from an accredited institution plus one year of structured training in a laboratory acceptable under these standards.

3. He has a high school diploma or the equivalent plus two years of experience, with not less than one year of structured training, in a laboratory acceptable under these standards and has achieved a degree of knowledge and skill commensurate with the associate degree level as demonstrated through the mechanism of educational equivalency and work proficiency examinations.

Standard: Laboratory assistant—Duties

Laboratory assistants may function only under direct supervision of a clinical laboratory technologist, supervisor, or director.

1. Each laboratory assistant performs laboratory procedures which require varying degrees of technical skill.

2. No laboratory assistant reports test results in the absence of a clinical laboratory technologist, supervisor, or director.

Standard: Laboratory assistant—Qualification

He has a high school diploma or the equivalent and training commensurate with the duties assigned.

PERSONNEL POLICIES

Standard: General

A manual of personnel policies, job descriptions, and administrative procedures must be maintained by the laboratory. The factors explaining this standard are:

1. Current employee records are maintained that include a résumé of each employees' education, experience, dates of employment, periodic review of performance and health records.

2. There is a documented program for employee orientation and in-service education.

3. Records must be maintained showing employee attendance at workshops, scientific meetings and refresher courses.

4. Current personnel policies shall be made available to all employees.

QUALITY CONTROL

Standard: General

Provision must be made for a quality control program covering all types of analyses performed by the laboratory for verification and assessment of accuracy, measurement of precision and detection of error.

Standard: Methods documentation

Blood Bank.—All personnel qualifications, methods and procedures for hemotherapy conform to current "Standards for Blood Transfusion Service" published by the American Association of Blood Banks.

Clinical Laboratory.—Each method must be clearly outlined including use of standards, calibration procedures, pertinent references, dates of review, sources of reagents and media. A separate record must be maintained which includes:

(*a*) the principles involved in the analytical method.

(*b*) copies of appropriate reference manuals and other literature.

(*c*) calibration records.

(*d*) documentation of correction or improvement in methodology or instrumentation.

(*e*) other pertinent information such as normals and sources of error.

Standard: Specimen collection documentation

Information must be available which includes:

(*a*) procedure for ordering of tests.

(*b*) precautions for special procedures.

(*c*) procedures for the collection, identification, preservation, transportation, and storage of specimens.

Standard: Instrumentation

(*a*) The laboratory shall have a scheduled, clearly documented instrument maintenance program which includes written records for each piece of equipment indicating:

1. the date and type of service performed, including notations on repairs and recalibration.

2. the date next service is due.
3. records of daily calibrations and/or temperature checks where appropriate.

(*b*) A copy of the manufacturer's maintenance manual must be readily available. This manual should conform to the format approved by the National Committee for Clinical Laboratory Standards.

(*c*) All blood bank refrigerators shall be monitored on a 24-hour basis and have audible and visable alarm systems.

Standard: Statistics

Each method is checked with adequate controls on each day of use. At least one standard or refernce sample is included with each set of unknown specimens. Acceptable limits for standards and controls are established as well as the course of action to be instituted when the analyses are outside satisfactory control limits. Control limits on all tests must produce results commensurate with meaningful use. If the result of the test on he reference sample is not within acceptable limits, the entire batch of analyses is repeated and control verified before reports are issued. The precision of each quantitative test shall be determined by calculating the SD or CV of a number of determinations done under prevailing conditions of assay. Positive and negative controls, when available, must be included at least once a day with the initial batch of unknowns for each qualitative test performed.

Standard: Cytology

Cytologic smears shall be screened only by cytotechnologists with training and experience adequate to qualify for certification in this specialized field. The pathologist must review at least 10 percent of slides classified as normal smears by cytology screeners. All smears from sources other than the female genital tract should be reviewed by a pathologist. All abnormal or "suspicious" smears (class 2 and above) must be evaluated by a qualified pathologist.

Standard: Proficiency testing

As an adjunct to the quality control program, laboratories must demonstrate satisfactory performance in an acceptable comprehensive proficiency testing program. Records of the proficiency program shall be submitted to the LSAC bi-annually for review and appropriate action to be taken as deemed necessary.

Standard: Compliance with quality control

1. The "inspection" agency shall utilize as inspectors individuals knowledgeable in the mechanisms and evaluation of quality control.

2. The quality control program in each laboratory shall be carefully reviewed at the time of inspection and from annual reports and, if found to be inadequate or incorrectly utilized, approval of the laboratory or approval for performance of specific tests shall be suspended until corrective measures are undertaken and approved.

Quality Clinical Laboratory Services for the American People

(By M. M. Brooke, Sc.D.)

Although those close to the clinical laboratory have long recognized that laboratory errors can occur, the problem has not been openly discussed until recently. Walter Cronkite in a Columbia Broadcasting System program in 1965 focused attention on the poor performance of certain mail-order laboratories and stimulated, in part, the introduction of bills in Congress to establish performance standards for clinical laboratories engaged in interstate commerce.

In testifying before a Senate subcommittee, Dr. David J. Spencer, Director, National Communicable Disease Center (NCDC), cited proficiency testing studies that demonstrated significant degrees of unsatisfactory performance in various fields of clinical laboratory work (1). Although the results varied from laboratory to laboratory, he concluded that "this information indicates that erroneous results are obtained in more than 25 percent of all tests analyzed by these studies." As might be expected, this statement caused great concern and, at first, certain groups challenged 25 percent as being too high a percentage or maintained that it applied to laboratories other than their own. Others have maintained that this percentage is too conservative.

Although scientists in clinical laboratories would like to be immune to error, there is no reason to expect human beings and machines to obtain perfect results

in a clinical laboratory when they do not elsewhere. Additional objective evidence obtained since 1965 makes it unnecessary to belabor the point that medical laboratories can make errors or to debate the extent of the errors. All types of medical laboratories—independent, hospital, and public health—are now generally recognized to be subject to error, and we can therefore proceed with the task of improving laboratory services.

A number of significant programs and cooperative efforts have been started which should result in major improvements. Only a few can be considered in this discussion, but they illustrate what must be done to provide quality laboratory services for the American people.

LEGAL AND REGULATORY EFFORTS

Until recently, there has been little or no governmental control of clinical laboratories. Beauty parlors, barber shops, and their operators are licensed in most States and cities, but the clinical laboratory and the personnel who examine blood specimens and throat swabs from patients, have been allowed to operate without control.

The first nationwide effort to establish controls for clinical laboratories came through the program of Health Insurance for the Aged (Medicare). The Medicare regulations (2) developed by the Public Health Services' Division of Health Standards established specific standards that State agencies follow in certifying laboratories as qualified to receive payment for tests under Medicare. Significantly, however, the law prohibits the application of these standards to laboratories in hospitals—although probably more than half of the laboratory tests (approximately 700 million) are performed in hospitals.

State control has evolved slowly, but it is now gathering momentum. When the Medicare program began in 1966, only six States required some form of laboratory licensure. Currently, 19 States, New York City, and Puerto Rico have laws or policies requiring the licensure of clinical laboratories and laboratory personnel, or both. Many other States have licensure legislation in various stages of consideration. Some present laws, for example, those of New York State, New York City, Kentucky, Tennessee, and Puerto Rico, provide for progressive regulations which will lead to laboratory improvement; others do little more than maintain the status quo in accordance with the vested interests of the existing laboratories.

Guidance is available to those interested in the enactment of good local laws to improve the performance of laboratories. In 1966, NCDC prepared a comprehensive guide (3) for such suggested legislation, and in 1969, the Council of State Governments published a model bill (4) to assist State legislatures in drafting licensing laws for regulating the clinical laboratory.

The Clinical Laboratory Improvement Act of 1967 (CLIA), P.L. 90–174, provided for Federal licensure of clinical laboratories (independently and by hospitals) that are engaged in interstate commerce. This law is serving, even more than Medicare, as an impetus to the development of local regulations. The act exempts clinical laboratories in States that enact laws establishing standards equal to, or more stringent than, those of the interstate regulations.

In addition, CLIA of 1967 is refining still further the Federal standards for licensure of clinical laboratories. Working with several ad hoc committees whose members are clinical chemists, microbiologists, pathologists, bioanalysts, and technologists, NCDC has developed regulations (5) which are being used in the interstate licensure program.

Although until now Medicare regulations have emphasized qualifications of personnel, the CLIA regulations have emphasized the accurate performance of the tests through proficiency testing programs and internal quality control. The Division of Health Standards of the Service and NCDC are working together to make Medicare and interstate regulations as uniform as possible.

Hopefully, as new State laws are enacted, they will provide for laboratory improvement programs which will meet the CLIA requirements and the existing deficient laws will be revised to conform with Federal standards. In this way, most clinical laboratories in this country eventually would operate under comparably high standards of performance.

PRIVATE IMPROVEMENT EFFORTS

Several private professional organizations have constructive programs for regulating and improving clinical laboratories.

As stated earlier, Medicare standards for independent laboratories cannot be applied to hospital laboratories. This exemption occurred because Medicare

provided that laboratories in hospitals accredited by the Joint Commission on Accreditation of Hospitals were automatically eligible to participate in Medicare and, in addition, that the laboratories in other hospitals cannot be subject to Medicare regulations that exceed the Joint Commission's standards. The laboratory requirements for the Commission's approval have been far below those of Medicare and, as a consequence, a double standard has resulted which has seemed unfair to the independent laboratories. The Commission is revising its standards, and this revision is expected to bring the standards more in line with those of Medicare. Hopefully, these improved standards will be implemented in the near future.

The College of American Pathologists (CAP) has expanded its laboratory improvement activities by initiating its "programs of excellence." These include laboratory surveys (proficiency testing programs) that cover all areas of laboratory work, laboratory inspection, and accreditation. Commendably, its proficiency testing programs are no longer limited to members of the college but are available to any laboratory which wishes to subscribe.

The laboratory accreditation program of the College has been accepted as a substitute for Federal evaluation for interstate licensure under CLIA. To date, it is the only private program to adjust its standards to comply with those established for interstate licensure.

Although exact numbers are unavailable, it is estimated that more than 300 million tests are performed in the offices of physicians in private practice. Practically all existing laws, both Federal and local, exclude from regulation those laboratories in the offices of one or two physicians who perform tests primarily for their own patients. Laboratory services performed under these circumstances are considered to be the practice of medicine.

Some of the laboratories that are presently subject to regulation are concerned over this exclusion, particularly since they reason that a comparable percentage of error may occur in these private office laboratories. Although this situation constitutes a deficiency, at this time efforts should be concentrated on making it possible for all organized laboratories—independent, hospital, and public health—to operate under comparable standards of quality.

The American Society of Internal Medicine is interested in seeing that quality laboratory service is performed in the offices of physicians in private practice. In cooperation with the Division of Health Standards of the Service, the Society has canvassed its members about participation in a 1-year proficiency testing program to determine the level of competency with tests for urea nitrogen, hemoglobin, and glucose. Recently, the American Society of Internal Medicine gave the Service a list of 500 internists who are interested in participating.

The CAP has developed a special office laboratory survey (proficiency testing) so that physicians can monitor regularly the performance of their laboratories. Because of the increased complexity of laboratory work, the increased automation, and the need for specialized laboratory competencies, the amount of laboratory work performed in office laboratories will probably decrease. Nevertheless, these constructive efforts of the internists and pathologists are commendable and important because laboratory work in physicians' offices will probably continue to be excluded from regulatory legislation in the foreseeable future.

STANDARDIZING REAGENTS AND MATERIALS

One cause for variations in laboratory results is the variability of reagents used in diagnostic tests. Considering the variety of antigens, control serums, chemicals, stains, and mediums needed by the clinical laboratory and the number of companies that manufacture them, setting standards constitutes a major difficulty in laboratory improvement.

The National Bureau of Standards shortly will have available 10 standard reagent materials for clinical chemistry determintions. The Laboratory Division of the National Communicable Disease Center has described specifications for approximately 900 microbiological reagents. Reference reagents meeting these specifications have been prepared and are available to reagent manufacturers and to national and international public health agencies. Although the Federal standarization efforts of the National Bureau of Standards and the National Communicable Disease Center have been undertaken with the cooperation of manufacturers and in consultation with outside specialists, there has been a need for even greater cooperative efforts.

Recently, a significant step was made in the direction of standardization. Through the initiative of the standards committee of the College of American

Pathologists, an independent National Committee on Clinical Laboratory Standards was organized in April, 1968. Membership is open to all industries, professional organizations, and government agencies that have an interest in the clinical laboratory field. Currently the membership is 50–31 industrial representatives, 16 professional representatives, and representatives from three Government organizations. Each member appoints a representative and an alternate submits names of persons available for assignment to area committees or working groups as experts in their areas of interest.

The objectives of this committee are to promote the development of national and international standards, such as written specifications for reagents and equipment, through a mechanism which insures that consensus has been obtained by all interested groups. Task forces and working committees have been organized to develop and propose standards for the fields of clinical chemistry, blood banking and immunohematology, microbiology, hematology, and instrumentation.

LABORATORY MANPOWER

We do not know exactly how many people are engaged in clinical laboratory work in this country, but some has estimated as many as 100,000 (6). In any event, acute shortages of well-qualified persons exist, and we anticiapte greatly increased demands for trained personnel to meet expanding health needs, such as Medicare, Medicaid, mass screening programs, and the new technology. In the past there has been considerable support for research training but little for the training of persons seeking careers in the diagnostic laboratory. Fortunately, emhpasis is beginning to be placed on training for services.

Through the Division of Allied Health Manpower and Regional Medical Programs, educational facilities are being established or expanded for training clinical laboratory assistants and medical technologists and for specialization to the master's degree level of medical technologists.

Training of other specialists, such as clinical chemists and microbiologists, has been neglected; however, four national conferences on training held in 1967 (6–9) recognized that the present and future clinical laboratories must be staffed by sepcialists. For instance, the report (10) of the conference convened by the National Institute of General Medical Sciences recommended financial support of post-doctoral residency programs to prepare the required specialists for the diagnostic laboratories.

The most encouraging feature of these current trends and programs that may bring about significant improvement in clinical laboratory performance is the extent to which the various interested groups are working cooperatively toward a common goal.

PUBLIC HEALTH SERVICE RESPONSIBILITIES

We in the Public Health Service are participating both directly and indirectly in this national effort to improve clinical laboratories. In the Public Health Service Hospitals, Indian Health Service Hospitals, outpatient clinics, and Federal prisons, we have a direct responsibility to assure that competent laboratory service is provided for the patients under our care. In 1964, the chief, Division of Hospitals, invited laboratories in Public Health Service installations to participate in the Center's proficiency testing programs. By 1967, 75 of these these laboratories were participating in some phase of the program and as of now, 118 are receiving regular shipments of test specimens in one or more fields.

A number of the pathologists and technologists in the large Service installations have taken NCDC laboratory courses, but there is a definite need for greater consultation and training, particularly for technicians working in the smaller hospitals and clinics. Since Federal laboratories are exempt from legal regulation, we must make certain that Public Health Service laboratories meet the standards required of others.

Indirectly, through programs associated with Medicare, Medicaid, interstate laboratory licensure, and services to States and municipalities, the Public Health Service has the responsibility to assist in improving the performance of laboratories at all levels throughout the country. The consultation and training program of the laboratory division at NCDC is dedicated to assisting the State public health laboratories to improve their diagnostic competencies and to provide the States and others with guidance and help in the training of personnel in laboratories at local levels.

Laboratory improvement, however, constitutes a tremendous undertaking requiring the cooperative efforts of Federal, State, and municipal health departments, academic institutions, professional organizations, and industry. Concerted, continuous programs are required to provide consultation, training, and other assistance needed by the 12,000 to 14,000 clinical laboratories in this country.

With assurance of payment of laboratory bills through health programs, the development of automated laboratory procedures, the establishment of mass screening programs, and the growth of comprehensive health insurance plans, the number of laboratory tests in this country may increase from an estimated 1,300 million now to more than 3 billion by 1975. Although our ultimate objective in laboratory improvement is to upgrade patient care and prevent needless human suffering, a tremendous economic savings will result as laboratory analyses become more and more accurate.

In summary, the clinical laboratories of this country have significant difficulties. Fortunately, Federal and State agencies, professional associations, and academic institutions are accepting the challenge of laboratory improvement and have made commendable strides toward desirable goals.

We in the Public Health Service must be deeply involved in this challenge. First, we need to make certain that our patients receive the highest quality of laboratory service. Second, we need to assist and support constructive programs of others that are directed toward bringing quality laboratory service to all segments of the population.

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(5) U.S. Public Health Service: Clinical laboratories. Code of Federal Regulations, tit., 42, ch. 1, pt. 74, 1968.
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(9) Conference on Training of Clinical Laboratory Scientists, convened by the National Institute of General Medical Sciences, Durham, N.C., Dec. 13–15, 1967.
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PRESENT POSITION OF THE AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS ON EQUIVALENCY AND PROFICIENCY TESTS

Equivalency and proficiency examinations have been proposed to measure competency of personnel in the medical laboratory. Both tests have received increasing attention in the last few years. Lack of nationally accepted definitions has created a tremendous amount of confusion. The purpose of this statement is to present the definitions of equivalency and proficiency acceptable to the American Society of Medical Technologists and to elaborate on the position of this Society regarding the most effective use of these two measurement tools.

Competency to practice medical technology is currently based on passing a certification examination following completion of a prescribed course of study. Collaboration between the eductation system (academic credit) and the profes-

sion (certification examination) is used to establish minimal personnel standards to ensure quality patient services. Academic Credit is conferred upon evidence of adequate learning (cognitive, attitudinal and psychomotor skills). Because of variation in standards in educational institutions, certitification of the individual is used to validate academic credit. These two mechanisms, therefore, have developed as the current measurement of competency.

It is now recognized that learning occurs outside the academic environment. The need to measure this learning has precipitated the development of equivalency and proficiency testing.

Written equivalency examinations are being proposed for comparing learning outside academia to learning within colleges and universities. Written proficiency examinations are also being developed which are supposed to test job skill so as to establish levels at which experienced, but not necessarily certified, practitioners can be hired. This Society has participated in the development of these equivalency examinaions. Support of the proficiency examinations has not been given primarily for the reasons stated in the following paragraphs. Secondly, we feel we must withhold support until the validity of the norming technique has been determined. To clarify the current confusion, we will define equivalency and proficiency and indicate what we believe to be the limitations of the written examinations. We will also indicate how the tests can partially fulfill the end for which they have been designed.

Equivalency testing refers to examinations used to equate non-formal learning with learning achieved in academic courses. Proficiency testing refers to the assessment of an individual's competency to perform at a certain job level, (ie) the knowledge and *skills* required to produced results which meet predetermined criteria for accuracy and precision.

For both academic credit and job performance, knowledge is *one* necessary component and it is this component which can be measured with a written test. "Equivalency" and "proficiency" tests developed to date are in the "paper and pencil" format and therefore, should be useful in this regard.

In order to grant total equivalence for academic credit, however, attitudinal and psychomotor skills must be measured. Job performance also requires adequate psychomotor skill. Because of the nature of these components, the written examination in this instance is not an appropriate measuring instrument.

The American Society of Medical Technologists believes that written examinations can and should be used to measure knowledge however it may have been acquired. We believe further, that tests in other formats should be developed to measure those components (attitudinal and psychomotor skills) which are necessary to prove total equivalence in terms of both academic credit and job performance.

Speaking for a broadly based membership representing all areas of practice in medical technology, ASMT accepts its responsibility to work with other appropriate organizations and agencies to produce the type of tools which we believe will most effectively measure the quality of laboratory personnel serving the patient.

LAW OFFICES, BIRD AND TANSILL,
Washington, D.C., Februcry 17, 1972.

Re H.R. 1.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In your recent consideration of the captioned Bill, I would appreciate it if you would consider amending Sections 3121 and 3306(b) of the Internal Revenue Code to avoid the multiple taxes imposed by the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA) with respect to members of an affiliated group of corporations.

The problem of the duplication of taxes under these two Sections arises, for example, when an employee of a holding company performs services for one or more subsidiary corporations. The Internal Revenue Service has taken the position that if that employee's salary or compensation is allocated to the various subsidiary companies for which he renders services, each company is a separate employer for FICA and FUTA purposes. If these subsidiary companies were operated as divisions or departments of a single corporation, there would be no—

such duplication of tax. The employees, on the other hand, is not subjected to duplicative taxation because he is allowed a credit for his excess contributions. There is no such credit for the employer.

The Tax Section of the American Bar Association has recommended to the American Bar Association that it urge the Congress to amend the law in this respect. I am enclosing an excerpt from the Bulletin of the Tax Section published in the summer, 1971. The explanation urging Congressional action is stated in a far better way than I could do. However, if you would consider this statement as a part of my statement for the purposes of any Committee action, I would appreciate it.

It is my understanding that a somewhat similar proposal was adopted by your Committee in connection with the Social Security Act Amendments of 1967, but that it was deleted in conference.

I am sure the Committee is well aware of the increasing tendency on the part of banks, insurance companies and similar institutions to create holding companies in order that their operations may be diversified. In view of these developments, it seems only fair that the recommendation of the American Bar Association be given serious consideration. The existing duplication of tax on employers creates an economic disincentive militating against business organization in the most efficient manner.

Respectfully submitted,

ROBERT J. BIRD.

COMMITTEE ON EXCISE AND EMPLOYMENT TAXES

1. TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO AVOID DUPLICATION OF TAX IMPOSED BY THE FEDERAL INSURANCE CONTRIBUTIONS ACT AND THE FEDERAL UNEMPLOYMENT TAX ACT WITH RESPECT TO MEMBERS OF AN AFFILIATED GROUP OF CORPORATIONS

Resolved, That the American Bar Association recommends to the Congress that the Internal Revenue Code of 1954 be amended to avoid duplication of tax imposed by the Federal Insurance Contributions Act and the Federal Unemployment Tax Act with respect to members of an affiliated group of corporations; and

Further Resolved, That the Association proposes that this result be effected by amending sections 3121 and 3306;

Further Resolved That the Section of Taxation is directed to urge the following amendments, or their equivalent in purpose and effect, on the proper committees of the Congress:

Sec. 1. Section 3121(a)(1) is amended to read as follows (eliminate matter [in black brackets] and insert new matter in italics):

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to $7,800 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. *For the purpose of determining whether an employer has paid such remuneration equal to $7,800—*

(A) if an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, [then for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to $7,800 to such individual during such calendar year,] any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection), with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer; *and*

(B) if an employer at the date of payment of the remuneration is a member of an affiliated group of corporations as defined in section 1504 (a) (without regard to section 1504(b)), such employer shall be considered as having paid any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect

to employment previously paid (or considered under this paragraph as having been paid) to such individual during the same calendar year by any other corporation which is also a member of such affiliated group on such date;

Sec. 2. Section 3306(b)(1) is amended to read as follows (eliminate matter [in black brackets] and insert new matter in italics):

(1) that part of the remuneration which, after remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) equal to $4,200 with respect to employment has been paid to an individual by an employer during any calendar year, is paid to such individual by such employer during such calendar year. *For the purpose of determining whether an employer has paid such remuneration equal to $4,200—*

(A) [*If*] if an employer (hereinafter referred to as successor employer) during any calendar year acquires substantially all the property used in a trade or business of another employer (hereinafter referred to as a predecessor), or used in a separate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, [for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to $4,200 to such individual during such calendar year,] any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer; *and*

(B) *if an employer at the date of payment of the remuneration is a member of an affiliated group of corporations as defined in section 1504(a) (without regard to section 1504(b)), such employer shall be considered as having paid any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment previously paid (or considered under this paragraph as having been paid) to such individual during the same calendar year by any other corporation which is also a member of such affiliated group on such date;*

Sec. 3. The amendments made by sections 1 and 2 shall apply to calendar years beginning after the date of enactment thereof.

EXPLANATION

SUMMARY

The Federal Insurance Contributions Act and the Federal Unemployment Tax Act impose a tax on employers based on wages paid to employees. The one is limited to wages of $7,800 and the other to wages of $4,200. Because the tax is based on wages paid by an employer to an employee, duplication of tax will occur when an employee changes employment during a calendar year. The proffered Legislative Recommendation will prevent duplication of tax when an employee is transferred between members of an affiliated group of corporations or performs services for more than one member of an affiliated group of corporations at the same time.

DISCUSSION

The Federal Insurance Contributions Act and the Federal Unemployment Tax Act are structured in such a way that the tax is limited by the amount of wages paid an employee with a limitation placed on the amount thereof. The theory underlying this limitation is that benefits paid out of funds provided by the taxes are based upon the amount of wages earned by an employee during his employment up to a set amount. If an employee remains employed by a single employer during the entire calendar year, both the employer and employee pay a tax under the Federal Insurance Contributions Act which is limited to wages $7,800. On the other hand, if an employee changes his employment during the calendar year, both he and his second employer must commence paying tax as though he had not been employed during the year. This is also true for employers under the Federal Unemployment Tax Act with respect to wages of $4,200.

In 1939, employees were relieved of this duplication of tax by the introduction of a provision for special refunds of excess tax paid. In 1950, successor employers were granted relief from this duplication of tax in cases where they acquired substantially all the property used in a trade or business of a predecessor and immediately thereafter employed employees who immediately prior to the acquisition were employed in the trade or business of the predecessor. This relieved a partnership from having to pay tax on wages in excess of the stated limitation when a member died and the partnership was thereby dissolved and a new one established. It also relieved successor corporations when mergers or consolidations were effected or when an individual incorporated his business and continued to operate a similar enterprise through ownership of the stock of the corporation.

There is no more reason to grant relief in the case of successor employers than in the case of affiliated corporations. Usually there are numerous transfers of individuals among parent and subsidiary corporations. It places an unfair burden on business enterprises which are multi-corporate to require them to pay these taxes as though they were entirely unrelated. There is ample precedent for treating affiliated corporations as a single unit for tax purposes and such treatment is amply justified with respect to the taxes involved here.

It is not unusual for an individual to be an executive of a parent company and perform services for several subsidiary companies. He may receive his compensation from the parent company but in the allocation of administrative expenses a proportionate part of his salary is charged to the several subsidiaries. In this situation the Service had indicated that the wage limitation applies to remuneration attributable to each company rather than to total remuneration received by the executive. (Letter from D. S. Bliss, Dept. Comm'r., Nov. 25, 1936.) In such a case, there is no reason for the duplication of tax that results from the present wording of the law. The form in which a business enterprise chooses to function for sound business reasons should not result in an undue tax burden.

The Section's Committee on Excise and Employment Taxes carefully considered extending the scope of the proposal to include sister corporations which are not affiliated corporations, by reference to section 1563 instead of 1504. The committee decided not to do this because the tax problems relate principally to members of affiliated groups and it was found that reference to section 1563 would creat undue complexity.

The subject matter of his Legislative Recommendation grew out of a meeting of several members of the Committee on Excise and Employment Taxes who are employees of corporations which are members of affiliated groups and who are aware of the technical inequity which the Recommendation intends to correct. The Legislative Recommendation addresses itself to a problem of general concern and has received the approval of 15 members of the committee (no member voted against the Recommendation), some of whom are in private practice, employed by governmental agencies and employed by private corporations. For the reasons stated, the Recommendation has been conceived in the public interest and not for the benefit of any specific member of the committee or of any employer or client of a member.

FALLS CHURCH, VA.,
February 15, 1972.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: The Report of the Advisory Council on Social Security of 1971 on "Social Security Financing" starts thus: "Financing of the cash benefits and financing of the Medicare parts of the social security program are closely interrelated and should be considered together. For this reason the Council's findings and recommendations on financing are dealt with in this section rather than in the separate reports on cash benefits and Medicare."

This assumes that the operation and financing of programs are not organically related and may be considered apart from each other. But according to Dr. Ezra Solomon, now a member of the President's Council of Economic Advisers, in *The Theory of Financial Management*, 1963, Chapter 1, "The Scope of the Finance Function," pages 2 and 3, the correct "approach is that financial management is properly viewed as an integral part of over-all management rather than as a staff specialty concerned with fund-raising operations. In this broader view the central issue of financial policy is the wise use of funds, and the central process involved is a rational matching of advantages of potential uses against the cost

of alternative potential sources so as to achieve the broad financial goals which an enterprise sets for itself. The underlying fund-using proposals which originate within the operating departments of an enterprise are still assumed as given. So are present and prospective conditions in technology and in the markets for goods, services and capital. Given these data, the function of financial management is to review and control decisions to commit or recommit funds to new or ongoing uses. Thus, in addition to raising funds, financial management is directly concerned with production, marketing and other functions within an enterprise whenever decisions are made about the acquisition or destruction of assets." Dr. Solomon quotes with approval from a 1925 American Management Association's Financial Executives' Series: "The job of the financial executive demands that he phase in his viewpoint with the operating executive in each division of his organization, compelling him as well to view every problem presented, not only from the standpoint of his ability to finance the project, but also from the perspective of the operator, who considers it primarily from the standpoint of facilitating more efficient operations and production. . . ."

Dr. Solomon (in the second chapter on "The Objective of Financial Management," pages 22–24), shows how this principle applies in considering "the owner point of view," "Society's point of view," and "Management's point of view. He says "profits" is an owner-oriented concept. But "profitability" is an operational concept, concerned only with the production or creation of new wealth. "In this more restricted sense the potential profitability of different courses of action provides the criterion for economizing the use of social resources, and profit-maximization is simply the quest for economic efficiency . . ." (page 17).

Substitute the word "welfare" for the word "wealth" in the above book and it makes good sense. (However, this is the "welfare" we have in mind when we talk about the "Economics of Welfare," i.e. well-being, and not merely the "welfare" problems your committee has so painfully before it when dealing with poverty problems.) Notice, also, the phrase, "profitability of different courses of action," and its applicability to how to make decisions about the alternate uses of Social Security Trust Funds, just as much as to other kinds of funds.

My letter to Senator Harry F. Byrd, Sr. then Chairman of your Committee (Hearings on H.R. 6675, "Social Security," 89th Congress, First Session, May, 1965, pages 1123–5) included criticism of the Report of the Advisory Council on Social Security of 1965, because of its failure to recognize a new dimension in Medicare. Until then the Social Security system was concerned only with transfer payments to beneficiaries who themselves chose how to spend the money they received. With Medicare, a new responsibility came to the Social Security Administration, namely, spending the beneficiary's money for him for medical and hospital services. (This difference is still concealed in the way these government expenditures are classified, erroneously, in the national income accounts). Operationally, the Medicare program differs entirely from the cash benefit program. You wrote me that you were influenced by my arguments when you said, on the Senate floor (*Congressional Record*, July 9, 1965, page 15582), speaking about Medicare, that "it can better be judged by an economist than an actuary, better by a social worker than an accountant, and even better by those of us here today who have the opportunity to go among our folks back home and see the needs that are met, the fears that are dissolved, the wants that are satisfied by what we have wrought." This is cost-benefit analysis in a nutshell and states specifically that we should be concerned not only with how much money is spent but also with how well it is spent. Are we getting our money's worth? Even better, are we getting not merely our "money's" worth (each unit of money being worth less and less,) but are we getting the maximum benefit from our labor, trouble and/or pain (or, for the more affluent, inconvenience)?

There is a slight improvement, on the subject of Medicare, in the 1971 report of the Advisory Council on Social Security, over that of the 1965 report which guided Congress when that program was originated. The latter report includes a *Report of the Panel of Actuaries and Economists to the Subcommittee on Cost Estimates and Financial Policy of the Advisory Council on Social Security*, December 31, 1970, with Wendell Milliman, a consulting actuary, as chairman. While there are two actuaries and three economists who prepared this report, in my opinion, this report does not do justice to the economic dimension. It discusses "economic assumptions," assuming the main purpose "crystal-ball gazing." It remains the kind of "actuarial" report, the limitations of which are spelled out in the only book generally available attempting to define "actuarial soundness," Dorrance Bronson's *Concepts of Actuarial Soundness in Pension Plans* (1957).

Mr. Robert J. Myers, former Chief Actuary of the Social Security Administration, testifying before your committee on January 21, criticized one of the findings by saying that "it is not prudent now to count on profits arising from future economic changes over a long future period, before such changes occur." That's right. The reason is their great uncertainty, their unpredictability. But I would add that Mr. Myers' argument applies just as much to counting on costs arising from future changes over a long future period, before such changes occur. It is *Hubris* (the Greeks had a word for it) or *Chutzpa* (and so did the Hebrews) to attempt to operate programs on the basis of hypothetical assumptions about what will happen 75 years from now, or even as soon as 25 years from now (as in the Medicare projections). The validity of such forecasts requires airing among the general body of economists.

According to Dorrance C. Bronson's *Concepts of Actuarial Soundess in Pension Plans*, (1957) "actuarial soundness means different things to different people" and it is an "amorphous concept." In essence, an actuarial statement about the future is a probability statement based upon assumptions. It is a hypothetical statement, not a flat prediction. For instance, an acuary says that if certain assumptions turn out to be correct there will be a cerain cost or benefit in a program. The assumptions always have to be changed so that really all bets are off. The actuary is never proven to be wrong and never proved to be right, either. Meanwhile, his projections, often misinterpreted as factual statements, may have an irrevocable effect in preventing the "potntial profiteability of different courses of action," to use Dr. Solomon's term, from being rationally considered.

I understand that you are putting into the official record of your *Hearings* an article in the April 1970 *Reader's Digest* by Robert J. Myers, "Social Security at the Crossroads." Mr. Myers was then still Chief Actuary of the Social Security Administration. This article discusses a "conflict of philosophies" between what he called a "moderate" (his own position) and an "expansionist" approach (that of the Honorable Wilbur J. Cohen, ex-Secretary of Health, Education & Welfare, among others). He states here: "In the past, Congress has held the expansionists in check, and thus kept the system actuarially sound."

Mr. Myers may be right in contending that we should prevent excessive Government encroachment into the pension field which stifles desirable private enterprise here. But this is not a question of actuarial soundness, but of opposing economic philosophy. Presumably, actuarily sound programs can be devised for programs of varying magnitudes, from niggardly to moderate to generous but economically feasible to expansionist and so on.

Mr. Myers had a difference of opinion with some H.E.W. officials. He resigned, not for actuarial reasons, but for policy reasons. According to him, while in office, "principal responsibility for cost estimates for the Medicare program (except for certain economic assumptions) has always been assigned to me." (Finance Committee Hearings on Medicare and Medicaid, July 1 & 2, 1969, page 445). But, in a letter addressed to me (Finance Committee Hearings on H.R. 12080, "Social Security Amendments of 1967," 90th Congress, First Session, Part 3, page A208) Mr. Myers stated that is was not his responsibility to determine "economic feasibility" of the program.

In your Committee's Hearing record on H.R. 17550, "Social Security Amendments of 1970," 91st Congress, Second Session (pages 1336–9) may be found a discussion by me of the question of the proper role of actuaries in the Medicare program. This question is still unsettled, in fact, it is not even adequately discussed. Accordingly, I request that you include in the record of your present Hearings, together with this letter, several other letters, four printed in newspapers and one to President Johnson, in the interest of getting more attenion to this crucial subject from actuaries, economists, public officials and others.

Yours sincerely,

SIDNEY KORETZ.

[From the New York Times, Aug. 11, 1967]

MEDICARE ECONOMICS

(By Sidney Koretz)

Your Aug. 7 editorial "Slowdown on Social Security" might also have mentioned a flagrant omission by the House Ways and Means Committee. It was pointed out in the recent report to the President on medical care prices from the Gorham group in the Department of Health, Education and Welfare that the

Social Security Administration has been too slow in coming to grips with the economic problems of Medicare.

This report deplores the absence of moves toward "cost-reducing methods" in the reimbursement guidelines: "The present Medicare reimbursement scheme, based on 'reasonable cost' does not provide hospitals and other health facilities with adequate incentive to be efficient."

According to Robert J. Myers, Chief Actuary of the Social Security Administration, the reduction of benefits is the only way to reduce costs. His main interest is in "actuarial soundness." No corresponding interest exists yet in the economic problem of getting the most for Medicare money.

The Social Security Administration passively submits to unsound or not-adequately studied reimbursement guidelines presented by the American Hospital Association and Blue Cross. Reports by the American Medical Association and the Public Health Service are in direct conflict with the implied view that the "reasonable-cost" concept foisted upon Congress is economically reasonable.

ARLINGTON, VA., *August 19, 1967.*

PRESIDENT LYNDON B. JOHNSON,
Washington, D.C.

DEAR MR. PRESIDENT: I was in the Social Security Administration where I prepared a report recommending a similar approach to that in the Gorham Report on Medical Care Prices addressed to you.

In the bill—H.R. 12080—passed two days ago in the House of Representatives, Title IV, Section 402 has the caption: "Incentive for lowering costs while maintaining quality and increasing efficiency in the provision of health services." This is a step in the right direction, but the Social Security Administration has not been planning on it.

"Health Insurance for the Aged: The Statistical Program" by Howard West, in the January *Social Security Bulletin*, gives no inkling of contemplated research in the "program evaluation" or "cost reduction" direction, as envisaged in the Gorham Report, to make possible the Programming-Planning-Budgeting System (PPBS) which you have called for. The announced Social Security Administration research program mentions certain residual "analytical studies," including "studies of utilization and costs of health services," "studies of effectiveness of administration," and "studies relating to specific provisions." Conceivably the study called for under Title IV, Section 402 of H.R. 12080 could come under one of these headings but it is still only a gleam in their eyes. We are told they must await future findings of the "statistical system."

PPBS means basic thinking "before we start to bend metal." It does not mean simply awaiting the results of "actuarial experience," more often than not an excuse for merely muddling through. Economy, in its true social sense, means not merely foreseeing the future, as in a crystal ball or an actuarial report. It means shaping; the future to get the most from limited resources. The "most" is not measured just in dollars and cents or "economic" accumulation in a material sense. It is measured by how it enriches human life.

Yours sincerely,

SIDNEY KORETZ.

[From the Northern Virginia Sun, July 9, 1969]

FREUDIAN SLIP 'IN CONGRESS

(By Sidney Koretz)

Testifying before the Senate Finance Committee on July 2, in hearings on alleged abuses in Medicare and Medicaid, Social Security Deputy Commissioner Arthur E. Hess made a "Freudian slip" of the tongue when he quickly changed the phrase "our drafting" to the "the drafting" of a certain section of the law. It appears that merely from reading the law, Sen. Jack Miller failed to get full implications of Section 1862 (a) (2) of Title 18 of the Social Security Law. Only after an H.E.W. lawyer explained the "legislative history" behind the law, could the senator understand why the government had to make certain payments even when there was "no legal obligation to pay." The law, of course, was drafted by the Social Security Administration, not by Congress, which merely went through the motions of passing it. Later members of Congress have to learn what it means, i.e. hearings occur to determine what was the "Congressional intent" in passing it.

In his speech of May 14, Sen. John J. Williams said that "the law requires intermediaries and carriers to exercise effective controls on utilization of services." (Congressional Record, page S5202). Inquiry of the Senate Finance Committee elicited the information that this requirement is found in Sections 1816 (b) and 1861 (k) of Title 18 of the Social Security Law. Actually, these sections have to do with requirements by the H.E.W. secretary not to enter agreements "not consistent with the effective and efficient administration" of the program which in fact has no guidelines of any kind to help bring about the exercise of effective controls on utilization of services, other than the existence of a "utilization review plan."

I don't see that these provisions dealing with the functions of the secretary necessarily impose upon intermediaries and carriers the requirement "to exercise effective controls" to the point of solving the problems uppermost in Senator Williams' mind during his speech, namely the "rising cost" of Medicare and Medicaid. In my letter to Senator Abraham Ribicoff, who held hearings in 1968 on "Health Care in America," (Hearings, Subcommittee on Executive Reorganization of Senate Government Operations Committee, 90th Congress, Second Session, pages 1010-13), I drew attention to testimony by the then H.E.W. Secretary Wilbur J. Cohen that the present law only permits certain exceptional "experiments", under Title IV, Section 402, to produce the sort of "effective controls" Senator Williams has in mind. Mr. Cohen said that after they come up with "a good idea, a workable idea on incentive, efficiency and economy" they would approach Congress to give them "some kind of authority" to make a beginning in the direction Senator Williams desires. Under Secretary of H.E.W. John G. Veneman, on July 1, told the Finance Committee that the "program lends itself to creating costs" not to reducing them.

Before Medicare was passed, I was given an assignment in the Social Security Administration to relate a University of Michigan Study of Hospital Economics to possible application to Medicare. The Division of Disability Operations of the S.S.A. of which the present Deputy Commissioner Arthur E. Hess was then Director, had had no use for economists in its program. The Health Insurance Task Force, set up in that division to plan for the implementation of the expected Medicare law, had accountants, statisicians, sampling theorists and various types of administrative specialists, but nobody who thought in terms of economics.

The economist's main concern is not with money but with what money buys; that is, he asks for the best health results at a given cost or the least cost for given health results. He wants to know what is being paid for, why it costs so much, and how to get it at less cost. The Medicare program is now in the hands of actuaries, not economists. In actuarial parlance, every benefit to a human being is a cost to a fund but in economic language every benefit has a cost we want to minimize. The actuary says if less benefits are promised we have "actuarial soundness" or "health" (a synonym for "soundness"). He hopes for the worst in human health so that the fund may be healthy. The economist dare not merely hope for the best but it commanded to show the best way to bring about good results. Economy means not merely foreseeing the future, as in a crystal ball or an actuarial report, but shaping the future to get the most from limited resources.

My report showed that Blue Cross and the American Hospital Association, both given the green light by the Report of the Advisory Council on Social Security, 1965, which guided Congress in setting up Medicare, had not yet mastered the economic principles for correct costing and pricing accepted by business people generally.

It fell upon deaf ears within the Social Security Administration, but was reflected in material in the record of the House Ways & Means Committee's Hearings "Medical Care for the Aged," on H.R. 3920 in 1964, including a prophecy that Medicare contracts would have to be "renegotiated" and an exchange of Letters with Gov. George Romney, who tried to defend the University of Michigan Study against my criticism, which, however, he called "thoughtful."

I wrote a letter to the then Chairman of the Senate Finance Committee, Harry F. Byrd Sr., which he put into the record (Hearings on H.R. 6675 "Social Security," 89th Congress, First Session, May 1965, pages 1123-25, This impelled Senator Russell B. Long, now Chairman, to write me that my comments gave him inspiration to say in the Senate, just before Medicare was passed, that it could be "better judged by an economist than an actuary, better by a social worker than an accountant . . . (Congressional Record, July 9, 1965 p. 15582 and

letter to me from Sen. Long, dated July 16, 1965). I now call upon our Senator Harry F. Byrd Jr., recently joining the Finance Committee, to remind the Chairman that the judgment he called for at the inception of the Medicare program is long overdue.

[From the Northern Virginia Sun, Nov. 17, 1971]

A New Dimension to Medicare

(By Sidney Koretz)

The Health, Education and Welfare Department announces another increase in the Medicare hospital patient's bill. He will have to pay the first $68, instead of $60 as hitherto.

Unlike cash Social Security payments to the beneficiary, most Medicare payments are to providers of hospital and medical services and not to the beneficiary. In the case of non-profit hospitals (most of them), it is the hospital, and not the patient, that is considered the final consumer, in the national income accounts.

A new dimension was introduced to the Social Security system with Medicare. The H.E.W. was concerned only with transfer payments until it came along. Now it was to have responsibility for spending the beneficiary's money for him, instead of letting him do it himself. Nevertheless, over my protests, embodied in letters to the President, other Government officials and editors, (much of this material printed with Congressional hearing records), an erroneous classification was adopted by the Commerce Department and approved by the Budget Bureau and the Social Security Administration.

Social Security Commissioner Robert M. Ball (before Group Health Institute, Group Health Association, Washington, D.C. June 2, 1971) said that "when Medicare was passed in August 1965 the general concern was that it not make basic changes in the health system.

"The basic concern in Congress and elsewhere was that this Government-operated program not interfere with the way in which the going system of medical care is organized and operated. The public emphasis was almost entirely on keeping the economic burden of illness from overwhelming old people and their sons and daughters. Its object was to prevent economic disaster and to do so without interfering in any major way with the traditional organization of the medical care system."

My letter in the Washington Daily News of September 20, 1965, however, criticized Mr. Ball because in an address before the American Hospital Association "he gave no indication that there had been any planning about 'program evaluation' and 'cost reduction.'"

I went on to say: "Congress failed to give adequate attention to the economic analysis of the subject. There is nothing about 'program evaluation' or 'cost reduction' in the Senate Finance Committee Report on the 1965 Social Security Amendments. Only Senator Russell Long, just before Senate action, raised the question at all, when he said the program could be 'better judged by an economist than actuary.'"

Isn't it amazing that Mr. Ball should think that it is possible to make revoluntary changes without revoluntary effects? Dr. Charles L. Schultze, formerly Bureau of Budget Director, said on September 23, 1970 at a National Economists Club luncheon, that it was generally thought "you ought to have your head examined," if you suggested when Medicare & Medicaid were started that they should be examined in terms of economic priorities.

This puts me in that category, but also Dr. Schultze himself who suggests it as Budget Director and in Congressional testimony, though he ignored it later as Chairman of the Health Insurance Benefits Advisory Council. The law set this up to do something which so far has not been done, namely, put some economic sense into the medicare program. Senator Russell Long, now Finance Committee Chairman, also suggested it at the time as I have indicated above.

The only suggestions for study in the Reports of the Ways & Means Committee and the Finance Committee in 1965, had to do with survey sampling and "actuarial" reporting. They were dependent on the professional staff of the Social Security Administration which was long on survey statisticians and actuaries

but short on economists. This situation, apparently, continues to this day. The Analysis of Health Insurance Proposals Introduced in the 92nd Congress, by the actuaries of the Social Security Administration, printed for the use of the House Ways and Means Committee, fails to provide the information needed to decide among these proposals.

"Cost, price, and expenditure may be, but generally are not, equal," it was noted in Volume I, of the American Medical Association's Report of the Commission on the Cost of Medical Care. Too many fail to heed this warning with the result that we don't always know the difference between "up" and "down" in health economics.

The Social Security Administration actuaries fail to distinguish between "costs" and "expenditures." (They received criticism from Senator Edward M. Kennedy on this score.)

You would think that the rich generally have higher costs than the poor because they spend more. When a President boasted that the health expenditures of the Government had more than doubled, was he boasting of higher costs? The Social Security Administration regularly confuses a program of higher utilization with one of "higher costs." They also confuse problems of cost distribution with those of cost increase (or reduction, which, however, now is considered contrary to nature).

When John Gardner was H.E.W. Secretary, he convened a National Conference on Medical Costs which made a good beginning in public education in health economics. The Social Security law was amended in 1967 in response to criticism of the "reasonable cost" unreasonable economic concept fathered by the attitude described by Mr. Ball of "not interfering in any major way with the traditional organization of the medical care system." The H.E.W. Secretary was empowered to engage in "economic experiments," but they are still dragging their feet.

[From the Northern Virginia Sun, Feb. 12, 1972]

(By Sidney Koretz)

My letter in the Northern Virginia Sun of November 17, 1971, "A New Dimension to Medicare," included criticism of Congress for neglecting the economic analysis of the Social Security health insurance program in favor of excessive reliance on survey statisticians and actuaries. Senator Russell B. Long, Finance Committee Chairman, had agreed with me, when he said on the Senate floor, just before Medicare was passed that it could be "better judged by an economist than by actuary."

I sent a copy of this letter to Senator William B. Spong Jr., and he replied that this "begs the question." He sent me a copy of his speech in Richmond on September 7, 1971. Here he started by saying that a "health crisis in the nation" is a "claim easy to document." Then, after citing increasing expenditures on health, representing an increasing portion of the Gross National Product, he deplored the "growing financial burden" this represents for all Americans.

I replied to him that the so-called "health crisis" is not easy to document. I said he confused increasing expenditures with increasing costs. True, we are spending more on health, the question is are we getting our money's worth? This is a debatable question without an "easy" answer.

In the New York Times National Economic Survey, in the first week of January, there was a statement by a doctor that Americans "pay what is believed to be the highest per capita costs for medical care . . . of any country without evidence to show that the extra investment results in better health for the individual." But on the same page there was precisely such evidence. Lawrence K. Altman, in "The High Cost of Medicine," after detailing 33 pages of a patient's hospital bill, totaling $15,000 for six-weeks treatment for a near-fatal attack of appendicitis continued: "Had Mrs. Brown had the same illness just 10 years ago, there would have been no financial problems. Mrs. Brown would have died within days from the complications."

The dead do not praise God, according to a Biblical Psalm. Nor are they in poor health. The main culprit causing "increasingly costs" for health care is guess who? The medical doctor in collusion with a hospital. They complicate things by letting a greater percentage of the sick survive than before.

The section on "Health and Medical Care," (pages 135–141) of the Annual Report of the President's Council of Economic Advisers discusses the "paradoxes" which add to the difficulty of diagnosis of the so-called "health crisis." (Since

every area of modern life is now in "crisis", it would be unhealthy if health were not in the swim of things, too.) The answer is not easy. "To start to answer the general question of how we can best 'produce' health, we must find a way of measuring changes in the level of health. What much be measured is the actual output—health—not simply such inputs as amounts of medicine consumed, days spent in hospitals, or the hours in consultation with doctors . . . It was once assumed that rising incomes would lead to improved health, but this assumption is now open to question."

The H.E.W. Social Security Administration still drags its feet when it comes to recognizing what I called "a new dimension."

TESTIMONY SUBMITTED BY THE NATIONAL ORGANIZATION FOR WOMEN (NOW), BY MERRILEE DOLAN, CHAIRONE, TASKFORCE ON WOMEN IN POVERTY

They were married at the end of their freshman year in college. Jane dropped out of college and took a job in a department store to support them while John got his degree. Upon graduation, John got a good job and Jane became a full-time housewife.

Their marriage started going noticeably sour about the time of her third pregnancy. Over the next few years, their marital discord deepened, and in 1970 they were divorced.

Of course, Jane got the kids and the house (and the mortgage). At the beginning, John was faithful in making the support payments ($400 a month was a very good deal, Jane discovered, when she compared notes with other divorced women), and she was managing to scrape by.

The recession wiped out the convenient part-time job she obtained after the separation, so she devoted her energies to getting her belated college degree.

A few months after the divorce, John was transferred to another state. Within a year, he remarried, and then the trouble with the support payments began. Jane's lawyer told her he was doing all he could, but that interstate support problems were tricky; and besides, the DA's and the courts were not partial to harassing middle class men.

What was Jane to do now? Her income had suddenly dropped below the danger point, and the prospects were ominous. Obviously, she had to look for a job. But in a recession, who hires a 32-year-old woman with no skills, no work history for more than 10 years, and with a pre-school child to cause child care problems?

A friend suggested she ask the welfare department if she could get some help. The suggestion shocked Jane. She was white, middle class, educated, and proud. Welfare? She'd starve first.

She could sell the house and live on the proceeds until she graduated and got a job. But when she checked out rents for a suitable apartment, when the real estate agent calculated how little equity there would be after sales costs and moving, and most of all, when she saw the children react to the threat to what remained of security, she couldn't go through with it.

Yes, the welfare worker said, she was eligible for Aid to Families with Dependent Children—a small grant as long as the support payments were low and irregular, plus food stamps and medical care. And so Jane and her children became a part of the alarming upward spiral of welfare dependency. They fell into the clutches of the reputed monster that is supposed to break up families, that allegedly rewards immorality and indolence, and is said to be sapping the moral fiber of a nation which became great through hard work and self-reliance.

Is it misleading to introduce a critique of welfare with an example of a white middle-class woman and her children? We think not. The number of such women on welfare is increasing.[1] Hardline welfare reformers have lately been shifting their attacks from total reliance on veiled racist innuendo to more and more indignation over welfare recipients who live in "nice" neighborhoods, who own "nice" things, who have the nerve to accept public funds and then not act destitute.

Our point is not racial or racist. It is, on the contrary, an assertion that while black women and brown women are more vulnerable to welfare dependency, it is because the racial discrimination they suffer is heaped on top of their funda-

[1] In California the percentage of AFDC mothers with some college education increased from 4.8% in June, 1968 to 6.8% in December, 1970. In unpublished manuscript, "AFDC Socioeconomic Characteristics of Families Receiving Aid", California Department of Social Welfare.

mental vulnerability, that of being a woman trying to support a family. The fact is that in March 1970, 46% of the white children who live in families headed by a woman lived on income below the poverty level.[2]

Our point is that the AFDC program was founded on the premise that any woman faced with trying to support children alone is going to have a difficult time. This premise continues to be true. We believe that the hue and cry about the "welfare problem" is either a deliberate effort to obscure this issue, or evidence of an alarming inability of public policy-makers in this country to see the facts as they are.

Our point is that every woman who works full time at rearing her children, and who depends for the income to do that job on what her man provides, is a potential welfare recipient. Virtually all AFDC mothers, before they became economically dependent on the state, were economically dependent on a man.

The "welfare problem" cannot be understood apart from an understanding of how difficult it is for a woman to be the sole or primary support of her minor children. There are 8 million American children living in families headed by a woman.[3]

At least 60% of these fatherless households are on welfare.[4] They are not on welfare because they like it. They are on welfare because they do what they can to provide for their children, and because the necessity of caring for their children often interferes with their ability to work, or because even when they work, the income they can produce in the labor maket does not replace a man's earnings.

There are some obvious conditions of economic dependency which this society has learned to tolerate, and even sanction. We clearly no longer expect young children or the aged to support themselves in the labor market. We are becoming more tolerant toward economic dependency caused by physical or mental disabilities. We have even come to admit that not all unemployment of able-bodied men is due to individual incompetence or malingering. For such groups we generally provide publicly for economic dependency as a matter of right or compensation (U.I.B. and D.I.B.), with a trend away from moral stigmatization of income replacement.

Why then is welfare reform rhetoric so intolerant, so vitriolic when AFDC is involved. What is it that makes the dependency of women and children different when it is caused by the absence of the man of the family rather than based on his presence?

Regardless of the increasing participation of wives and mothers in the labor force, it surely cannot be said that the economic dependency of women is no longer regarded as normal. To our knowledge, no one has proposed legislation in Congress or in any state that would force married women with children over 3 years of age into the labor market when their husbands are supporting them. On the contrary, we still hear the argument that this country wouldn't have such an unemployment problem if women would just stay home and mind the kids, and let the men earn the money.

But for some reason, the economic dependency of former wives who continue to raise their children without their husband's support is considered improper and even immoral. What is it that makes cooking and cleaning the house and washing clothes and getting the kids off to school and taking care of the baby normal, in fact ideal, when these activities are supported by the income of a husband/father, yet deviant when supported by public funds?

We regret that Congress has not seen fit to analyze the "welfare problem" as in the early 1960's it analyzed the "poverty problem". Then it became clear that while poverty was no respecter of race, black and brown Americans were poor in disproportionate numbers, largely because they were subject to discrimination which was systematically denying them access to the opportunity not to be poor. Hence anti-poverty programs were focussed to a considerable degree on improving access to equal employment and educational opportunities for the poor.

With all the imperfections and incompleteness of the anti-poverty efforts of the 60's, and despite the persistence of the poison of racism in our society, there

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[2] Elizabeth Waldman and Kathryn Gover, "Children of Women in the Labor Force," *Monthly Labor Review*, July 1971, p. 24.

[3] Robert L. Stein, "The Economic Status of Families Headed by Women", *Monthly Labor Review*, December 1970, p. 4.

[4] Ibid., p. 3

are fewer poor Americans today than there were ten years ago. Fewer poor black and brown Americans. And fewer poor white Americans, who benefitted directly from programs designed to open economic opportunities to all, and indirectly from the positive changes in attitudes toward the poor.

While the total number of families with incomes below the federal poverty standard has declined significantly in the decade, at the same time, the profile of poor families has shifted dramatically.

In 1959, 28 of every 100 families (with children) whose incomes fell below the national poverty standard were single-parent families headed by the mother. In 1969, 47 of every 100 poor families were headed by the mother.[5] The job and training opportunities generated by the war on poverty were directed toward men. Hence the significant change in family profiles.

We truly do not understand why Congress will not face the poverty of women who are on welfare the same way. Poverty is the issue, but it is the systematic blocking of equal economic opportunities for women that keeps them poor.

Rather than attempting to devise a viable national policy for reducing the poverty of these families, we continue to approach welfare reform from the standpoint of reducing welfare rolls. Welfare costs are high; the appearance of so many families on welfare in recent years is shocking and alarming. But to continue to look for solutions through reforming the welfare system is keeping us from approaching solutions.

The hard-line welfare reform approach, typified by the proposals of Governor Reagan of California, is to dwell on the current dollar cost of welfare, and to reduce that cost by imposing greater and greater restrictions on welfare eligibility and welfare benefits. Such restrictions can reduce welfare rolls, but they cannot reduce the poverty problems of welfare families. In the long run, this approach means greater costs, not only in dollars, but in the degradation of the society which perpetrates such callousness.

In too many respects, HR 1 reflects these same attitudes. We most strenuously object to the forced labor provisions of HR 1. We see no way that such a regressive and repressive policy can reduce the suffering of welfare recipients.

We do believe that every welfare mother who sees that it is in her interests and in the best interests of her children to participate in the labor market should be encouraged to do so and should be assisted to do so. The work incentive policies adopted by Congress in 1967 have been useful in this direction—they should not be undermined by the reduction of allowances for the extra cost of working, and the incentives should not be turned into negative ones. The investment in positive incentive policies has resulted in a reduction of poverty for many families. They should be improved, not whittled down.

We strenously object to the encouragement of exploitation by employers in the HR 1 provisions which forces a welfare mother deemed employable to accept employment at 75% of the minimum wage. This unconscionable proposal is not mitigated by the wage subsidy offered to its victims. One of the reasons that many of these women are on welfare in the first place is that the wage structure for women is so low. Any effort to further depress wages for women must be met with the most vigorous opposition.

We object strenously to the proposed denial of aid to a family headed by a mother who chooses to enhance her future earning and living potential by undertaking full time studies. This provision is self-defeating, if economic independence is a genuine objective of welfare reform. On the contrary, education should be encouraged as the basis for future independence.

A society which has always taught its daughters to be dependent is not going to reverse their dependency in one fell swoop. A society which tolerates a wage structure which pays a woman who works full time 60% of what it pays men who work full time,[6] is not going to reduce the poverty of poor women by forcing them willy-nilly into such a labor market.

For these reasons we agree with the HR 1 provision to establish a minimum floor on income for families which cannot meet their needs through employment. We commend HR 1's recognition that low-paying jobs are not exclusively confined to women, and approve the "working poor" concept. However, we submit that the proposed income floor is totally inadequate to meet the minimum needs of a family with no outside income, and advocate a base which is decent and

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[5] Ibid., p. 5.

[6] Report of the Advisory Commission on the Status of Women, "California Women", 1971, p. 63. See attached table "Comparative Income of Women and Men, 1970".

adequate. One of the serious problems the inadequacy of the base presents is the proposal to adopt it without guarantees that states which grant higher benefits will continue to do so. Should Congress decide to adopt an inadequate base simply to establish the principle, it must also require states with a higher base to maintain benefit levels.

We agree with HR 1's recognition of the urgent need for an enormous expansion of child care programs and facilities. We believe, however, that such an expansion should not be limited to programs aimed exclusively at getting welfare mothers to work. Funds made available for working welfare mothers through HR 1 should be integrated with a broad program of child care services for all families, with definite standards spelled out in law. No one should be denied child care services because of an inability to pay—likewise, where facilities are limited, no one should be denied such services because of the ability to pay.

In summary, NOW believes that "welfare reform" is an inadequate solution to the "welfare problem." Welfare is a pressing national problem because it reflects the poverty of a majority of families with children whose sole or primary support is the mother. The poverty of these families is the result of the transfer of dependency from a husband/father to the state. The necessity for the transferrence of this dependency is due to the generally inferior economic status of women in America. All women who depend on a man for the support of themselves and their children are potential welfare recipients. Should the man vanish from the scene, chances are enormous that the woman will be unable to replace his income adequately, if at all.

Much of welfare reform rhetoric promotes the myth that shoring up the nuclear family will solve all our problems. We do not agree. The solution to the problem does not rest with finding another man. Rather, the solution lies in recreating our social and economic institutions so that the independence of women (rather than dependence) is the basis for their choice of life-style.

In addition to the inferior wage structure for women, and the restriction on the kinds of jobs generally available to women, impediments to self-support include obstacles to equal educational opportunity, especially at advanced levels, and lack of adequate child care provisions. None of these barriers to economic equality for women can be overcome by welfare reform. In fact, many of the provisions of HR 1 would actually intensify the problems.

Congress should recognize welfare reform for what it is—an effort to save money at the expense of the poor. The more positive elements of HR 1, such as a minimum floor on family income (amended to provide an *adequate* base), assistance to the working poor, increased funding of child care services, should be adopted. The punitive and regressive features, such as forced labor, subsidies to employers who pay substandard wages, prohibition of full time studies, should be stricken. But more important, Congress should readress itself to positive programs that get at the causes of poverty, and should specifically focus on the causes of the poverty among women.

COMPARATIVE INCOME OF WOMEN AND MEN, 1970 (MEDIAN INCOME)

Occupation	Year-round full-time workers			All workers		
	Women	Men	Women's income as percentage of men's	Women	Men	Women's income as percentage of men's
Professional, technical and kindred workers	8,005	12,477	64.2	6,675	11,577	57.8
Managers, officials and proprietors, excluding farm	6,624	11,937	55.5	5,523	11,292	48.9
Clerical and kindred workers	5,650	8,931	63.3	4,646	7,965	58.3
Sales workers	4,268	10,243	41.7	2,279	8,321	27.4
Craftsmen, foremen and kindred workers	5,100	9,417	54.2	4,276	8,833	48.4
Operatives and kindred workers	4,589	7,786	58.9	3,885	7,017	55.4
Private household workers	2,203	.....	.....	825	.....	.....
Service workers, excluding private household	4,035	7,234	55.8	2,541	5,568	45.6
Laborers, excluding farm and mine	4,405	6,731	65.4	3,151	4,839	65.1
Total all workers	5,483	9,225	59.4	3,844	8,036	47.8

Source: U.S. Department of Commerce. Bureau of the Census Current population reports: Income in 1970 of Families and Persons in the United States." p. 110.

TESTIMONY OF FRED SELIGMAN, M.D., M.P.H., ON BEHALF OF THE ASSOCIATION OF CHILDREN AND YOUTH PROJECT DIRECTORS

INTRODUCTION

I am Fred Seligman, M.D., Director, Division of Comprehensive Health Care, and Associate Professor of Pediatrics, University of Miami School of Medicine, Miami, Florida, and Chairman of the Association of Children and Youth Project Directors.

Mr. Chairman and members of the Committee: I appreciate the opportunity to present to you testimony concerning an extraordinarily successful program which is scheduled to terminate on June 30, 1972, after five years of existence—the special project grants under Title V of the Social Security Act.

I represent the staffs of the 68 Children and Youth Programs throughout these United States and the more than 500,000 children and youth who receive comprehensive health services through these Programs.

RECOMMENDATION

I endorse most emphatically the continuation of these Programs under Title V of the Social Security Act. Specifically, our Association supports without reservation amending H.R. 1 to extend Title V of the existing act at a funding level of $630,00,000 as described in S. 2135 which has been introduced to the Senate by Senators Gaylord Nelson and Edward Kennedy, Abraham Ribicoff and 14 other sponsors. A companion bill, H.R. 8799 has been introduced to the House of Representatives by Congressman Edward Koch and co-sponsored by 86 members of the House.

The remarks in this testimony will be limited primarily to Children and Youth Projects, although our Association favors continuation of all the programs as described in S. 2135.

LOCATION OF PROGRAMS

These programs exist throughout this Nation: in the Virgin Islands, Puerto Rico and Hawaii. There are Programs in all corners of the Mainland—Miami, Concord, Los Angeles, and Seattle; Central America—Chicago and Omaha; Rural America—Little Rock, Charlottesville and Helena.

TREND OF HEALTH CARE

This Nation is moving in the direction of comprehensive health services to defined segments of the population. Many proposals have been receiving serious legislative concern by many members of the Congress. Mr. Chairman, neither our Association, nor any member of your Committee has advocated that we move recklessly in establishing a national health plan. This task requires considerable thought. Even though our health delivery system is far from perfect, we must resist the temptation to destroy what we already have, only to create something new. We must instead build on those components of our system that have proved their effectiveness and modify only those segments of the health care system that require revision. We cannot afford the economic and human cost of abandoning programs that have demonstrated their efficacy. We cannot afford to ignore the critical health problems that daily face this Nation's young.

While potentially holistic plans are under consideration, we must not act so cautiously that progress is stifled. Because no perfect system has been developed, Children and Youth Projects should continue to demonstrate and develop improved health care delivery patterns to children. Ultimately, Children and Youth Projects will phase into an overall national health plan, or, if in the judgment of this Committee the counsel of our Association be considered wise and visionary, a national health plan should ultimately be phased into and expanded upon a merging of the basic triad of Title V of the current Social Security Act, namely Children and Youth Projects, Maternity and Infant Care Projects and Crippled Children's Projects.

THE TIME TO ACT IS NOW

The extension of these Projects is vital and essential to any cornerstone of health care that will be created in this country. These are Programs that are working. We must build upon them as we go into experimentation of all kinds. For the record, I would like to identify that these Programs have a parental

history that I consider very illustrative. These Programs were conceived by the wise parental advocation and insight of both your Committee and the House Ways and Means Committee. Individuals such as Senator Hill and Congressman Fogarty have left us a legacy that your Committee should be proud of, and to which your Committee must devote its continued inspiration. I emphasize the importance of maintaining the foresight that your Committee has shown in the field of health services to children.

Initial opposition by the Administration in regard to extension of these Projects no longer exists. The Administration has gone on record as favoring extension. In spite, however, of the signing of P.L. 92-184 entitled "Supplemental Appropirations Act" on December 15, 1971, fewer than 25% of the Projects will be able to continue past June 30, 1972. If immediate extension is not adopted, a decreasing amount of funds will go to states with urban populations. Both for fiscal reasons and because of lack of state resources, many states will not be able to continue these Programs.

NO ADEQUATE SUBSTITUTES

There are no adequate substitutes for these Programs should they be terminated. In urban areas especially, Medicaid cannot substitute for Children and Youth Programs. There are no physicians in most areas. The number of physicians giving primary care to children is dropping rapidly: in many central cities, the only quality health care resources for children are Children and Youth Programs.

PROGRAM DESCRIPTION

The Children and Youth concept as a Program is National in scope but is characterized by an American ideal of being tailor-made to fit the idiosyncrasies of each local area, be it central city, rural, or a mixture of population densities. The various Projects are as diverse in tailor-making health care delivery to their local areas as their areas and this Nation are diverse. Organizational forms include a full spectrum from classical fee for service private practice physicians to indigenous community workers coordinating home care delivery teams. In many areas, they are the only meaningful health care resources to the target population. For example, in our own ten square mile geographic area in central city Miami, there is only one practicing pediatrician available to more than 21,000 children.

Essential factors of quality health care include comprehensiveness and continuity. Concentration on a defined geographical area provides for efficiency. Neighborhood Health Center Programs are currently the only publicly supported Programs other than Children and Youth Projects that are explicitly committed to the delivery of comprehensive health services to a specific population group in a well defined geographical area. There is a significant body of professional literature documenting that the Children and Youth Projects provide this care more effectively, at lower cost, and with higher quality.

Children and Youth Projects are both organizationally and philosophically distinct from all previously conceived programs. Children and Youth Projects focus medical, dental, and mental health care to all children in a family; however, the provision of most ancillary services such as public health nursing, social services, nutrition, and health education are usually family based. Unless there is a specialized focus and concern for children, children frequently do not receive the priority they deserve in a family oriented medical system. Children and Youth Projects have developed a meaningful model of health care delivery with built-in standards accepted by the appropriate professional bodies that are applicable to children nationwide and upon which can be built family-centered care to children and adults.

QUALITY CONTROL AND EVALUATION

Children and Youth Projects are the only publicly supported comprehensive health care system that has developed meaningful quality control and evaluative components.

Critical to the Children and Youth concept is a rarely occurring, if not unique, organized flow of services with its data documentation system. This data system has been developed and operated by Minnesota Systems Research, Inc. and has been created to produce ongoing evidence of the effectiveness of alternative

modes of delivering health services. This data system was created to be the decision making basis for allocating resources, documenting flow of children receiving services, documenting the kind of problems diagnosed and the frequency and effectiveness of treatment, and requiring a written care plan tailormade for each child to assure that timely and effective preventive services were indeed received by the child. As an example, each Children and Youth Project receives each quarter a report on its absolute performance by an array of measures such as medical and dental backlog, well child rate, reassessment intervals, etc. These measures tell the Projects how they are performing, how long it will take to produce healthy children at their current productivity rate for all registrants, and how they have allocated resources relative to the major jobs to be done in their Project areas. In addition, each Project receives a relative ranking to all other reporting Projects on each performance measure.

To our Association's knowledge, this is the only health program which is national in organization, which has an ongoing performance measuring system to reflect an accountability for health maintenance, with appropriate health care which is adaptable to any locale in this diverse nation, and capable of adjusting locally required inputs by a process of providing services which result in accountable outcomes.

Our Association is aware of Congressional interest in continued evaluation of these and other Programs. We are aware also of discussions which will improve the evaluation of these Programs. We wish to go on record as supporting this intent and believe that it is wise to continue as well as to improve the evaluative mechanism. We additionally support the concept of evaluating the monitoring system itself and recommend that resources be made available to accomplish this task. Additionally, our Association wishes to point out that out of the Children and Youth concept has developed a Clinic Self-Evaluation Procedure which has been cooperatively developed by the Johns Hopkins University Children and Youth Project and Westinghouse Electric Corporation, which is presently in its second year of field testing in Children and Youth Projects.

COST BENEFITS

The dramatic performance in annualized cost reduction in the Children and Youth Projects is simply summarized as follows: as of January 1, 1968, at the beginning of such mandatory reporting, the annualized cost per child was $201; by December 31, 1969, it had fallen to $162; and by December 31, 1970, it had fallen to $140. The preliminary estimate of costs per child as of June 30, 1971, was $129; and the predicted cost for the annualized cost per child ending June 30, 1972, is slightly over $126 per child per year. As compared to the national average annual health cost per man, woman, and child in this nation of more than $350, these Projects are performing economically, particularly considering that these children are drawn from the least healthy geographical areas.

Our Program at the University of Miami, like many throughout the country, has demonstrated the efficacy of health care delivery that is based on a preventive rather than an episodic approach. Since initiation, we have decreased our overall cost per patient by more than 80% in spite of inflation. Nationwide, the Projects have increased the frequency of "well children registrants" by 50%. There have been significant decreases in the number of diagnosed preventable conditions, as well as diagnosed correctable defects. Such factors demonstrate the impact of these Programs in preventive services, correction of defects, and health promotion.

The value of a preventive approach is seen in respect to hospital admissions. In fiscal year 1969, hospital admissions in Children and Youth Projects nationwide decreased by 36%. The continued need for these Programs is demonstrated by the fact that a relatively high percentage of children, particularly in the 5–9 year age group have a lower immunization level in the geographical areas served by these Programs. One out of ten registrants in these Programs fails the vision and hearing screening tests. There have been many public studies documenting these facts relative to Children and Youth Projects.

COMMUNITY INVOLVEMENT AND EDUCATIONAL SPINOFFS

Children and Youth Projects are administered by teaching hospitals, official health departments, and Pediatric Departments in medical schools. A significant number of these Projects have meaningful community inputs and participation, and have also functioned as initiators to expanding other health and

health-related services in their communities. The impact that these Programs have had on both the agencies and communities has been profound, particularly on the voluntary hospitals that have been involved, and especially on the medical schools. Medical students at universities such as Johns Hopkins, Miami, etc., have the opportunity to see medical care in the community, to see effective preventive therapy in action, to see an innovative interdisciplinary health care delivery system—a system that is concerned with maximizing quality and efficiency.

New manpower models have been developed in these Programs. As a medical educator, I can speak to the fact that medical students and other trainees in the health sciences are learning how they can ultimately interface with the many new ancillary health professionals in the field. An increasing number of these trainees are now choosing careers in community medicine having had meaningful exposure to these Projects.

FOUNDATION FOR OTHER PROGRAMS

Many Programs in Child Development have and are making plans to use Children and Youth Projects as major foundations.

Recently the Senate passed a bill to provide for the establishment of projects for the dental health of children. This project will rely heavily on interfacing with Children and Youth Projects.

Parent and Child Centers that are having significant impact in changing the patterns of development of poor infants, as well as their parents have frequently grown out of Children and Youth Projects. Several of the new Advocacy Centers in Parent and Child Centers will depend upon Children and Youth Projects for total health care.

Many Head Start Programs rely solely on Children and Youth Programs for the provision of health care for their children. For example, the sole resource for providing health services to the Head Start children in the islands of St. Thomas and St. Croix in the Virgins Islands is the Children and Youth Project. Title IV of the Elementary and Secondary Education Act has half of its projects through the Cooperative Research Act of the Office of Education, which are intimately associated with Children and Youth Projects in Topeka, New York City, Dayton, and Galveston.

CONCLUDING REMARKS

These Programs have attempted to solve the manpower crisis in health by retraining talented individuals both professional and non-professional who have been attracted to these programs. These individuals have been able to gain meaningful experience and expertise in the delivery of comprehensive health services, particularly to children.

Termination of these projects will mean that these now talented and vibrant individuals will return to the less meaningful professional and ancillary ventures that they came from. Mr. Chairman, our Association invites your Committee members to visit our Programs. There you will sense the enthusiasm of health workers, you will perceive the vitality of concerned people, you will feel the hope and well being of patients, you will sense an atmosphere of excitement and creativity, and you will witness quality health care.

Gentlemen, what this Nation needs most is people who care. We speak of a health care crisis in America. Our emphasis has been on "health". Our crisis is not so much in "health" as in terms of "caring", in terms of developing a cadre of professionals who truly care for the people they serve.

Termination of the Projects will mean that both professionals and recipients will feel penalized for caring. Already there have been professionals who have left these projects feeling that those in positions of power and authority do not care. The history of your Committee has shown that you do care, but the staff and patients in these Programs are asking that you show your care immediately by extending these Projects.

Termination of these Projects means that the children and youth in our various communities decide again that they have no friends in the Establishment and will return to anti-social behavior, juvenile delinquency, poor health habits, sickness, and the cycle of poverty.

Without question, the need is critical, the evidence is in, the facts are available for the reading. In a sense, the question becomes—is this just another

great idea and a noble demonstration in the graveyard of the health field? Or, is it one that has proven itself to become expanded and extended as a prototype for millions more of our children.

SUMMARY

1. We endorse amending H.R. 1 to include S. 2135 and H.R. 8799 with full funding. Continued federal funding for the special Projects has the endorsement among others of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association, and the National Association for Retarded Children;

2. We advocate not destroying a crucial element of our health system to mothers, infants, children, and teenagers that works. Both Children and Youth and Maternity and Infant Care Projects have been the most effective publicly supported health care programs developed over the last 30 years;

3. We feel that these Projects are the framework upon which to build a national health plan and that mothers and children should be of the highest priority in any such plan;

4. We emphasize that Children and Youth and Maternity and Infant Care Projects are economical, that they have demonstrated the efficacy of comprehensive services, that they have trained new personnel and thereby have had a major impact on professionals and recipients, and that they have developed a quality system of health care that is sensitive to the needs of people; and,

5. We feel that extension of these Projects until 1977 is critical. An extension of these Projects for only an additional year would be demoralizing and would be the first step to the ultimate death of these Programs.

I would like to express my appreciation to this Committee for the opportunity to present this testimony. The leadership of this Committee has traditionally provided wise direction and support for health and welfare programs for children throughout this Nation. We are confident that his leadership will be maintained.

STATEMENT OF THE AMERICAN PHARMACEUTICAL ASSOCIATION

The American Pharmaceutical Association, the national professional society of pharmacists, representing 52,000 practicing pharmacists, pharmaceutical educators, scientists and pharmacy students, presents the following comments in support of Amendment 464 to H.R. 1.

The American Pharmaceutical Association has long supported efforts in Congress to include in federally sponsored health programs pharmaceutical services to non-hospitalized patients. We urge the Committee to adopt Amendment 464 to add such benefits to Medicare under Title XVIII of the Social Security Act. This amendment would expand prescription drug benefits to include non-hospitalized patients while providing a more rational basis for drug product selection by physicians and a more equitable basis for reimbursement for comprehensive pharmaceutical service.

When Congress enacted the Medicare program in 1965, no one doubted the necessity for including prescribed drug costs for hospitalized patients. It was recognized as futile to put patients in hospitals without providing for their full recovery through necessary treatment. Yet, some apparently believed, and have continued to believe, that a distinction can be made in the case of the non-hospitalized patient. The result under Medicare is that the program pays for a non-hospitalized beneficiary's examination and diagnosis by a medical practitioner, but if the individual does not have the financial resources with which to obtain required medication, he may be forced to go without it. The result is that some elderly patients are unnecessarily hospitalized so that they can receive the pharmaceutical service they require. More often, the health of the elderly patient deteriorates, beacuse of the lack of pharmaceutical service, to the point that prolonged hospitalization—the most expensive component of health care—becomes necessary.

After six years of experience under Medicare, the time has come to correct this obvious mistake. APhA takes the position without reservation that the providing of comprehensive pharmaceutical service to non-hospitalized Medicare patients is an absolute requirement if they are to receive comprehensive health care. This isn't just our opinion.

In May of 1967, at the direction of President Johnson, HEW Secretary Gardner established the HEW Task Force on Prescription Drugs. This Task Force was charged with the responsibility for studying the question of adding an out-of-hospital prescription drug benefit to the Medicare program. Two years later, on February 7, 1969, the final report of the Task Force was presented to then Secretary Finch. The essential conclusion of the Task Force flowing from its exhaustive study was that an out-of-hospital prescription drug benefit could and should be added to the Medicare program.

In March of 1969, Secretary Finch named a 17 member "blue ribbon committee," under the Chairmanship of Professor John P. Dunlop of Harvard University, to review the findings and recommendations of the HEW Task Force. This Committee concurred in the basic findings and conclusions of the Task Force.

Despite the in-depth studies of the Task Force and the careful review of the Dunlop Committee, yet another committee to review the question was appointed by the Secretary of HEW. This committee, under the Chairmanship of Mr. Walter J. McNerney, President of the Blue Cross Association, added its support to the work and conclusion of the Task Force. Finally, the report of the 1971 Advisory Council on Social Security (the Flemming report) also recommended expansion of the Medicare program to include coverage of out-of-hospital prescription drugs.

These recommendations have received substantial bi-partisan Congressional support. Senator Montoya and Representative Obey both with numerous cosponsors have introduced bills (S. 936 and H.R. 2355) which have wide support. We believe that Congressional concern regarding the cost of the program has been the prime reason why Congress has not adopted these proposals to date. We are convinced, however, that it is possible to provide the necessary pharmaceutical service benefits with reasonable and controlled costs.

According to a recent HEW report, in 1970, 17 cents of every dollar spent for health care was for drugs and appliances. The total national bill for these items in that year was $11 billion. The Raymond E. Gosselin Company, which specializes in statistical reporting on drug distribution, reports that only approximately eight cents out of every health dollar, for a total of approximately $5.1 billion, was spent in 1970 for prescription drugs by all non-hospitalized patients. In 1967, according to the HEW Task Force, only slightly over $1 billion was spent by the elderly for prescription drugs. Any increases in expenditures under Medicare must be reduced by savings in hospital and other costs.

Much attention in health care circles is being devoted to the subject of "rational prescribing," i.e., providing the right amount of the right drug for the right patient at the right time. With proper drug utilization review programs including pharmacy participation and expertise, we believe that substantial improvement in prescribing practices and reduction in the cost of drugs prescribed can be achieved. The objective would be to achieve the greater possible value for each penny of the taxpayer's dollar devoted to drugs and pharmaceutical service.

The *Lilly Digest* reports that in 1970, the average prescription charge in the United States was $4.06. Of this figure, more than 50 percent is attributable to the acquisition cost of the drug product dispensed. We believe that drug product costs are often artificially inflated due to a lack of meaningful price competition among manufacturers of prescription drug products. This situation can be corrected by adopting the formulary system proposed in Amendment 464.

The medical community has long recognized that the proper use of a formulary system can result in rational prescribing on quality medical treatment within necessary cost control standards. Formulary use is not a unique concept in the United States. Currently, there are at least thirteen states which utilize a cost control formulary in their prescription drug programs. These state formularies have been developed on the basis of recommendations by expert committees of pharmacists, physicians and other health care professionals.

The federal government has also adopted and achieved significant success in many of their programs utilizing the formulary concept. Formularies have been approved and are used by all military services, Neighborhood Health Centers operating under Office of Economic Opportunity grants and the Public Health Service to name a few.

The formulary system has been readily adopted and accepted by most American hospitals, including those at major universities and medical center hospitals.

The American Pharmaceutical Association has long supported the concept of formulary utilization APhA has concurred in and supported the conclusion of the Task Force on Prescription Drugs that formulary use is and has been associated with the highest quality medical care. The final report further stated that although the use of a formulary was not in and of itself a guarantee of high quality medical care, rational prescribing, effective utilization review and cost control would be difficult to achieve without one.

Amendment 464 would remove from the political arena the highly controversial issues of quality versus cost and brand name versus generic name drug products. By placing resolution of these issues in the hands of a highly qualified Formulary Committee within the Department of Health, Education and Welfare, it assures that the highest quality drug products will be provided at the lowest possible cost consistent with high quality health care.

As proposed, the Formulary Committee will have direct control over the cost of those prescription items which are dispensed to Medicare beneficiaries. If a drug product or biological falls without the defined standard cost guidelines, the claim will not be eligible for reimbursement.

Manufacturers of pharmaceutical drug products, as a condition of inclusion of their drug product within the formulary, may be required to provide complete data regarding the performance of their drug products. Once the Formulary Committee has the essential pharmacological and financial data, it will be able to rationally select drugs to be used within the program at most reasonable costs. Thus, acceptable quality and reasonable cost would be the basic test for admission of any drug product to the list of those eligible for federal financial support. Once a drug product has attained Formulary status, it is still subject to stringent controls.

A prescription drug or biological may only be dispensed pursuant to a physician's prescription order or certification that it is a lifesaving entity, to be self-administered by the patient when not in a hospital or extended care facility. Further, it must be dispensed by a pharmacist at predetermined cost. The patient co-payment provision reduces still further the program's costs and should act to control utilization.

This system of therapeutic and economic checks assure maximum patient protection from drug overuse while protecting expenditures from uncontrolled program costs.

The American Pharmaceutical Association supports the pharmacist reimbursement system utlized in the determination of the maximum allowable cost for a prescription drug. It is well designed to compensate the pharmacist for the professional service provided to the patient and afford him an equitable return of his educational and capital investment. Under this approach, taxpayers are not placed in the position of subsidizing uneconomical operations. Fees are determined solely on the basis of their relation to the provision of the pharmaceutical service to the patient. We believe that this concept promotes efficient and economical professional service while providing high quality patient care at low government cost.

In summary, APhA supports Amendment 464 to provide the much needed expansion of prescription drug benefits which has long been neglected by the Medicare program.

Amendment 464 provides a rational approach to informed drug product selection and utilization through the use of a formulary while assuring that high quality medical care is provided at low cost to the government.

Amendment 464 additionally provides equitable reimbursement for pharmacists for their professional services while guaranteeing that the patient receives the most comprehensive pharmaceutical service available.

FAMILY SERVICE ASSOCIATION OF AMERICA,
New York, N.Y.

STATEMENT OF POSITION ON H.R. 1 TO U.S. SENATE COMMITTEE ON FINANCE

I am Clark W. Blackburn, General Director of Family Service Association of America. I am here today to represent the Executive Committee of the Board of Directors and the professional staff of the Association on HR 1, the 1971 Social Security Amendments. Family Service Association of America is a federation of

more than 330 autonomous voluntary Family Service Agencies located throughout the country.

The training, experience, and value system on which FSAA and our Member Agencies base our purposes and programs have shown us that to help people, whether in meeting their concrete or their emotional needs, programs must enhance rather than undermine the individual's self-respect and self-confidence. Our long experience in providing counseling and other family support services to troubled families from all walks of life qualifies us to speak on public policies that affect the strength, structure, and quality of family life.

Public Welfare represents society's commitment to provide the basic necessities for life, health, and decency to those among us who are unable to provide for themselves. FSAA has consistently supported a strong public welfare system based on the dignity and worth of every human being. We share with many others a deep concern that the present welfare system is inadequate to solve the problems of those individuals in need or to fulfill the responsibilities of a wealthy nation for those citizens caught in the toils of a highly industrialized, complex society.

Family Service Association of America strongly urges reform of the welfare system to incorporate the principles of a Federal income floor below which no family or individual would have to exist, incentives and opportunities for adequate self-support, and equitable provision for anyone incapable of such self-support.

The Administration is commended for bringing the need for welfare reform to the public attention through the proposed Amendments to the Social Security Act. The Senate Committee on Finance is commended for giving this measure the thoughtful consideration it must have and for holding public hearings that give opportunity for many different opinions to be expressed before taking final action.

The Executive Committee and the professional staff of FSAA have given very careful study to the Bill and the conditions in our country today related to public welfare programs and their beneficiaries, and have taken the position that we must oppose HR 1 in its present form and as it may be altered by Amendment #559 or any others presently proposed. We urge that this Committee also reject HR 1 and instead take leadership in offering another approach to welfare reform for the long run. FSAA will wholeheartedly support measures to provide immediate relief for the financial difficulties of the various states so that they will be able to maintain their public welfare responsibilities despite increased costs.

The remarks that follow summarize our thinking about what is needed to reform the welfare system and our reasons for concluding that HR 1 will not solve the problems.

Family Service Association of America strongly supports a welfare system that incorporates the following provisions:

FSAA supports full Federal financing and administration of public assistance.

FSAA supports public assistance granted on the basis of current need without categorization that excludes some people—childless couples and single individuals under 65 for example. Methods of determining eligibility should be simple, equitable, and protective of self-respect.

FSAA supports public assistance grants at levels that keep recipients above the poverty line ($4000 for a family of 4 in 1971). Provision for emergencies, overwhelming disaster, and special need should be available.

FSAA supports the provision of work incentives and the removal of barriers to employment. FSAA believes such incentives include the following and should be incorporated in legislation for welfare reform and for related programs in the public interest:

When sufficient work is not available for all able-bodied adults who are willing, competent, and seeking work, the Federal government should create enough public service jobs to meet the need.

No one who works full time all year should earn less than $4000 a year. There should be Federal responsibility for supplemental assistance to the working poor to the level of BLS Low Living Standard. The system should include maintenance of income for seasonal workers when employment is not available.

Education and training for developing marketable skills and for learning new skills when old ones have become obsolete must be universally and realistically available.

Discrimination on any basis in wage rates, job access, and educational opportunity must be fully eradicated.

Since good health is a basic requisite to maintain earning capacity, effective provision of medical care, including rehabilitation services and prevention of illness and disability, and an effective national health insurance program are essential.

High quality substitute care for children should be readily available to all mothers who choose to work outside their homes. No mother should be required to leave her home for work if she believes it is not in the best interests of her children.

Accessibility to jobs, health, education, and social services through adequate transportation at reasonable cost for all people should be provided.

A wide variety of social services intended to assist the individual and the family in solving problems and improving functioning in all areas should be universally available. Services do not and should not substitute for adequate cash income, but must be considered essential supportive mechanisms in any effective welfare system. Utilization of social services should be voluntary and not required for receipt of cash benefits.

Rights of beneficiaries should be fully and explicitly protected. Qualifications for eligibility to assistance and rights of recipients should be publicized in all effective ways.

Position on title I.—Amendments to the Federal old age, survivors and disability insurance program

FSAA strongly supports the amendments included in this section of HR 1 since they strengthen the role of social insurance in providing income security by improving the level of benefits and liberalizing eligibility. Since we hope for a reduction in the need for public welfare to provide income security, we look forward to the extension of social insurance to cover presently uncovered risks, to increase the number of persons covered by insurance programs, and to raise the level of benefits, and we believe that Title I takes some important steps forward in these directions. We urge the Congress to continue to explore ways of strengthening this program in the future. Since we are opposing HR 1, we would urge that this title be reintroduced independently and be passed promptly by Congress.

Position on title II.—Improvements in administration of health programs

FSAA strongly supports the intent of this Title to improve the operating effectiveness of Medicare, Medicaid, and the Maternal and Child Health Services. We recognize the difficulty of assuring efficient and economical operation of health services while simultaneously protecting quality of service.

Since we believe good health is a basic requisite to maintain earning capacity and since poor health is both a cause and a result of poverty, comprehensive health services and good medical care are another effective means of reducing the need for a vast public welfare system. We therefore cannot support changes in the law that will 1) restrict eligibility too greatly, 2) impose charges on recipients (who by definition have no leeway in their incomes to meet such charges and so must either be deterred from seeking desirable medical care or suffer even more deprivation in meager food, clothing, and housing budgets), 3) narrow the scope of covered services. We specially regret elimination of the requirement that all states have in effect by 1977 a comprehensive Medicaid program and, in the provisions relating to Medicare, the elimination of a requirement for social services in extended-care facilities. It is our observation that social services are particularly useful to patients in such facilities.

FSAA suggests that the Congress consider a new approach to the matters covered by Title II.

Position on Title III.—Assistance for the needy aged, blind and disabled

FSAA strongly supports a Federally financed and administered program for the needy aged, blind and disabled with a Federally determined floor and uniform eligibility conditions. We also strongly support administration of such a program by the Social Security Administration.

We urge that the level of the Federal minimum be brought up quickly at least to the official poverty line and eventually to the Bureau of Labor Statistics Low Living Standard. We also urge that pending achievement of a higher Federal level of benefits, states be required to supplement at least to their June, 1971 level of grants, including the cash value of the food stamps bonus. To insure that states can meet this requirement there should be Federal participation in the costs of such supplementation.

We do not see the necessity of substituting a quarterly review of eligibility for the current annual review of this group of recipients whose need is by definition of a long-term nature and whose circumstances are not likely to improve. Such frequent review is costly and time-consuming, and in our opinion constitutes unnecessary harassment and demeanment of these most vulnerable citizens.

We recommend to the Committee that the positive features of this Title be retained in a future plan for welfare reform.

Position on Title IV and Title V.—Family Assistance Plan (FAP), Opportunities for Families (OFF)

While FSAA supports the principles of 1) Federally financed and administered assistance payments with nationally uniform eligibility requirements, 2) the supplementation of earnings of those whose efforts at self support yield too little income, and 3) the objective of encouraging and facilitating self support when possible, we do not find the actual provisions of these Titles achieving any of these goals to any effective degree. We do find the proposed system more complex than the existing system, with greatly increased administrative costs. The detailed controls imposed on the lives of recipients reflect a general attitude of mistrust and blame for their situation to be placed squarely on the people themselves without any consideration of the realities of our society. Therefore, we strongly urge that Titles IV and V be stricken in their entirety from HR 1. We also strongly urge that the Congress and the Administration take a wholly new look at the welfare system, depending much more widely on the opinions and recommendations of organizations and individuals experienced in the delivery and consumption of services in the field of human services, voluntary as well as governmental, in developing an equitable, humane plan that will serve our people well and restore some measure of our faith and pride in this powerful and affluent nation.

The following Family Service Agencies have requested that the U.S. Senate Finance Committee be advised that they also concur in the foregoing statement:

Northern Virginia Family Service, Falls Church, Virginia.
Jewish Family Service, Philadelphia, Pennsylvania.
Family Services, Inc., Winston-Salem, North Carolina.
Family Service Bureau of Newark, New Jersey, Newark, New Jersey.
Family Service of Philadelphia, Philadelphia, Pennsylvania.
Jewish Family Service, New York, New York.
Family Service of Rochester, Inc., Rochester, New York.

The following individual wishes to associate himself with the foregoing statement:

J. B. Brannen, Executive Director Family Service of Amarillo, Texas, Amarillo, Texas.

SUMMARY OF STATEMENT OF AMERICAN ASSOCIATION OF BLOOD BANKS (AABB)

1. The motivation and recruitment of sufficient voluntary blood donors to keep pace with the increasing demand for blood is the main problem facing blood banks today. In a nation of over 200 million people, with more than 100 million individuals qualified to give blood, only 3% of the eligible population are blood donors.

2. Recent studies indicate that blood from commercial sources is 10 times more likely to transmit hepatitis through blood transfusions than from blood obtained from voluntary donors.

3. The Hepatitis Associated Antigen Test for the identification of blood that may be a carrier of serum hepatitis is estimated to be only 20–30% effective.

4. The public expects blood to be available and safe when needed for transfusion. To meet the increasing demand for quality blood, banks must get more voluntary donors. Blood is only available because of another individual's willingness to give.

5. Throughout the United States non-profit blood banks offer to individuals, families and groups, blood assurance programs which will cover their blood and blood component requirements for a period of a year or more through voluntary blood donations.

6. To nourish voluntary replacement of blood, most blood banks place a monetary value on the blood itself—a blood replacement or blood deposit fee. This fee is kept relatively high, not to provide greater income for blood banks, but to provide a strong incentive to patients to seek blood donors. When blood replacements are made, or previously established credits are released in the patient's name, the fee is refunded or credited to the patient's account.

7. It is imperative that positive efforts be made to encourage voluntary blood donations in advance of need (predeposit and blood assurance programs), and to retain the moral and financial obligation for patients to replace blood they receive with blood, not dollars.

8. Blood banks cannot transfuse dollars. Monetary payment of the blood replacement fee by private health insurance or the Government indirectly forces blood banks to turn to the use of paid donors or commercial blood sources in many communities.

9. Providing payment for blood and components under any proposed National Health Insurance plan will result in the increased use of commercial blood and the associated risk of increased hepatitis.

10. The AABB urges the Government's support in preserving the principle of voluntary blood replacements, and strongly recommends that the payment for blod itself (replacement fee) and for blood components not be included in any National Insurance legislation.

11. The AABB urges the Senate Finance Committee to continue the blood deductible provision of Medicare and to consider the extension of this deductible provision to Medicaid.

STATEMENT

INTRODUCTION

The American Association of Blood Banks (AABB) is a non-profit medical professional organization with a membership of over 5000 including hospital and community blood banks and transfusion services throughout the United States, as well as physicians and other individuals closely allied to the field. It is the largest national organization devoted exclusively to blood banking.

Member institutions of the AABB collect more than half of the nation's total blood needs, and these factilities report a combined annual blood usage of more than 6 million units of blood and blood derivatives.

The AABB as well as the American Red Cross, the American Medical Association, American Hospital Association, College of American Pathologists and others, support the concept of voluntary blood donations from persons to replace blood used by a relative r friend; to establish protection against future blood needs for themselves and their families, or to fulfill a community responsibility.

MEDICARE

The original Medicare Bill (Title 1, H.R. 1) was amended to provide for a deductible in an amount equal to the cost of the first three pints of whole blood furnished for an individual during a spell of illness. As stated in the Report of the Ways and Means Committee (House Report No. 213, 89th Congress, First

Session), this deductible provision was included "in the interest of the voluntary blood replacement programs which encourage donations of blood by waiving charges for blood which the patient arranges to replace."

The blood deductible provision of the Social Security Act was subsequently amended by Public Law 90-248, 90th Congress, January 1968, to provide for a deduction equal to the first three pints of whole blood *or equivalent quantities of packed red blood cells.*

This recognized that important blood components are only derived from whole blood. Most hospitals and community blood banks also place a monetary incentive or replacement fee on blood components to encourage patients to seek replacement donors since the fee is refunded or credited to the patient's account upon receipt of the blood donation(s).

BLOOD DONOR INCENTIVE

The payment for whole blood or blood components removes the responsibility from the patient to recruit replacement donors from among their family or friends. Since you cannot transfuse dollars, payment makes blood banks more dependent on paid donors or commercial sources of blood to supplement their requirements. Such a trend does not assure a safe, adequate and economical blood supply and is detrimental to the public interest.

The services provided by blood banks are unique since people are the only source of human blood and the blood banks must depend on the willingness of individuals to give blood to meet the needs of patients requiring transfusions. Although blood may be paid for, payment cannot assure that blood will be available when required unless sufficient incentive is provided for individuals to make blood donations. It was for this purpose that the AABB developed the enclosed brochure "Supply, Demand and Human Life", which you will note is endorsed by the Public Health Service, Department of Health, Education and Welfare.

The need for blood in the United States is increasing at the rate of 10-12 percent a year and there is a need for more voluntary blood donors. While patients covered by the Social Security Act may themselves be ineligible to give blood, it should be remembered that the majority have families or friends who are eligible, or often belong to business, fraternal or social groups which maintain donor club accounts with various blood banks. Also, through the mechanism of the AABB National Clearinghouse Program, replacements can be recruited anywhere in the United States to transfer to the patient's account.

DONOR MOTIVATION AND RECRUITMENT

The motivation and recruitment of sufficient voluntary donors to keep pace with the increasing demand for blood is the principal problem facing blood banks today. More than 7 million units of blood are required annually to meet the nation's blood requirements. Yet in a nation of over 200 million people with more than 100 million individuals qualified to give blood, only 3% of the eligible population are blood donors. It is obvious that not enough people are motivated to give blood.

USE OF COMMERCIAL BLOOD AND PAID DONORS

Within the last year, a great deal has been written about bad practices in blood banking, particularly with respect to commercial blood banks and the inherent risks of using paid donors.

Recent studies have indicated that it is 10 times more likely to transmit hepatitis through blood transfusions provided by blood from commercial sources than from blood obtained from voluntary donors. Commercial blood programs attract donors from a population composed largely of people living on marginal incomes or less, and who generally live in crowded slum areas where addiction to alcohol and drugs are common environmental problems. Such individuals are far more likely to become exposed to hepatitis, and to lie about their medical con-

dition to collect the payment of $5, $10 or more for their blood, than a voluntary blood donor.

Although a test for hepatitis known as the Hepatitis Associated Antigen is now being used routinely in all blood banks, the sensitivity of this test is estimated to be only 20-30% effective. This test reduces the possibility of using infected blood, but far from eliminates the problems associated with the use of paid donors.

It is estimated that 15–20% of the blood used in the United States is obtained from commercial sources; in some parts of the country, the percentage is as high as 50%. In Washington, D. C., there was a commercial blood bank which drew blood from paid donors locally and shipped it to Chicago for use. (The needs of Washington hospitals are provided by the Washington Regional Red Cross Blood Center, and by hospital blood banks which are affiliated with the non-profit Metropolitan Washington Blood Banks program.)

The Chicago Tribune recently ran a series of articles focussing on commercialism and other bad blood banking practices. Because the news media is increasingly bringing these problems to the attention of the public, several bills have been introduced into the current Congress with the sincere aim of discouraging commercialism in blood banking. *The problem, however, will not be solved until sufficient blood can be obtained from voluntary donors to meet the nation's total blood needs.*

VOLUNTARY DONOR CONCEPT

The two principal organizations in the United States which collect blood from voluntary donors are the American Association of Blood Banks with its more than 1500 hospital and community blood bank members, and the American National Red Cross, which among its other activities, operates 59 regional blood centers. The two organizations each collect about half of the blood used in the United States.

The Government also has been a strong supporter of encouraging the voluntary donation of blood. For the past two years the Congress has passed a joint resolution to have the President proclaim January as "National Blood Donor Month." "Giving Blood Saves Lives" was one of the last commemorative appeals of the U.S. Post Office Department. Over 135 million of these commemorative stamps were sold. Its purpose was to encourage more generosity from the 100 million potential donors of blood.

VOLUNTARY BLOOD REPLACEMENTS

Blood is only available because of another individual's willingness to give. It is imperative, therefore, that positive efforts be made to encourage voluntary blood donations in advance of need, and to retain the moral and financial obligation for patients to replace blood they receive with blood, not dollars.

To nourish the voluntary replacement of blood provided for transfusion, most blood banks place a monetary value on the blood itself—a blood replacement or blood deposit fee. This fee is kept relatively high, not to provide greater income to blood banks, but to provide a strong incentive to patients to seek blood donors. This fee is refunded or credited to the patient's account when blood replacements have been made or previously established blood credits have been released in the patient's name. A replacement fee is not charged within the ARC Blood Program; however, many individuals give to their local Red Cross centers to replace blood provided to friends and relatives because the transfusing hospital charges a blood replacement fee.

PAYMENT FOR BLOOD ITSELF

There are an increasing number of companies that provide private health insurance plans which include payment for the blood itself (the replacement fee) in addition to blood bank and hospital fees stemming from the cost of processing

and transfusing blood. The latter are legitimate cost expenses which should be provided for by health insurance. Payment of the blood replacement fee, however, defeats the very purpose for which it was established. This means that instead of voluntary blood replacements, blood banks receive monetary payment from insurance companies. Blood banks cannot transfuse dollars. Such insurance plans, therefore, indirectly force blood banks to turn to the use of paid donors or commercial sources in order to maintain adequate blood supplies to meet the need of patients in many communities.

NATIONAL HEALTH INSURANCE

A number of bills introduced on National Health Insurance provide for the payment of all blood and blood components used. Other bills provide for a limited deduction for whole blood and red blood cells.

As with private health plans that pay for the blood itself, such plans will foster the "buying and selling" of blood and "dry up" the voluntary blood supply. Providing for the payment of blood and blood components under National Health Insurance can only result in the increased use of commercial blood and the associated increased hepatitis risk by eliminating the patient's financial incentive to solicit blood donation replacements from his friends and relatives.

The Association strongly recommends, therefore, that the payment for blood itself (replacement fee) or for blood components not be included in any National Health Insurance legislation, in order that patients receiving blood can be held responsible to obtain voluntary donors to replace the blood or components they use.

A moral issue also is involved. Blood is living human tissue, and blood transfusions constituted the first successful transplants. As such, blood should not be bought and sold. With each advance in transplant surgery, it becomes more meaningful and more necessary for all of us to defend this principal. If this is not done, we may see price tags on hearts, kidneys, lungs, and other parts of the human body.

To meet the increasing demand for quality blood, the voluntary donor concept for blood must be preserved. To do this, we need a concerted nationwide effort of individuals and organizations involved in blood banking, as well as the cooperation of business, industry, labor unions, health professionals and the Government. It is with this goal in mind that the AABB recently announced a massive public education program to increase voluntary blood donations for the benefit of blood banks throughout the nation.

We recognize the fact that it is not the role of the Congress to legislate morality. Conversely, the Government does not have the right to impose on its citizens legislation that would erode the quality of medical care. The public expects blood to be available and safe when needed for transfusions. Hepatitis is a serious illness anytime a person contracts it. But if a patient gets hepatitis from a trasfusion of bad blood, it can be fatal. If blood is to be safe, blood banks must get more volunteer donors.

All of us should have a personal commitment to a strong voluntary blood program, for from birth to death we never know when one of us may need a blood transfusion, be it for one unit or 50 or more units. When we are in good health, we should demonstrate our concern for others by giving blood ourselves and by encouraging others to make voluntary blood donations.

The Senate Finance Committee is respectfully requested to support the continuation of the voluntary donor concept which is the backbone of blood banking as we know it today and the continuation under Medicare, and extension of the present legislation regarding blood deductibles to Medicaid. Such actions will result in more blood as well as minimizing the risk of transfusion hepatitis and in a financial savings to the Government.

WILL BLOOD BE AVAILABLE WHEN YOU NEED IT?

The next person to need blood could be you! You may use 20 pints. You may use two. Regardless, your need is just as great.

If you believe that your immediate need for blood is remote, consider that each and every day more than 13,000 units of blood are transfused in the United States—nearly 6,000,000 units per year.

The demand for blood increases, yet it is estimated that the annual blood requirements of the nation are provided by less than 3% of the eligible donor population of the United States—approximately 3,000,000 donors.

The nature of blood is such that it must be transfused in its whole state within 21 days after being drawn, and the blood given to a patient must be compatible with his own blood group and type.

Unless more people become donors, the supply will not keep pace with the growing *demand* for blood. Someday your *life* may depend on its availability.

To assure that blood will be there when you need it, give blood now and encourage others to become voluntary blood donors.

Artist Charles Lewis uses the symbol of a patient's outstretched arm seeking life-saving blood to depict the great need throughout the United States for more voluntary blood donors.

BLOOD BANKS

A blood bank is a medical facility which draws, processes, stores and distributes human whole blood and its derivatives. Some blood banks also perform other services and administer blood transfusions.

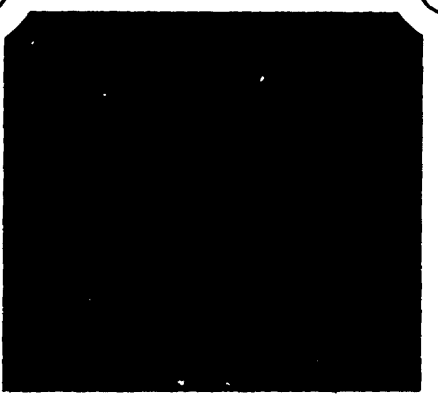
Hospital blood banks are self-operated and function primarily to meet the blood needs of their own patients. Many hospital banks depend on other facilities to supplement their blood supplies.

Community blood banks are usually locally organized and operated to serve the blood needs of a majority or all hospitals in a community.

Most hospital and community banks are members of the American Association of Blood Banks. These banks supply about half of the blood used each year in the United States. The other half comes from regional blood centers of the American National Red Cross. A very small percentage of blood is supplied by commercial banks which are privately owned. With the exception of the latter, most blood banks are nonprofit and depend primarily on voluntary blood donors.

Through a National Clearinghouse Program of the American Association of Blood Banks and a reciprocal agreement between the AABB and the American National Red Cross, banks can exchange supplies from one area to another to balance blood surpluses or shortages. The clearinghouse program also enables a blood donor to replace blood for a patient receiving a transfusion in most any area of the country. For example, you can donate a unit of blood in Hawaii for someone undergoing surgery in New York and have the credit transferred through the program to the patient's account.

These facilities operate to protect you against the unexpected. Support your local bank by giving blood.



THE VOLUNTARY DONOR

You cannot put a price tag on the life of someone you love. Money, the best medical skills and all the newest, most spectacular drugs often are not enough to save a life without the gift of blood which can only come from another human being.

Most banks obtain blood from persons who give voluntarily to replace blood used by a relative or friend, to establish protection against future blood needs for themselves and their families, or to fulfill a community responsibility. Some banks also obtain blood from paid donors. A few banks sponsor plans which provide future blood protection for an annual blood donation or cash premium. Cash payments, however, cannot assure a safe, adequate and economical supply. **Therefore, the voluntary blood donor is still considered the backbone of blood banking today.**

The following organizations know the importance of voluntary donations and urge healthy people to be blood donors:

American Association of Blood Banks
American Hospital Association
American Medical Association
American National Red Cross
Blue Cross Association
Health Insurance Council
National Association of Blue Shield Plans
Public Health Service, U.S. Department of Health, Education and Welfare.

WHAT IS BLOOD AND WHY IS IT SO IMPORTANT?

Blood can do wonderful things. It is composed of trillions of tiny cells suspended in a watery fluid called plasma. Red cells carry oxygen from the lungs to all parts of the body. White cells fight off disease and infection. Platelets help blood to clot when bleeding occurs. The plasma also contains proteins, required to control bleeding, and other essential materials.

To fully meet the needs of physicians and surgeons, blood of every group and type must be available at all times. Donors often respond when there is a special need or emergency. *But blood banks depend much more on donors who are willing to give to meet day-by-day blood needs.* Banks throughout the country must rely on a constant stream of donors to keep a "river of blood" flowing each day.

No substitute for blood has ever been developed. The only source is still the human body. As long as blood cannot be manufactured, blood banks must depend upon people like you to assure an adequate blood supply.

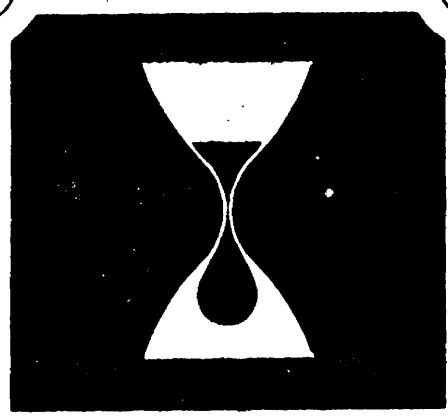
GIVING IS SAFE AND SIMPLE

Nature makes it easy to give blood. An average person has about 10 to 12 pints in his body. A normal donation is about one pint. Medical authorities say that donating a unit of blood quickly stimulates a healthy person's bone marrow and his blood count is as normal after the donation as before.

Under medical supervision, the collection of blood is made by a medical technologist, or a nurse. The procedure is simple and safe. The entire process takes less than an hour.

After you have given blood, you receive a card which lists your blood group and Rh type. This is important as the blood of every human being is almost as distinctive as his fingerprint.

The giving of blood can be a satisfying and rewarding experience for you.



DON'T WAIT—DONATE!

Although most people have blood to share, many are not blood donors because they have not experienced the need for blood or they are apprehensive about the needle. However, millions of individuals are living today because of donors who have overcome their fears and realize the importance of giving blood. Blood donors are *special people.*

The need for blood increases daily. The balance between *supply, demand and human life* depends on blood donors. Your physician, hospital or local blood bank can give you more information and answer any questions about blood and blood donations.

Make a date with your local blood bank now. Don't wait—donate!

This brochure is made available as a public service by the

AMERICAN ASSOCIATION OF BLOOD BANKS

30 North Michigan Avenue

Chicago, Illinois 60602

STATEMENT OF THE AMERICAN PODIATRY ASSOCIATION PRESENTED BY ERNEST M. WEINER, D.P.M., PRESIDENT

INTRODUCTION

Mr Chairman and Members of the Committee: I am Dr. Ernest M. Weiner, President of the American Podiatry Association and a practicing podiatrist in New York City. The American Podiatry Association is a voluntary, non-profit organization, established in 1912 and composed of fifty-three (53) component societies—one in each state, the District of Columbia, Puerto Rico, and a society for podiatrists in Federal Service.

The Social Security Amendments of 1965 and 1967 represented a significant beginning by the Federal government to improve for the nation's aged and disadvantaged citizens the accessibility of needed health services; and though health services available and delivered to these individuals have increased during the last four years, questions of program efficiency and quality remain as overriding national concerns.

The American Podiatry Association supported, and continues to support, the principles embodied in Medicare and Medicaid; but the Association equally recognizes and endorses the necessity for revisions in the law to hasten the attainment of an essential national goal—comprehensive health services for all citizens regardless of economic status. Certainly, the impetus H.R. 1 would give to prepaid group practice is among the more important of the bill's major features.

In recognition of this necessary and challenging assignment, the American Podiatry Association commends the Committee for its 1970 report, Medicare and Medicaid, problems, issues, and alternatives. With few exceptions, the report's recommendations provide extensive and constructive guidance for remedying many shortcomings of both Titles XVIII and XIX. And it is to the further credit of the Committee that H.R. 1 embodies many of the same recommendations included in the Committee's staff report.

The American Podiatry Association is cognizant of the many current program weaknesses which H.R. 1 proposes to correct. But recognizing the Committee's desire to conserve time and avoid repetitious testimony, I will restrict my statement to those program areas which require remedial action if quality foot health services are to continue to be efficiently delivered to the beneficiaries of both Medicare and Medicaid.

First, however, we would urge the Committee to consider and remedy one major flaw in H.R. 1, a bill which we generally support as both responsible and constructive. I specifically reference the bill's repeal of the Medicaid provision requiring states to have comprehensive Medicaid programs by 1977. In our opinion, this provision should be retained as a meaningful goal toward which society should strive to achieve, whether the mechanism be Medicaid as we currently understand it, or an improved substitute. The American Podiatry Association supports, as we know individual members of this committee support, the desirability of this goal. That it may require periodic postponement is one thing; to eliminate it entirely is at best regressive and repugnant to millions of Americans who deserve and require its benefits. *Not only do we encourage the retention of this essential aim, we urge that every effort be extended to attain it prior to the conclusion of this decade.*

Administrative Policy Recommendations

On the specific subject of podiatrists' services, the American Podiatry Association has devoted considerable time and effort to assure the meaningful participation of podiatrists in Title XVIII and XIX. Countless meetings with our membership, carriers, and appropriate federal officials have been held to interpret and clarify regulations, to resove misunderstandings, and to seek counsel on specific problem areas. These productive experiences convincingly underscore the vital importance of close cooperation among carriers, the Social Security Administration, and podiatrists as we strive to accomplish mutual objectives. And according to our podiatry carrier consultants, these relationships could be made even more productive if the Social Security Administration would employ on a regular basis the services of consultant podiatrists; and both the Health Insurance Benefits Advisory Council and the Medical Assistance Advisory Council had podiatrist representatives.

We are pleased that these recommendations have also attracted increased interest at HEW, as evidenced by the Medical Services Administration's appoint-

ment of a podiatrist-consultant to advise MSA on the planning for and delivery of podiatric services under Medicaid. We are confident that such policy, if implemented in other federal health programs where podiatrists' services are an important part, could immeasurably strengthen both the quality and efficiency of important health services under public supported health insurance and assistance programs. We are therefore hopeful that our specific recommendations earlier advanced can be swiftly accomplished to achieve this objective.

Peer Review

We heartily endorse the Committee's recommendation to make peer review a more effective instrument for evaluating the quality and efficiency of health care. Since 1960, the American Podiatry Association has formally engaged in peer review activities in cooperation with carriers representing public and private insurance programs. More recently, however, the Association has underwritten a national indemnity plan for the protection of its peer review bodies in the performance of their arrangements. To our knowledge, we are the only professional association with such an indemnity program. This is in keeping with our long standing objective to assure the highest quality podiatric care at the most reasonable cost for all citizens.

In pursuit of this objective, our experiences during the past 12 years have clearly revealed that, *where peer review committees and carriers work hand in hand, quality and efficiency result, the interests of the public are fully protected, problems are more readily detected, and remedial measures, when required, are more effectively applied.*

Conversely, however, where such a spirit of cooperation does not prevail, where peer review is lacking or is viewed only as a "court of last resort" and not as a bonafide preventive mechanism, the potential for abuse, indeed abuse itself, sharply increases. Though quality care is the primary and moral responsibility of the concerned health professions, cooperation among all concerned parties—patients, carriers, and providers of health care—is the most essential requisite for any successful peer review program. In this regard, the absence of any federal guideline with respect to peer review activities under public supported health programs has retarded the effectiveness of peer review. This problem must be overcome. *And we urge HEW—in cooperation with the concerned health professions—to develop and implement meaningful guidelines to improve the effectiveness of peer review.*

We are aware that there have been abuses of both the Medicare and Medicaid programs. And where the evidence has been justified, our component societies have taken prompt and effective action in response to these circumstances. We seek to cooperate at all times with all concerned parties to assure the delivery of high quality and needed podiatric services. And we fully support, therefore, H.R. 1's recommendations to prevent and control program abuses.

I must reference once again, however, that where close working relationships have existed between peer review committees and carriers, both public and private, problems have been minimal and oftentimes non-existent. Thus whatever can be meaningfully done to strengthen peer review by promoting closer cooperation between the public and private sectors has our unequivocal support.

Professional Standard Review Organization (PSRO)

A partial solution to his problem was recently filed with the Committee in the form of an amendment to H.R. 1. Authored by Senator Bennett, this amendment would establish at the local level Professional Standard Review Organizations (PSRO) to improve the coordination and conduct of professional review mechanisms. And though the American Podiatry Association supports the concept embodied in the amendment, we are nonetheless deeply concerned with specific features of the amendment as presently drafted.

In its stated purpose, each local PSRO would have the responsibility for reviewing all services for which payments may be made under the Social Security Act. In discharging this responsibility, the PSRO is called upon to determine the medical necessity of the services involved and to judge their conformity to "professionally recognized standards of health care."

The amendment further stipulates that, in making PSRO designations at the local level, the Secretary of HEW must give first priority to local medical societies or subsidiary organizations. Only when such groups are either unwilling or unable to accept such PSRO responsibility would the Secretary make such

agreements with other private nonprofit, or public agencies with similar professional competence. Yet the role of other health care practitioners, including podiatrists, in this review process has either been overlooked or totally obscured in the amendment. And we strongly object to this aspect of the amendment.

The 1967 Medicare amendments to the Social Security Act expressly provided for the inclusion of the podiatrist within the definition of the term "physician." This legislative act gave recognition to the fact that the doctor of podiatry, as well as doctors of medicine, osteopathy and dentistry, has the independent right to diagnose and treat by medical, surgical and other means, subject, of course, to the applicable state law. Accordingly, it follows that the medical necessity for the services performed by these practitioners is primariy a matter of their own professional judgment.

We fully support this concept as one significant way to assure the efficient and qualitative delivery of health services, regardless of the means of payment for these same services. But such review procedures can and should be made by the practitioner's own colleagues, employing the well-established methods of peer review.

Section 1152(b) of the proposed amendment refers to qualified professional standards review organizations as being primarily composed "of physicians engaged in the practices of medicine or surgery." Yet, the same section mandates that the organization have "available professional competence to review health care services of all types and kinds." It is apparent that to be effective and meaningful in the case of podiatric services, this task must be performed by members of that profession.

While the use of the term "physician" in the proposed Section 1152(b), when read together with the summary, appears to exclude podiatrists, the word "physician" occurs elsewhere in the amendment without additional explanation. To further complicate the matter, a new term, "health care practitioner," is introduced for which no definition at all is provided.

As we have earlier stated, the American Podiatry Association has long been active in the peer review facets of health insurance programs. We believe that our members' experience will make a significant contribution to the effective application of review standards to services authorized under the Social Security Act. However, to most effectively discharge this responsibility, the amendment as presently written must be strengthened to assure the involvement and full participation of other health care practitioners, including podiatrists, in PSRO activities. Such a change must include, though not necessarily be limited to, a clear definition of "physician" in the amendment, employing for this purpose the precedent established in Title XVIII of the Social Security Act.

Legislative Recommendations—Medicare

In addition to the aforementioned recommendations, there are additional legislative proposals which, if enacted, would decisively improve the delivery of foot health service under Medicare and Medicaid.

Following the enactment of P.L. 90-248, which added podiatrists' services to the physician benefits of Medicare (Title XVIII, Part B), the elderly were afforded important program benefits. Experiences to date, however, have exposed certain inadequacies with respect to the administration and provision of foot health services under Medicare; and to continually assure quality foot health services for the elderly, it is essential that these problem areas be remedied.

Section 1862 of the Social Security Act lists the services excluded from coverage under the Medicare Program. However, podiatrists' experiences have clearly demonstrated that present exclusions neither control costs nor assure that only necessary foot care is furnished. Instead of considering the treatment of the foot on the same basis as other parts of the body, Section 1862 (paragraph 13) employs language which even five years after enactment defies clear interpretation. As a result, the Social Security Administration is still seeking the correct application of this paragraph to specific problem areas. *It is our recommendation that the Medicare Program, like other health insurance plans, provide for complete, medical and surgical care of the food, as is the case for other parts of the body.*

Secondly, a conforming amendment to Title XVIII, Section 1861(b)(4), is required to bring podiatric inpatient hospital services in line with other physicians' services. This section enables a hospital under Part A to be reimbursed for the reasonable costs of the services of interns and residents in an approved

teaching program. However, Section 1861, which identified the various accrediting agencies that approve such programs, inadvertently omits the Council on Podiatry Education of the American Podiatry Association. This oversight should now be corrected. *The Association's Council on Podiatry Education, recognized by the U.S. Office of Education and the National Commission on Accrediting as the national accrediting agency for podiatric education programs, should be specifically included in Section 1861(b)(4) of the Act.*

Legislative recommendation—Medicaid

Podiatrists now participate in thirty-nine of the fifty-two approved state Title XIX programs. And our experiences have clearly demonstrated a lack of consistency between the Medicare and Medicaid programs. I refer specifically to the lack of uniformity in the Act's definition and interpretation of the term "physician."

Section 1861(r) of the Act includes the podiatrist under the term "physician" for the purposes of Title XVIII. Title XIX, on the other hand, does not define the term "physician." Instead the meaning of the term has been left to administrative interpretation. The result has been to exclude the services of podiatrists from the meaning of "physician services" for purposes of Title XIX. This particular lack of consistency has produced serious consequences for carriers, administrators, and—most importantly—the program's beneficiaries.

A specific example of this problem is the Medicare "buy-in" arrangement, in which more than forty states participate. These states, by paying the Medicare Part B charges, qualify the elderly poor for Medicare benefits, including podiatrists' services which are defined as physicians' services under Title XVIII. Yet in many of these same states, Medicaid beneficiaries under 65 are denied a podiatrist's services.

We recommend that this inconsistent application of the law be remedied by amending Title XIX for the purpose of defining the term "physician" to include the podiatrist.

SUMMARY

In conclusion, Mr. Chairman, I fully appreciate the massive but essential task with which your Committee is charged and as each of us realizes, the achievement of a national health policy, one which assures every American equal access to quality health care, will not be easily or quickly accomplished. Yet it is imperative that the nation responsibly build on an already impressive record by immediately responding to Medicare and Medicaid's inadequacies, which—as far as podiatrists are specifically concerned—must summarily include:

Reinstating in H.R. 1 the requirement that states accomplish by 1977 comprehensive Medicaid programs.

Providing a podiatrist-consultant to the Social Security Administration and assuring podiatrist representation on both Health Insurance Benefits Advisory Council and the Medical Assistance Advisory Council.

Improving the effectiveness of the Professional Standards Review Organization concept by assuring the involvement and full participation therein of the various health care practitioners participating in federal health insurance and assistance programs.

Amending Section 1862 of the Social Security Act to provide for complete medical and surgical care of the foot, as is the case for other parts of the body.

Amending Section 1861(b)(4) of the Social Security Act to identify the Association's Council on Podiatry Education as the national accrediting agency for podiatric education programs.

Amending Title XIX of the Social Security Act for the purpose of providing a definition of physician which would include the podiatrist.

The American Podiatry Association is grateful for the opportunity to present its views on this vital subject and looks forward to cooperating with the Committee and the Congress in providing improved health care for all Americans.

STATEMENT OF THE NEW YORK WOMEN'S BAR ASSOCIATION

Child care facilities

This organization is on record in favor of U.S. subsidized child care facilities for everyone, both poor and middle class. We believe that those who can afford to pay for such services should pay a reasonable fee for them.

Household and dependent care expenses

This organization heartily commends the Senate Finance Committee for adding to the Revenue Act of 1971 provisions that substantially liberalize the child and dependent care expense deduction under section 214 of the internal revenue code. However, the requirement of itemizing deductions makes this liberalized deduction of relatively little use to the low-income wife and mother. And the income limitation renders it of little use to middle-income wives and mothers.

We believe that child and dependent care expenses are truly business expenses of a working woman. The Senate Finance Committee Report on the '71 Act said that "these expenses . . . are to some extent like an employee's business expenses." We submit that these expenses are as real business expenses of a working mother as the salary she pays her secretary.

We therefore recommend that the deduction for household service and dependent care expenses be made a section 62 deduction, deductible in arriving at adjusted gross income, and that the income limitation be raised to at least $35,000 before the phaseout begins.

Social Security costs and benefits.

Under the present system, no one pays more for social security than a man and woman who both work. At the 1972 wage base of $9,000, a man and wife who each earn $10,000 a year will pay a combined social security tax of $936. If the wage base goes up to $10,200, and the rate goes up to 5.4%, as provided in H.R. 1, their total tax bill be $1,080.

On the other hand, if a husband made $20,000 a year, and his wife didn't work, their 1972 tax bill under present law would be only $468. At the proposed higher base and rate, their bill would be only $550.80.

The benefits the working couple get in return for their high taxes will be greater than those received by the couple with the non-working wife, but not in proportion to the high cost to them of the insurance. They will receive 200% of the basic benefit, whereas the couple with the non-working wife will get 150% of the basic benefit.

The inequity is quite great. We recommend that, to end this inequity, the working couple receive an annual credit against their income tax equal to 25% of the total amount of social security taxes they pay. Such a credit would not interfere with the collection of the tax, or lessen the amount the employer pays. But it would make the amount of tax paid bear a much closer relation to the benefits to be received.

Head of household.

Despite the liberalization of head of household and unmarried individual rates in 1969, the burden borne by single people is still too great. We recommend that anyone who actually contributes more than half the support of a household should have the benefit of the head of household rates.

Submitted by Florence B. Donohue, Chairman, Committee on Taxation and the Working Woman, New York Women's Bar Association, February 14, 1972.

STATEMENT OF THE NATIONAL LEAGUE FOR NURSING, COUNCIL OF HOME HEALTH AGENCIES AND COMMUNITY HEALTH SERVICES

The Council of Home Health Agencies and Community Health Services of the National League for Nursing is the national spokesman for approximately 1,400 home health agencies and community health agencies. These agencies provide health services to people outside of hospitals; in other words, in patients' homes, in schools, public health clinics, and other community settings.

Excessive Utilization

It is unfortunate that Medicare has perpetuated the problems created by voluntary health insurance programs that traditionally have given the highest priority to hospitalization as a covered service. This emphasis on hospitalization has increased not only the utilization of hospitals but also their costs. Between 1940 and 1965 the number of general hospital admissions on a per capita basis doubled. Over the past five years hospital costs have doubled. Under Medicare the financial incentive is for hospitalization even though care in the home would be more appropriate in the case of countless patients.

There are many elderly individuals with varying degrees of chronic illness, who could be maintained at home if reimbursement for broad home health services were provided. The denial of reimbursement for intermittent skilled nursing services and other therapeutic services to these individuals in their homes under Medicare has, in many instances, forced them into a hospital or extended care facility at a much higher cost to the taxpayer. In the long run, it costs more in both human misery and hard cold cash to institutionalize our senior citizens than to provide an adequate program of home health services.

Senator Bennett on January 25, 1972, reported that a survey in New Mexico showed that 35 percent of the Medicaid population in nursing homes were not in need of institutional care. We have reason to believe these figures apply equally to Medicare patients.

Restrictive Regulations

Furthermore, the limited benefits for home health services under Medicare have been curtailed sharply in the recent past through increasingly restrictive regulations of the Social Security Administration. Payment for needed services in the home is denied, frequently on a retroactive basis. Thus, the total reimbursements for home health services under Medicare are estimated to *decrease* from $79 million in 1969 to $50 million in 1971 while hospitalization reimbursements will *increase* from $4 billion to $4.5 billion in 1971. See below:

MEDICARE REIMBURSEMENTS FOR HOME HEALTH SERVICES AND INPATIENT HOSPITALIZATION, 1969-71

Year	Reimbursements in millions of dollars	
	Home health [1]	Hospitalization
969	$78.8	$4,039.5
970	67.4	4,425.8
971 [2]	49.5	4,538.5

[1] Includes pts. A and B.
[2] Estimated on the basis of data through Oct. 6, 1971.

Source: Social Security Bulletin, January 1972; vol. 35, No. 1. DHEW.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to:

Eliminate the three-day hospital stay requirement for home health benefits under part A; and

Authorize reimbursement for a comprehensive program of home health services to meet the health needs of hte elderly and decrease the utilization of hospital inpatient care; and require providers of inpatient health services to coordinate with community-based home health agencies to reduce unnecessary hospitalization costs.

Program Improvement

In many respects, the administration of Medicare as it relates to home health services is deficient. There has been little consistency in the regulations of Social Security Administration and a wide variation in their interpretation by fiscal intermediates. Too frequently a home health visit that was reimbursable in the past is no longer a covered service today. When payments are denied retroactively the home health agency finds itself in financial difficulty. The development of regulations and their restrictive interpretations is based upon what has been described as "the intent of Congress." We ask Congress to:

Clearly state its intent for medicare to provide for the maintenance and improvement of the health status of the elderly with coverage of the broad program of home health services.

Home health services are a part of the programs of three major administrative units of the Department of Health, Education, and Welfare. They are the Social Security Administration, the Social and Rehabilitation Service and the Health Services and Mental Health Administration. There is little coordination among the three programs and no provision for obtaining consultation from non-Federal organizations and agencies in the field of home health services.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to:

Provide for the establishment of a home health advisory committee of representatives of home health agencies to assist the Department of Health, Education, and Welfare in the administration and coordination of its home health programs.

Quality of Care

To improve the quality of home health services, the National League for Nursing and the American Public Health Association sponsor a national program of accreditation for community health services. The criteria are more comprehensive than those required for certification in Sections 1861 (m) and (o) of P.L. 89-97.

Home health programs should be required to participate in utilization review programs. Such participation is now required for hospitals and extended care facilities. The utilization review process has a great potential for improving the level of services and monitoring utilization.

An important aspect of any program with the objective of measuring the quality of health services is the active participation of those most experienced and qualified in the provision of those health services. It is also important to involve the public as consumers of health services in such programs.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to:

Identify NLN-APHA as the national accreditation body for home health services with an agency's accreditation accepted in lieu of certification;

Extend the utilization review requirement to home health agencies participating in medicare and medicaid; and

Modify amendment No. 823 relating to professional standards review organizations to require that review activities in the case of home health services be the responsibility of a multi-disciplinary health team experienced in the field of home health services with representation from the general public.

In conclusion, the Council urges that the scope of Medicare be expanded from the narrow concept of the treatment of acute illness, primarily inpatient, to a program designed to promote and maintain health through the prevention of illness and the amelioration of chronic conditions through a comprehensive program of home health services. Such an expansion would provide better health care for the elderly at a reduced cost.

STATEMENT BY MARTIN D. LOWENTHAL, DIRECTOR, SOCIAL WELFARE REGIONAL RESEARCH INSTITUTE, BOSTON COLLEGE

My name is Martin Lowenthal. I am Director of the Social Welfare Regional Research Institute at Boston College. The Regional Research Institute was established by a grant from the Social Rehabilitation Services Division of the Department of Health, Education, and Welfare in 1970 to undertake research on the subject of the employment and employment potential of welfare clients. Since that time we have been involved in a number of studies, including a study of what we already know on the subject of work and welfare, the evaluation of the new work registration program in the Commonwealth of Massachusetts, a study of the labor markets for women, particularly female recipients, a study of AFDC mothers who work and the factors in their lives that impinge on decisions about work and welfare, an investigation of the legal rights of women on welfare as they seek employment, and various studies on day care.

This testimony is based primarily on the studies conducted by the SWRRI. The major points of the testimony are the following:

1. *Work registration requirements which seek to limit the welfare roles do not work.* They unnecessarily harass clients, result in higher costs, are ineffective in moving people to self-support, and hamper the provision of employment services to those who want them and can best utilize them.

2. Generally accepted criteria for the determination of "non-employability," such as those contained in recent Amendment to the Social Security Act and in new legislation in Massachusetts and New York tend to increase the administrative problems and consequently the costs.

3. The use of State Employment Offices does not tend to be an effective way of getting people into jobs. Most people get jobs on their own efforts.

4. The ability of most AFDC family heads to meet the minimum income needs of their families through employment is quite low. This is due largely to the fact that the jobs available to them in the labor market tend to be low wage, irregular, and part time or seasonal. Significant interventions in the economy which would affect the unemployment rates and wages for nonwhite, poor whites, and women are necessary in order to move large numbers of welfare families to self-support through employment.

5. Persons who work their way off the assistance roles, but subsequently lose their jobs should become automatically re-eligible for assistance, within certain financial limitations.

6. A few state-wide pilot programs should be undertaken to work out the problems previously mentioned. Massachusetts might appropriate for this purpose because of its characteristics, its experience and its commitment to welfare reform.

Evaluation of the General Assistance Work Registration and Check Pickup Program in Massachusetts

This study was undertaken at the request of Commissioner Steven Minter of the Department of Public Welfare. In his charge to the Regional Research Institute, the Commissioner asked that an objective evaluation of the new General Relief—Division of Employment Security Program to restore employable General Relief clients to self-support, be undertaken at the outset of the program in October 1971.

The Program was initiated by the Legislature of the Commonwealth of Massachusetts in the late summer of 1971 by the following provision in the appropriations bill: "that after October first, nineteen hundred and seventy-one every person eligible for an assistance check under chapter one hundred and seventeen of the General Laws, determined by the department to be an employable person, shall receive such check from the nearest office of the division of employment security." Little, if any, formal study had preceded this provision so that its effects, problems, and possible approaches toward implementation were generally unknown.

SUMMARY OF FINDINGS

1. A great deal of human suffering and individual costs on the part of those clients who were unable to obtain their checks and often went long periods without sufficient funds to meet their minimal needs resulted from this program. In October 1971, of those people who did not pick up checks, 38.7% were ill, disabled, or hospitalized, according to two surveys on the first pay period of the program. Another 22.67% reported that they did not know of the new requirement and administrative errors by DES and DPW were involved in 15.5% of the cases. Approximately 17% were already working—those who were already working full time were not supposed to report, and part-time workers stated they were working at the time of the appointment with DES.

2. Even if the human costs are disregarded, the *administrative costs alone far exceed the savings in this program.* Administrative costs of the program in the local offices of the DPW alone run over $70,000 a month, according to our survey of the social workers in the Welfare Service Offices throughout the state. In reviewing over 1700 cases, the additional cost incurred by the local offices of the DPW as a result of the new GR–DES program is $1.69 per GR case per payroll period, or $3.38 per case per month. This comes to $7.96 per "unemployable" GR client in the month of December.

When the costs of the central administration, overhead, and those of the Division of Employment Security are added to this figure, it will probably come to two or three times this amount.

Liberal estimates of the possible savings through the program range from approximately $51,000 to $71,000 a month from those who do not pick up their check at the employment office without good cause and from those who find employment through this program. These figures tend to be somewhat inflated due to the fact that they are not adjusted for normal turnover in the General Relief program and assume that the average payments to these individuals are the same as those for the program as a whole. In fact the payroll for General Relief, not including vendor payments, went down only $48,929 from September through

December, which covers the first months of the program when the highest savings were expected.

3. Using generally accepted criteria for determination of "unemployability," the operational decision by the Department of Public Welfare to consider clients "employable" unless they could be determined to be "unemployable" inflated the number who had to report to DES, many of whom were subsequently determined to be unemployable. This involved additional costs to DPW, to DES, and to those clients who were unable to report due to illness and other reasons. Further, it placed the burden on the clients to prove to the Department that they were in fact unemployable and had good cause for not reporting to DES. This resulted in suffering for hundreds of clients and additional problems for the social workers to remedy incorrect classifications and check cancellations. The Department could have operated on the opposite assumption that clients were unemployable unless determined to be employable. Those who were seeking employment and were obviously employable could have been classified initially and then on the basis of a case-by-case intensive review, those who were found to be employable in the remainder of the caseload could have been so classified. This would have involved fewer errors which resulted in client hardships and marginally lower costs in following up incorrect classifications. Further, it would have permitted a phasing in of the program which would have allowed the Department time for training and revision of procedures where problems arose.

4. Only 524 clients actually obtained jobs as of December 31, 1971 covering ten weeks of the program. The average number of referrals from the Welfare Department per pay period was 7450 with the DES considering an average of 4763 "employable" by their standards. The average placement rate per pay period of those referred was only 1.4% and of those considered employable by DES only 2.2%. In addition, only 5 of the 20 clients surveyed, out of the 99 in Boston who got jobs in the beginning of the program, obtained employment through the services of DES. Fifteen reported that they had found jobs through their own efforts. In other words, of the small sample only 25% obtained their jobs through the new work registration program.

5. Our findings on the management problems in administering the new GR–DES program concern the Department of Public Welfare which asked the Institute to look at this subject. Six problem areas were identified which represent deficiencies in the administrative implementation of the program by DPW. These were the following: (1) overloading of DPW staff in the Welfare Sevice Offices (which is obviously due to the lack of additional funds for the administration of the program), (2) incompatibility of DPW and DES operational definitions of non-employability, (3) problems arising from changes in the General Relief payroll procedures, particularly the transitional problems due to the shift from the local Finance Units to a central computer system for the state, (4) inadequate information and training in the new payroll procedures for the WSO payroll clerks, (5) insufficient staffing, equipping, and procedures at the GR–DES Project Office, and (6) low staff morale resulting from the manner in which the changes in the General Relief program were developed and implemented.

One of the most difficult and time consuming problems in the new procedure for all parties—social workers, employment counselors, and clients—is the basic conflict between the operating procedures with regard to employability of the two agencies participating in the program. DPW operated as if a GR recipient is employable unless specifically exempted. The six categories of exemptions listed in the State Letter provided the grounds for deeming a recipient non-employable. In order to classify a client as non-employable the social worker had to fill out Form GR–DES 1—stating the reasons for the exemptions and verifying it. A worker is thus under severe pressure to place a recipient in the employable category unless he can produce written verification to the contrary in the recipient's file (i.e., in most cases, a doctor's letter). Then, and only then, is the recipient placed in the non-employable category.

However, DES operated on the opposite set of assumptions. Despite written instructions to the contrary, we found in practice that DES staff operate from the premise that a client is considered employable only if he is potentially employable, i.e., has work related characteristics—age, sex, previous work experience, education—which make it likely for him to be placed in a job or in a training program. Employment counselors at DES are under pressure to deem employable only those GR recipients who are likely to be placed and to deem non-employable those with little chance of placement. This approach serves two pur-

poses for DES staff. First it conserves staff time—the employment counselor does not have to continually see clients who are not likely to get jobs. Secondly, it produces good monthly reports—the rate of placements per number of active cases is not depressed by a large pool of clients who are not likely to get jobs.

The result of these conflicting agency positions is that many GR recipients find themselves constantly shuttled back and forth between the WSO and DES office. The worker classifies the client as employable and sends him to DES. At DES the employment counselor interviews the recipient, finds him or her not likely to be employed and sends their form back checked "non-employable." The worker must then follow up—find out why the recipient was marked non-employable and try to get verification in order to fit the recipient into one of the exemptions for non-employability. The recipient often does not qualify for an exemption and is sent back to DES where the process is repeated.

These findings for the state of Massachusetts are similar to those of a recent study of the new welfare-work legislation in New York state done by the League of Women Voters of the Rochester Metropolitan Area and the Center for Community Issues Research. Their conclusions about the program as it operated in Monroe County emphasized that the new regulations "have not resulted in substantial numbers of welfare recipients becoming self-supporting" and that the program "is costly to administer . . . in October, the additional administrative expenses of $S2,474 a month far outweighed the savings of $44,690 due to case closings."

LABOR MARKET STUDIES

The labor market studies of SWRRI reveal important connections between the welfare caseload and labor market conditions.. Unemployment rates exert pressures on welfare directly through AFDC-UP. through General Relief, and through AFDC as mothers are laid off, and indirectly through the impact of unemployment on family stability and organization. The structure of the labor force which is reflected in one way through wage differentials also creates a pressure to use welfare because of inadequate earnings of the millions of poor people. It also places limitaitons on the extent to which employment can be used as a way of reducing welfare costs and caseloads because of the restricted job opportunities and consequent low wages. The structure of labor markets and their differential effects on earnings and unemployment are a crucial factor in assessing both the employment potential of women on welfare and of the policies required to create meaningful opportunilites for work.

The implications of unemployment levels reveals a clear interdependence between labor market phenomena and the welfare system. Rising unemployment levels in a labor market result in increased demand for welfare. Individuals and women with families who formerly were able to support themselves are no longer able to find or to hold jobs.

A second area in which the unemployment rate affects the welfare system is the difficulty for welfare mothers to move out of the welfare system when unemployment is high. If no jobs are available, then employment programs, no matter how well designed, will face high costs and probable failure in efforts to induce movement off welfare.

Our labor market studies, under the direction of Professor Barry Bluestone, suggest that poverty is due in large part to the job opportunities available which tend to be concentrated in those industries and occupations which pay low wages, are often part-time, are irregular in their duration, and have poor working conditons. These peripheral jobs are filled by workers who make up a kind of peripheral labor force because only seasonal or part-time work is available to them, or because only temporary jobs or no work is available.

The relevance of this discussion of labor market operations to women welfare recipients is clear. Women are likely to be "peripheral workers," particularly women with children who need to work part-time or intermittently. The concentration of welfare women in the peripheral economy, the only labor market to which they have access because of needs, skills, location and experience, means that the wage rates available to them are likely to be low and the work conditions and promotion prospects poor.

The generally low occupational status of AFDC mothers is confirmed by all studies. Of those reporting previous employment in 1967, 48 percent had been service workers, almost 10 percent were unskilled laborers. The data on the participation rates of AFDC women reflected the pattern of the general popula-

tion with 19 percent of the nonwhite welfare women working and 12.5 percent of the white women in the labor force. However, the white mothers who did work, earnd more on the average than the black mothers who were employed.

TABLE 1.—AFDC MOTHERS IN THE HOME BY USUAL OCCUPATION

	Percentages	
	1967	1961
Total mothers in the home	100.0	100.0
Professional, semiprofessional, proprietors, managers, and officials	1.0	0.6
Clerical, sales, and kindred workers	9.4	5.8
Craftsmen, foremen, and kindred workers	.5	.5
Farmowners and managers	.1	.2
Farm tenants, renters, sharecroppers, and farm laborers	4.0	4.8
Operatives and kindred semiskilled and skilled workers	7.2	6.4
Service workers, except private household	18.7	16.3
Private household service workers	13.5	17.7
Unskilled laborers	12.6	10.5
Never held employment	24.9	31.2
Unknown	8.0	6.1

Source: U.S. Department of Health, Education, and Welfare "Preliminary Report of Findings—1969 AFDC Study," SRS, NCSS, March 1970; and U.S. Department of Health, Education, and Welfare, "Findings of the 1967 AFDC Study; pt. 1," SRS, NCSS, July 1970.

The earnings of AFDC mothers in 1967, when they were employed, were much lower than the median earnings of employed women in the general population. About half of the AFDC mothers employed were working full time, but earnings were not high enough to make the family ineligible for assistance. The average monthly earnings of all AFDC employed mothers was $135.00. The average was less than $100.00 in 12 states and more than $200.00 in only 4 states.

It is not possible to assess the family support potential of AFDC mothers without considering the experience of women in general in the labor market. Drawing data from U.S. Department of Labor reports, the following points emerge: (1) the labor force participation of women is largely related to age, marital status, presence and ages of children and education; (2) only 29% of mothers with children under 6 were in the labor force and only 25% of those with children under 3; (3) labor force participation by women increased with their educational levels; (4) in 1967, women were generally concentrated in relatively low-paying occupations; (5) 82% of employed women were in occupations producing median earnings for women of $3,700 per year or less; (6) the median wage for all women workers in 1967 was $2,295 with 75% earning less than $4,000 and 31% earning less than $1,000; (7) non-white women at all educational levels are more likely to have been employed than white women, but their median earnings were less than white women at $1,635 in 1967.

If we assume that no major economic intervention will be forthcoming in the near future to make jobs readily available and increase wages substantially in low-wage sectors, the ability of most AFDC family heads to meet the minimum income needs of their families by working is probably quite low. The anticipation that many are or will be able to earn their way off assistance is probably unrealistic. Only a minority of welfare recipients will be able to get off public assistance through employment sooner than the normal attrition rates. For a family of four headed by a women, she would need to earn $2.25 or more an hour on a full-time basis to be removed from the welfare rolls in 30 states. In only nine states could the family head earn less than $2.00 per hour and become completely self-suporting. In some states where the cost of living and the welfare payments are higher, a mother would have to approach earnings of $3.00 per hour or more.

TRAINING FOR WELFARE RECIPIENTS

We are only gradually beginning to realize that it is not enough to design programs which attempt to alter the supply of labor by training, rehabilitation, and education in order to assure higher levels of income and living. The structure of the occupational system, the operation of labor markets, and the levels of wages, which make up the demand side of labor market equations, required appropriate and significant intervention.

The evidence for evaluating the performance of efforts to train welfare recipients, particularly women, is scarce. What is known about WIN is not encouraging to those who would expand such programs as a part of welfare revision. A total of 167,000 had enrolled in WIN through April 30, 1970. More than a third had dropped out, and of the 89,000 enrolled in the fall of 1970, nearly a third were in the intake, assessment, orientation, or holding stages, which generally involved waiting for placement.

Estimates are that 25,000 had moved on to work, with less than half of those being able to move off of welfare—approximately 10,000 received pay adequate to leave public assistance. Most of those who found jobs were among the early participants in the program when, according to most observers, "creaming" was prevalent. These early enrollees included a large percentage of employable fathers receiving AFDC–UP (as much as 40 percent) who could find work most easily and probably would have found jobs in time without WIN. (AFDC–UP cases make up only 5 percent of the AFDC population.) Further, it is doubtful that WIN has had much effect on the pattern of use of welfare in view of the average stay on welfare of two years.

Another consideration in the training approach toward substituting work for relief is the costs—the costs of training, the costs of providing work incentives, the costs of day care, and the costs of creating employment or subsidizing employment during those times and in those places where jobs are not available. The likely costs of these efforts will substantially exceed any savings in welfare payments.

This picture can be seen by taking estimates of costs under the WIN program and matching them with the characteristics of the typical AFDC family. The Department of Health, Education and Welfare conservatively estimates the average cost of after-school and summer care for school-age children at $400 per year, and for full-day pre-schoolers at $1,600. The average AFDC family has three children and if we assume the mother has one child under six and one in school still requiring some attention, the annual cost of the child care arrangements will be $2,000. Training under WIN averages around $2,250 per slot and the recipient is allowed to retain $30 and one third of earnings. If the family earned even $2,000, which studies suggest only a third of employable recipients could do, the welfare payments would be reduced by only $973. Thus, for $3,250 in day care and training cost (not including any subsidies for job creation, services, or work related expenses such as transportation), the reduction in welfare payments would amount to less than $1,000. Further, the low placement rates under WIN would indicate that jobs are not available and that employers are not seeking recipients as workers. This suggests that a large scale and costly public employment or publicly supported private employment programs would be required.

In an investigation of the WIN program in Boston, Sum and Piore (1969) observed that of the 127 enrollees under study in October 1969, only a small number were employed. Only 12 enrollees were working; forty-four were still in training; fifty eight had been terminated; and 13 were in holding status (approximately half of these were in the process of being terminated). They found that females had a higher termination rate and a lower placement rate than males.

Of the 12 who had obtained employment, seven were male heads of households on AFDC–UP. Five of these had found employment on their own. Only one of the five found a position which was training-related, and three returned to their previous occupation, with one setting up a business. The remaining two enrollees were placed by the WIN team in their previous occupations—one of them with his previous employer. Two of the 12 employed were female heads of households on AFDC. Neither had any children under six at the time. The other three employed enrollees were teenagers.

In the Auerbach evaluation (1970) of WIN, it was found the unified supportive services promised in the program were largely unavailable. The training programs were of doubtful relevance to the client population and little emphasis was placed on on-the-job training. Many of the crucial features of the training strategy were having severe difficulties in practice.

In surveys of the employment and actual earnings of WIN graduates in 1969, labor market factors clearly emerged and it was found that two-fifths were employed in low-paying occupations such as clerical, sales, and service jobs. One survey showed that at the end of 1969, female WIN graduates earned

substantially less than males and one-half of the females earned less than $2.00 an hour. As the small number of AFDC men complete WIN and women comprise a large proportion of the trainees, average earnings, which were put at $2.30 an hour, can be expected to decline. These trends also appear to make it unlikely that WIN can function as a major instrument for reducing the caseload in AFDC.

In New York a similar criticism was made by the bipartisan Legislative Commission on Expenditure Review, pointing out that most opportunities offered to minority persons had been limited to typist and attendant jobs. The Commission also called attention to many other problems of the manpower programs in New York. The Work Incentive Program, WIN, was particularly criticized in the Commission report, which called the program "almost totally ineffective." Of the 17,814 enrollees in the first 21 months of the program through June 1970, only 17 percent were placed in jobs, and only 4 percent remained employed beyond six months.

One of the conclusions that emerges from a review of WIN and other manpower programs is that in slack labor markets, there are increasing difficulties and rising costs to placing recipients in jobs. The justification for this training approach is difficult to make on the grounds of a productive investment which will significantly reduce the costs of welfare. The argument that training is a one-shot investment in the long-term work pattern to be established for mothers when their children no longer need care must be weighed against (1) the uncertainty of jobs in the labor markets that most recipients work in, (2) the fact, as revealed in most studies, that women work anyway when their children are old enough, (3) the likelihood for many that future child-bearing will interrupt work experience, and (4) the low earnings that most are likely to desire.

Concerning the placement process, the Wright Institute study of WIN, like that of the SWRRI study in Massachusetts, found that, by far, the most important sources of job referrals for mothers was their friends and relatives. Official government programs—WIN and the employment offices of the Human Resources Department—were often used in job-seeking attempts but efforts through these channels were rarely successful. Based on this finding, it was suggested that the government should consider supporting the more successful referral system of friends through possibly a system of commission payments.

The rehetoric of manpower and rehabilitation policies has exaggerated the potential impact and the importance of manpower programs. To show that the rhetoric of mass employment of the disadvantaged is a gross exaggeration is not to imply that the methods are ineffective or irrational in all cases or that they do not have value. In fact, it is only when assessed in terms of inflated claims and expectations that such programs can be considered a failure. When seen in terms of smaller numbers and specific client problems, such methods are useful and necessary.

SOME IMPLICATIONS FOR H.R. 1 FROM OTHER SWRRI STUDIES

1. Our study of ADFC recipients who work suggest that among other factors which might discourage them from moving completely off welfare, two should be mentioned here. The first concerns the loss of other benefits such as medical care, day care, housing supplements, and various food programs. The second is the fear of losing their job and not being easily able to get back on welfare. Since most of the jobs obtained by female recipients tend to be somewhat irregular, the security of a job is small. In this case, welfare payments are much more reliable and stable and so some mothers avoid the risk of relying entirely on their employment for their income.

This latter effect might be remedied in the bill by removing the requirement that recipients remain in employment as a condition of support once they have a job and by inserting language to the effect that a person who works their way off the roles and loses their job becomes automatically re-eligible, within certain financial limitations.

2. Our study of AFDC mothers also shows that they did not know how much of their earnings they would be allowed to keep and how much would be deducted from their public assistance grants. Our impression is that most mothers do not know about the work incentive disregard aspects of the 1967 Amendments and, when they do, the computations are often too complex. The Wright Institute study of WIN revealed most welfare mothers base their calculations with respect to job opportunities more on group and community standards of expectation than

on their individual situations. If this conclusion is correct, it would imply that community-wide programs of information diffusion would be required in order for the work incentives to affect the work efforts of many clients.

Furthermore, the problem of getting the correct information to the target populations would have to be solved in order to have the working poor use the new programs in HR 1. More study and experimentation is needed on this particular aspect of the Act.

3. Our work indicates that more experimentation and study are needed on various parts of the welfare reform package. The following work needs to be done:

(*a*) One or more statewide pilots programs should be undertaken to trace the effects of the various provisions of the Act and to work out the administrative problems. This should be done using a higher minimum than that contained in the House version of the bill. Massachusetts should be considered if such a pilot is contemplated since it has both urban and rural areas, is committed to welfare reform, is manageable from an experimental and research point of view (as we have found), and has some experience with aspects of the new programs, such as working arrangements between the Welfare Department and the Employment Offices.

(*b*) While we would recommend that enforced work registration be dropped as improper, costly, ineffective, and counterproductive, if such mandatory referrals to employment offices are kept, more appropriate and realistic criteria for the determination of employability must be developed to minimize (1) the harmful effects on recipients, (2) the costs of the program, (3) the administrative problems resulting from the continual registration and processing of people who are not employable, and (4) the barriers within the program to those who can really use employment services. A study should be undertaken to determine a workable and operational definition of "employability" for use in present programs and in those contained in HR 1.

STATEMENT OF NATIONAL ASSOCIATION OF COORDINATORS OF STATE PROGRAMS FOR THE MENTALLY RETARDED, INC., SUBMITTED BY CHARLES E. ACUFF, PRESIDENT

As an Association whose members are responsible for planning, implementing and coordinating state services for mentally retarded children and adults, we have a vital interest in a number of programs authorized under the Social Security Act including social security benefits to the disabled, public assistance, social services, maternal and child health and crippled children's services, medicaid and medicare.

According to the latest estimates available from the Department of Health, Education and Welfare:

176,000 recipients of childhood disability benefits under social security suffer from mental retardation.

Approximately 4.6 percent (or 331,000) of the children in AFDC families are mentally retarded.

Roughly 155,000 recipients of APTD have mental retardation as their primary disability.

Over 43,000 retarded children and their families are served annually in community clinics supported by maternal and child health funds.

However, even these figures don't reveal all the ramifications for the retarded in programs authorized under the Act. For example, a large but unspecified number of retarded children and adults are benefiting from social service programs funded under Titles IV, XIV and XVI. Other groups of retarded citizens are the recipients of skilled nursing home services and intermediate care benefits.

Because of the wide diversity of programs which touch the lives of the mentally retarded, our Association has a strong interest in the legislation now before the Committee. In this brief statement we would like to call the Committee's attention to several aspects of the House-passed welfare reform-social security bill (H.R. 1) which will have significant impact on services to the mentally retarded.

1. Federalization of the Adult Welfare Categories

The House version of H.R. 1 calls for the replacement of existing state operated programs under Title I (OAA), X (AB) and XIV (APTD) with a single federally financed and administrated program of cash assistance to needy

aged, blind and disabled citizens. Under this plan, uniform national eligibility standards and benefit payments would be established in a new Title XX.

NACSPMR strongly endorses the House's plan for "federalizing" the funding and administration of the adult welfare categories. The adoption of uniform eligibility standards and minimum benefit levels will help to eliminate numerous inequities built into the present federally financed, state administered system.

In many states we feel sure that the availability of increased monthly assistance payments to totally disabled children and adults will provide renewed incentive for placing retarded persons in smaller, more home-like community residences. As President Nixon pointed out in his November 16 statement on mental retardation, up to one-third of the present residents in state institutions for the retarded could be returned to the community if adequate residential alternatives and supportive services were available. Federalization of the adult welfare categories should help to reinforce this trend toward the development of community residential alternatives—particularly in states which now offer low monthly payments to APTD recipients.

We are especially pleased to note the provision in the House bill which would extend eligibility for benefits to disabled children from needy families. Numerous studies indicate that the incidence of mental retardation and related chronic conditions such as cerebral palsy and epilepsy are much greater among the poor in general and AFDC families in particular. For a variety of reasons, handicapped children in such families often have little access to the remedial and habilitative services they so desperately need. One major roadblock to serving these children is the family's lack of financial resources. Permitting such a child to be classified as eligible for disability assistance is an important step toward making services available at an early stage in the child's development when the potential for remediation or amelioration of the condition is highest.

2. Prohibition Against Cash Assistance to Institutional Residents

The House passed version of H.R. 1 would continue the existing prohibition against the payment of cash assistance under the adult welfare categories on behalf of "inmates of a public institution" unless they are patients in a medical facility. This exclusionary language tends to draw an invidious distinction between the provision of care in public and private settings and works at cross purposes with the goal of establishing the widest range of residential alternatives for the mentally retarded.

We urge this Committee to modify the language of Section 2011(e)(1)(A) of H.R. 1 to permit cash assistance to flow to residents in publicly operated facilities for the mentally retarded. Such assistance would help to upgrade services in existing institutions and, perhaps more importantly, would eliminate a major impediment to developing group homes and other small, community based residential centers under public auspices. By limiting cash assistance to eligible residents in nonpublic facilities, the present Act tends to discourage the establishment of publicly operated programs which, in some instances, will be the best and most feasible alternative.

We also recommend that Section 1905 of the Act be amended to eliminate language which excludes otherwise eligible residents in non-medical public institutions from receipt of Medicaid benefits. Such individuals should have the same right to coverage for acute medical and health problems as a similar individual residing with his family, in a proprietary boarding home or other non-public setting.

3. Extension of Medicare Benefits to Social Security Disability Beneficiaries

NACSPMR wholeheartedly endorses the provision in the House version of H.R. 1 for extending Medicare benefits to all social security disability recipients—including some 260,000 childhood disability beneficiaries (65% of whom have been diagnosed as mentally retarded). As the House Ways and Means Committee pointed out in its report (H. Rept. 92-231) "a major unmet need for health insurance protection exists among the disabled . . . Yet, the disabled have limited incomes in comparison to those who are not disabled, and most disabled persons are unable financially to purchase adequate private health insurance protection, or to obtain such insurance at all." We can certainly attest to the veracity of this statement—particularly as it applies to recipients who have been disabled since birth or early childhood.

We would like to propose, however, one modification in the House provision for a two year waiting period before a disability recipient becomes eligible for

Medicare benefits. We feel that the two year requirement should be waived for adult beneficiaries disabled since childhood because the basic rationale for the waiting period—i.e. to insure that disabled workers use all of their residual health benefits available as a result of their work career—is totally inapplicable to this group of persons who, in most instances, have had little or no work experience. Since the so-called childhood disability recipients constitute only fifteen percent of the total number eligible for assistance, it is our understanding that the cost of extending an additional two years of coverage to this group would be relatively modest.

4. Limitation on Social Services Funds

We urge this Committee to examine closely the provisions of the House bill in regard to placing a ceiling on social services spending under Titles IV and XVI of the Act. From our vantage point as state administrators of programs for the mentally retarded, social services funds are being utilized most effectively in a number of states to initiate and expand a variety of community services to children and adults who are desperately in need of help. A few examples of programs now being partially supported through social services funds may help to illustrate this point:

Social services funds under Title IV A have permitted Tennessee to open thirteen day training centers. These programs range from developmental classes for high-risk, pre-school children in inner city neighborhoods to day care programs for moderately to severely retarded youngsters who are too handicapped to participate in public school programs.

Through the use of Title XVI funds Nebraska has extended services to 215 moderately to severely retarded adults in a series of 14 developmental centers across the State. The program, which is designed to assist persons who are too seriously handicapped to function in a competitive work situation, provides an intensive daily program of physical stimulation, psychomotor coordination, visual-perceptual training, self concept awareness, nutrition and health care. If these new services were not available within the community, many of the program participants would have to be placed in a state institution where they would receive less services at a significantly increased cost.

As an essential back up to specific educational, training and developmental programs for retarded children and adults, Nebraska has also launched a series of eight family resource service centers through the use of Title IV A and XVI funds. The purpose of these centers is to coordinate and orchestrate the delivery of the broad range of generic and specialized services required by the mentally retarded and furnish the supportive assistance necessary to maintain clients in community based programs.

Washington State is funding 23 long term sheltered employment programs for mentally retarded adults through Title XVI funds. As of September, 1971 the state was receiving reimbursement on behalf of 600 retarded persons involved in this program.

Washington is also financing recreation, day care and activities programs for retarded adults through social services funds authorized under Title XIV. By utilizing 75 percent federal matching funds, the Washington Office of Developmental Disabilities has been able to expand this program—previously funded entirely through state and local resources—much faster than originally anticipated. As of September, 1971 thirty-five agencies were receiving Title XIV aid on behalf of 700 retarded adults.

In all of the examples cited above, retarded and multi-handicapped children and adults are receiving services which would not otherwise be available to them if it were not for Title IV A, XIV and XVI funds. Unfortunately, only ten to twelve states are presently using social services funds in any meannigful way to expand and improve mental retardation services. If a ceiling were placed on program funds as proposed by the House, those states which are not presently taking full advantage of social services monies to assist the retarded would find it difficult to mount a program—especially for retarded adults.

As program managers we can sympathize with the Administration's concerns about the rapidly escalating cost of this program and the accompanying lack of clear cost data on the program's effectiveness. At the same time we are convinced that this program is being used very effectively in a number of states and offers great potential for improving and expanding community-based services to the retarded as well as other handicapped and disadvantaged citizens.

For this reason, we urge the Committee to permit continued open-ended funding of programs under Titles IV and XVI of the Social Security Act. As a more limited alternative the Committee might wish to define the term "child care" (the funding for which is left open-ended in the House bill) to include community based developmental and habilitative services to both seriously handicapped children and adults.

* * * * * * *

We appreciate this opportunity to bring the views of our Association to the attention of the Committee. You and your colleagues in the Senate face a mammoth task in attempting to amend and extend the many programs authorized under the Social Security Act. We wish you well in this important undertaking and hope that you find our testimony helpful.

TESTIMONY OF CHARLES L. RITCHIE, JR., PRESIDENT, BOARD OF COUNCIL, EPISCOPAL COMMUNITY SERVICES, DIOCESE OF PENNSYLVANIA

Mr. Chairman and members of the Committee, my name is Charles L. Ritchie, Jr. I am the President of the Board of Council of the Episcopal Community Services of the Diocese of Pennsylvania.

The Episcopal Community Services is a non-profit health and welfare agency serving the people of the five-county area of southeastern Pennsylvania. Founded in 1870 as the Philadelphia Protestant Episcopal City Mission, the agency is involved in serving the community through its five divisions, the All Saints Hospital, Children and Family Service, Church Work Among the Blind, Institutional Chaplaincy Service and Services to the Elderly. Last month, 1247 individuals and families were receiving services from these divisions. I am testifying because of our commitment to these people.

Until the early 1930's, our agency devoted a major part of its resources to providing clothing, food and cash to people in need. The soup kitchen, the clothes collection, the children shelter were the "beat" of the relief worker. With the development of social security and a greatly expanded public welfare program, our involvement shifted to individual and family counseling with direct material assistance reduced to responding to emergency situations. However, in our family and children programs, our work with the aged, blind and prisoners, we are in daily contact with many who receive some form of public assistance.

For these people, public assistance is a *must*, without it many would literally face starvation. These persons consider it not a way of life, but a temporary expedient to help them work out of an acute situation. In spite of being plagued by a variety of problems including health breakdowns, marital discord, wretched housing, our experience has indicated that the great majority make strenuous efforts to secure employment, and when possible, training. One young mother has sufficiently overcome obstacles of poor health, estrangement from her family and lack of vocational skills, to secure admission to the New Careers Program at a local university. She wants to contribute to society. Another woman, with seven children, separated from her emotionally disturbed husband, is battling to overcome all obstacles and is seeking admittance also to a local university. Currently, she is taking evening courses in typing at a nearby high school. She has steadfastly encouraged her children to secure education and employment, although they have been handicapped by medical problems including worms, allergies and eye infections.

Our experience indicates that this desire for self-sufficiency is not exceptional and the majority of recipients share in the broader society's feeling that work is not only a means to earn a living, but is considered a source of personal development, social status and meaningful activity. However, welfare recipients face tremendous barriers in their struggle to obtain independence. Poor health, lack of skills, inadequate education all contribute to make economic advancement difficult. Despite the efforts of welfare rights groups, many recipients live isolated, desperate lives. Mothers struggle to encourage their children to attend school—children who face the daily tensions and temptations of the streets. The welfare mother lives with the dilemma of feeling the need to increase the family's economic independence, but at the same time not to desert her responsibilities as a mother.

It has been said "If there were a single solution to the welfare and poverty problem we would have thought of it long ago". However, we have no choice but to continue to seek for methods to improve our welfare system.

The following resolution, penned by our Board of Council, represents the stand of our agency:

"We believe that everyone should have a guaranteed adequate income. When income is inadequate we believe that a declaration of need should be accepted as proof of need.

"We believe that everyone who is able to be employed has a right to employment at an adequate wage. To insure this we recommend that the Federal Government be the employer of last resort. We recognize that in many cases wage earning is not possible or not advisable".

In light of the above, based on our experience, we advocate the following points *must* be included in any new legislation:

Higher minimum level of benefits.—A family of four should receive not less than $4000 (the U.S. Government-defined "poverty line"). This should provide recipients some relief from the tensions of eking out a bare subsistence. Welfare payments should eventually be tied to level of consumption component of Bureau of Labor Statistics' lower standard budget.

Work requirements should not be mandatory for mothers with children under 18 who still need care and supervision, and that recipients should not be required to accept employment paying less than the federal minimum wage.

Rights and obligations should provide full due process, fair hearings on disputes regarding payments, suitability of employment or training. No individual should be referred to manpower services, training or employment unless they are actually available.

We are aware that the extent of poverty in the United States has steadily declined for several decades. This achievement should persuade us that we have the capability of responding to the current situation even more effectively in the 1970's.

However, past accomplishments should not deter us from overlooking the grinding problems created by poverty that still affects too many Americans and the urgent need to provide opportunities for the people to fully share in the life of our country.

We are sure it will be of interest to the Senate Committee on Finance that the Diocese of Pennsylvania shares our deep concern about Public Welfare and indicated this in the resolution adopted by the Diocesan Convention in October, 1970:

Resolved, That the Convention of the Diocese of Pennsylvania:

(*a*) re-affirms its conviction that an adequate, humane and well-administered system of Public Welfare is vitally important in the life of the nation, and is a valid concern of the Church.;

(*b*) finds the present welfare system inadequate and inhumane in providing insufficient levels of benefits, and in affecting adversely the human dignity, spiritual integrity, family unity and individual initative and resourcefulness of recipients.

(*c*) commends to the members of the Diocese for study and appropriate action the opportunity which will be presented to the Congress by the Administration's proposal of a new Public Welfare System:

(*d*) in particular commends to the Rectors and Vicars of the various parishes and missions of the Diocese that they encourage their lay people to write their congressmen in regard to this new welfare system approving of its strengths where it will indeed lessen the inhumane and spiritually degrading aspects of welfare for the poor, and to disapprove of any system of work requirements that would separate parents from their families or force work on any of the 95–98% of persons on welfare who are incapable of working; and further urge that the strongest federal regulations be placed on this new system to insure that the money to be funded to local, state and city governments go to the persons most needing it, regardless of their race or creed; and;

(*e*) authorizes and requests the Bishop by such means as he may determine, to make available in the Diocese occasions for the presentation to and discussion and study by members of the Diocese, of the subject of Public Welfare, to the end that churchmen may be well informed and articulate in regard to the issues with which the Congress will be dealing in considering the Administration's proposals or any amendments thereof of substitutions therefore.

STATE OF ALABAMA,
STATE AGENCY FOR SOCIAL SECURITY,
Montgomery, Ala., February 15, 1972.

Hon. RUSSELL B. LONG,
Chairman, U.S. Senate, Senate Finance Committee, New Senate Office Building, Washington, D.C.
(Attention of Hon. Tom Vail, General Counsel).

DEAR SENATOR LONG: Further reference is made to my letter of July 16, 1971 in which opposition was made to enactment of Section 1818, Section 202, Title XVIII of the Social Security Act entitled "Hospital Insurance Benefits for Uninsured Individuals Not Otherwise Eligible", which appears on page 144-147, Senate 2nd Reading of H.R. 1 on June 28, 1971.

This type of legislation has been opposed by various states for several years. It was not their objection to any group having medicare but the manner in which the group who is sponsoring the amendment is attempting to get the protection. Too, states should not be burdened with the cost of financing a program for individuals who have every opporunity to avail themselves of this protection. It appears that many insurance actuaries are not failing to do their share to create unrest among the younger employees. If this continues, it may come to the point where states would be compelled to terminate their contracts. This would be a sad national situation.

I have been requested by several States to request your Committee to give serious consideration to our objection to this proposed amendment. I am including their statements if you desire to make them a part of my presentation to your Committee.

Again, I wish to thank you for your past assistance, not only just Alabama but the other States as a whole.

Sincerely yours,

EDNA M. REEVES, *Director.*

SUMMARY OF STATEMENT OF EDNA M. REEVES, DIRECTOR, STATE AGENCY FOR SOCIAL SECURITY, STATE OF ALABAMA

First: On behalf of the State of Alabama, as well as the Alabama Educational Association and several other States, I am requesting the deletion of amendment to H.R. 1 making provision of medicare available to retired and active public employees who have reached sixty-five (65) years of age.

Second: States have gone through the process of selling Social Security and *Medicare* protection to employees. To enact the provision permitting medicare after age sixty-five (65) without their contributing anything whatsoever to the program completely defeats the action of State Administrators and will greatly weaken the State's program.

Third: The States will be required to assume unknown liabilities. The proposed legislation makes it optional with States; however, once the law is enacted another pressure campaign will begin to make it mandatory for the states to pay the biggest portion of the premiums. This, of course, would be far more expensive than the present employer portion of the contribution.

Another problem that is sure to arise, many states will be burdened with the inability to enter the program due to the fact additional legislation will be required and legislative bodies of the various states meet at different times.

Fourth: The ever increasing dissatisfaction among younger employees will increase to an alarming degree and in many states will completely wreck the states' coverage agreements under the provisions of Section 218 of the Social Security Act.

Fifth. The enactment of this proposed legislation will set a precedent. If special legislation is enacted for one pressure group, then any other group should have the same right to request other special legislation.

It is felt this proposal is unfair to the nine million public employees presently paying their portion of contributions.

Sixth. The groups who are making an all-out effort for the proposed legislation are from states with token Social Security coverage. Here again the employee has had the major control on coverage. They have not wanted to have their salaries taxed.

STATEMENT

When H.R. 1 was introduced in the House of Representatives it met the wishes of all States. This section reads as follows:

"SEC. 202 . . .

"HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

"SEC. 1818 . . .

"(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such contract or arrangement is administratively feasible."

The word "states" had been deleted. However, it is noted that the Ways and Means Committee's press release reads:

"People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Those who enroll would pay the full cost of the protection—$31 a month at the beginning of the program—rising as hospital costs rise. States and other organizations, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

"Effective date—January 1972."

The State of Alabama has an administrative responsibility under a master Federal-State coverage agreement entered into pursuant to Section 218 of the Social Security Act. Through this agreement, Social Security coverage is currently enjoyed by over two hundred thousand employees of State and local governments.

The plain statement that coverage under Section 218 of the Social Security Act has increased throughout these United States to the substantial amount of over eight million State and local governmental employees does not do justice to the full story of the administrative and, as many members of the Committee know, legislative developments in the twenty-one years that Section 218 has been in existence. In some states, the extension of Social Security coverage has been extremely controversial, and continues to be controversial with respect to many classes of employees. In fact, in several areas it has been necessary for Congress to specify individually those states in which certain enabling coverage provisions shall apply.

In addition to those situations where the States have come to Congress for assistance in making coverage possible, it has been necessary for some State Administrators to come to the Congress from time to time to seek assistance in solving problems caused by the complexity of Section 218 and the existence of conditions that were not contemplated when basic legislation was enacted. It was my privilege to request an option to provide retroactive coverage as a part of a coverage group for former employees whose earnings were erroneously reported to Internal Revenue Service, if no refund had been made, as well as other measures applicable to individual states.

It is in the same spirit that I present to you today the problems that can arise in the administration of Section 218 with the enactment of Section 202, Title XVIII of the Social Security Act as amended by adding thereto Section 1818. The Ways and Means Committee amendment provides that a State or any other public agency may be permitted to pay monthly benefits for retired (or active) age-65-and-over employees who are ineligible for hospital insurance protection under medicare, but may enroll on a voluntary basis for hospital insurance under the same conditions under which people enrolled under the supplementary medical insurance part of medicare.

Alabama entering the program in 1951, has consistently extended Social Security to non-retirement personnel and all retirement personnel since the 1954 amendments.

First: To permit a group to come in only when it is in need of certain benefits completely disrupts the normal processes of our Federal-State program. I would, also, go as far as to say that if this piece of legislation is passed, it will

place most, if not all, State Administrators in a most embarrassing position since we have used as part of our promotional material the fact that the only way medicare could be obtained was through Social Security coverage. I would say that a great percentage of the coverage for teacher retirement personnel for Social Security in Alabama was based solely on the fact that the older teacher would have to have Social Security coverage in order to protect himself for medicare. You can readily see that this legislation would completely place a State Administrator in a position of misrepresenting facts.

Second: To extend coverage of this type to groups of retirees (or active) age 65 who have not seen fit to participate in the general Social Security program when such coverage was made available to them completely defeats the action of the State Administrator in attempting to make available to public employees all the benefits of the Social Security Act, and would greatly weaken the State program.

Third: This would require a State to assume unknown liabilities. We in Alabama feel the State should not be burdened with such liability, since it is felt that this plan would be materially more expensive than the program that each State now has in effect.

Another problem of major concern would be placed on a State. As you know, the General Assemblies and/or Legislatures of the various States meet at different times some once every two years while others meet annually, and, of course, before this amendment could be put into effect, State legislation would have to be enacted in order for the State's Federal-State contracts with the Department of Health, Eduaction and Welfare to be amended.

Fourth: We in Alabama are increasingly aware of the strong opposition from younger people to the paying of Social Security contributions (taxes). Their belief, of course, is that for the same amount of money, they may perhaps have more to show for it in the way of private inevstments. The fact that they could qualify for medicare without being a member of the Social Security system would, of course, greatly strengthen their desire to get out from under coverage—a desire which may extend to many of the older people as well.

At this point, I would like to state that I have recently met with city governing bodies, where the younger people are trying every angle to be deleted from the program. I have tried to settle the unrest and dissatisfaction among the younger employees, many of whom have raised the particular question why the engineering personnel or policemen and firemen cannot be removed from the group's contract—this bearing out what I have just stated. The presently covered employees would, in many cases, especially the young, begin proceedings to have their coverage cancelled since the majority feel now that they are required to finance programs for many employees who have made no contributions at all to the financing of the program. Too, they contend many investment companies offer greater retirement programs. They never give the disability or survivors benefits any consideration. They, also, contend they can continue to work after 65 years of age without wage limitation.

Fifth: To enact special legislation at this time for a special group sets a precedent. I feel special legislation for a special group is just the beginning of wrecking or destroying our present Social Security program, because other pressure groups will arise and their wishes should be handled in the same light as the pending problem. It is felt that in all fairness to public employees who fought and tried for twenty-one years to gain this added protection, and many have been contributing since January 1, 1951, this special legislation should not be enacted.

Most retirement personnel who are members of public agencies have had the same privilege of earning this medicare protection, together with Social Security Insurance, since the amendment of 1954 and have rejected the coverage, but now that they have retired, they can readily see their unwise decision, and feel that they should be handled differently in other words, they wish the better of two worlds without sharing their portion of the cost. Frankly, I feel that this is one of the most unfair pieces of legislation that has been introduced in the Congress.

I would like to make one further statement: I have made a survey and have found that the groups pressuring for the passage are from states that have not seen fit to extend this coverage to their employees. In other words, the employees themselves have controlled the issue. In these states, only token coverage exists—this being controlled by the employees.

As I stated previously, what this proposed legislation boils down to is treating these employees as a special privileged group. Why should special legislation be

enacted to arrange for medicare for those selfish individuals who have refused the coverage and have not made any contribution at all to the program—a program that others have been paying for over a period of many years and whose contributions have been raised many times and will continue to be raised many times prior to retirement? In other words, special legislation for a special group to obtain medicare is most inequitable.

Why should we who are presently covered and wish to retain our protection be penalized for a selfish group.

It is the first step toward complete wreckage of the entire program. If this special type legislation is enacted, mind you, in no time at all some other disgruntled group will be back demanding enactment of legislation to suit their particular wish.

I should like to reiterate my thoughts of September 23, 1970 when I had the privilege of appearing before your Committee on identical proposed legislation as Legislative Chairman for the National Conference of State Social Security Administrators. I do not oppose social security and medicare for any individual. My position was then, and still is, let all pay their share of the contributions and share medicare on the basis of earned protection.

If H.R. 1 can be enacted as originally introduced and as read in the Senate by relieving the states of any liability for entering into any agreement for purchasing this protection, I will not be opposed to these individuals making arrangements with some private agency or organization to handle their medicare program.

I, as well as several other State Administrators, are definitely opposed to any legislation which will materially cost the states more in contributions for any special group not heretofore covered—both from the standpoint of the additional cost to the state to say nothing of the unfair position for those employees who have been covered and who have been paying their share of premiums all through the years.

If they do not wish that approach, then it appears that under prior amendments of Congress all individuals who are sixty-five (65) years of age and are citizens of the United States (unless they are or have been listed on the small list of subversives) can voluntarily be enrolled in Medical Insurance, commonly known as "Part B".

Too, if medicaid requirements are met, and I believe most states have a medicaid program, their state will purchase this "Part B" medicare for them.

It is entirely possible that the two above provisions are not known to the retirees, as well as the sponsors of the proposed medical insurance provisions now before the Congress.

In other words, completely relieve the state of any liability and permit the retirees (or active) aged sixty-five (65) to contract with a private carrier for their medicare coverage.

I am enclosing as a part of my objections, statements and/or objections of others which clearly endorse my position.

I express my appreciation for this opportunity to present our views on this a most "controversial subject".

ALABAMA EDUCATION ASSOCIATION, INC.,
Montgomery, Ala., February 15, 1972.

Miss EDNA REEVES,
Director, State Agency for Social Security, Public Safety Building, Montgomery, Ala.

DEAR MISS REEVES: After studying the material which you left for me concerning HR 1, I, too, share your concern. The teachers of Alabama has benefited immeasurably from having Social Security benefits coordinated with the Alabama Teacher Retirement program. Any change in the present law which would encourage or tend to encourage teachers to forego this program at the expense of losing present benefits causes our organization to become concerned.

We are almost constantly bombarded with disgruntled persons who have been gullible to a something-for-nothing scheme. There are, no doubt, persons who for personal financial reasons might like nothing better than to see teachers en mass withdraw themselves from the Social Security program. In my judgment, any change which might promote hucksterism on the part of persons who may attempt to foist a financial savings plan which would supposedly give the teacher more benefit than Social Security for less cost would be detrimental unless such program were put to the test to prove its claims. In such cases where this has been done, these generally fall short of the benefits available under Social Security.

As I understand, some aspects of HR 1 might tend to encourage persons to withdraw from Social Security with the expectation at a later time of life, presumably at age 65 or upon retirement, that they might re-establish benefits through medicare. This, in my judgment, would tend to encourage persons who presently are covered under Social Security to consider dropping this benefit with the expectation of later being able to renew it. High pressure "salesmen" might seize upon this opportunity to encourage teachers to drop out of the present Social Security program. In my opinion, this possibility should receive careful and studied consideration before being enacted.

Sincerely yours,

PAUL R. HUBBERT,
Executive Secretary.

STATE OF WISCONSIN,
DEPARTMENT OF EMPLOYEE TRUST FUNDS,
Madison, Wis., January 13, 1972.

Senator GAYLORD NELSON,
Member, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR NELSON: I wonder whether you are aware of the far-reaching implications of the provision in Section 1818 (e) on page 381 of H.R. 1 (now before your committee) which would authorize Medicare coverage for persons not under Social Security otherwise.

Theoretically of course this would apply also to private employment, but due to the fact of almost universal Social Security coverage in private employment the real result would be to make this available primarily in public employment.

Initially this may sound quite "innocent" and reasonable—as it probably did to the Ways and Means Committee.

The danger in this is that it would almost certainly give great impetus to the growing movement to remove public employes from Social Security coverage where such coverage now exists.

For example, in the South Actuary William Groves of New Orleans who has always opposed Social Security coverage for public employes—for obvious selfish reasons—is now drumming up considerable business for himself by persuading governmental units in many states in that area to act to be removed from Social Security coverage.

This movement is not confined to the South.

In California many governmental units have so acted, and there is even a possibility there that state employes may ultimately be removed.

Somewhat the same situation prevails in Alaska, Washington and Oregon.

Perhaps your committee may want to ask HEW to report on the extent of this movement to remove public employes from coverage.

The obvious motive is that these public employes want "to have their cake and eat it too". They recognize the value of Medicare coverage—which they want—but they believe that they can obtain more liberal retirement benefits from a state or local retirement system.

Of course I have always believed that public employes should have retirement benefits equivalent to those prevailing in private employment.

However, I have never been able to understand how public employes can have any justification for seeking retirement benefits which are more liberal—and more expensive—than those enjoyed by the private citizens who are paying taxes.

Sincerely,

ALTA E. MOORE, *Director.*

NORTH DAKOTA OLD AGE AND SURVIVOR INSURANCE SYSTEM,
AND THE SOCIAL SECURITY CONTRIBUTION FUND,
Bismarck, N. Dak., February 2, 1972.

Hon. MILTON YOUNG,
U.S. Senator, North Dakota, Senate Office Building, Washington, D.C.

DEAR SENATOR YOUNG: One of the functions of my office is to administer the provisions of Section 218 of the Social Security Act. This Section provides federal Social Security coverage for state and local governmental employees on an optional basis. Our state legislature authorized the participation in the program as of January 1, 1955.

The Senate Finance Committee's chief counsel, Tom Vail, has advised the legislative chairman of the National Conference of State Social Security Administrators (of which North Dakota is a member) that hearings would start on H.R. one on January 20, 1972 and that written statement for records of hearing could be filed no later than February 18.

You may not be aware of the far reaching implications of the provisions in Section 1818 (e) on page 381 of H.R. 1 now before Senator Long's committee. This provision would authorize medicare coverage for persons not under Social Security otherwise.

We are not opposed to permitting these persons to acquire medicare coverage—it is the method of financing that could become a problem. Secondly, this procedure could lead to a greater impetus to the growing movement to remove public employees from Social Security coverage where such coverage now exists.

In the south, an actuary by the name of William Groves is reported to be drumming up considerable business for himself by persuading governmental units in many states in that area to act to be removed from Social Security coverage. Apparently these states are being advised on the presumption that the necessary financial assistance will be furnished when a person needs it so why pay in now.

Many of the people who would benefit by the adoption of Section 1818 (e) on page 381 of H.R. #1 had the opportunity to elect coverage for Social Security (and Medicare) when they were actually employed but declined to do so. They would now get the Medicare coverage at the state's expense.

The movement started in the South is not confined to that area. We are informed that legislation has been introduced in Congress to relieve certain California governmental units from coverage. There is also similar situations developing in Alaska, Washington, and Oregon.

Here in North Dakota we have been approached by the city of Bismarck, Solen Public School District, Mott Public School District and several others to learn of the procedure to withdraw from coverage. The primary reason we believe is to get out of coverage (Social Security) for persons covered by other retirement systems such as police, firemen and teachers. The drawback here is that by withdrawing from Social Security they also withdraw from Medicare.

The provisions of the pending legislation would encourage more units to withdraw since they could than obtain Medicare coverage without the expense of supporting the overall Social Security costs (retirement, disability and Medicare).

We believe that the Social Security Administration of HEW could furnish your office with a report on the extent of the movement to remove public employees from coverage.

As we stated we are not opposed to anyone acquiring Medicare coverage but it appears that once the enabling legislation has been passed pressure will be brought on the state legislative assemblies to "buy" into this coverage at a substantial premium rate per month with no cost to the enrollee.

The latest figure we heard is that the premium would be $32.00 per month per enrollee.

Yours very truly,

MARTIN N. GRONVOLD,
Executive Director.

MADISON, *January 28, 1972.*

Senator GAYLORD A. NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: Since I was chairman of the committee of the American Municipal Association (since renamed the National League of Cities) which spearheaded the fight to make municipal employes eligible under Social Security I am naturally disturbed by the current movement in many parts of the nation which is inducing governments to withdraw social security coverage for public employes.

Unfortunately this movement has as its basis a selfish motive—some whose aim is to accelerate their professional business profits—some who hope to secure greater benefits themselves.

It seems to me to be very bad to stimulate this by the provision contained in HR #1 which is now pending before the Senate committee of which you are a member. I refer to the language on page 381 which would make Medicare

available to public employes without being under Social Security. Since persons in private employment are almost universally mandatorily covered under Social Security it would have little effect in the private sector.

If this becomes law it will certainly stimulate the growing movement to remove public employes from Social Security.

I was not aware when this was proposed in the House so I have not discussed this with Byrnes, but perhaps Ways and Means was not cognizant of what they were doing.

Sincerely,

FREDERICK N. MACMILLIN.

STATEMENT IN BEHALF OF THE UNITED CEREBRAL PALSY ASSOCIATIONS, INC., SUBMITTED BY ELSIE D. HELSEL, PH. D., WASHINGTON REPRESENTATIVE

SUMMARY OF RECOMMENDED CHANGES IN H.R. 1 BY UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

Title XXI

1. Section 2178(b) Page 386:

The local advisory committee should have added to it a person who knows the needs of handicapped children and their families. After "the general public" line 2, page 386, add "*the handicapped.*"

2. Section 2179 Page 387:

Since approximately 12% of the child population is handicapped, we recommend that an earmark be made for day care for handicapped children.

Title II

1. Section 1831(2)(B) Page 137 After Line 15:

Add at the end of this Section a statement that: "Individuals who have been covered by Medicare under Children's Disability Benefits and who are transferred to Disability Benefits on their own earnings need not wait an additional 24 months."

2. Section 239(a)(9)(B) Page 246:

Insert a requirement that institutions reimbursed by Medicaid funds must meet Standards at least equivalent to those used by the Accreditation Council for Facilities for the Mentally Retarded.

Title XX

1. Section 2001 Page 282:

Consideration should be given to a more adequate support base for severely disabled APTD recipients who have no supplementary income resources.

2. Section 2012 Page 292-293:

Make Sections (A) and (B) completely equivalent by adding to (B)—(ii) "an amount equal to any expenses reasonably attributable to the earning of any income."

Change present (ii) to (iii).

3. Section 2015(a)(2) Line 8 Page 302:

Delete "and" and change to read: "Or in the case of disabled children, to such other appropriate state agencies as the Secretary may direct, for service and periodic review with the Secretary reimbursing the cost of such services not specifically authorized for reimbursement by other state or federal legislation.

STATEMENT

United Cerebral Palsy Associations, Inc., appreciate this opportunity to present our views on behalf of our constituency—individuals disabled by cerebral palsy, and their families. We would like to adress only those sections of H.R. 1 which have a unique relevance for help or hindrance with services for this group. Because of the nature of cerebral palsy, we have been forced to address all types and degrees of handicapping conditions—usually in combinations of two or three disabilities in one individual. Damage to the brain, which causes cerebral palsy, also causes many other problems.

About two-thirds of the cerebral palsied are also mentally retarded. Approximately one-half have speech and communication problems. Half are non-ambulatory. One-third have visual disorders; one-fifth have defects in hearing. An undetermined number have learning difficulties associated with perceptual and conceptual problems.

For 23 years we have been the primary advocate for this group. Our National staff of over 100 and our 300 state and local affiliates in 42 states and the District of Columbia have gained considerable expertise in ascertaining needs and developing appropriate programs to meet these needs. We have enlisted the backup support of 500,000 volunteers in our endeavors. We feel, therefore, that we have been privileged to gain some unique insights into problems for this group; some expertise in meeting these problems; and some knowledge concerning legislative needs in order to assist this group in developing their full potential and contributing, to the degree that they are able, to our society.

THE IMPORTANCE OF H.R. 1 TO THE CEREBRAL PALSIED

H.R. 1 is probably the most important single piece of substantive legislation on the lives of the cerebral palsied. Its various titles authorize programs and services that provide access to or delivery of: basic income support (Titles I and XX); screening, diagnosis & treatment; health care; skilled nursing home care and intermediate care facilities (Title II); developmental day care (Titles IV and XXI); social services (Title IV, Title V and Title XVI); habilitation, rehabilitation and training (Titles XX and XXI).

For many of our clients H.R. 1 provides the only life support system outside of public institutions. It means the difference between being able to live in the community and be a part of society or living out their lives often in a meaningless existence in public institutions.

We commend the committee for its willingness to come to grips with some of the most perplexing problems of our Nation, namely, how to assure that segment of our population that, for one reason or another, is vulnerable, a decent standard of living and an opportunity to maximize potential irregardless of how limited this might be.

TITLE XXI

UCP will not comment at length on Title XXI concerned with the welfare programs. Not that we do not have a concern and interest in this area, since poverty spawns disability. However, we feel the Committee has access to expertise far greater than ours in trying to work out solutions to the complex multi-faceted problems in this area.

We would point out however, three very important points that have import for maximizing the residual abilities of cerebral palsied children and for reducing the strain of the birth of a severely handicapped child on a family.

The new Medicaid Regulations published in the Federal Register of November 9, 1971 (Title 45—Public Welfare, Chapter II Social and Rehabilitation Service Assistance Programs, Part 249 Early and Periodic Screening, Diagnosis and Treatment of Individuals Under 21) requiring screening and treatment of vulnerable children in needy families will reduce the impact of cerebral palsy significantly by maximizing residual abilities and by keeping secondary handicapping conditions to a minimum. It seems inconceivable to us that four years could elapse between the time this program was authorized under the 1967 Social Security Amendments Title IV A and the issuance of Regulations to implement the law. However, we are grateful that at long last Regulations have been issued and we hope the Committee would monitor this situation to see that the states comply.

Under Title XXI both the Opportunities for Families Programs and the Family Assistance Plan have provisions for quality day care. Approximately 12% of these children are going to be handicapped, some of them severely handicapped. UCP is concerned that no recognition or provision for such children exists in the law. It has been our experience where no such provision is made in the law that these children and their families are denied services. We suggest that since handicapped children make up such a significant proportion of the child population that some earmark be made for day care for such children and that the Committee insist that those drafting Regulations for these programs include someone knowledgeable concerning the needs of handicapped children. Present Standards for day care for children do not give adequate recognition to the inescapable fact that some of those children are going to be handicapped children.

Section 2178 of Title XXI requires that communities on the local level establish local advisory committees to evaluate the effectiveness of training, employment, *child care* and related aspects of the program. We respectively request that the law indicate that someone on these committees know the needs of families with handicapped children.

In our thinking, providing quality day care which can accommodate handicapped children is a much better solution than merely providing that a mother with a handicapped child need not seek training for work because she must stay home and care for her handicapped offspring.

TITLE I

The general benefit increase of 5% in Social Security Benefits is another small step for mankind—especially those disabled individuals who are dependent on benefits of retired or deceased parents for income maintenance. Until an equitable income support base is available to all disabled citizens we will be grateful for any increases in any program that will help disabled individuals or their families have some measure of control over their destinies by being able to purchase with their own money some of the basic essentials for living—food, clothing and shelter. The alternative for individuals disabled by cerebral palsy is public institutional placement.

TITLE II

The extension under Title II of Medicare to the disabled represents of course a tremendous breakthrough in providing more adequate medical and hospital care for persons unable financially to purchase adequate private health insurance protection or indeed to obtain such insurance at all. We commend the Committee for this extension.

Although we understand the reasons the Committee has placed a delay, before benefits begin, of 24 months after the disabled beneficiary has been entitled to Social Security benefits, we would like to point out that this works an undue hardship on individuals who have been receiving Disabled in Childhood Benefits and then have worked in a sheltered workshop long enough to qualify for disability coverage on their own earnings. Under the present provisions, such an individual would be without protection for two years as they move from one benefit program to the other.

Since the number of such individuals could be fairly accurately predicted and would undoubtedly be small, it would seem that individuals who once had fulfilled the two year waiting requirement should not have to wait the two years a second time. We would, therefore, like to suggest that at the conclusion of Section 1831 (B) a phrase be added stating that individuals who have been covered by Medicare under a childhood disability benefit program are specifically exempt from a second two year waiting period when they transfer to a disability program for which they qualify on the basis of their sheltered workshop earnings.

DISINCENTIVES FOR CARE IN SKILLED NURSING HOMES

In Section 207, UCP is concerned that the disincentives to discourage prolonged stays in institutional settings may limit the use of skilled nursing homes for long term care for some of our cerebral palsied clients for which such care is particularly appropriate. We realize the Committee has included a protective clause "Unless . . . there is in operation in the state an effective program of control over utilization of skilled nursing home services" and we further realize that the Committee does not intend skilled nursing home placement as a permanent long term care service. However, until some other mechanisms for paying for long term care are devised we feel skilled nursing home placement should be an option for our clients. If there is a reduction of one-third of Federal participation after 90 days, we feel this will eliminate the use of this alternative leaving only the inappropriate public residential institution for the retarded for long term care. Once again, the numbers involved are small and with this resource available, our affiliates are able to provide the supportive day to day activities in sheltered workshops or adult developmental centers so that severely disabled individuals can live in the community and earn part of their own way.

INTERMEDIATE CARE FACILITIES

For those individuals with cerebral palsy who do not require the care provided for skilled nursing homes yet do require a program of active treatment to keep them functioning at their optimal level, the extension of Medicaid to Intermediate Care Facilities is a godsend. We are very pleased with P.L. 92-223

which incorporates the Committee's views. We should like to submit for the record a definition of *"active treatment"*:

"Daily participation, in accordance with an individual treatment plan, in activities, experiences or therapies which are part of a professionally developed and supervised program of health, social or rehabilitative services offered by or procured by the institution for its residents.

An individual *treatment plan* means a written plan developed for the individual by an appropriate interdisciplinary professional team setting forth a goal-oriented combination or developmental sequence of activities, experiences or therapies designed to assist the individual to attain or maintain the optimal physical, intellectual, social or vocational functioning of which he is presently or potentially capable."

STANDARDS

Section 239(B) of Title II provides for the establishing and maintaining of standards other than those related to health for public or private institutions receiving Medicaid funds. UCP urges the Committee to insist that Medicaid funds purchase only quality care. With the inclusion of intermediate care in the services that are reimbursable and the provisions that this care may be offered in a portion of a public residential institution so long as active treatment is provided, we urge the Committee to insist that such institutions be required to meet standards at least equivalent to those developed by the Accreditation Council for Facilities for the Mentally Retarded. These Standards are equally applicable to private residential facilities as well.

A copy of the Standards is attached for the Committee's information.[1] These Standards were developed over a period of five years by a consortium of national agencies with a priority concern for improving care in institutions for the retarded namely, American Association on Mental Deficiency, American Psychiatric Association, Council for Exceptional Children, National Association for Retarded Children, and United Cerebral Palsy Associations, Inc.

TITLE XX

We are encouraged by Section 2011 which provides for a planned increase in the income maintenance provisions for Aid for the Permanently and Totally Disabled. However, we should like to call to the Committee's attention the special, desperate plight of the severely disabled, specifically those individuals severely disabled by cerebral palsy. For such individuals even the maximum projected amount, $150 per month, can in no way cover the cost of living expenses for such an individual either in his own home or in a residential setting in the community. Indeed this amount would not even cover the cost of care in a public institution. Although states *can* supplement this amount, it is our considered opinion that very few will. This judgment is based on present low levels of support in most states.

Contrary to the Committee's statement in its Report that "contributary social insurance and other sources of income—private pensions, annuities and other income from assets—are sufficient to keep the total income of the majority of the aged, blind and disabled from falling below the poverty line," the severely disabled individual has no such other resources—nor can he be expected to acquire such resources. Often the APTD Benefit is his only income resource. At some point and in some fashion some realism must be intergrated into costs of long term care for severely disabled people and some way must be found to provide an adequate base of support. These individuals and their families should have some freedom of choice in choosing places to live. The public institution, with its tax support base should not by default always be the only choice for long term care. Other patterns of care can be less costly and more appropriate.

We urge the Committee to give special consideration to this severely disabled group. As the Committee pointed out in its Report the programs for the aged, blind and disabled in general are characterized "by smaller numbers of people, smaller budgets and more nearly static beneficiary roles—and are more susceptible to rapid and efficient reform than the family program." The severely disabled represent a small component of even this group. With the new provisions for identifying this group as children, firm data on numbers will be available.

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[1] The material referred to was made a part of the official files of the committee.

Aid for the Permanently and Totally Disabled with backup support for medical and hospital care through Medicaid or Catastrophic Health Insurance would seem a logical place for providing the basis of support for this group. We urge the Committee to address this problem now and provide a more adequate level of support.

EQUITY IN DISREGARD PROVISIONS AMONG THE DISABLED

We are pleased to see in Section 2012 at long last *almost* equivalent treatment for the disabled in the disallowances for earned income. We do not understand however, why the blind in Section 2012 (b)(3)(A)(ii) should have a disallowance for "amounts equal to any expenses reasonably attributable to the earning of any income" whereas other disabled do not have these allowances. We respectively suggest that the Committee make Section (A) and (B) completely equivalent by the addition of such a disallowance for the disabled.

REMOVAL OF PARENTAL LIABILITY AFTER AGE 21

We applaud in Section 2014 (f)(2) the recognition of the Committee of the severe financial drain on a family that a severely handicapped individual poses. The provision of limiting, for purposes of determining eligibility, consideration of income and resources to eligible individuals over the age of 21 and their spouses will be of considerable help to families of the severely handicapped.

Parents of severely handicapped children have long suffered under the double burden of the psychological blow of learning to live with the knowledge that their child will always be severely handicapped and the additional medical and caretaking expenses such a child imposes. As parents themselevs approach retirement years, it has been doubly unfair to saddle them with not only the worry of what will happen to their severely handicapped son or daughter after they die but also with the financial burden of an additional adult member long after the time when a normal child would have been self-supporting.

The middle income family that pays its own bills and is eligible for almost no tax supportive services because of means tests has been hardest hit by such discriminatory legislation. We are delighted to see the recognition of this problem by the Committee and the attempt at amelioration.

INAPPROPRIATE REFERRAL TO VOCATIONAL REHABILITATION

Section 215—since under Section 2014(a)(3)(A) disabled children are to be eligible for benefits (and we want to go on record as heartily endorsing this provision) we would like to point out a problem concerning Section 2015(a)(2) concerning the referral of such children to the state agency administering the state plan for vocational rehabilitation services, for a quarterly review of his condition and continuing need for services. We would suggest that Section 2015(a)(2) be changed to indicate that disabled children be referred to such other appropriate state agency as the Secretary may direct for services and review, and that the cost of those services not specifically authorized for reimbursement by other state-federal legislation be reimbursed by the Secretray.

Further, since Regulations concerning the screening and treatment of very young needy children have recently been issued (Title 45, Chapter 2, part 249)—Early and Periodic Screening, Diagnosis and Treatment of Individuals Under 21 published in the Federal Register of November 9, 1971) and since the old Title V agency has been suggested as the screening agency for such children it might be logical to use this agency for determination of eligibility of children for Aid for the Permanently and Totally Disabled as well.

The Committee should realize there will be a further problem with APTD children as Federal eligibility standards are drafted. The Committee's Report indicates that the definition of eligibility to be used will be the same as that used for old Title II Disability Benefits. Such definitions will now have to be applicable to very young infants. For example a mongoloid infant can be identified as severely disabled at birth.

FEDERALIZATION OF ADULT CATEGORICAL PROGRAMS

We enthusiastically endorse the federalization of the financial assistance programs to the needy, aged, blind and disabled with Federal standards, uniform eligibility payments and uniform benefit payments under Section 2001 and 2002.

Assignment of administration of this program to the Social Security Administration through its present administrative framework and facilities will transform a program that has been stigmatizing and demeaning to its recipients into one which reflects a humanitarian concern by government for its most vulnerable citizens.

TITLE V

The separation in Section 526 of Social Services from the determination of eligibility for cash assistance payments not only frees professional people for tasks they were professionally trained to do but increases the opportunity for some of the disabled to move from dependency to independence as their social workers have time to see that the full rehabilitation resources of our states are brought to bear on problems at the most effective time. By starting to work with the disabled early, we are hopefully preventing many of the crises and secondary handicapping conditions from occurring. In light of this new potential for prevention and maximization of residual abilities, it is a little difficult to understand why the requirement for "state wideness" for social services has been abandoned in Section 522. We would hope that states would not exercise this option and would develop service delivery systems that could provide for social service coverage for all political subdivisions in their states.

Our affiliates report to us that states have been slow to pick up fully on their options for federal-state programs in social services. Until these programs are more generally available therefore, we oppose strongly the removal of open-ended funding for social service programs.

United Cerebral Palsy Associations, Inc., thanks the Committee for this opportunity to express its views. We would be very happy to supply any additional information the Committee might wish to have.

Respectfully submitted.

ELSIE D. HELSEL, Ph. D.,
Washington Representative.

NOTE.—Sections are referenced into H.R. 1. In the Senate—June 28, 1971.

STATEMENT OF THE NATIONAL ASSOCIATION OF MANUFACTURERS ON TITLES I AND II OF H.R. 1

We welcome and appreciate the opportunity to present our views to this Committee on behalf of the National Association of Manufacturers. NAM member companies—large, medium and small in size—account for a substantial portion of the nation's production of manufactured goods, as well as for the employment of millions of people in manufacturing industries.

SOCIAL SECURITY—A PAYROLL TAX SUPPORTED SYSTEM

Before commenting on specific proposals, the National Association of Manufacturers believes that it cannot be too strongly emphasized that the primary purpose of the Social Security program should be to provide a basic floor of protection against the covered risks. As in the choice of features for a private retirement plan, there are also unlimited features which may seem to be desirable and attractive for a public program such as Social Security. It is extremely difficult to choose among those features which benefit the greatest number of covered workers and are economically justified. This has been the dilemma not only for those who design a private retirement system, but also for those who are charged with the responsibility for designing and legislating the Social Security program.

NAM also believes that the Social Security system should continue to be sustained and supported by payroll taxes. It has been, and should remain, a basic retirement program for people who have had an active attachment to the work force. These people have contributed and their employers have contributed toward their eventual retirement. The system's acceptability by the American people is based on this premise and it should not be converted to a welfare system

based on the concepts of "relief" or "need". NAM strongly opposes any attempt to finance benefits through the use of funds from general revenues. Such a fundamental change in the financing of the program would destroy its identity and its historic concept and would convert the program to a giant welfare scheme bearing no relationship to "earned right."

We think it enlightening to note the tremendous growth in the Social Security system. In 1950, there were approximately 3½ million people receiving some form of Social Security benefits. By the end of last year, one out of every eight Americans—26 million people—were on the benefit rolls. Since 1950, Social Security beneficiaries have increased almost eight-fold and cash benefits payable have increased by 32 times.

While there are many features contained in H.R. 1, we will limit our discussion to the following areas which in our opinion are the most important.

1. *Benefit Increases.*—H.R. 1 provides for a five percent across-the-board increase in Social Security benefits effective in June, 1972. Since 1969 we have supported recommendations for across-the-board increases which were effective in January of 1970 and June of 1971.

While the National Association of Manufacturers believes that another increase is justified in view of the current economic circumstances, we believe that the 15 percent increase made effective for January, 1970, together with the 10 percent increase, effective in June of 1971, has been more than sufficient to account for the drop in purchasing power from 1968 through January of 1973; and we therefore recommend that the effective date for any new increased benefit be no earlier than January of 1973.

2. *Retirement Test.*—Present law provides that a beneficiary under age 72 may earn as much as $1,680 per year and still be paid full Social Security benefits for that year. Earnings in excess of $1,680, to a maximum of $2,880 per year reduce the recipient's Social Security benefits by $1 for each $2 of earnings within that bracket. Earnings in excess of $2,880 per year reduce the recipient's benefits by $1 for each dollar of earnings.

H.R. 1 would increase the amount that a retiree under age 72 can earn without any reduction in benefits from the present $1,680 per year to $2,000 per year. It also provides for a basic change in procedure since there would be only a $1 reduction in benefits for each $2 of earnings in excess of $2,000. There would no longer be any dollar-for-dollar reduction.

The Social Security program is intended to provide a worker with a partial replacement of his job-related earnings when he stops working. Those persons who would receive the additional benefits proposed are those who are obviously able to work and who will continue to work. The Social Security Administration indicates that 90 percent of such persons are not affected by the Retirement Test because they are unable or unwilling to work or are age 72 or over. NAM believes that Social Security benefits should continue to partially replace income lost by reason of retirement.

NAM believes that there may be some justification for increasing the earnings test to reflect increases in the average earnings level but certainly not to more than $1,800 per year. We fail to see any justification for any change which would modify the basic principle which has been in effect for a decade or more and which would eliminate the dollar-for-dollar reduction in benefits for those earning in excess of a specific amount.

We urge this Committee to support the concept of the three-part Retirement Test, with a possible ad hoc adjustment in the annual exempt amount, as we have hereinafter recommended.

3. *Disability Benefits and Workmen's Compensation.*—When Congress first enacted disability benefits in the Social Security Act of 1956, it included a provision for deducting any benefits under a "workmen's compensation law". This offsetting of workmen's compensation was designed to prevent any doubling-up or duplication of both Social Security and state workmen's compensation benefits for the same disability.

We are pleased that H.R. 1 reaffirms the opinion as expressed in your report which states, ". . . that it is desirable as a matter of sound principle to prevent the payment of excessive combined benefits."

4. *Financing Provisions—Taxable Earnings Base.*—The current law provides for an earnings base of $9,000 per year. H.R. 1 would raise this to $10,200 per

year, and automatically increase this wage base after 1973 as average covered wages rise.

The revenue necessary to sustain existing benefit levels and to provide new and liberalized benefits is derived from a payroll tax. The amount of revenue produced is a function of the taxable earnings base and the tax rate. Since 1951, and subsequently in the 1954, 1958 and 1965 amendments, the level of wages subject to Social Security tax was held to a fairly constant relationship (approximately 80 percent) of taxable earnings to total annual earnings in covered work.

The amendments of 1967 resulted in an increase of the taxable earnings base to $7,800 per year. NAM testified at that time that the $7,800 base was unnecessarily high. Subsequently Congress increased the earnings base to $9,000 per year effective on January 1, 1972. While we recognize that there is some justification for periodically adjusting the taxable earnings base to maintain the ratio of taxable earnings to total earnings at approximately 80 percent, we believe that the current $9,000 base should be maintained and that it more than satisfies these criteria.

5. *Automatic Adjustment of Taxable Earnings Base.*—H.R. 1 provides for automatic escalation of the taxable earnings base based on the general level of average taxable earnings of all persons for whom taxable earnings were reported to the Secretary for the first calendar quarter of the calendar year. The first automatic adjustment would take effect in 1974, and thereafter it would be made once every two years. No maximum limitation is set in the legislation nor is there any provision for a comparable automatic decrease in the taxable earnings base. It can be projected that if this Congress enacts this automatic adjustment feature in 1972, it will amount to having voted to fix the amount of earnings subject to tax in 1989 to as much as $22,000. This would result in an inequitable situation in which the taxes to pay for the preponderance of future benefit increases and other liberalizations would be paid for mostly by people in the middle-income brackets—as well as by their employers.

6. *Automatic Adjustment of Benefits.*—H.R. 1 would tie Social Security benefits directly to changes in the Department of Labor's Consumer Price Index (CPI). In the event that the CPI rises three percent or more for the third calendar quarter of a year as compared with the calendar quarter designated as the base period, then Social Security benefits would be increased by a like percentage amount. This recomputation of benefit would be repeated once a year and adjustment made in the benefit levels payable for the following January.

Such an arrangement appears to be a form of capitulation to the inflationary forces at work throughout our economy. It seems to say that inflation is to be an accepted economic way of life despite the efforts of Congress and the Administration to contain it. Such automatically escalating benefits would affect one out of every eight persons in the United States in terms of greater benefits, but would also affect millions of persons in the work force who have to pay for these increased benefits. The impact of automatically increasing benefits would continuously stimulate the economy and tend to institutionalize inflation.

The National Association of Manufacturers is opposed to this provision and strongly urge this Committee to reject the concept. Attempting to solve inflation problems through the device of automatically escalating benefit levels for approximately 26 million people may seem to be an extremely attractive expedient, but it would create tremendous pressure on government and business for all kinds of similar automatic inflationary devices.

Another apparent attraction of the automatic adjustment concept is that it would minimize political pressures for continued liberalization of the program. NAM believes that this would not be the case, and it is distinctly possible in our view that the opposite result would occur and that such political pressures would only find relief in other areas of the program, and tend to provide higher benefits on top of the automatic increases. One has only to look at the many such proposals which are currently before the Congress.

A review of the record indicates that the Congress has, by ad hoc methods, more than kept abreast of rises in the cost of living by increasing benefits. The complaint that Congress has acted too slowly and that the aged have suffered because of a lag in the adjustment of benefits may have had some merit in the

distant past, but the record indicates that Congress now acts as rapidly as the needs dictate.

NAM believes that a rigid formula would deny Congress the opportunity and responsibility to determine the level of Social Security benefits while also keeping in view the entire economy, including economic trends and pressures that would assuredly escape the mechanical application of such an inflexible device.

AGE 62 COMPUTATION POINT FOR MEN

H.R. 1 provides for a three-year transition period designed to equalize the benefit computations for men as compared with that of women. NAM commends the approach proposed in H.R. 1 and supports the methodology employed.

REDUCTION IN WAITING FOR DISABILITY BENEFITS

H.R. 1 proposes to reduce the six-month period throughout which a person must be disabled before he can be paid disability benefits, to five months. NAM is opposed to such a reduction in the waiting period because it would create confusion in the operation of most private short-term disability wage and salary insurance plans. Such plans have traditionally been structured to pay benefits during the six-month period not covered by Social Security Disability Benefits. Thereafter they have, for the most part, been integrated with Social Security Disability Benefits to provide a relatively stable level of combined benefits. In addition, this liberalization can be viewed as another step toward Social Security encroachment on the states' Workmen's Compensation Systems with respect to occupational disabilities. We believe that this is an undesirable provision and we urge the Committee to reject it.

BURDENSOME COSTS OF H.R. 1

With each succeeding liberalization of Social Security there is increasing concern as to the overall cost impact. We believe that increasing Social Security costs and even higher taxes are becoming most unreasonable. H.R. 1 would increase the employer-employee tax rate from 10.4 percent to 14.8 percent within approximately a five-year period. This rapidly increasing tax rate would apply to a taxable wage base which is also increasing, beginning with a sizable jump immediately from the current base of $9,000 to $10,200 per year. To illustrate this expanding burden we attach to this statement a table showing the taxable wage base, tax rate and maximum contributions of H.R. 1 as compared with the present schedule. This is shown in Exhibit 1.

To more graphically illustrate the cost acceleration which would take place should H.R. 1 be adopted in its present form, reference is made to two graphs (Exhibits 2 and 3). Exhibit 2 depicts the increase in taxable wage base under the automatic escalation feature which would tie that base to the average wages in the United States. The automatic escalation is projected on the basis that there could be a five percent annual increase in the average wage level in the United States over the next decade. While we do not predict that this figure will be realized, it is not out of line based on recent past experience and current conditions. From this it can be seen that the taxable wage base can be as high as $22,000 as early as 1989.

Exhibit 3 depicts the Social Security contribution which will be paid by each individual employee and by his employer (not combined). This is based on the projected taxable wage base shown in Exhibit 2. In addition, Exhibit 3 indicates the percentage increase of contributions required by H.R. 1 as compared with scheduled contributions of the current Social Security law.

In only five years (1977) the amount of Social Security contribution which each employee and each company would be required to make would increase by 75 percent ($920.00) over the scheduled contribution required under current law ($526.50). By 1989 each company and each employee would make a maximum contribution ($1,630.00) which would be 200 percent greater than the one required by today's Social Security schedule ($544.50).

This bill goes a considerable distance toward moving the philosophy of the Social Security program from a "floor of protection" concept to one which would pose a serious threat to the continued expansion of the private pension plan system. For many years a combined employee-employer tax rate in the neighborhood of 10 percent was considered to be a ceiling for Social Security tax purposes—it is now scheduled at 12.1 percent.

We realize that there is no magic in the 10 percent figure but this bill would increase it by almost 50 percent (to 14.8 percent). We think it is time to put a brake on ever-escalating Social Security taxes. We believe that Social Security costs are getting out of hand. We urgently recommend that this Committee modify H.R. 1 and many of its provisions, particularly those automatic escalation features which would tend to skyrocket costs and lock in inflationary pressures. We further believe that consideration should be given to reestablishing Social Security financing on essentially a pay-as-you-go basis, thus permitting a rdeuction in scheduled maximum contribution amounts.

MEDICARE AND MEDICAID

NAM supports and commends the attempt made in this bill to streamline and make more efficient both programs. Our views on Medicare and Medicaid are set forth in greater detail in our position paper entitled "Financing Health Maintenance, Care and Delivery", a copy of which is attached to this statement and we respectfully request that it be made a part hereof. In addition we do have some specific comments as follows.

MEDICARE COVERAGE FOR DISABLED BENEFICIARIES

The bill would cover the disabled under Medicare after having received disability benefits for not less than 24 consecutive months. The cost of including such persons is estimated at about $1.8 billion for the first full year and $2.5 billion per year in the long run. Coverage of the disabled under Medicare was considered during the hearings conducted on H.R. 17550 last year but wisely, we believe, was not included in either the House or Senate versions. NAM believes there are important reasons for regarding the disabled as different from the elderly since dealing with the medical care costs of the disabled in many cases affects the insurance of other members of the disabled person's family. Since there are currently several other private and public proposals for health care for the disabled person and his family, we believe that these approaches should be studied first. Further, we should make sure that we have adequately financed the increasing costs of Medicare for the 65-year-old and older group before making additional commitments.

PART B—PREMIUM CHARGES

H.R. 1 proposes that the supplementary medical insurance premium paid by the enrollee could be increased in the future only to the extent that benefit levels are also increased. The bill further proposes that should costs of this program exceed such additional revenue, then the balance would be financed out of general revenue.

GENERAL COMMENT

As we interpret it, there appears to be an increasing trend, as evidenced by this bill, toward the use of and reliance on general revenues for financing liberalizations of the program. NAM believes that such a trend is contrary to the concept and acceptability of the Social Security program to the American people. This program was intended to provide work-related benefits, and efforts to make it over into a welfare plan should be staunchly resisted. Continued acceptance of the social insurance concept by the American people depends upon Congressional restraint on including benefits not rleated to earnings or attachment to the labor force or pure welfare benefits. Reliance on expanded general revenue financing only serves to weaken further the social insurance concept and leans more heavily towards the operation of the entire program as a national welfare program. We believe that the Social Security program should continue to be financed on a payroll tax basis.

EXHIBIT I

PRESENT SOCIAL SECURITY LAW				H.R. 1				H.R. 1 (Projected)			
Year	Tax Wage Base	Tax Rate	Scheduled Maximum Contribution	Tax Wage Base (exclusive of auto.)	Tax Rate	Scheduled Maximum Contribution	% Increase	Automatically Escalated Taxable Wage Base	Maximum Contributions	% Increase over Current Law Schedule	Year
1971	$7800	5.2%	$405.60	$7,800	5.2%	$405.60	0%		$405.60	+0%	1971
1972	9,000	5.2	468.00				+18%		550.80	+18%	1972
1973				10,200	5.4	550.80	+18%		550.80	+18%	1973
1974	9,000	5.65	508.50	+			+10%	$10,700	580.00	+14%	1974
1975				10,200	6.2	632.40	+24%	11,235	700.00	+38%	1975
1976				+			+20%	11,800	730.00	+44%	1976
1977	9,000	5.85	526.50				+43%	12,400	920.00	+75%	1977
1978							+43%	13,000	960.00	+82%	1978
1979							+43%	13,600	1,010.00	+91%	1979
1980							+41%	14,300	1,060.00	+101%	1980
1981								15,000	1,110.00	+107%	1981
1982	9,000	5.95	535.50	10,200	7.4	754.80	+41%	15,800	1,170.00	+118%	1982
1983				+				16,500	1,220.00	+128%	1983
1984								17,300	1,280.00	+139%	1984
1985								18,200	1,340.00	+150%	1985
1986							+39%	19,100	1,410.00	+163%	1986
1987	9,000	6.05	544.50					20,000	1,480.00	+180%	1987
1988								21,000	1,554.00	+195%	1988
1989								22,000	1,630.00	+200%	1989

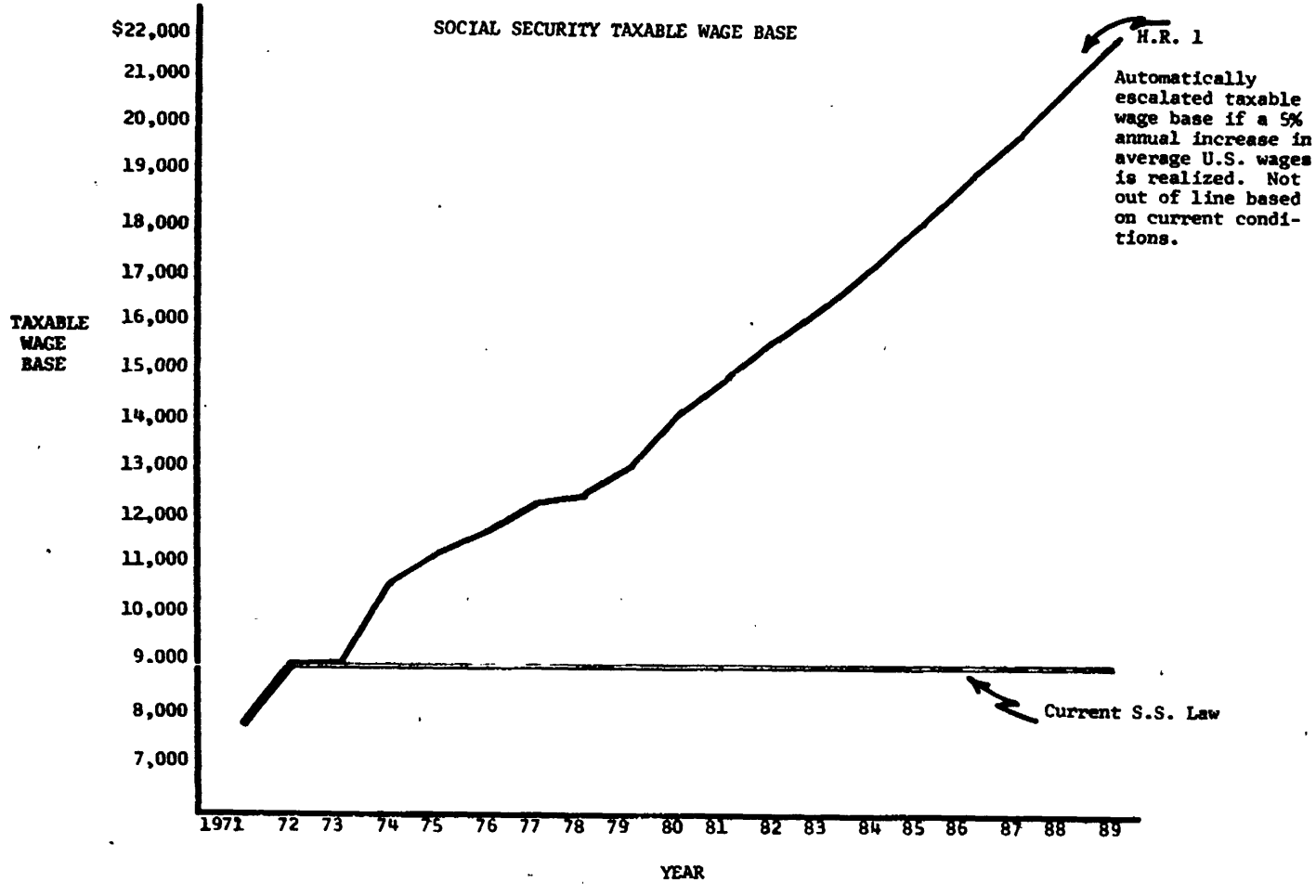

EXHIBIT 2

3340

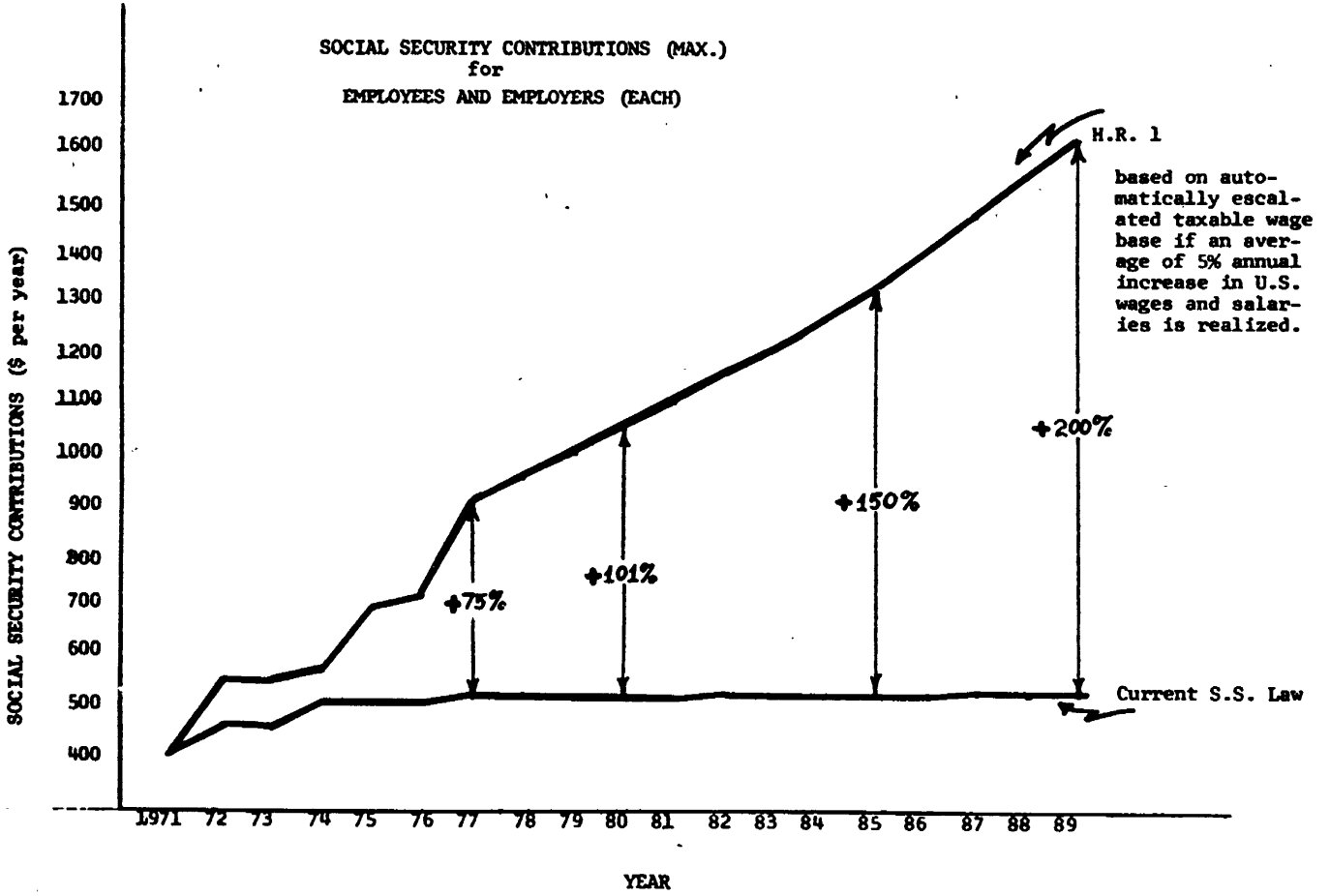
SOCIAL SECURITY CONTRIBUTIONS (MAX.)
for
EMPLOYEES AND EMPLOYERS (EACH)
SOCIAL SECURITY CONTRIBUTIONS ($ per year)
1700
1600
1500
1400
1300
1200
1100
1000
900
800
700
600
500
400
1971 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89
YEAR
H.R. 1
based on automatically escalated taxable wage base if an average of 5% annual increase in U.S. wages and salaries is realized.
+200%
+150%
+101%
+75%
Current S.S. Law

EXHIBIT 3

Financing Health Maintenance, Care and Delivery

NAM

Government Operations/Expenditures Committee

Financing Health Maintenance, Care and Delivery

AN

NAM POSITION PAPER

Prepared by the

Expenditure Process Subcommittee

Government Operations/Expenditures Committee

NAM Policy Statement on *Financing Health Maintenance, Care and Delivery*

THE GOAL OF NATIONAL POLICY for health care and delivery should be a competitive industry capable of providing incentives for maintaining health, as well as necessary services for the sick. National policy should give maximum encouragement to the private health and insurance industries to develop incentive-oriented methods of health maintenance, care and delivery which are designed to provide better and more comprehensive health services and bring costs under control without sacrificing quality.

The federal and state governments should: (1) encourage the removal of legal and other barriers to the introduction of new or improved health care and delivery systems; (2) avoid providing and financing health services to the entire population; and (3) assure that federal and state income assistance intended to enable the needy to obtain adequate health care be used exclusively for that purpose.

—Adopted December 2, 1970

INTRODUCTION

In the past several years, the problems of providing adequate medical and health services have been compounded by the enactment, and apparently uncontrollable expansion, of medicare and medicaid. As a result, a period of "retroactive planning" with respect to these programs began early in 1970.

As this re-examination progressed, it has involved much broader issues of financing health care delivery in the United States and public-private roles therein. The public policy debate which is developing will center on the choice between a compulsory national health insurance and a pluralistic approach to the problems of providing more comprehensive health services without sacrificing quality. The new NAM position is addressed principally to this issue.

The Public and Private Costs of Medicare and Medicaid

Congress enacted Titles XVIII (medicare) and XIX (medicaid) of the Social Security Act in 1965. There seems little doubt that these major federal programs have been important factors in accelerating the demand for more and better health care services and in crystallizing the problems of health care delivery throughout the nation.

While medicare and medicaid are different programs, they are related and can be considered jointly at least as far as overall cost impact is concerned. Both programs involve federal payments for health care services to the poor and aged: medicare currently pays for health care services for 20 million aged; medicaid coverage extends to more than 10 million poor. This aid to the general population is in contrast to older health programs directed toward such specific categories of federal beneficiaries as members of the armed forces, veterans, merchant seamen and American Indians. From the point of view of financing, it was stated in a recent Congressional debate that medicare and medicaid now pay 72 percent of the health bills for the nation's aged—a dramatic change from only 4 years ago when 70 percent of the health expenses of the aged were privately paid.

Table I summarizes the increase in federal health outlays in relation to total federal outlays and to total expenditures for health. Between fiscal years 1960 and 1965, federal outlays for health increased but remained a relatively stable portion of total federal spending. Between fiscal 1965 and 1969, the amounts spent on health increased both absolutely and

TABLE I

Federal Outlays for Health Related to Total Federal Outlays and Total Expenditures for Health

	Fiscal Year						
	1960	1965	1967	1968	1969	Est. 1970	Est. 1971
Total federal outlays (billions)	$92.2	$118.4	$158.4	$178.9	$184.6	$197.9	$200.8
Federal outlays for health (billions)	$ 3.5	$ 5.2	$ 10.8	$ 14.1	$ 16.6	$ 18.8	$ 20.6
Federal health outlays as percent of total federal outlays	3.8	4.4	6.2	7.9	8.2	10.0	10.5
Total national health expenditures (billions)	$26.4	$ 38.9	$ 48.2	$ 53.9	$ 60.3	*	*
Federal health outlays as percent of total national health expenditures	13	13	22	26	28	—	—

*Not available

Source: "Federal Health Programs" in *Special Analyses, Budget of the United States, F.Y. 1971*, p. 147.

proportionately. The percentage of total federal spending allocated to health is expected to level off in fiscal 1971, although actual spending is estimated to increase by $1.8 billion again.

There can be little doubt that, as the Budget for fiscal 1971 stated: "The major factor in the yearly increase continues to be Medicare and Medicaid." Outlays for these two programs were estimated at $11.6 billion in fiscal 1971—and are expected to account for 83 percent of the increase in federal spending for health in that period.

The original cost assumptions for both programs fell far short of actual experience.

- In 1965, it was estimated that medicare costs in calendar year 1970 would be $3.1 billion; the current estimate is $5.8 billion.
- In fiscal 1965, medicaid expenditures amounted to $1.3 billion, of which the federal share was $555 million. For fiscal 1971, the estimate for total medicaid outlays is about $6.2 billion, with the federal share amounting to $3.1 billion. Recent estimates indicate that the federal share for medicaid may be as high as $12 billion by 1975, with the states contributing an equal amount.

The unexpected demand for more and better medical services and increased utilization of health facilities resulting from the enactment of medicare and medicaid has affected the health costs of the entire population. Some authorities blame the architects of these programs for ignoring the fundamental laws of supply and demand. Vast new demands were created for medical services without any real understanding of the impact on the supply of health care services. This helped fuel an explosion in medical care costs that is even more aggravated than the general inflation currently plaguing the economy (see Table II).

In addition to their impact on spending and on the total economy, these programs are also beset by administrative and management problems resulting from legislation which was enacted in haste, without adequate planning and analysis, and which imposed complex problems and systems for reimbursement. Therefore, the first question has been how these existing programs could be made more effective and their costs brought under control.

Medical Economics and Proposals For Changing Medicare and Medicaid

There is a growing recognition that the facts of medical economics, heretofore of relatively little general interest, provide essential clues to the question of what went wrong with medicare and medicaid. For example, one of the traditions of medical care is free service to the needy by both doctors

TABLE II

Consumer Price Indexes for Food, Rent and Medical Care, 1960-1969

Year	Food	Rent	Medical Care
1960	101.4	103.1	108.1
1961	102.6	104.4	111.3
1962	103.6	105.7	114.2
1963	105.1	106.8	117.0
1964	106.4	107.8	119.4
1965	108.8	108.9	122.3
1966	114.2	110.4	127.7
1967	115.2	112.4	136.7
1968	119.3	115.1	145.0
1969	125.5	118.8	155.0

Source: Bureau of Labor Statistics

and nonprofit (voluntary) hospitals. When funds were made available through these programs to pay for medical care to the aged and the poor, could the practitioners and the institutions be expected to continue to provide services at no cost?

To cite another instance, between 1946 and 1970, the supply of hospital beds was increased by the construction or modernization of 467,000 beds at a cost of approximately $12 billion. The federal share was $3.7 billion, or roughly 30 percent. However, the increase in hospital costs was even steeper than that of medical care generally. A good deal of this results from the increase in wage costs, particularly for non professional personnel, and the continuing low productivity of the industry as a whole. Although these trends were already discernible in the mid-1960s, both medicare and medicaid were so structured as to encourage hospitalization. Further, the "reasonable cost" reimbursement formula provided no incentive for increased economy or efficiency. In fact, insofar as it encouraged the building of excess bed capacity and, in some places, the duplication of expensive equipment, it tends to raise the cost of hospitalization.

Further, the increased demand for medical services, arising in great part from third party payments (private insurance, medicare, medicaid) raises questions about the adequacy of the supply of medical manpower. On the general assumption that there is a shortage of physicians, registered nurses and other professionals, there has been an effort to increase the

supply and shorten the training cycle. The federal government is now the dominant force in medical education insofar as it contributes so large a portion of the funds that go to medical schools. In addition to the matter of supply, however, there is the problem of relating manpower needs to the structure of the health industry. Professor Eli Ginzberg, an economist specializing in manpower problems, has raised interesting questions summarized in the comment: "There is no point to increasing the supply without altering the pattern of utilization."

Similarly, Dr. Paul M. Ellwood, Jr., consultant to the Department of Health, Education and Welfare, believes that merely increasing the supply of physicians, without changing the structure and organization of the health industry, would further increase demand and escalate costs:

> "Further, it's doubtful that more physicians would solve the problem of availability of medical care anyway, unless unacceptable steps were taken to simultaneously regulate the specialties they choose and the locations where they establish practice. For example, 53 counties in the United States have no available physicians, while some urban areas have more doctors than can be efficiently utilized. Present rigidities in licensing procedures, constraints of malpractice, and other barriers to medical practice in the various states, also restrict optimal utilization of available health personnel. Maldistribution and suboptimal utilization of health manpower are the result of conditions which cannot be treated by simply increasing the supply, and in fact, may be aggravated by this approach." (Unpublished paper, 1970)

The major proposals which have been made for improving medicare and medicaid have recognized the implications of these aspects of medical economics, some of which require long-term solutions, as well as the need to make immediate improvements in the administration and management of these programs. As the McNerney Task Force on Medicaid and Related Programs stated in its *Report* of November 12, 1969:

> "Recommendations at this time are focused largely on what can be implemented essentially within the framework of the present Medicaid system. Let it be clear, however, that the Task Force sees many weaknesses in this framework. Fundamental changes may well prove necessary in the long run. But when human services are at stake, no purpose is served by continuing to live with inefficiencies and inequities that can be remedied, particularly when the short-run improvements can be designed to fit or, at the least, not run counter to probable long-run courses."

The chief recommendations that have been made to date with respect to medicare and medicaid are embodied in the Administration's budget

proposals for fiscal year 1971; the Social Security Amendments of 1970 (H. R. 17550), and the President's Family Health Insurance Plan, which will not be detailed in legislation until early 1971. These are summarized below.

The Fiscal 1971 Budget Proposals

The President's Budget Message recommended revisions of medicaid "to stimulate the use of proper, but less expensive, medical treatment outside hospitals and long-term care institutions." In the budget document proper, the Administration proposed legislation that would:

- Shift 0.6 percent of the Social Security combined payroll tax from the retirement system to the hospital insurance part (Part A) of medicare, effective January 1, 1971.
- Increase the monthly premiums for Supplementary Medical Insurance (Part B of medicare) from $4 to $5.30 on July 1, 1970.
- Limit medicare and medicaid depreciation reimbursement to facilities whose capital improvements have been approved by an appropriate health planning agency.
- Exclude from the program those physicians, hospitals, and other health services providers found guilty of flagrant abuses.
- Expand utilization review authority to include the initial need for hospitalization.
- Require long-range construction planning by providers of services as a condition of program participation.
- Expand the Department of Health, Education and Welfare's authority to experiment with and install financial incentives to efficiency and economy.
- Direct medicaid more toward preventive and acute medical treatment programs and away from long-term residential care which has represented almost one-third of all medicaid outlays.

There were also proposals to shift medical facilities construction funds (largely Hill-Burton) *away* from direct grants and the "quantity of beds" approach and *toward* more funding for ambulatory facilities, reliance upon guaranteed loans with interest subsides for construction and modernization of private non-profit hospitals and long-term care facilities, and direct loans for public institutions. These requests were so transformed in the Medical Facilities Construction and Modernization Amendments of 1970 (H.R. 11102) that the President vetoed the bill. The veto was overridden by both Houses. However, the Bureau of the Budget's views on the relationship between the Hill-Burton approach and present health care needs is of interest:

". . . new conditions and changing needs make sole reliance on

grant programs or emphasis on additional hospital beds inappropriate. With medical price increases and the inability of the health system to deliver services effectively, there is growing recognition of the need to develop ambulatory care facilities (hospital outpatient departments, clinics, and community centers), particularly where they can serve as more efficient and economical alternatives to hospital care. In addition, the growth of third party payments (e.g., private insurance, Medicare, and Medicaid) to cover the costs, including depreciation, of hospital and skilled nursing home care, has improved the ability of these institutions to finance needed capital improvements through borrowing." *(Special Analyses of the Budget, Fiscal 1971,* p. 153)

Social Security Amendments of 1970

The health care amendments comprise Part B of Title II of the House-passed H.R. 17550. These are intended to improve the operating effectiveness of medicaid, medicare and maternal and child health programs. At the time of writing, this legislation had not been enacted.

There is potential for improved administration in recommendations that, if enacted, would:

- Encourage experiments and demonstration projects to develop incentives for economy in the provision of health services.
- Extend utilization review requirement to hospitals and nursing homes under medicaid.
- Require institutional planning in the form of overall plans and budgets for hospitals under medicare.
- Expand utilization review to include the question of the initial need for hospitalization.
- Establish incentives through variable federal matching rates for states to emphasize outpatient care under medicaid programs.
- Provide incentives through federal grants to the states to install and operate claims processing and information retrieval systems under medicaid.

The bill also included provisions addressed to the problem of controlling the inflationary factors inherent in the present "reasonable cost" reimbursement practices. These appear to raise as serious problems as they may solve. For example, it is generally recognized that disallowance of costs *after* services have been provided by institutions creates uncertainty. Therefore, the solution offered is to set limits on a prospective basis, evaluate necessary costs on a class—rather than a case—basis, and provide that

extra or more expensive services be charged to the beneficiary if he is so advised prior to admission. These steps seem to be logical guidelines for a systematic approach to the definition of "reasonable cost."

Because there appears to be no adequate body of timely cost data for making the necessary comparison of costs of health care institutions or measuring the efficiency of health care delivery, the House Ways and Means Committee suggested that the Secretary might be able to set "reasonable limits" for a class of institutions so that only extraordinary expenses would be subject to any limitations. This does not seem to be an effective approach to control of inflationary tendencies nor does it provide any real incentive for the institutions to control their costs or reduce the length of hospitalization.

One of the findings highlighted in the Senate Finance Committee's staff report on medicare and medicaid was that medicare payments are usually significantly higher than those made by carriers under their own programs. This suggests that another approach to the matter of "reasonable costs" would be to *require* that these two sets of reimbursements be brought into line—instead of *considering* "customary and prevailing charges," as in the present statute. This would provide a direct guideline without introducing a clumsy administrative apparatus or rigid controls.

The attempt to implement this approach to the "reasonable cost" issue in H.R. 17550, as it applies to services under the supplementary medical insurance program, is both less direct and more complex. The present administrative policy of using the 83rd percentile of customary charges as the limit of "reasonableness" would be modified by using the 75th percentile as the standard after June 30, 1971. Beyond that, beginning with fiscal 1972, increases in fees would be recognized as reasonable in terms of their relationship to two economic indexes: Consumer Price Index (exclusive of medical care) and earnings in the area as reported to the social security program. The compulsory regulation of fees does not seem to be a substitute for incentives for more efficient delivery of health care services. In fact, this approach might merely discourage practitioners from caring for medicare patients..

One of this group of amendments goes beyond both the administrative improvement and the direct cost control approaches. That provides for payments to health maintenance organizations for persons eligible for benefits under medicare. Such payments would be on a prospective per capita basis. Premiums would be determined annually, taking into consideration premiums on non-medicare enrollees, but would be no more than 95 percent of the estimated amount that would be payable if such covered medicare services were furnished outside of the health maintenance organization framework. The Ways and Means Committee's Report noted that

there is sufficient authority in the present medicaid program to permit states to arrange for medicaid coverage through a health maintenance organization if beneficiaries are guaranteed freedom of choice of health providers.

Family Health Insurance Plan

In June, President Nixon proposed a Family Health Insurance Plan. The details will be transmitted to the Congress early in 1971. The proposal came as part of the Administration's response to the Senate Finance Committee's request for amendments to the Family Assistance Act. Therefore, it is directed at elimination of: (1) state by state variations in coverage, benefits and eligibility; (2) categorical inequities arising from the exclusion of male-headed ("working poor") families; and (3) the abrupt termination of benefits when income reaches the welfare or the "medically indigent" cutoff points.

The program the Administration is developing is a form of graduated contributory insurance with family contributions scaled by income. Coverage might be mandatory for families receiving benefits where their cash benefits were equal to or in excess of the required premium.

According to Administration statements, benefits under this proposal would be tailored to provide encouragement of: (1) the use of lower cost outpatient services; (2) prevention and early care; and (3) reimbursement policies designed to encourage efficiency, economy and utilization control. It could, according to their estimates, be provided without significant increases in federal outlays beyond medicaid expenditures projected for fiscal year 1972.

* * * * * * *

The health maintenance organization proposal for medicare beneficiaries in the pending Social Security Amendments and the Administration's proposed Family Health Insurance Plan for some medicaid beneficiaries indicate the probability of fundamental changes in both programs. Because of the magnitude of these programs and their impact on health care generally, such changes would affect all health care services and costs.

To say that the federal programs are moving in the direction of "insurance" is an oversimplification. On the one hand, Part B of medicare and the cost sharing or deductible provisions of medicaid already have some of the qualities of insurance, as does the financing of Part A (hospital insurance) of medicare. On the other hand, the proposals for national health insurance vary greatly, as do the types of private health insurance now available. What is really being discussed is how to achieve better and less costly health care delivery.

The Federal Role

It has been suggested that the Administration must make a major decision on its strategy for dealing with the "much proclaimed health crises" by choosing between:

- reliance on continued or increased federal intervention through regulation, investment and planning, and
- promoting a health maintenance industry that is "largely self-regulating and makes its own investment decisions regarding resources such as facilities and manpower." (Dr. Paul M. Ellwood, Jr.)

Obviously the Administration is moving in the direction of the second alternative. In Secretary Richardson's words: "One of our goals is to open the market place and provide opportunities for new delivery systems."

The nature of the health care industry, British experience with its nationalized health services, and the basic attitude toward federal intervention in the provision of basic services all appear to make that the more attractive choice.

The Administration's preference for the second alternative also is related to the larger issue of substituting an "income strategy" for a whole slew of service-type programs. The Family Assistance Plan, if operative, would give the poor, including the working poor, a better basis for buying medical services which are now provided to those "on welfare" through medicaid. The Administration's proposal to transform medicaid into a prepaid medical insurance coverage for the same population, with "premiums" based on a sliding income scale, appears to be a logical extension of the "income strategy" approach.

Some observers look for significant overall cost saving in the "income strategy" approach, assuming that much more selective use of medical services would be made with more consumer discretion (and financial responsibility) for the extent of those services. Unnecessary and costly overtaxing of hospital facilities, of course, has been one of the main criticisms of the medicare-medicaid programs.

As the national debate on health care policy continues, however, the alternatives of federal intervention or a self-regulating health industry are likely to become less clear as a variety of subquestions are raised. For example:

- There is great interest in prepayment as a method for improving the quality and controlling the cost of health care, but should prepayment be on a capitation or a services-rendered basis?
- If prepayment is a synonym for insurance, does that mean a national insurance program financed through taxes? a dual system? a private

system with government subsidy to those unable to afford to pay their own premiums? a system of tax credits?

- If prepayment is on a capitation basis, is it likely to require or favor group rather than individual practice?

Such questions—to some extent even the basic choice as to the federal role—in turn go back to the fundamental issue of what it is that we are trying to accomplish. Clearly there are two major goals: (1) improving the quality and accessibility of health care; and (2) controlling the cost. Almost all people who are discussing the issue want to do both: to provide quality care at reasonable cost.

"Quality" in health care is something which the majority of patients—or consumers—are unable to evaluate. As is frequently pointed out, it is usually health care practitioners, rather than those who pay the bills, who are the consumers of health services in the sense that they select what is to be done for the individual. It is probable that the individual patient, or his family, respond to subjective criteria—a private room or a private nurse are pleasanter than being in a ward or sharing the attention of floor nurses with others; there are more amenities in a private hospital than in a city hospital; the elderly patient in a nursing home enjoys the attention of frequent visits from "his" physician, and so on. Therefore, the judgement of "quality" from a technical point of view must depend on peer review by professionally qualified people.

The financing of health care delivery and the approaches to cost control, beyond specific administrative reforms of medicare and medicaid, are the areas in which debate over the federal role will be concentrated. There are four major types of financing proposals before Congress and the public:

1. national health insurance
2. catastrophic health insurance
3. tax credits for private health insurance
4. federal subsidies for purchase of health insurance by low-income families

Implicit in the discussion of "income strategy" is the possibility of a fourth approach which would work toward replacing medicaid and, eventually medicare, by income additions to allow purchase of health care services on the open market.

Health insurance is already a familiar factor in health care. What will be debated is not its value but its financing.

- About 85 percent of the American population have some form of private health insurance, which covers about one-third of health care expenditures.
- Coverage is most complete for hospitalization for all income groups;

followed in a declining scale by inpatient and surgical services and outpatient services.

- 56 percent of the population with incomes under $5,000 have some coverage.
- Only 36 percent of those with incomes under $3,000 have some hospital insurance coverage.
- Medicare provides hospital insurance under Part A for people over 65 and voluntary insurance for health services under the optional Part B for almost all of them.

National Health Insurance

The idea of converting the Social Security system to provide a national health insurance is not new. This broader definition of "social insurance" is prevalent in other countries and the idea has been discussed time and again since the enactment of the Social Security Act. Medicare gave the concept a new impetus.

Three closely related proposals were made in the 91st Congress and are likely to be introduced again in the 92nd.

The National Health Insurance Act (H.R. 17806), sponsored by Rep. Martha Griffiths, would extend and adapt the Social Security mechanism to provide comprehensive medical care for the total population and comprehensive dental care for children under 16. Eye care and prescription drugs would also be included.

To finance this program, employees would pay 1 percent of payroll and employers 3 percent, with the federal government matching the employers' contribution from general revenues. There would be a minimum cost-sharing (e.g. $2 per visit to the doctor after the first visit) by the patient. A rough beginning cost is $40 billion per year.

The *Health Security Program,* a similarly comprehensive program, was announced on July 7th by the Committee of 100, a private group formed by Walter Reuther. Senator Edward M. Kennedy introduced it as S.4297, the Health Security Act, and it has a bipartisan group of sponsors.

The program would be financed through a health security trust fund, similar to the Social Security trust fur . . The fund's income would come from three sources—40 percent from general revenues, 35 percent from a 3.5 percent tax on employer's payrolls, and 25 percent from a 2.1 percent tax on individual income up to $15,000 a year. In addition, the bill would "allow" the employer to pay all or part of the employee's tax. On the basis of data for fiscal year 1969, the program would have paid for $37 billion —or 70 percent—of the $53 billion in personal health expenditures. Its sponsors have estimated that the cost of the program at present would be $40 billion; others have placed its cost at about twice that amount.

The *National Health Insurance and Health Improvement Act* (S. 3711) is sponsored by Senator Jacob K. Javits. It would provide for a new trust fund, in addition to the one providing benefits for the elderly under medicare. The total cost would be financed from payroll taxes reaching the rate of 3.3 percent on a $15,000 earnings base by 1975. The estimated cost by 1975, excluding savings on medicare and medicaid, would be $22.7 billion.

This plan would be implemented in steps with the total population eligible for basic benefits now provided by medicare by 1973. The first step would be the merger of Parts A and B of medicare and their extension to include the disabled under the age of 65. After coverage became universal, prescription drugs, dental care for children under 8, and diagnostic services, including eye and ear examinations, would be added.

Catastrophic Health Insurance

The Senate Finance Committee approved an amendment to the Social Security Bill, proposed by Chairman Russell B. Long, adding a Catastrophic Health Insurance Program. This would provide coverage against the cost of catastrophic illness for about 95 percent of the population under 65. The plan would pay 80 percent of covered medical costs after a family had spent $2,000 a year, and about 80 percent of hospital costs after an individual had been hospitalized for 60 days. The program would cover the same services included in medicare and would be financed through social security taxes. First-year costs are estimated at $2.3 billion.

Tax Credits

A number of proposals have been made to provide a tax credit as an incentive for the purchase of private health insurance. This proposal is most closely identified with the American Medical Association. The A.M.A. proposal, originally offered in December, 1968, was modified in 1969. Testifying on medicare and medicaid before the Anderson Subcommittee of the Senate Finance Committee in June of 1970, Dr. Gerald D. Dorman, A.M.A. President, summarized the Medicredit program:

> . . . To meet the problems of Medicaid, each low-income person would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The cost would be completely federally financed.
>
> . . . For the middle and higher levels of income, tax credits would be offered, on a sliding scale, favoring lower-income groups, based on the tax liability of a family for the purchase of qualified health benefits coverage.

A draft bill, the Health Insurance Act of 1970, is available but it has not

been introduced. The American Medical Association has been coupling its proposals for professional review with its financing proposals. Senator Wallace Bennett has proposed a professional standards review amendment to the Social Security Amendments of 1970.

An Incentive System

A self-regulating health industry would be designed to provide economic and professional incentives toward maintaining health, rather than just providing services for the ill. It depends on an element of competition and a variety of approaches to the matter of financing.

Medicare and medicaid have disappointed almost everyone. The most obvious problem, which was responsible for much of the attention focused on these programs in the past year, is their skyrocketing costs and related inflationary pressure on all health care services. The emphasis of medicare and medicaid has been almost entirely on institutional care of the sick—specifically hospitalization—rather than on preventive medicine and the maintenance of health.

The proposals for compulsory national health insurance, although they may recognize the importance of health maintenance, are otherwise extensions of the basic approach of medicare and medicaid, which simply has not worked. Government has not proved to be an effective purveyor of services—particularly of such individualized services.

The present problems of health care, maintenance and delivery require more than one approach. The development of alternative systems should be encouraged and their results evaluated and publicized. In this connection, the federal and state governments do have roles to play. There are some laws and practices—the prohibition of group practice, unwillingness to license paramedical personnel, insurance programs that encourage hospitalization are examples—that are barriers to the introduction of new or improved health care and delivery systems. Government should encourage the removal of those barriers.

Although government should avoid financing health services for the general population, it should provide a substitute for medicaid to enable the needy to obtain adequate health care directly from the funds they receive in the form of federal and state income assistance. Procedures to assure its use for medical purposes will be necessary.

In summary, national policy should give maximum encouragement to the private health and insurance industries to develop incentive-oriented methods of health maintenance, care and delivery designed to provide better and more comprehensive health services and bring costs under control without sacrificing quality.

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National Association of Manufacturers
277 Park Avenue, New York, N.Y. 10017 (212) 826-2100

STATEMENT BY CAPT. PAUL METCALF, CHAIRMAN, COMMITTEE ON DISCRIMINATION IN PILOT EMPLOYMENT, AIR LINE PILOTS ASSOCIATION, INTERNATIONAL

The Air Line Pilots Association, International, appreciates this opportunity to present its views on H.R. 1, amendments to the Social Security Act.

The Association, whose membership consists of about 40,000 airline crew members, employed by more than 45 common carriers, has a unique interest in the proposed amendments. Since almost all of the nation's airline pilots are represented, in collective bargaining and in safety matters, by the Association, we owe a special obligation to our members and to this Committee to focus attention on a blatant inequity in the present law which this Congress now has an opportunity to alleviate.

The inequity to which I refer derives, in a large part, from an administrative regulation which requires airline pilots to retire at Age 60 regardless of their actual health, fitness, and qualifications. The current Social Security law however, aggravates the injustice of this regulation and the Association is gratified that H.R. 1, as we will show, takes some modest but progressive steps towards a partial remedy.

In December 1959, the Federal Aviation Administration promulgated a regulation (Federal Aviation Regulation Setion 121.383(c)) which prohibited any person from serving as a pilot on an airplane engaged in certificated air transport service once that person has reached his 60th birthday. Despite Association objection, the federal courts have, thus far, upheld the regulation as being within the Administrator's discretion to promulgate.

The regulation has also survived in the face of Congressional enactment of P.L. 90-202, the "Age Discrimination in Employment Act of 1967". Although Congress there asserted that the public policy of the United States was ". . . to prohibit arbitrary age discrimination in employment", subsequent administrative rulings were issued characterizing the FAA Age 60 limitation as a bona fide occupational qualification for airline pilots, and therefore not violative of the new statute.

As a result of FAR Section 121.383(c), about 1,000 airline pilots have been involuntarily retired from airline service during the past 11 years. This year, and in the years shortly to come, the number of airline pilots annually affected will increase as the aviation industry comes of age. Association records show that 161 pilots will reach age 60 this year; during 1973, 183 pilots; during 1974, 254; and, by 1980, 887. Apart from the overwhelming financial and psychological losses afflicting the pilot upon his 60th birthday, by virtue of FAR 121.383(c), there are additional injuries caused by the terms of present Social Security law.

The airline pilot's social security benefits—like all workers'— are based upon his average monthly earnings in covered work up to the year he reaches age 65, becomes disabled or dies. In order to lessen the adverse impact on his average earnings caused by periods of illness or unemployment, the law currently permits up to 5 years in which earnings are lowest to be excluded from this computation. This five-year dropout rule, however equitable for other workers, is wholly nullified for the typical airline pilot because of FAR Section 121.383(c).

Airline pilots precluded from flying at Age 60 are generally unable to transfer to another new occupation. Their prior dedication to a rigorous profession will often preclude them from establishing a new earnings potential in a different field at this advanced stage of his life. Accordingly, most pilots will experience little or no income between ages 60 and 65 and will be obliged to have these years expended as dropout years.

Since the current maximum wages credit for computing benefits is $9,000.00 per year, as compared to a maximum credit of $3,600.00 per year, or less, before 1954, pilots required to deduct current earnings years from their benefit computations, rather than earlier years, will experience significant reductions in their benefits. The combination of present Social Security law and FAR Section 121.383 (c), therefore, works to create a special and unwarranted reduction in the size of the retired pilot's benefit.

H.R. 1 offers two partial remedies for this inequity. First, the bill would provide each worker an additional dropout year for each 15 years of coverage. Since most pilots enjoy long, continuous and stable careers, we believe this provision will allow a significant number of involuntarily retired pilots to exclude two of their low-earning years after age 60 from the benefit computation.

Second, the bill would change the way in which benefits are computed so that men and women are treated alike. Currently, the period of years used for comput-

ing a woman's average wage ends at age 62, while, for men, it ends at age 65. By adopting an age 62 cut-off for men, the bill would not only cure a needless discrimination but would also reduce the financial penalty imposed upon the male victims of early mandatory retirement.

Accordingly, the Association fully endorses these specified aspects of H.R. 1. In addition, we would urge these improvements: (1) the amendments should be revised so that their impact is fully effective immediately, rather than, as is now intended, spread out through a lengthy transition period and (2) the amendments should be made applicable to those already on the retirement rolls.

Further, the Association recommends that this Committee exercise the present opportunity to fully and directly resolve the Social Security inequities created by the juxtaposition of FAR Section 121.383(c). While the above-described amendments which we endorse would largely alleviate the inequities, the most simple and equitable solution, we submit, would be to allow additional dropout years to airline pilots for every year after their 60th birthday.

TESTIMONY BY THE PLANETARIUM NEIGHBORHOOD COUNCIL, SUBMITTED BY JOHN KOWAL, PRESIDENT

As a preamble to its testimony on H.R. 1 the Planetarium Neighborhood Council wants to most respectfully express its concern about the closed nature of Senate Committee "Public Hearings." It seems that the committee chooses very carefully the few individuals or organizations to be admitted to a hearing and even then the hearings are attended by only a few committee members at a time. Since we were not among the chose few but feel we have a great deal of direct experience to offer from a middle class point of view we submit the following testimony for inclusion in the printed record of the hearings.

The Planetarium Neighborhood Council is an umbrella organization on the westside of New York City. The Council membership includes, P.T.A.'s, block associations, political clubs and religious institutions as well as a large number of businessmen, educators, professional people, housewives and students.

During the last decade the council has sponsored numerous demonstrations directed toward improving the quality of life for the poor and middle classes. When conditions improved for the poor in our community they consequently improved for the middle and upper classes. Our demonstrations, which dealt with welfare recipients and working poor, have influenced both city-wide and national thinking and planning. It is with these years of first-hand experience and thought that we submit this testimony and urge you most strongly to *defeat* Title IV of H.R. 1. We have taken this position for the following reasons:

CONCERNING MONEY

A base of $2,400 for a family of four is totally inadequate for any family and is most detrimental to our economy. No benefit should at any time be below the Regional Lower Living Standard of the Bureau of Labor Statistics. Even the 1970 Census data "Poverty Line" exceeds H.R. 1 standards by more than $1,500.

When one writes and passes a reform bill one must *improve* the present situation and think beyond the moment.

The inadequate financial standard which now exists and which is proposed in Title IV can only foster total breakdown in family life, health, education and overall development of future generations. With the inadequate financial base of $2,400 you will be guaranteeing a large *future* population who will be increasingly dependent, and useless to society, bearing the scars of an environment of constant denial. This deteriorating process will uncontrolably increase the need for and huge expense of health services (physical and mental) protective services, and a variety of complete custodial institutions. This creates a great economic burden on a large portion of your constituencies, impairs the U.S. economy and develops a larger and larger group of poor. What then happens to the "Great American Dream," to the great American middle class?

Were the existing recipients and working poor to receive an adequate income they would immediately and steadily pour this money back into the economy and produce a healthy future middle class with a lower tax burden to bear. An adequate income subsidy can only be looked at as a direct spur to the economy.

Any realistic reform bill must include future changes commensurate with the U.S. median family income level. H.R. 1 allows for no future increases.

It must make provision for non-recurring needs which if met will enable a family to move forward; if not met, will create far more serious dependency and expense.

No matter what the size of a family, its current needs must be met.

It is totally unrealistic to say "We will only feed a portion of your large family." Will the remainder of the family go back into the womb?

CONCERNING WORK AND WORK INCENTIVE

It has been our constant experience that almost all people are influenced by a work ethic which requires fulfillment through meaningful work. "Meaningful" need not mean only industrial labor of professional jobs but can also be essential, local community service jobs with upward mobility and realistic benefits. Given the proper conditions such as health ability, job related training, good child care and dependent people care, reasonable income and benefits and the *availability of jobs* people would work without being forced and coerced. None of these conditions are adequately provided for under Title IV of H.R. 1 Given the above conditions if a mother or care-taker relative of a child still felt it necessary to remain at home it would be for good reason and one of her inalienable rights to do so. *A mother's prime responsibility must be to her children.*

CONCERNING WORK INCENTIVE

H.R. 1's work incentive is punitive and unrealistic. The amount a worker may keep is totally inadequate and a sham. Further, unless a worker is allowed to totally disregard all reasonable work-related expenses, such as transportation and taxes as well as full day-care expenses in calculating a family's income it will often be to a family's advantage to have no one employed.

CONCERNING ELIGIBILITY

The bill as it now stands has several clauses of serious consequence to your present constituency as well as future generations of Americans. There are in the U.S. at the moment many unattached individuals, childless couples, and families headed by full-time college students who are not fully self-supporting for various reasons. Rendering them ineligible for benefits under Title IV does not make them nor their needs disappear. Neither will it enable them to become self-supporting.

It can only seriously aggravate their problems and again increase the cost of health care and custodial services, thus increasing the present and future economic burden.

The section requiring a spouse to take on financial responsibility of a child for which he is not legally responsible only furthers family separation, illegitimacy, fatherless households and all the ills involved in such relationships. Are we trying to reduce the need for welfare in our country or are we only pretending for political advantage. Let us not pass legislation guaranteeing further the environment which breeds instability, poverty, total dependency.

As the legislation now stands before you it totally disregards the fact that although one was earning and barely existing on a very inadequate income earlier in the year one might need assistance now. No matter what his past income, one must consider an applicant's present need. If a person's income is large enough to set savings aside he will do so for the most part. Very, very, few people want to be on welfare.

Again, if a person arrives at a point where he requires public assistance, possibly on a temporary basis, H.R. 1 requires that this person be stripped of his minimal resources beyond any realistic point in order to be eligible. Does this help a family to return to self-sufficiency?

A 30-day residency requirement is a political ploy unworthy of any welfare reform bill. People do not come to the U.S. to go on welfare. Immigration laws concern themselves that.

CONCERNING RIGHTS AND ADMINISTRATION

No one should be expected to work for less than federal standards. H.R. 1 does not guarantee this.

Recipients must be guaranteed full due process fair hearings, accompaniment at hearings by advocates of their choice, and, after request, speed of hearing

date and decision (i.e. 15 days for each). Until proven guilty he must be treated as innocent with no reduction or withholding of grants. H.R. 1 makes no such provisions.

There must be definite provision guaranteeing that clients be notified of their rights on a regular basis when there are changes in procedures.

The entire program should be administered federally thus eliminating state inequities and resultant problems.

In order to prevent the confusion and expense inherent in multi-agency administration responsibility should lie with HEW.

Therefore, because of the above expressed total inadequacy of Title IV of H.R. 1 we again, most strongly, urge you to vote against it and consider the Harris Bill in its stead. We would also suggest the inclusion of a strong service section in the bill since people in serious need often require more than monies to become self-sufficient.

It is the Council's sincere feeling that legislators must go far beyond merely representing their constituencies. They have far wider exposure to the nations real problems and therefore must develop and enact legislation which will further America, rather than a political career. They must take their national exposure and knowledge back to their constituencies and help them to understand issues on a broader level, rather than be swayed in a non-prudent direction by local politics. A Senator has *national* as well as regional responsibility.

STATEMENT OF THE COALITION OF INDEPENDENT HEALTH PROFESSIONS ON PEER REVIEW SYSTEMS

The Coalition of Independent Health Professions, composed of 11 health care groups with a combined total membership of over 350,000 health practitioners, is grateful for the opportunity to express its concern regarding the effects of the amendments to the Social Security Act which deal with a professional standards review system. Members of the Coalition of Independent Health Professions who are endorsing this statement are:

American Association of Bioanalysts
American Association of Pastoral Counselors
American Occupational Therapy Association
American Optometric Association
American Physical Therapy Association
American Society of Medical Technologists
American Speech and Hearing Association
National Association of Social Workers
American Psychological Association

The Coalition commends the foresight of Senators Hansen and Bennett for recognizing the need for a mechanism of self review as a means of improving the quality of health care services under Title XVIII and Title XIX of the Social Security Act. We are, however, most concerned about certain specifics in these proposals.

While there are imperfections in the existing standards review system, we feel that the only possible action was taken to review medical services under the original Medicaid and Medicare programs. Congress adopted the best possible system of standards review without the valuable commodity of experience that comes from years of program operation.

Now that Medicare and Medicaid have been operating long enough to permit evaluation, it is apparent that some general improvements are in order as they relate to the professional standards review sections.

The Coalition recognizes that a peer review system based on equitability, proper composition, and the principles of fairness can perform invaluable services both to the health professions and beneficiaries of the Medicaid and Medicare programs. Program operation and management costs can probably be reduced while at the same time the system can be reinforced to perform more effectively.

To those outside the health professions, the term "peer review" seems to have lost its original meaning. When first proposed, the control mechanism meant simply that the health professional would be subject to a review of standards by his peers whose training and expertise are equal to his own. This, we believe, was the intent and purpose of Congress, the Executive Branch, and the practitioners performing services under both health care programs.

This key factor in effective control seems to have been overlooked, as the proposals before you suggest a standards review program be administered not by peers whose training and expertise are equal, but rather by a board of individuals whose professional background and education may or may not be similar to the practitioner subject to review. The Coalition questions how effectively and equitably one professional of a specialized background and education can evaluate the judgment and services of a practitioner engaged in another equally specialized field when the only common denominator is essentially the fact that both are providers of health care services.

The adoption of either bill, S. 1898 by Senator Hansen or Amendment No. 823 by Senator Bennett would authorize establishment of a board made up primarily of doctors of medicine to review dentists, osteopathic physicians, veterinarians, optometrists, and all other health professionals. This is not, obviously, the best method of evaluation and review. It defies all logic and rationale. A surgeon is no more qualified to evaluate the professional performance of a dentist than a dentist is capable of evaluating the work of a surgeon.

One does not have to look far to discover that there are well organized professional standards review mechanisms readily available for true peer review, within each of the health professions. Just as there presently are state medical societies made up of M.D.s; there are similar groups capable of performing review services for their respective health professions. Each organization is willing to assume the responsibility for reviewing the services provided by its own practitioners.

As a point of fact, many allied health professions have had favorable experience with such systems, dating back to the early 1960s when a peer review system became necessary under the Kerr-Mills legislation, the forerunner of today's Title XIX.

The Coalition of Independent Health Professions believes that each profession it represents has the public interest foremost among its considerations. Decades of success in developing and enforcing peer review systems attest to the concern of our professions and expresses the fact that we desire to stand accountable before the public.

Each national or State health society for each health care profession is earnest in its desire to provide the best possible health care services for every patient within the scope of its particular health discipline. Each society is sensitive to the need for maintaining a high degree of ethical practice. Each society is cognizant of the desire to provide the highest quality health care for the government's and taxpayer's dollar.

Each of these organizations is willing to accept the formidable responsibility for creating an awareness of the values and process of peer review among those qualified in its discipline and for the constant surveillance of its membership's delivery of health care.

True peer review, a process whereby each health care professional is evaluated by members of his own discipline, has been shown to be an effective means of providing effective health services to each and every beneficiary of Federally-sponsored health care programs.

The Coalition of Independent Health Professions urges careful re-examination of the proposed amendments before any decision is reached, to assure establishment of the most equitable plan possible to achieve the goals this Committee has so diligently sought.

We earnestly request that "peer review" be allowed to do that which it is intended to do: provide a viable system of reviewing standards, performance and utilization for the benefit of all whose health care is in any manner provided under the Social Security Act.

Statement Submitted in Behalf of the American Public Health Association

The American Public Health Association has directly or indirectly dealt with the problems of the poor, the sick, the disabled, and the aged during its first 100 years. We believe that an income that assures the basic level of health by facilitating an adequate standard of living and access to quality health care are both basic human rights, and impact upon one another. Therefore, we support both the right to health and the right to an adequate minimum income. "Furthermore, a nation of wealth and responsibility must deplore the continuing incidence of poverty within its borders."

TITLE I

Provisions relating to old age, survivors, and disability insurance

Although we believe that many of the provisions of this title are the improvements regarding OASDI, it falls short of what is needed to maintain an adequate standard of living and standard of health for our aged and disabled. The APHA feels in the light of increases in consumer price index that the overall increase of the benefits must be higher than the 5 per cent proposed to effectively raise many of our aged citizens above the level of poverty. The average social security benefit is about ½ of the Bureau of Labor Statistics budget for a retired couple. The APHA advocates raising the level of benefits that correspond to need and encourages a 20 per cent increase in the benefit levels effective July 1, 1972. Social security is a bulwark in the protection that the government offers its citizens against the adversities of age, poverty, sickness and disability.

It is a program that has quietly and efficiently done its job and has become part of the warp and weft of the fabric of American life. Causes of ill health like the causes of poverty are complex. There are no quick and easy solutions. This bill proposes profound changes in the social security system. There is much in this title that we approve of and a few things that are unfortunate. We approve of Section 102 and the provisions that tie future increases in benefits to increases in the cost of living. This would assure that the aged and the disabled would not become victims of the vicissitudes of economic change. We support Section 104 the increase in social security benefits from 82½ per cent to 100 per cent payable to widows and widowers. These beneficiaries are more likely to be financially disadvantaged and require more health care. This proposal would serve to alleviate poverty and would positively affect the health status of these beneficiaries as well. We feel that Section 107 outlining the uniformity of method of computing benefits for men and women is a sound and humane proposal and should be enacted into the law. Fairness dictates that men and women should have equal rights and privileges. Moreover, early retirees having often lost their jobs and having difficulty obtaining new jobs may be too ill to be fully productive and yet not sick enough to obtain disability benefits. The uniform computation point at age 62 will go far to alleviate the plight of those forced to retire on low benefits. However, these benefits in order to help those who are already caught in a financial squeeze between lowered incomes and rising health care and other expenditures must be enacted immediately. We urge that the effective date of this section be January 1972.

Regarding Section 105, we should strive to make social security an adequate source of income even when unsupplemented. For this reason, we advocate the step-wise increase and the earnings base to cover all incomes eventually, and recommend raising this earnings base to $20,000 by 1976. This would serve to reduce the regressivity of the tax while increasing revenues. Barring this, we would advocate the use of general revenues to finance a portion of social security. This is not new. General revenues are now used for Part B matching, hospital insurance for the non-insured, etc., and would only serve as an extension to an already ongoing source of funds. We are strongly in favor of Section 111 liberalization of the retirement test. We question however, the equity of a uniform retirement test. We question however, the equity of a uniform retirement test for all levels of benefits in all areas of the country and of a monthly exemption. (We feel that the replacement of the monthly retirement test with a quarterly retirement test in principle would be more fair to beneficiaries.) We support Section 122, which is reportedly to affect nearly 1,000.000 persons, which reduces the waiting period for benefits for disabled workers, disabled widows, and dependent widowers from 6 to 5 months. However, this is woefully inadequate. Since these people require income supplementations and medical care now, we urge no waiting time be imposed.

TITLE II

Report of testimony for Senate Finance Committee

The American Public Health Association is particularly concerned with the manner in which Health Care is financed and delivered in this country. With this in mind, the Association has developed 9 points which it feels should be an integral part of a National Program for Personal Health Services. These nine points include:

1. Universal coverage for all residents of the U.S.

2. Comprehensive benefits including preventive, diagnostic, therapeutic, and health maintenance services as well as rehabilitation services which are provided through primary care teams of physicians, dentists, nurses, and allied health workers.

3. Financing by a combination of federal social insurance and general tax revenues that will insure health care as a social right and aid in achieving reasonable equity in paying for this care.

4. A reform of the Health Care Delivery system in order to assure equal access to good health, efficiency and effectiveness in the delivery of Health Care, and the facilitation of interaction between the private sector, delivery functions, and governmental financing functions.

5. The organization and administration involving federal, State, and local government with the assistance of regional organizations for planning and evaluation.

6. Public accountability that assures maximum responsiveness of the health system to public needs, and that provides adequate data systems for monitoring performance and comparative evaluation.

7. Economic leverage of governmental financing on the delivery system including payment on a per capita basis, annual negotiated rates for institutional providers, and a choice of prepayment or fee-for-service payment for professional providers; and incentives for providers to adopt patterns of organization of payment aimed at achieving more effective beneficient services.

8. Revamped state program for licensure of health facilities and health personnel to insure that they need a minimum federal standard, encourage the evaluation of standards to the highest possible level, provide for consumer participation, and provide for reciprocity of professional licensure of health workers moving from one state to another.

9. Adequate manpower, service, and facility resources with massive federal support for reorientation and expansion of basic and continuing education programs; recruitment and support of students from segments of the population heretofore excluded because of economic, race, and sex discrimination; fostering the education of more professional health personnel who are interested in providing primary, personal, family health care; and retraining present health workers and developing new types of health workers on a career ladder. Also, federal support for the reorganization of the Health Care Delivery system with emphasis on primary care teams and the expanding of research in health services to discover new and better ways of providing quality care more economically.

It is within this context that the American Public Health Association will view any proposed health legislation.

Long before the adoption of Medicare and Medicaid, APHA supported enactment of legislation that would finance Health Services for those portions of the population that were unable to pay. We feel that Titles XVIII and XIX were commendable steps toward helping the aged and medically indigent, yet, they did not go far enough. Large segments of our population remain unable to cover their medical expenses, many of our services remain fragmented and inaccessible, and costs keep rising to the point where more and more citizens, reaching into the middle and upper income levels, will find themselves ruined by a single, catastrophic medical bill.

The answers to these problems do not lie in simply amending various aspects of Medicare and Medicaid. These Titles are still aimed at specific portions of our citizenry, and are not even totally comprehensive to those who are fortunate enough to be eligible. Deductibles, co-insurance, and co-payments required under certain portions of both these bills are often, in themselves, out of the financial reach of many of our aged or medically indigent. The fact that even though services are paid for does not, in itself, guarantee that these services are always accessible to the individual (particularly the infirm or disabled), nor does it ensure that the quality of the service would be of high standard and that the person will be treated with the dignity and concern he deserves.

Until a system of universal health insurance is adopted, coupled with a more rational approach to delivering services that are responsive to the needs of the consumer and are oriented to a controlling cost, we will not be able to solve the problem. The American Public Health Association is not advocating an approach that would be detrimental to the health professionals of this nation, nor is it opting for complete governmental control of the system. Rather, we envision a cooperative effort between consumers and providers, one in which care is made available in all parts of the country, and which creates new types of careers

in the health field that will facilitate the physician's task, and eliminate the fear of the financial tragedy that can befall an individual as a result of a single medical crisis in his family.

We realize that these issues are already being discussed in this Committee and in other Congressional committees as well, and, that, while decisions will be made regarding these, it is still necessary to extend and amend existing legislation to more effectively care for the most needy segments of our population. With this in mind, the following are offered as APHA's thoughts on the proposed amendments to Medicare and Medicaid.

Section 201—APHA strongly endorses the extension of Medicare coverage to the disabled. The existence of a portion of our population that had neither the resources, nor the ability to get these resources, in order to pay for health care makes this an important addition to the Medicare legislation. We do hope, however, that implicit within this Section, is the possibility of paying for all medcal services to the disabled and thereby eliminating the need for the existing multple funding sources (e.g. vocational rehabilitation, Medicaid, etc.).

Section 202—Although we recognize that there is a need to cover many people who have reached retirement age and are not eligible for social security, APHA cannot support the extending of Medicare benefits to these people at an approximate monthly rate of $31. Many of the people within this category, which includes migrant workers and domestics, are those least able to pay any sort of premium in order to receive their health care. The possibility of some private or public agency paying for these individuals might eliminate this problem in some cases, but would not be universally applicable. An important rationale for the passage of Medicare legislation, in the first place, was to cover medical expenses for the elderly who have little income and, in many cases, few assets. Although many of the people who would become eligible under the provisions of Section 202 are those who are self-employed and are not indigent, large proportion remains that are the most disenfranchised and who were least able to provide for themselves even during their productive years. To impose an annual premium rate of $368 or more on these people would make it impossible for them to share in these benefits. As well, the coverage provided in this section is only for Part A or hospital insurance, which would leave these people liable for all other medical costs. Even if Part B is included, the added premium required for that would make it even more difficult for these people to take part in the program.

Section 203.—APHA supports the tying of Part B premium increases to social security cash benefit increases. We feel that the limited income of many Medicare beneficiaries makes payment of the Part B premium rate difficult. Moreover, a constantly increasing cost of living in this nation, without some corresponding increase in the income from social security cash benefits renders their situation even more trying. Therefore, we support the provisions of Section 203 as providing a much more equitable alternative to the present method of setting premium rates.

Section 204.—The present existence under Medicare of both a $50 deductible plus a 20 percent co-insurance rate make it very difficult for many Medicare beneficiaries to pay their share. Although an increase from $50 to $60 in the deductible, will represent a savings to the government, this savings can not make up for the hardships that the $10 increase might cause to many of our elderly citizens.

Section 205.—As was stated above, the existence of a deductible, co-insurance, and co-payment often represent an unnecessary burden to beneficiaries of Medicare. In Section 205, the added expense of a co-payment of $7.50 per day from the 31st to the 60th day of hospitalization increases that burden. Although the number of lifetime reserve days has been increased frim 60 to 120, and that the co-payment provision might serve as a cost savings device for the fund, we do not feel that these two facts compensate for the added financial burden to the individual who can least afford it.

Section 206.—Given the fact that many people who are eligible for Part B under Medicare, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance and coverage, we endorse the provision of this Section. We do feel, however, that this still does not take away the major stumbling block in Part B, which is the required premium payment.

Section 207.—As indicated in our statement on personal health services, APHA strongly supports the increased utilization of less costly out-of-institution health

care. We concur with the provision within this Section for a 25 percent increase in the federal Medicaid matching formula for amounts paid by states under contract with health maintenance organization or other comprehensive health care facilities. As well, we recognize the need for the discouragement of unnecessary overutilization of costly institutional care. The excessive number of patient-days spent in hospitals, the unnecessary admissions to inpatient facilities where care could have been administered on an outpatient basis, and rapidly rising costs of hospital care are all indicative of problems that exist within our health care system. A one-third reduction in the federal Medicaid matching share for excessive stays in the hospital, however, is not an effective solution. Problems leading to overutilization and high costs are deeply embedded in our system of third party reimbursement, in the insufficient emphasis on health education to our citizenry, in the lack of effective home health programs and availability of comprehensive primary care facilities. This one-third reduction, in our opinion, would have little effect on these more global problems, and, most probably, would ultimately penalize the acutely or chronically ill Medicaid recipient. Reduction in federal funds would lead to cutbacks in state services provided under Medicaid, higher eligibility requirements, or increased deductible, co-insurance or co-payments by the recipient. This Section does point out major defects in the delivery and financing of health services and, as well, the need for a much more comprehensive attack on these problems.

Section 208.—The imposition of graduated enrollment fees on the medically indigent, and the possibility of deductible and co-payment requirements for certain optional Medicaid services. These means of cutting costs, are totally unacceptable. This Section exemplifies the erroneous assumption that results from our much vaunted health crisis. It places added burden on those who are most vulnerable and least capable of paying for the services. It will discourage many people from taking part in the Medicaid program, urge others who do take part in the program not to make full use of it, and will prevent people from obtaining drugs, prosthetic devices, hearing aids, etc. that have been prescribed. To penalize these people and make them responsible for resolving the ills of the system is inexcusable and will prove, in the long run, inadvisable.

Section 221.—APHA approves of this Section which prohibits reimbursement to providers under the Medicare and Medicaid Program for capital costs associated with expenditures of $100,000 or more that are specifically determined to be inconsistent with state or local health facility plans. A major problem in our health care system is the lack of any overall plan as to the distribution of health facilities and the scope of services that they provide. This has led to a great deal of duplication, an overabundance of services in some areas and a dearth of these services in others, and much unnecessary expenditure. Since the passage of the Comprehensive Health Planning Act (Public Law 89-749, there has been a mechanism available both on the state and the areawide level to alleviate this problem. The work done by these 314 A and B agencies, as well as the Certification of Need programs existing in many states, should be adhered to by the Federal Government in reimbursement under Medicare and Medicaid. Also, the ability to prohibit reimbursement under these two Titles of projects which are inconsistent with state or local plans gives these planning agencies more leverage and helps them to fulfill their mandate.

Section 222.—The American Public Health Association shares the opinion with many other groups that present methods of payment are inadequate, often costly, and, thus, require revision. We, therefore, support provisions of this Section that give the Secretary, directly or through contracts with public or private agencies, the authorization to develop and carry out experiments and demonstration projects designed to determine the relevant advantages and disadvantages of various alternative methods of making payments to hospitals, extended care facilities and other provider services. We also hope that the findings of these experiments and demonstrations will in the future, enable us to develop a more rational approach to a universal health insurance system.

Section 224.—The problem of developing a viable method for determining reasonable or prevailing charge levels under Medicare has existed since the passage of the legislation. We endorse the concept advocated that would allow reimbursement of only those charges that fall within the 75th percentile and major increases would be limited to increased costs of practice along with increases in earning levels within an area. It has, however, been difficult in the past to effectively determine a means of deciding on reasonable and prevailing

charges. This provision will not effectively limit a continued increase in these charges and, therefore, will have no major impact on controlling these costs. The provision of Section 224 that recommends that the Health Insurance Benefits Advisory Council conduct a study of methods of reimbursement for services under Medicare is, we feel, a necessary addition to this Section. Studies of this kind, combined with the experiments and demonstrations authorized under Section 221 of this title, might prove very beneficial in solving this very serious problem.

Section 225.—Although we recognize the cost saving benefit of a five percent ceiling on reimbursements under Medicaid to nursing homes and intermediate care facilities, we feel that this is too limiting in its purpose. The need for improvements in the facility, expansion of services, and the general costs of living increases, might far exceed the five percent increase allowed under this provision. The states that many of these facilities are in now, in terms of physical condition, services provided and adequacy of manpower make it imperative that we do not discourage them from making the necessary improvements. This does not indicate that we are supporting unnecessary expenditures on the part of these facilities but, that some provisions should be made to allow those nursing homes and ICF's to improve themselves without the fear of not being able to increase their charges for the coming year.

Section 226.—The provision to authorize Medicare to make a single combined Part A and B payment, on a capitation basis, to a health maintenance organization is, in our opinion, desirable. This would serve to provide an alternative, more comprehensive means of care to many of our elderly citizens, as well as offering them the opportunity to receive this care on a capitation basis. We do not agree, however, with the provision that such payments may not exceed 95 percent of present Part A and B per capita cost in a given geographic area. This is not taking into account the possibility that a higher cost within an HMO could be as a result of expanded services, start-up costs, or the provision of more comprehensive care. We feel that each situation should be judged on its merits without the inclusion of this blanket requirement.

Section 227.—Given the problems that have occurred in the past in terms of reimbursing salary positions on staff teaching hospitals, we endorse this provision of the bill that prohibits charging for their services unless the patient is bona fide private. Since 1965 hospitals have charged all patients and collected from a majority on a fee for service basis. This provision would inhibit the possibility of repeated billings for the same procedure to the same patient and represent a cost saving under Medicare.

Section 228.—We endorse this provision which authorizes the Secretary to establish by diagnosis minimum periods during which the post-hospital patient will be presumed to be eligible for benefits. We recognize that, in the past, retroactive claim denials resulting from determination that skilled care was not required, while often justified, have created substantial friction and ill will. However, we hope that this provision will not discourage an early release of a patient from an in-hospital setting where home health care is possible and preferable in terms of reducing the cost accrued in that inpatient setting. It is necessary that standards be developed for length of treatment particularly for multiple diagnoses.

Section 229.—Medicare and Medicaid have been widely critized for their high costs. Although many of these critics have indicted providers in general, in reality, it has been specific individuals or groups who, by taking advantage of the system, have been responsible for much of this problem. The provision of Section 229 that gives the Secretary power to suspend or terminate Medicare payments to a provider found to have abused the program is a desirable solution to this problem. Although we do not see this as a means of eliminating all abuse, this provision will serve as an effective deterrent to those who might consider taking advantage of the system. The provision that no further federal participation will take place in Medicaid payments to people who have already abused this program is also desirable.

Section 230.—APHA cannot support this Section which repeals the requirement that each state show that it is making efforts in the direction of broadening the scope of services in its Medicaid program, and is liberalizing eligibility requirements for medical assistance, At a time when we talk about expanding services to more segments of our population and of developing a more comprehensive approach to providing medical care, this Section appears to be antithetical to those purposes. Although it will take a significant financial burden

away from the states, this does not make up for the decrease in services available to the poor without proposing any viable alternative to them. Without the presence of federal minimum standards that outline what is included in comprehensive coverage, and without some similar federal stipulations on minimum levels of eligibility for Medicaid recipients, a situation ensues in which there is a wide variation in quality and scope of services from state to state. This provision illustrates, the need for a universal health insurance system that will provide coverage for all segments of our population and standards to determine what services will be provided.

Section 231.—As was stated before regarding Section 208 and 230, the reduction in care and services provided under the Medicaid program as stated in this Section are undesirable. Although the six basic services will be maintained, the option given to a state to modify scope, extent and expenditure for optional services will decrease the effectiveness of the Medicaid program. If we are to provide these medical services but do not pay for required drugs, eyeglasses and other ancillary services, we will be destroying some of the good provided by this program. For example, a person who has received medical attention but is unable to purchase the drugs necessary to complete his care is not being optimally served. We are not dealing with the segment of the population that has the funds to provide for itself and in the interest of saving the states money, we might destroy the effectiveness of the total program.

Section 232.—Variations from state to state in terms of hospital costs make it advisable that the states are given the power to develop their own methods of hospital reimbursement as provided under this Section of the Act. To facilitate this, it would also be desirable for the States to establish a commission or task force to investigate means of controlling hospital costs under both Medicare and Medicaid.

Section 234.—The provision that institutional budget planning be required under the Medicare program is desirable in terms of hospitals more realistically planning their budgetary requirements and helping them to cut costs.

Section 237.—We agree with the provision in this Section requiring hospitals to use the same utilization review committees that are now mandated under Title XVIII. There has always been a lack of adequate and coordinated utilization review in Medicaid and Maternal and Child Health programs, and, therefore, the use of these already existing mechanisms required under Medicare would help to rectify this problems.

Section 239.—We support the idea that the same state agency will certify health facilities for participation in Medicare and Medicaid. The provision of this Section will help to eliminate duplication of efforts and provide a more uniform set of standards for health facilities that are certified for Medicare and Medicaid. The requirements that federal participation in Medicaid payments be contingent upon the State health agency establishing a plan for statewide review of appropriateness and quality of services rendered will aid in ensuring better quality of care within these facilities. We suggest, as well, that the 314 A and B agencies have input into this process.

Section 240.—We support the flexibility suggested in this Section in terms of giving the state permission to wave federal statewideness and comparability requirements if a state contract with an organization which has agreed to provide health services in excess of the state plan to eligible and desiring recipients. We feel this gives the state more opportunity to test out different health services delivery approaches, and provide more responsive care. It is important, however, to insure that this approach is not misused for political or economic reasons outside of health considerations.

Section 241.—APHA is acutely aware of the present shortage of qualified manpower in the health care field and the problems existing presently in terms of certification and licensing of some new types of health personnel. We support this Section that requires the Secretary to develop and apply appropriate means of determining the proficiency of health personnel who are presently disqualified or restricted under present regulations because of lack of formal training or education requirements. We do not, however, view this provision as a panacea and hope that steps are taken in the very near future to come up with some more long range solutions to this problem.

Section 254.—We are in favor of including, under Medicaid, coverage for care offered in Intermediate Care Facilities. The present high costs of hospital care makes it desirable to more fully utilize these ICF's where a patient's needs can

be taken care of in that setting. Covering this care under Medicaid gives the medically indigent patient the opportunity of taking advantage of this service, and offers the possibility of cutting the costs of health services in general.

Section 256.—The inclusion of payment under Medicare of hospital admissions for dental services extends the coverage provided under this Title and is, therefore, desirable in terms of expanding the services covered. APHA supports this Section.

Section 264.—This provision which authorizes payment of Part B of Medicare for corrective lenses furnished by optometrists is a desirable addition. The previous need for a physician's request in order for lenses to be covered was unfair to both the patient and the optometrist, in terms of the added expense of requiring the individual to see an ophthalmologist, and in encouraging patients to use an ophthalmologist in preference to an optometrist. We feel that this provision eliminates that problem.

Section 267.—The waiver of the requirement of registered professional nurses in skilled nursing homes in rural areas under Medicaid is an unacceptable provision. The lack of sufficient numbers of registered professional nurses in many rural areas often precludes the possibility of treatment of individuals in these nursing homes because of lack of coverage under Medicaid. The existence of other people qualified to serve this population, although they do not have licenses, and the pressing need for these services makes this a desirable solution to this problem. We want to add, however, that before this section is put into effect that certain Standards (e.g. types of personnel and services offered) should be defined as to maintain at least the same quality care.

APHA report on professional standards review organization.

(This Report Is Based on a Draft of the Council on Personal Health Services Task Force on Peer Review)

In the mid 1960's, the federal government increased its role in the financing of health care with the enactment of Medicare and Medicaid. Prior to this time, the lack of organization in medical care precluded the development of quality control mechanisms on any large scale. The need to develop information about what federal dollars were buying necessitated the inclusion of utilization review requirements. These were pioneering efforts in measuring and controlling the appropriateness and quality of services. Recently, both Congress and the Department of Health, Education, and Welfare have expressed concern over the adequacy of utilization review in Medicare and Medicaid. In 1970. the AMA, in response to administration interest in state review teams, proposed the establishment of Peer Review Organizations (PRO's) which would be formed by the State Medical Societies to review health services under Title XVIII (part B, Title XIX, and Title V of the Social Security Act) with respect to quality, need and appropriateness of charges for covered services. Senator Bennett made a proposed amendment 851 to H.R. 17550 in 1971 which went considerably beyond the AMA proposal. Professional Standard Review Organization (PSRO) would be set up by local medical societies to review the professional activities of providers of health care to assure the medical necessity of these services, to precertify elective admissions to health facilities or extended care facilities to assure their medical necessity, to determine parameters for length of stay, and to develop and review provider profiles. The PSRO would apply standards based on norms of care in the area. There would be state and national Professional Standards Review Councils. These monitoring bodies as well as the PSRO would be entirely composed of physicians. The legislation would allow the PSRO to make arrangements for but services performed by other professionals are reviewed by such professionals. APHA has long recognized the need for regulation and accountability in public programs to assure quality and prudent control of program costs and for this reason supports the broad purposes of this amendment. The APHA also supports the mechanisms of external audits to review and compliment internal audits in all medical settings.

However, the objective of Peer Review should be to assure the greatest efficacy of the patient-provider encounter, and cautions need to be raised about the means of meeting this objective.

1. While Peer Review normally embraces biomedical, technological concerns, it barely touches on overall patterns of care, psychosocial aspects of quality, outcome and structure. If the concept of "Peer" were broadened to encompass a number of different types of professionals concerned with health care delivery,

and the PSRO were also to include consumers of care, these organizations might come to have great impact on the shape and quality of the health care system.

2. Peer Review is thwarted in its evaluation efforts by incomplete, incoherent records, particularly in non-institutional settings.

3. The lack of availability of standards and the question of whether—even if objectively delineated standards exist—these standards of care are minimum, optimal, or simply community norms has to be considered.

4. While one may question the appropriateness of federal regulation of professional activities, as a result of the increased role of the federal government in financing health series a new consumer voice has emerged. This spokesman, the government, is demanding public responsibility—not possible through a totally provider dominated review mechanism.

5. There is concern regarding possible conflict of interest in having physicians responsible for not only review of other physicians' services but acting as almost sole arbiters of the entire medical care process. To an extent, particularly in a small system, a physician's professional practice and reputation depends on referrals and goodwill from other physicians. These potential conflicts of interest, we realize, are not unique to physicians but are inherent problems in any form of Peer or professional Review.

6. Presently, utilization review committees function in fragmentary fashion. They look at a patient usually when he is institutionalized and follow him through only a single episode in his health care history. Furthermore, even within these limitations, committees seldom work within the totality of patient care. The proposed amendment, therefore, needs to be more broadly defined in its mandate and more comprehensive in its applications than existing quality control mechanisms.

7. There are few agencies with the proficiency to monitor the quality of health care. To be effective some agency must assume community-wide responsibility and would need the capabilities for making inter-institutional and inter-provider comparisons as well in order to follow the patient as he moves from one health care service to another.

8. Presently, under Medicare and Medicaid, there are few sanctions available to regulatory bodies that provide incentives for providers to comply with utilization review requirements of this act. This problem is stressed in Title II of H.R. 1 as well as under the provisions of the Bennett amendment.

9. There is some question whether the state of the art is advanced enough to carry out the amendment's proposed activities. Adequate, continuous information concerning the patient must be developed along with efficient means of retrieving of this information. This involves not only the patient's medical record—though those data are certainly of key importance—but cost and utilization information as well. The development of these activities will require technological competence and the various supportive hardware and software necessary to develop the statistical information required, as well as to process individual cases. This will require administrative and systems manpower distributed in areas of need.

10. There is a danger that the PSRO will become another layer of bureaucracy, without relating to other agencies concerned with planning, research and development, programming. Certainly Peer Review is not the only mechanism known to regulate quality of health services. Linkages to agencies concerned with facilities planning, manpower development and licensure and accreditation are necessary.

11. We must be prepared for—indeed hope for—instances where Peer Review will not reduce costs but will raise costs by correcting instances of under-utilization of services. We expect that the proposed organized effort will not lessen the need for Congress to continue to search for means of improved quality control in health services.

12. Consumers must not only participate in the review of quality and appropriateness of health services but must be educated to understand the processes and components of the system.

On the basis of these factors, the APHA makes the following recommendations concerning this amendment:

1. The PSRO designee should not be the local medical society but should be an organization more representative of the disciplines and types of practice represented in the community. The organization should include a) physicians from academic as well as from private practice settings; b) other health pro-

fessionals; c) allied health personnel; d) and consumers of health services. These interests should also be represented at the state and national regulatory advising groups.

2. The PSRO should be phased in through pilot projects prior to a larger national commitment, in order to facilitate the gradual assumption of responsibilities of the PSRO.

3. Sufficient authority should be given to DHEW to monitor PSRO operations and to evaluate their effectiveness.

4. PSROs should be allowed to use existing utilization review mechanisms, institutions and agencies to carry out part of their responsibilities under close supervision.

5. Adequate funds should be made available for the support of PSROs; as well as for evaluation of their effectiveness, for studying alternative strategies; and for the development of new systems.

6. The development of PSROs should be coordinated with the education and retraining of manpower necessary for their operation and must work with area-wide planning bodies in the development of community standards.

7. Legislation concerning PSROs must address itself to legal problems which might arise in regard to "medical necessity" and provider responsibility.

TITLE III

Assistance for the aged, blind, and disabled

(New Title XX of the Social Security Act)

We support this aspect of the bill which would create a new single national program to provide assistance to the needy aged, blind, and disabled. Under the new federal program, uniform eligibility requirements and uniform payment benefits would replace the multiplicity of requirements and benefit payments under the existing state-run programs. The American Public Health Association supports the full federalization of the welfare system. Because Title III is a step forward toward this goal as well as being meritorious in its own right leads us to support this proposal. We believe that the Social Security Administration's long experience in administration of payment programs would enable it to administer this program efficiently and humanely. However, two aspects of these proposals cause us concern. The proposed minimums are considerably below poverty levels and we urge immediate federal minimums at no lower than the poverty levels. Therefore, there is no provision for adjusting minimums in accordance with price increases, and we urge the provision of automatic adjustment for keeping the benefit level in accord with the cost of living. While we would hope that total federalization of the welfare system would relieve states of financial support of welfare programs, we realize that as an intermediate step supplementary payments by the states would be required. Therefore, the APHA urges that the states should be required to supplement the federal payment at least to the current payment levels.

TITLE IV

Family assistance plan

Although many points of this Title are outside of the realm of APHA policy and expertise, we wish to comment on several areas that directly affect the public health.

1. The construction and support of child care facilities for working mothers is supported by this Association. We are in favor of the potential gains that job creation will have on environmental and personal health services. This is an aspect of H.R. 1 that can have vast benefits if properly carried out in serving society and promoting health.

2. We support the growth of new services as parts of the provisions of legislation. New programs involving job counseling, family planning, vocational rehabilitation, etc., will have impact on health in coming years.

However, there are aspects of these commendable ideas that vitiate the thrust of this legislation:

1. The level of benefits are grossly inadequate. The $2400 benefit level for a family of four is far below the poverty level. One does not make people self-sufficient and productive by keeping them below the level of poverty. This level of

payment would ultimately be harmful to the health of the recipient. In 1970, the Bureau of Labor Statistics lower estimate for *food only* for an urban family of four was $1,905 and the lower budget of all income including taxes according to the BLS was $6,960. Only five states now pay less than $2400 in AFDC and food stamps. This legislation, if unsupplemented by states, would effectively reduce benefits in 45 states. At the benefit level proposed, people will continue to be inadequately clothed, housed, and sheltered. The APHA recommends that the minimum benefit levels be at least at the poverty level to assure adequate health maintenance.

2. There are serious gaps in coverage of the poor. H.R. 1 fails to provide any assistance to single persons and childless couples who would be deprived of both adequate income and access to health care with no guarantee that these needs will be met by the states. Moreover, this defeats the stated purpose of the act to relieve states of their crushing financial burden. Gaps in coverage for noncategorically linked persons are enexcusable in legislation that purports to reform the "welfare mess" and to promote maximum self sufficiency. We think single persons and childless couples who are not aged, blind, or disabled ought to be added by this committee as eligible under this bill.

3. The legislation allows the states to discriminate against the newly eligible working poor. States can refuse Medicaid to the new eligible working poor who, deprived of health care, will be in danger of becoming increasingly dependent on society again. We recommend this committee correct these shortcomings.

Rights of public employees

With the enactment of H.R. 1 a number of state and county workers would face unemployment. Many have held jobs as caseworkers and social workers as well as in other administrative capacity. There is a possibility that some employess may be absorbed into other departments or programs, but those who are not would eventually lose their job and accumulated benefits. We urge protection for their rights as a public employee as provided in amendment 559 of H.R. 1 and that fair and equitable arrangements be made in the transition from State to Federal administration. And that in addition to monetary benefits paid these workers that, training or training programs also be made available.

Areas of Title IV with special implications for the state of the health of the community are Sections 2111, 2112, and 2114, which address themselves to the operation of health manpower programs, employable mothers, child care, and other supportive services. These are interrelated problems which affect the physical and mental health levels of future years by altering the stock of "human health capital." While the effects of these provisions on maternal and child health are known, the influence of manpower programs on health needs is seldom considered.

Recently, the Comprehensive Child Health Development Act was vetoed by President Nixon. Professional concern with the health of mothers and children requires APHA to ask this committee that this legislation establishing a comprehensive child development program for all families be added to this legislation. We support the proposal that was approved by Health, Education, and Welfare Secretary Richardson last year and passed by the Senate guaranteeing comprehensive health care, setting strong federal standards and providing free services for low income families and a fixed fee schedule for other families based on ability to pay.

The American Public Health Association believes that the protection of the environment and the delivery of health services cannot be easily separated from the problems of poverty, assuring adequate levels of income, manpower training, and job creation, and the care of children. We are grateful for the opportunity to comment on these areas as they affect our interests and mission in public health.

Miscellaneous new social services provisions

(Amending Titles IV and XI of the Social Security Act)

The American Public Health Association has always advocated the extension of availability of family planning services to all who want them. We welcome the extension of family planning services to recipients. One has no right to criticize out of wedlock births and large families receiving public assistance as long as it withholds from those people the knowledge and the means of family

planning. Another area of Title V that concerns the American Public Health Association is the provision that would permit the Secretary of HEW to remove the state-wideness requirement. We feel that this would be a step backward away from uniformity and equity, and may result in the reduction of services to vulnerable populations within states.

The American Public Health Association has been an advocate of consumer participation in health programs. We also believe this has to be extended to other human services and we deplore the absence of a participatory role for recipients in responding to the policies and regulations of the programs that directly affect their lives. Such areas as income, training, employment, child care as well as medical and other health services require the input and understanding of the recipients of these services. We recommend that the bill provided that all advisory committees on state and federal level to evaluate effectiveness of programs and services offered under Title contain representatives of the recipient population.

STATEMENT BY RICHARD F. HUEGLI, EXECUTIVE VICE PRESIDENT, ON BEHALF OF THE UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT

As the citizens voluntary health and welfare planning agency for the Metropolitan Detroit area, United Community Services over the years has been concerned with the problems of poor people, many of whom have received "welfare." It has a membership of 180 public and voluntary health, social service, and recreational agencies which provide services to the poor, as well as to the non-poor.

United Community Services has at times made intensive studies of the public assistance programs in the Metropolitan area, proposing and supporting changes which make these programs more effective in helping recipients and more efficient in their administration.

Since the President introduced his proposal for Welfare Reform in 1969, United Community Services has examined this and other proposals carefully, weighing their relative merits in terms of both effectiveness and efficiency. We feel compelled to convey our concerns about H.R. 1, in the interest of citizens and welfare recipients in the Detroit area.

Attached to this statement is a chart which lists the policies adopted by the United Community Services' Board of Directors regarding welfare reform. It compares these positions with features of H.R. 1, and three other reform proposals which are under consideration in the Senate.

H.R. 1, as passed by the House of Representatives, contains significant elements of welfare reform. Unfortunately, it also contains some elements which would make welfare less helpful to poor people and more costly and inefficient in administration.

There are four primary ways in which welfare needs reform, as we see it:

1.—THE FEDERAL GOVERNMENT MUST ASSUME A STRONGER ROLE IN THE ADMINISTRATION AND FINANCING OF WELFARE

The differences in welfare programs among the fifty states cannot be justified in a space-age technological society such as the United States. The happenstance of place of birth or geography of residence within the United States often determines whether or not a poor person is eligible for federal-state welfare, and whether the poor family who is eligible receives $90 a month or $300 a month. *National eligibility requirements and a national income floor for eligible poor persons are a must in federal welfare reform.*

H.R. 1 would establish uniform eligibility requirements nationwide, and a national minimum benefit level of $2400 annually. It would result in federal administration of the adult program (for the aged, blind and disabled), of the federally financed portion of the programs for families (OFF and FAP). It gives states an option of federal administration for state supplementary welfare programs.

United Community Services supports these provisions.

H.R. 1 contains no provision for an increasing federal assumption of responsibility in future years, for example in the national minimum benefit level, or in establishment of eligibility requirements and benefit standards of state supplementary programs. Commitments for a gradually increased federal role in ways such as these merit consideration.

2.—THE BENEFIT LEVEL SHOULD BE INCREASED TO THE MINIMUM NECESSARY FOR HEALTH AND DECENCY

There are many sources of testimony as to the inadequacy of benefit payments to welfare recipients across the country, including the recipients themselves, welfare administrators, and home economists and dieticians. *Welfare reform must face this fact by planning to raise the benefit level so that recipients have a chance to live in health and decency, with annual cost of living adjustments to maintain this minimum level.* Financial limitations at state and federal government levels may make this goal unattainable today, but at least a commitment to reach this goal is essential, along with an increasing federal part in its attainment. *Until the goal of adequate benefits is reached, state programs of supplementary aid should be continued to prevent loss of benefits by many present recipients.*

H.R. 1 provides for an increase in benefits only in the few states where recipients now receive less than $2,400 a year for a family of four. It makes no attempt to set benefits at a minimum level necessary for health and decency, and makes no provision for cost of living related increases. H.R. 1 also would discourage states from making cost of living adjustments in state supplementary programs, if the state opted for federal administration.

H.R. 1 needs to be changed so that there is assurance of reaching nationwide minimum benefit levels which will provide for health and decency.

3.—THERE SHOULD BE ONE PUBLIC ASSISTANCE PROGRAM FOR ALL PERSONS IN NEED

Different eligibility requirements and benefit payments for various categories of people such as the aged, blind, disabled and children and their parents has resulted in inequities, extra administrative costs, and ineligibilty for many needy people such as single adults and childless couples who aren't disabled by aged, blindness, etc.

H.R. 1 includes the "working poor," a unique feature of the President's welfare reform proposal. This inclusion would remove the unfairness of the ineligibility of some poor people due to their partial or low-pay employment. It combines the adult categories into one for the aged, blind and disabled. H.R. 1 nevertheless falls short of genuine welfare reform because of its omission of non-disabled single persons and childless couples, and its continuation of a separate category for adults and another two for families. It, in fact, compounds the present problem of too many separate programs by splitting the present AFDC program into two new categories—OFF and FAP.

United Community Services urges that non-disabled single persons and adults be added to Title IV of H.R. 1.

4.—THE ADMINISTRATION OF THE WELFARE PROGRAMS SHOULD BE SIMPLIFIED SO THAT IT CAN BE MORE EFFICIENT AND MORE AVAILABLE AND ACCESSIBLE

The present structure in federal, state, and local government welfare administration is cumbersome and creates unnecessary duplication of effort, variations in programs not related to differences in needs of people, and complex and confusing bureaucratic organizations. Detroit and Michigan have simplified the administration of their welfare programs, with merger of local and state public assistance agencies.

Under the label of welfare reform, H.R. 1 proposes a number of administrative changes which are fertile ground for administrative chaos. These changes would increase the cost of administration and make welfare less available to needy poor people. Whatever the objectives behind these proposals, a more effective way of achieving them should be found, while still helping people.

H.R. 1 proposes a dual administration by the Departments of Labor and Health, Education and Welfare which seems unnecessary and unwieldy. Different administrative procedures and practices in separate departments could make them confusing and difficult to follow. Transfer of families from FAP to OFF and vice versa would have to happen frequently, due to family members reaching significant birthdays, the birth of new members, the illness or recovery of other members, the departure or return of an employable family member,

and so on. Events such as these would cause a family to become ineligible for FAP or/and eligible for the other program, with termination of one grant and application for the other. The result would be an increase in the administrative work of terminating grants, of processing applications, and of re-determining benefits—without any improvement in program. It would also increase the possibility of gaps in services wherein needy families with children would not be eligible for either program. *H.R. 1 should be modified in this respect so that the Department of Labor is responsible only for manpower programs, with HEW retaining responsibility for administration of payments and other services.*

The declaration or simplified application procedure saves administrative expenses and expedites giving aid to needy families who usually wait to apply for assistance until all other resources are exhausted. There is not sufficient evidence of fraud in welfare to justify a lengthy and costly application procedure with extensive verification of facts, which also is dehumanizing and demoralizing for applicants. Any prohibition on the use of a simplified application is completely unacceptable and its use should be required under H.R. 1.

The proposed requirement for mandatory closure of any case after two years is similarly unwise from the point of both the administrative cost and the effect on recipients. The coupling of this requirement with dual administration by two federal agencies and possible state prohibition on the use of the declaratory application, would multiply administrative costs and obstacles to needy people obtaining financial assistance which they deserve.

Mandatory acceptance of training and employment for mothers of pre-school and school-age children is another feature which seems unsound, and which may not accomplish a desirable objective.

Employment is acceptable, appropriate, and constructive for most adults. The goal should be a job available for everyone who can work, and training should be available for everyone who can acquire more marketable job skills. This would be whether a person is on welfare or not, is unemployed or not, or is underemployed or working in low-income employment. Our economy has yet to provide these opportunities for training and employment for everyone.

Employment is not appropriate for all mothers, however, whether they are on welfare or not. Some cannot do a good job of mothering in addition to a job out of the home. This is especially true when the mother has the responsibilities of both father and mother in the family. Forcing these mothers to work if they aren't capable of it, or reducing the benefits to the family because they don't accept work would be destructive, create resentment, and further increase the paucity of their lives.

Experience has shown that many welfare mothers want to work, and will accept training and employment when it helps the family. Work allowances and incentives provide the encouragement these mothers need, without the potentially destructive effect of forced work. Manpower and employent programs need to also provide more opportunity for them to work. Such programs need also to be geared toward jobs which are available now and new ones which will be needed in the future.

In summary and in conclusion, I want to emphasize that United Community Services supports welfare which is humane and which respects the dignity of individual poor persons. In order to achieve this, United Community Services endorses reform measures which:

1. provide for greater assumption by the Federal Government of responsibility for welfare,
2. increase the benefit level to the minimum necessary for health and decency,
3. move toward one program for all persons needing assistance, and
4. provide increased efficiency and effectiveness through simplified administration and more humane procedures and requirements.

The Finance Committee and the Senate have an unusual opportunity to lead the way in making "welfare reform" a genuine fact of life, by making substantial improvements in H.R. 1. United Community Services looks for your favorable action in making H.R. 1 an instrument of increased efficiency and effectiveness in this great nation's concern for its unfortuate and disadvantaged citizens.

UNITED COMMUNITY SERVICES POLICY AND VARIOUS WELFARE REFORM ALTERNATIVES

UCS POLICY SUPPORTS	H.R. 1	RIBICOFF	HARRIS	MCGOVERN
A. NATIONAL BENEFITS AND REQUIREMENTS				
Establishing national minimum benefits and eligibility requirements.	Sets national minimum benefit at $2,400 annually for families of 4; no food stamps; sets eligibility requirements.	Sets benefit at $3,000; otherwise the same as H.R. 1.	Sets benefits at $4,000; otherwise the same as H.R. 1.	Sets benefits at $6,500; otherwise the same as H.R. 1.
B. INCREASE BENEFITS.				
Increasing the benefit level to the minimum necessary for health and decency.	Increases "Adult category" benefits to $1800 for individuals $2400 for couples by 1974.	Same as H.R.1.	Raised to $1700 for an individual, $2600 for a couple, further increases later	$2,250 1st person, $4,000 for couple.
	Would provide an increase in benefits in only a few states. No provision for an increased benefit level; no benefits for 9th and additional family members.	Provision to move to annually adjusted poverty level by 1976, later changes pegged to Consumer Price Index changes; benefits included for 9th and additional family members.	Provision to increase benefits to annually adjusted BLS low cost budget by 1976; later changes based on changes in median family income.	$1,200 for 3rd and each additional, adjusted for local cost of living differences. $6,500 for family of 4 is current level of BLS low cost budget, using intermediate food budget. Future changes based on changes in median family income
-Supports Mich. Welfare Comm. Recommendations to use BLS low cost budget as benefit standard.	- Amount of benefit is below BLS budget.	- Benefit is below BLS low cost budget.	- Benefits to reach BLS low cost budget by 1976.	Above BLS low cost budget, as uses intermediate food budget.
B.1 CONTINUED STATE SUPPLEMENTATION.				
- States to continue supplemental benefits up to present level.	-State supplementation not required; no federal sharing of cost except as needed to keep state costs below its 1971 expenses, unless state opts for federal administration under which federal government pays full administrative cost.	-Requires continuation of state supplementation at 1-1-71 benefit level; federal cost sharing within limits.	- Requires continuation of state supplementation, with federal sharing of costs to keep state expenditures below 1971.	- No requirement for state supplementation.

DCS POLICY SUPPORTS	H.R.1	RIBICOFF	HARRIS	MCGOVERN
C. SINGLE PERSONS AND COUPLES				
Adding single persons and childless couples.	No provision for inclusion (except continuation of adult categories for aged, blind and disabled); excludes families with student heads.	Includes single persons and childless couples.	Same as Ribicoff.	Same as Ribicoff.

UCS POLICY SUPPORTS	H.R. 1	RIBICOFF	HARRIS	MCGOVERN
D. FEDERAL STANDARDS - STATE SUPPLEMENTATION				
Establishing federal benefit standards and eligibility requirements for state supplementation, to assure equity.	No provision.	No provision - not as necessary by 1976.	No provision - not necessary by 1976.	No provision, not necessary.
E. COST OF LIVING				
Periodic review regarding cost of living.	No provision.	Provides for changed benefits based on annual adjustment of federal poverty level until 1976, thereafter based on changes in Consumer Price Index.	Annual adjustment after reaching BLS standard in 1976, based on median family income changes.	Annual adjustment required, based on changes in median family income.
F. EQUITABLE ALLOCATIONS				
Equitable allocation to states based on per capita income, cost of living, etc.	No provision.	No provision.	No provision.	No provision.
G. ADMINISTRATION				
Administration should simplify availability and accessibility - (and) Declaration method of application should be used.	Availability & Accessibility is reduced by:			
	1) Both Dept. of Labor and Dept. of HEW responsible for determining eligibility & employability, and for making payments.	1) Only Dept. of HEW determines eligibility & availability for training, both Depts make payments.	1. Dept. of Labor responsible only for Manpower programs, HEW to determine eligibility, availability for training, and to make payments, including state supplementation.	1. Similar to Harris.
	2. Use of simplified (declaration) method of application is prohibited.	2. Declaration method permitted, not required.	2. Declaration method required.	2. Declaration method required.
	3. Reapplication every two years is required.	3. Not mentioned.	3. Not mentioned.	3. Not mentioned.
	4. Mandatory loss of benefits for failure to make reports.	4. Not mentioned.	4. Not mentioned.	4. Not mentioned.

UCS POLICY SUPPORTS	H. R 1	RIBICOFF	HARRIS	MCGOVERN
G. ADMINISTRATION Continued				
	5. Inclusion of students' income over $500.	5. Not mentioned.	5. Not mentioned.	5. Not mentioned.
	6. Inclusion of step-fathers' income (contrary to Supreme Court Decision).	6. Not mentioned.	6. Not mentioned.	6. Not mentioned.
	7. Residency requirement permitted for state supplementation (contrary to Supreme Court Decision).	7. Not mentioned.	7. Not mentioned.	7. Not mentioned.
H. WORK - TRAINING - MOTHERS				
Work/Training not mandatory for mothers of school-age children.	Requires registration and work/training for employable adults, including mothers of children over 6 years of age (over 3 years by 1974).	Work/training required for able-bodied adults, including mothers of children 6 years & over unless there is another able bodied adult in the home.	Work/training required for able-bodied adults except mothers of children under 18.	No forced work requirement.
I. TRAINING-EMPLOYMENT				
Training programs not be initiated unless reasonable assurance of employment.	No provision.	No provision.	No provision.	No provision.
J. FEDERAL ROLE				
Supports Mich. Welfare Commission recommendation of greater federal role.	Federal government fully responsible for administration and payment of federal minimum, and for administration of state supplementation under certain options.	Same as HR 1, plus full assumption by Federal Gov't of administration and payment by 1976.	Similar to Ribicoff.	Fully federalized administration and payment upon effective date of Act.

DCS POLICY SUPPORTS	H.R. 1	RIBICOFF	HARRIS	MCGOVERN
K. ONE PROGRAM				
Establishing one program for all persons needing public assistance	Combines present separate programs for aged, blind and disabled, and substitutes two new programs for present program for families with dependent children.	Similar to HR 1, with a lesser role for Dept. of Labor in one new program.	Combines all present federal-state programs into one, adding aid to non-disabled single persons and childless couples.	Same as Harris.
ADDITIONAL RECOMMENDATIONS APPROVED BY MAP BUT NOT BY BOARD:				
L. PUBLIC SERVICE EMPLOYMENT				
Expanding Federal-State Public Service Employment.	Creates 200,000 public service jobs with decreasing federal support for each individual employee over three years.	Creates 300,000 public service jobs with 100% federal support.	Provides for public service jobs, number not specified but less than Ribicoff and possibly less than HR 1.	No provision apparently.
M. MINIMUM WAGE				
Not require recipients to accept any employment at less than Federal Minimum Wage.	Public service jobs to meet minimum wage, private employment jobs must meet 75% of federal minimum wage.	Requires federal minimum wage in both private and public employment.	Same as Ribicoff.	No provision apparently.
N APPEAL.				
Continue recipients' right to appeal, to select counsel, and to receive benefits until decision on appeal is reached.	Appeal right continued, but selection of counsel is limited and benefits may be discontinued before appeal decision reached. No judicial review permitted.	Appeal right continued, recipient can select counsel, benefits continue during appeal, and judicial review permitted.	Similar to Ribicoff.	Appeal rights continued, benefits to continue during appeal, judicial review permitted (No reference to selection of counsel.)
O. OPEN ENDED APPROPRIATION				
Continue open ended appropriation.	Discontinued, except possibly for day care and family planning services.	Continued.	Continued.	Continued.

EWM Revised 1-12-72.

Testimony by Rosalie Riechman on Title IV of H.R. 1

The Women's International League for Peace and Freedom, founded in 1915 by Jane Addams with 150 branches across the United States and sections in 19 other countries has since our founding been concerned with welfare. We believe that peace and freedom are indivisible both inside our borders and outside, and that there can be no peace where there is hunger and where children are improperly cared for.

While H.R. 1's moral sin lies in the fact that it's inequitable and repressive as is explained below, we believe that its legislative sin lies in the fact that it's counter-productive. It's based on the ill-formed premise that welfare recipients are poor due to their own failures rather than society's. It is therefore punitive in its approach and ignores for the most part the actual causes of poverty.

It's counter-productive because its grants are too small to live on while its work incentives are self-defeating. It asks recipients to work for possibly as low as ¾ of minimum wage and then gain only the first $720 of their earnings plus ⅓ of the remainder. It creates the double burden of making life unbearable under welfare, but nearly impossible to get off it. This quagmire is intensified by other destructive measures in the bill that interfere with basic rights of citizens such as our right to raise our children as we see fit, and our right to an adequate education.

We believe the following provisions in H.R. 1 are insulting to citizens and at odds with the meaning of welfare:

1. $2400 a year for a family of four is far below the official U.S. poverty level and less than ½ of the minimum level of adequacy set by the Bureau of Labor Statistics. No one needs to live on that amount in this country. Those who believe it is possible for others might consider what percentage of their income $2400 is, and what accommodations they would have to make to live on it. In addition, there are no provisions for cost-of-living changes.

2. No standards for day care have been written into the bill and inadequate funding will work toward producing only custodial care. The bill will provide approximately $782 per year for a child in a day-care* center. Estimates for providing developmental day care range from $1500 to $3000 a year per child. Custodial day care coupled with forced work provisions if there is any child care available would either force mothers to have the children improperly cared for or to risk being removed from welfare for refusing to register for work or take a job. If the latter happens, the children's benefits can be paid to someone outside the home. In either situation, the mother is being forced to take less responsibility for her child's well-being.

3. Provisions which force mothers with children above 3 years to work if only the barest of day care facilities are available. There is no language as to the suitability of the work such as distance to travel or possible dangers to her health and safety. In Nevada, a woman could be forced to work as a prostitute. A recipient may be forced to take a job at only ¾ of minimum wage. This would force the recipient into an ill-paid position while making a potential welfare client of the person who previously was paid minimum wage for that position.

4. Families headed by college or university students are not eligible for benefits thereby diminishing a recipient's opportunity for meaningful training.

5. Discriminatory provisions against mothers, large families, families with children, single individuals and childless couples. The last 2 groups are ineligible for benefits. Mothers of children above 3 are forced to register and accept a job if it and day care (no matter how unsuitable either or both may be) are available. Welfare families with children (½ of whom are black) would receive only half as much as the aged, disabled and blind (4/5 of whom are white). Families of more than 8 members receive the same grant ($3600) that a family of 8 receives.

6. Illegal one year residency requirements as a condition for eligibility may be imposed by states that supplement.

7. There are no provisions to insure that advisory committees will include recipients and recipient groups.

There are alternatives to H.R. 1 and the U.S. has the resources to provide these alternatives. We believe the following to be necessary for real welfare reform:

1. A guaranteed annual income for all in need. For recipients to live in health and dignity, grant levels should be at the minimum level of adequacy set by the Bureau of Labor Statistics and be responsive to cost of living changes.

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*Custodial.

2. Income supplements for the working poor which provide real incentives for work.
3. Adequate job opportunities and job training for specific jobs that pay no less than minimum wage.
4. High quality, integrated day care that provides for parent participation and would allow parents of young children to work if they wanted.
5. No forced work provisions for single parents who would prefer to care for their children.
6. Full protection of constitutional rights of recipients.

We urge this Committee to approve a bill which meets the above criteria and asserts this country's commitment to human needs.

STATEMENT OF THE YWCA NATIONAL BOARD, SUBMITTED BY JEAN M. WHITTET, DIRECTOR, PUBLIC POLICY

Statement on H.R. 1, the Social Security Amendments of 1971, submitted to the Committee on Finance, United States Senate, for inclusion in the record.

The National Board of the YWCA of the U.S.A. wishes to record its opposition to Title IV of H.R. 1 and the Ribicoff Amendments #559.

REASONS

Because of its fundamentally false premise that poor people must be surrounded with a system of controls by which they can be coerced into honest work.

Because of its humiliating, demeaning and racist bias directed at women and children, especially poor black women and those of other minorities.

Because it downgrades the important role and the hard work of being a mother, especially when she is poor and carries the entire responsibility for the care and nurture of children.

Because of the inadequate provisions for a custodial type of child care without parental involvement, which would further segregate the children of the poor.

Because mothers would be required to accept whatever child care programs are offered by the Department of Labor or be cut from welfare rolls.

Because Title IV proposes a level of income maintenance which would *not* assure minimum standards of health and decency for the "working poor" and 90% of the current welfare population.

Because these and other provisions of the bill give no assurance that people will be any better off even with Amendments #559.

The National Board urges that in view of the critical fiscal crisis facing many states, emergency temporary legislation be passed to grant fiscal relief to those states which will maintain their 1971 levels of welfare expenditure. We would favor legislation such as that put forward by Senators Ribicoff and Nelson, and Congressman Wilbur Mills.

In regard to Title I, the National Board strongly supports improved social insurance benefits, and especially 100% for widows. We would urge the introduction of Title I as a separate piece of legislation. We would urge that Congress consider a new approach to Titles II, III, and IV.

TESTIMONY OF JOHN DOYLE ELLIOTT, SECRETARY, TOWNSEND FOUNDATION

Summary.—Testimony, Feb. 18, 1972, of John Doyle Elliott, Sec. Townsend Foundation, founded by the late Dr. Francis E. Townsend, to U.S. Senate Committee on Finance.

We urge swift passage of HR 1 as emergency aid to multitudes of misfortuned people—with Social Security benefit-raises retroactive to Jan. 1—all limitations, deductibles, premiums and co-insurances under Medicare A&B ended—attained age the only requirement for complete Medicare benefits—a "presumed wage in covered employment" for every person, providing a minimum, primary benefit sufficient to bar Welfare eligibility except in extreme cases. Have all the people under one, complete, non-discriminating plan. This Lobby, 30 years ago, urged the substantial benefits and advances in HR 1 as justly deserved, then. Now, HR 1's but a feeble turn towards what's right.

Since World War II, each Congress—now successive Sessions—have faced Soc. Sec. amendments—two White House Conferences, House-passed HR 1 and these hearings—all not because all's well with Soc. Sec., *but, because very much is very wrong.*

The special memo accompanying this testimony authentically shows the inferior, money-income position of the elderly, their very license to live, has not improved, from 1947 through 1970—despite all public and private, group and individual works, programs and policies. The truth.

However, it's gratifying that in the last three years both House and White House have reversed their formerly opposed views and, virtually point by point, adopted this Lobby's 36-year-old criticisms of misnamed Welfare. The Senate's Special Committee on Aging marks *income-lack* "more than ever" the "major problem" of retired Americans, saying only a federal plan can meet it. Now, HR 1 sincerely "flatters by imitation", adopting, after years of rejection, specific Townsend Plan features in both Social Security and Welfare reforms.

With my testimony I've filed HR 3296—the full, up-to-date application of Townsend Plan principles to the problems of social security and poverty. Only this great, national pension for all alike can insure prosperous instead of impoverished retirement, abolish discrimination and the mismanagement and waste of abundance.

As a living fact of life pervading our land, such real social security will take no money out of our economy, or out of the overall lives of honest people, or any honest interest—but, its effects will prosper every community in the Nation as nothing else can, solving problems which must be solved to achieve the faith, harmony and unity necessary for the world-inspiring society we ought to be.

Our people and Country have lost mightily from this unremedied problem. No other investment can so vastly benefit our people and profit our Country as its remedy. The longer we lack it, the mightier become both the irrecoverable losses which the problem inflicts and the need for the profit only its remendy can provide.

All other achievements and glories must continue mocked by impoverished retirement as life's final reward for most Americans, without one thing—a great, national pension, prosperity-sharing retirement assured for ALL. My testimony provides for prompt transition to the system we ought to have—defined in HR 3296.

I suggest that the sweeping changes and reforms in HR 1 bluntly raise this question: "Who's been right and who wrong all these decades?" Revelation's afoot. I believe it counsels a new, enlightened look at HR 3296, the up-to-date Townsend Plan Bill.

If we'd had this prosperity-sharing retirement for the last 30 years, would we be a better, stronger, or inferior society compared to what we now are? Can we possibly be what we ought to be—can be—unless we do what this Bill proposes, defines and provides?

It's in the light of those questions my testimony is relevant, Mr. Chairman.

STATEMENT

Mr. Chairman, I urge prompt passage of HR 1 *as emergency relief to outrageously misfortuned multitudes*, with benefit increases retroactive to Jan. 1. As this testimony will reveal, none have more fault with HR 1 than I but, the straits of people dependent on inadequate Soc. Security and misnamed Welfare, augmented by delay of this bill, defy description. Its faults, as we variously see them, ought not deny the people its good. Brutally senseless, I believe, is failure to enact now what was of debatable adequacy thirty years ago!

I hold HR 1 the most sweeping amendments yet to the Soc. Sec. Act. Each Congress—lately successive Sessions—have not found progress towards a working system but, the need for ever broader amendments. This is NOT because all's well with Soc. Sec. *It's because very much is very wrong.* Census Bureau's Current Population Reports. Series F-60, show the authentic, unanswerable facts:

MEDIAN INCOMES

	Men				Women			
	Over 65	55 to 64	Inferiority	Percent [1]	Over 65	55 to 64	Inferiority	Percent [1]
1947.....	$956	$2,344	$1,388	145	$551	$962	$411	75
1969.....	2,828	7,279	4,451	157	1,397	2,791	1,394	100
1970.....	3,076	7,678	6,602	150	1,522	2,946	1,424	94

[1] Inferiority as percent of income of those over 65. See attached special memo.

In 24 years, the income of men over 65 increased 222%—but, their *inferiority* to men 55 to 64 increased *232%*. For women income increased 176%, their inferiority *246%*. All public and private, group and individual works, policies and programs—*combined*—completely failed to better the aged. In the perspective of the problem's age and size, most of HR 1's advances should have been enacted 30 years ago—when, in substance, originally proposed by this Lobby. Today, they are but feeble turns towards what the aged ought to have.

Present Social Security is as inadequate and *obsolete* as Model-T Fords on today's roads and turnpikes. HR 1's an improvement only as was the Model-A Ford in its turn. Americans, retired by age and various disabilities, ought to have a competently up-to-date economic vehicle. This testimony presents the structure of that ought-to-be financial vehicle of Social Security and Prosperity Insurance, Mr. Chairman.

Only one thing can wipe out that excuseless income-inferiority of the aged—their *lack of the very license to live.* That is a great, national pension (now about $350 a month), equally vested in every individual at age 60, assuring prosperity-sharing retirement, even for those caught with no other resource.

That figure ($350 a month) measures not the *"cost"* of a burden—but, the size of the prosperity-flaw and crushing losses *which the problem of impoverished retirement inflicts.* It measures the profit only that problem's full solution, prosperity-sharing retirement, can ever provide. *What we can't afford is unjust poverty and its human ruin—not the cure.*

That great pension will be both anti-*in*flationary and anti-*de*flationary, amplifying living and business at up-to-date, average levels, by steering funds from both *in*flationary and *de*flationary business processes and extremes—*thereby weighting the norm.* How can anything better stabilize *honest prosperity* than that?

To the extent we lack prosperity-sharing retirement as life's final reward for all Americans, our other achievements must continue mocked by futility—our prosperity deformed and flawed, faith and harmony a shambles, inflation dissolving happiness, war to support employment and our Country's influence weakened and fading.

With the Senate repeatedly passing $100-a-month minimum Social Security benefits and the prolonged House Study and WHCoA requests, HR 1's $74 minimum (*$2.43 a day*) is a shocking jolt. And all the more jolt beside the "special" $150 for those "covered" for 30 years and an early $150 minimum for adults under Public Assistance.

When we must be away from home, it costs $2.50 a day to board our cat in a cage. If he needs a pill, it's extra. *H.R. 1 provides cat-and-dog pensions for people!* That it's better than we've had in most States, is all the more shame. *How can even twice the cost for a cat be remotely tolerable for human beings!!*

Since 1954, to move towards the plan we ought to have, I've proposed a "presumed wage in covered employment" vested in every individual, providing a minimum benefit barring eligibility for Public Assistance and Welfare—today, about $200 a month—ALL our people under the SAME plan—virtually wiping out Public Assistance and Welfare (but for rare cases) and most adult-dependent Social Security benefits, as well.

Whatever a uniform, national plan provides, it will cost less (especially administratively) than under degrading welfare. I admonish cost-fearers that nothing's as costly, wasteful and cruel as destruction of people by social injustice—and nothing is as profitable as happiness and health successfully pursued.

We hold patently unjust requiring mothers with dependent children to go to work; unless they so elect. Only exceptionally gifted women can do a properly good job of being mother and housewife and the breadwinner, too! It makes familyhood a myth.

Both House and White House have reversed their formerly opposed views, virtually point by point adopting our 36-year-old criticisms of misnamed welfare and wickedly inadequate social security. The President labeled it "blatantly unfair" and "outrageous." The House has strongly voted to replace it by a uniform Federal plan—condemning the very system THEY created and fostered all those years against our counsel.

Respectfully, I believe I now justly raise the question, "Who's been right—and who wrong—throughout those three and a half decades?"

H.R. 1 proposes automatic Soc. Sec. benefit-raises yearly if the Consumer Price Index rises 3%—only half the need. Advancing *standards* must also be matched,

or the income of the aged will still lose ground. *That benefits be "geared" to both advancing standards and costs* has always been a primary proposal by this Lobby, from the start.

After 3½ decades rejecting it and denying the people its now admitted justice, House and White House now have reversed their stand and passed ½ of it. The change of view is commendable; but, *H.R. 1's provision is feeble*—the Consumer Price Index but a partial, inadequate and by itself obsolete guideline. Again, validly, the question:

Who's been right—who wrong—all these years?

Mr. Chairman, since 1956, I've specifically urged direct use of *percapita income*, the average cost of human life, cradle to grave, reflecting all changes meticulously in both living costs and standards, to update benefits—along with the "presumed wage" to end discrimination and achieve transition to real social security. Nothing so closely and simply reflects ALL changes as does percapita income.

There are no good reasons—*only bad ones*—for this not being done. It's not a "cost"—*it's the most profitable economic and social investment possible.*

There is the retirement test in H.R. 1, dropping the depressing $1-benefit-loss for each $1 earned over the set limit. At last, *after 15 years rejection!* Fifteen years ago, in H.R. 7086, 85th Congress, this Lobby proposed $75 a month earnings (now $150, in H.R. 3296) without benefit-loss—then, a $1 loss for each full $2 earned above that amount.

This new, at least fair provision of H.R. 1 will enable workers to ease into retirement over long periods of time—ease in and out of work suitable to their abilities and advantage. It will encourage the disabled in rehabilitation; and help child-beneficiaries ease into employment (assuming its broadened application). Help, not penalty.

However, the *stingy benefits* of H.R. 1 blunt the good effects of this fine thing, because the smaller the benefits, the faster will earnings absorb them, leaving poorer workers stripped of benefits and dependent on mean earnings.

Again the question—"Who's been right—who wrong?"

Therefore, we urge suspension of the retirement test until minimum benefits at least bar eligibility for Welfare, then gradually applying it up to full force when they equal the prevailing federal minimum wage, updated in step with percapita income. Then we'll be walking the road to justice and to the faith and unity otherwise impossible—*but necessary for the inspiring society we ought, by every right, to be.*

H.R. 1 unconsciously proposes to raise the contributions-base in step with the average wage in "covered employment". The average "covered" wage better reflects both costs and standards—but, to apply it to taxes *but not to benefits* is defenseless. *Can such discrimination conceivably pass House, Senate and White House? Inconceivable!*

It's wicked discrimination to raise the contributions-base to obligate the public purse *to match retirement savings for the well-to-do*, the fortunate, those best able to finance themselves. Remember, we don't have the problem because of the prospering and well-employed, *We have it because of the misfortuned!* H.R. 1 is upside down—devilishly "regressive"—rich benefits for the successful—mean benefits for the poor.

How wrong can you get? How survive, deceptively compounding injustice by evils falsely presented as remedies for grievous wrongs—*like this provision of H.R. 1?*

All the criticisms so falsely lodged against prosperity-sharing retirement are fully valid against this one! To match richly retirement contributions of the fortunate, the well-to-do and rich who have the least right to a penny! How wrong can you get?

This Lobby believes two systems classifying certain Americans as inherently insured, others as indigent, are wrong. We must have one, prosperity-sharing insurance plan for all alike, barring the need for Welfare and Public Assistance (except in rare cases). Abolish discrimination the only way possible—by the great pension for all.

H.R. 3296—the Pay-As-You-Go Social Security and Prosperity Insurance Act—The Townsend Plan Bill—defines, provides and presents exactly that system. It creates a prosperity-floor—*not a poverty-ceiling*—below which we will not allow retirement living because of money-income lack—because of *lack of the very license to live.*

Only this great pension could in the past, or can in the future fill the punishing income-gap authentically documented at the outset of this testimony. Continuing such unjust, defenseless human poverty foredooms the economic, social and political progress this society ought to achieve, but isn't. There is no substitute to wipe out this not less than $125 billion a year prosperity-loss. Only this great pension.

Without prosperity-sharing retirement as the right of all under the same plan, instead of *paupered retirement for multitudes*, the disintegrating injustices causing our Country's rending divisions will remain—mounting. It's the prime requirement.

Oh—there's nothing wrong with other countries advancing—but, *there's very much wrong with us slowing down*, losing our leading pace because of excuseless injustice in our own house, mismanagement of abundance under the obsolete, prejudice-ridden rules of scarcity—nowhere so emphatic as among our retired elderly and disabled.

We completely disagree with HR 1's increased Medicare limitations. It's past time for complete Medicare. By the single requirement of attained age 60, it should cover all because too many ruinously costly illnesses, in the face of fading income, strike before age 65. All under the same plan.

Eliminate from Medicare A & B all limitatoins, deductibles, premiums and co-insurances. Cover all prescribed medicines, extended care, eye, ear, nose, feet—*everything prescribable for health treatment.* No bills to patients. The aged sick can't competently go to court about charges etc.; the Government can—and it can fairly set fair charges and see that they are paid and *patients not plagued.* It can only be done under complete Medicare; and it ought to be.

Medicare should cover the disabled and all other Soc. Sec. beneficiaries, because they are under the same financial dependency as the elderly.

Formidable demand is rising for universal and complete health insurance, cradle to grave. If the medical profession, the health and insurance industries and science cannot do the job and universal health insurance comes—there can be no better preparedness for it than complete Medicare in experienced operation.

Contrary to the prejudiced and obsolete thinking of many, the Government won't do the work, but will vest in the people the insurance which alone can finance the relevant professions, industry and science to do it. Only *complete Medicare* can win us the priceless profit possible only *if the financial problem's fully solved.*

Mr. Chairman, as a member of the Task Forces on Income of the White House Conference on Aging—and the Maryland Conferences—I was exceedingly gratified when, after extensive discussion, each and all of the Task Forces independently reached the above conclusions and recommended accordingly on Medicare.

Most equitably to finance the above defined, complete solution of the Soc. Sec. and poverty problems, Sections 214 & 229 of the first section of HR 3296 present the Gross Income (gross receipts) Tax. The gross receipts of all persons and companies is the broadest possible tax-base, for the lowest possible tax-rate. It will provide benefits for the poor *more meaningful in reverse proportion to their fortunes and contributions.* To the fortunate and rich—who by definition and fortune have secured freedom from the problems—the exact same benefits will acrue; but, they will be less meaningful as their fortunes and contributions are the higher (ability to pay). Just what "progressive" solution requires.

To the general population it will insure an incomparably sure investment in prosperity-sharing retirement, their contributions buying benefits "geared" to increase directly in step with advancing costs and standards. A better, or as sure an investment will defy imagination.

The Gross Income Tax will *automatically* amplify revenue to match advancing production, business-volume, costs, prices and standards—all—tremendously help-

ing to keep benefits up to date. Just how can you get any more equitable than that?

Further, this tax will *automatically* rescue funds from both deflating and inflating business activities and pump them into prevailing, normal standards and levels of business and living—reflating the deflated and deflating the inflated. How can you get more stabilizing, equitable and prosperity-sharing than that?

HR 3296 provides automatic transition from our present, futile systems to this great, national pension by starting with benefits sufficient to bar eligibility for most Public Assistance and Welfare, increasing them every three months until all eligibility for Welfare and benefits Soc. Sec. has been absorbed and the great, prosperity-sharing, national pension is established as the inherent right of every American.

Alternatively, if Congress advances the present system through the "presumed wage" I've advocated, to establish minimum benefits at least precluding eligibility for Public Assistance and Welfare—getting all our people under one, non-descriminating plan—then advancing the benefit to the adequacy necessary for the prosperity-sharing retirement envisioned in HR 3296—under that approach, this GI Tax should be used instead of any further tax-rate hikes and contributions-base increases under the present tax-system. They are both already intolerably burdensome—*regressive!*

Now, we've been told incessantly in recent years, in effect, that we *do* possess the technological means for production to end poverty—but, in the same breath, we've been informed that we have no "financial mechanism" so to distribute our produced abundance for such human well-being and freedom. That's not true.

This Gross Income Tax, used as herein prescribed, is exactly that "financial mechanism." That last ditch, defenseless excuse is groundless. In point of fact, it's been groundless since this Lobby first presented this tax so to be used, in 1937.

Conclusion.—With that "financial mechanism" in mind, I make this observation: If a *contract* is economically and otherwise valid between employers and employes of particular industries—like auto, steel etc.—providing prosperity-sharing retirement for those who've served 30 years in those jobs (proportionately less for shorter termers)—then, there's nothing wrong and *everything right* with a universal contract to do exactly the same thing for all the people, all the time, *equally*, covering all industries, all business and all occupations perpetually.

Indeed, if a thing's wrong with such a universal contract, then it's at least as wrong with any and all of these specia' contracts for special groups, in special occupations, prosperously employed—namely, discrimination.

This "financial mechanism"—the git of HR 3296—does exactly that—covers all business and industry, all occupations, all the people all the time providing exactly those prosperity-sharing retirements, permanently. Fully solving the problem.

The great, national pension—universal contract—will be a people-spending, not a government-spending program not taking a nickel out of our economy, or out of any honest lives, or interests. It will all be money right down in the communities, *everywhere, prosperously functioning;* where, now, in tragic measure, it isn't! Where its lack, now, constitutes the costly, running problem.

There's no good reason for retirement-living being in any respect financially inferior to that in any other period of life, at any time. Here's the plan, "contract," and "financial mechanism," the ways and means for prospering it.

I respectfully suggest Mr. Chairman, this Lobby's right about this, too.

Every argument used to prevent prosperous retirement agreements, decent pensions for the misfortuned and the people in general—falsely used—is completely valid against lavish pensions for the well-to-do and rich, in both public and private life, from the top down. Their extravagant pensions come, directly and indirectly, from prices and/or taxes, *from the public purse*—for those fortune's supplied every means for financing their own retirement. Who doesn't know endless examples of this shameless pension grabbing by the richly paid, unanswerably undeserving? Shameless and wicked.

SPECIAL MEMO, MAY 1971 FACTS ABOUT THE INCOME INFERIORITY OF THE AGED, MEDIAN INCOMES

	Men				Women			
	Over 65	55 to 64	Inferiority	Percent [1]	Over 65	55 to 64	Inferiority	Percent [1]
1947	$956	$2,344	$1,388	145	$551	$962	$411	75
1948	998	2,412	1,414	142	589	857	268	46
1949	1,016	2,366	1,350	133	516	1,000	484	94
1950	986	2,494	1,508	153	531	918	387	73
1951	1,008	2,840	1,832	182	536	968	432	81
1952	1,247	3,009	1,762	141	654	1,175	521	80
1953	1,150	3,271	2,121	184	659	1,170	511	78
1954	1,268	3,195	1,927	152	694	1,195	501	72
1955	1,337	3,440	2,103	157	700	1,257	557	80
1956	1,421	3,567	2,146	151	738	1,364	626	85
1957	1,421	3,681	2,260	158	741	1,342	601	81
1958	1,488	3,968	2,480	167	776	1,326	550	71
1959	1,576	4,190	2,614	166	797	1,431	634	80
1960	1,698	4,289	2,591	153	821	1,415	594	72
1961	1,758	4,597	2,839	161	854	1,480	626	73
1962	1,910	4,800	2,890	151	920	1,669	749	81
1963	1,993	4,901	2,908	146	920	1,774	854	93
1964	2,037	4,941	2,904	143	952	1,910	958	101
1965	2,116	5,250	3,134	148	984	2,019	1,035	105
1966	2,162	5,750	3,588	166	1,085	2,214	1,129	104
1967	2,304	6,122	3,818	166	1,123	2,352	1,229	109
1968	2,652	6,717	4,065	153	1,311	2,576	1,265	96
1969	2,828	7,279	4,451	157	1,397	2,791	1,394	100
1970	3,076	7,678	4,602	150	1,522	2,946	1,424	94

[1] Inferiority as percent of income of those over 65.

Source: Census Bureau, Current Population Reports, series P-60, annual tables on money-income distribution by age and sex, 1947 through 1970.

The income-status of the elderly *has not improved*—netting, *if anything*, a slight loss. What's more—a few, in certain groups like autoworkers, for example, won *contracts* for prosperous retirement. Since the aged generally didn't gain, the gains by these special groups mean that most of the aged *lost all the more.*

In that light study the above, authentic facts. See that ALL our programs and policies, *public and private combined*, have outrageously failed the aged—that only our Bill's great pension can ever provide them the lacking money-income, the *very license to live* on up-to-date, just standards—the problems, only solution.

It's far past high time we had prosperous, not impoverished retirement, a *contract* covering all business and all the people all the time—more valid than contracts in the auto and other industries for a special few. H.R. 3296 is that universal contract covering all all the time in every business and occupation. There's no other.

The authentic facts put the burden of proof squarely on those who still insist on trying to make the unworkable, old system work. You'll find every reason they give *is a bad one.* There isn't and there's never been any *good reason* for living standards in retirement being impoverished, or in any way inferior to other periods of life.

The Townsend Plan National Lobby, 5500 Quincy St., Hyattsville, Md. 20784.

JOHN DOYLE ELLIOTT, *Director.*

CALIFORNIA AAPS,
Covina, Calif., February 18, 1972.

Mr. TOM VAIL,
Chief Counsel, State Finance Committee,
New Senate Office Building,
Washington, D.C.

DEAR MR. VAIL: As indicated in our telegram sent today, attached is a written statement of Rafael Solari, M.D., Vice-Chairman of the California Chapter of the Association of American Physicians and Surgeons.

We wish to submit it as our testimony before the Finance Committee in opposition to further nationalization of health care. We regret that your busy schedule makes it impossible for you to hear this testimony in person.

Cordially,

WALTER R. BUERGER, M.D.,
Secretary-Treasurer.

The following is the text of the statement made before the "House Ways and Means Committee" in Washington, D.C., November 11, 1971 by Rafael A. Solari, M.D. (2166 Hayes Street, San Francisco, CA 94117). Dr. Solari is vice chairman of the California chapter, Association of American Physicians and Surgeons.

I am Rafael A. Solari, a Board Certified specialist in Internal Medicine, in practice in San Francisco with three other associates. I have practiced medicine in San Francisco for 18 years. This year, I have the privilege of holding the office of Vice Chairman of the California Chapter of the Association of American Physicians and Surgeons, a voluntary organization of practicing physicians in California. I am pleased to have this opportunity to present the views of the physicians of my organization as it relates to this committee's consideration of national health programs.

The majority of those national health plans presently under consideration are premised upon the assertion that "health care is a right". I would ask: "If health care is a natural right some citizens are born with, then who is born with the corresponding obligation to provide that service?"

This notion that every citizen of the United States has an undeniable right to health care, I would contend, *is fallacious.*

All of us recognize that optimal medical care is what we would desire for all citizens. We would also want top quality food and shelter for all.

However, when one speaks of rights, one must make a distinction between what is desirable and what are "rights".

If one insists upon the fallacious premise that health care is a right, *the concept immediately produces two victims.*

The first victim is *the physician.* A physician, like other citizens, performs his services voluntarily and offers it as a salable commodity, or donates it. He does not, however, perform as a servant, like the feudal serf of 700 years ago.

But unfortunately and most important of all, it is not only the physician who will be affected by such a system, but there is a second victim. This will be *the taxpaying citizen,* for in order that the "right" be fulfilled, or guaranteed, by federal provision the citizen would be forced to surrender part of his earned income for the benefit of others—or the benefit of himself, though he may prefer to spend the money elsewhere..

Medical care is a product, produced by men, and not found in nature. It is not a "right" and never has been historically. *Medical care is no more a right than food or shelter* is a right, and certainly these two are more essential to life than medical care.

Thus, I have tried to demonstrate that the contention that health care is a "right" is a false premise.

ALLEGED "CRISIS" IN HEALTH CARE

We are told that there is a need for a national health program because of an alleged "crisis" in health care. As a demonstrable fact this is just not so.

In the appendix of the material submitted I refer this committee to an article written by *Marvin H. Edwards, Editor of the magazine, "Private Practice,"* which has been widely circulated by the *American Conservative Union.* In this essay there is ample proof for the following statements: One of the prime contentions of this so-called "crisis" is *the assertion that free enterprise medicine has failed to deliver quality care. This is not true.*

Life expectancy in the United States has increased and compares favorably to other modern countries.

Decreasing infant mortality statistics compare favorably to that of other countries. This is amply demonstrated despite the widely proclaimed but falsely interpreted infant mortality statistics of the United Nations Demographic Yearbook of 1968.

Tuberculosis and poliomyelitis have been virtually eliminated. Duration of hospital stays for similar illnesses are shorter in the United States than in countries with national health plans.

The *rise in cost of medical care*, though noticeable and painful to the purchaser, *has been* a part of the general increase in all prices and wages *due to federal inflationary policies, and not to free enterprise medicine.*

The most substantial escalation of health care costs has not been in the charges of physicians, but in the daily room charges of hospitals.

Most of this recent *increase in hospital charges* is directly attributable to the dramatic hike in hospital wages during recent years. The net effect of increased wages reflects itself dramatically on the hospital room charge when one considers that wages account for about 70% of the hospital budget.

According to Senate testimony given in 1970 by the American Association of Councils of Medical Staffs the stay in a private hospital averaged 8.11 days while the stay in a Veterans Administration Hospital for a similar illness averaged 22 days.

Therefore, I have attempted to demonstrate that *there is no "crisis"*, and if there is a "crisis" it has been caused and aggravated by government itself.

THE "MEDI-CAL EXPERIENCE" IN CALIFORNIA

In California we have a pilot program called "*Medi-Cal*" which one *could compare to a future national health program.* I thought it might be interesting to this committee to relate *some of the difficulties we Californians have had* this past year and a half with this program.

Earl W. Brian, M.D., Director, Department of Health Care Services, announced during the early months of 1970 *several cut-backs* in the Medi-Cal program which were necessary to offset a projected $15–$20 million deficit. This deficit was allegedly brought on because of an original unrealistic budget, and compounded by short-sighted estimates of the increased case load. Later in December, 1970 *even more stringent regulations* were issued.

These included the following:

(1) Prior authorization for non-emergency admissions to hospitals.

(2) Hospital stays were limited to eight days.

(3) Only two office visits were allowed per month.

(4) An emergency drug formulary was adopted which markedly restricted the physician's ability to order appropriate medication. A requirement was set forth that all prescriptions must be prepared for a 30-day supply. Later as many as 24 drugs used for common illnesses were restored, and the formulary revised several times.

(5) Eye refractions were restricted.

(6) A 10% reduction in fees paid to providers, such as laboratory services, nursing homes, and physicians.

As a result of these actions, the Sacramento Board of Supervisors and the California Medical Association *filed suit* in Superior Court on January 13, 1971 against the Department of Health Care Services, its Director and the State *to force the State to rescind the cuts in Medi-Cal health services.*

In the suit, the CMA alleged that the emergency regulations would cause irreparable injury, including suffering, sickness, and the possibility of death to some Medi-Cal patients.

Meanwhile, the Medi-Cal consultants who had to issue the authorizations were swamped, resulting in *confusion and delays in the provision of health care.* CMA claimed that prior authorization was taking 10 to 15 days, delaying needed health care.

During the Superior Court trial ending March 15, 1971, witnesses said the *regulations impeded quality of medical care, were harmful to patients* and *buried the physician beneath mounds of unnecessary paperwork.* CMA's suit charges the *emergency restrictions were illegal and prevented the indigent from receiving quality medical care*, thus circumventing the program's original legislative intent.

The suit was finally won by the CMA in June of 1971, and restoration was effected on July 1, 1971.

In the meantime, however, *there had been much chaos* from December 1970 to the following July, and during that 7 month interval there was *dislocation of patients* from nursing homes, *much paper work* for physicians and hospitals and *poor care for patients.*

New legislation was enacted in October which has yet to be tested.

Now why do I burden this committee with this detailed account of our difficulties in California. I do so in the belief that it represents a miniature microcosm of what would happen were a federal health plan enacted.

What better test-tube has been witnessed here in the United States than this program in California?

How can we project costs for a national program when legislators can be so wrong on a state level?

When bankrupcy threatens, cut-backs, prior authorizations, limited hospital stays, interference with the amount and nature of drugs prescribed and *generally poor medical care inevitably follows.*

This all on a state-wide level. Can you imagine what could happen in an analogous situation on a national scale?

Let me now describe *some of the changes* in my daily practice *of medicine brought about by the enactment of "Medicare"*. I shall respectfully allow you to judge whether this has had a salutary effect on the practice of medicine.

Let me take you with me on one of my typical days. On my hospital rounds I miss seeing *my fellow physician* on the wards or in the clinic caring for patients because he *is now spending innumerable hours closeted in utilization committees*, trying to decide which patient has over-utilized her stay in the hospital, which diagnosis is justifiable, writing letters and trying to referee claims.

I see *physicians who were in active practice now doing administrative work* either in hospitals or with third parties. One boasted to me the other day: "I never see patients any more; I sit at my desk and shuffle papers about." These physicians have subtracted themselves from the active work force caring for patients.

As I enter the nurses' station, I am *greeted by the nurse, but not as to the condition of my patient, but rather would I immediately sign the certification form for Medicare which* is due that day, or will I sign the diagnosis slip for the same purpose without delay. Obviously priorities at nurses' stations have changed.

This year I no longer see on rounds my five *good physician friends* who are still vigorous in mind and body because they have *retired rather than put up with the increased paperwork and frustration* of practice.

On arriving at my office I find a number of letters written to me by insurance carriers for Medicare many of them indicating retroactive denial of claims for my patients. These necessitate a *continuous, endless stream of correspondence.* Also, on my desk are a clutch of *new forms* all needing to be signed authorizing admissions and procedures under Medicare.

My first *patient*, an elderly lady over 65, has arrived with her bags packed *demanding to be placed immediately in the hospital for what I would consider a mild ailment easily treatable as an out-patient.* Time is consumed in explaining the difficulties of Medicare coverage.

My next visitor is the *husband of a patient already hospitalized with Medicare benefits who asks that I not discharge the patient* until three days hence when he will have his regular day off.

And so the day goes until the evening, when my time at the Board of Directors' meeting of the Medical Society is not spent in a creative way either, improving therapeutics or improving methods of diagnosis. Eight to ten meeting this year have been spent discussing the possibility of transforming certain groups, hospital staffs, and even the Medical Society into HMO's or Health Maintenance Organizations, and thereby qualify for federal funds.

I have tried to give this committee some insight into the development or evolution of a physician practice since the enactment of Medicare.

The question is often raised as to why those who represent organized medicine seek, themselves, to implement certain national health programs. Speaking as

one who is on the Delegation from San Francisco to our California Medical Association and also a member of the Board of Directors of the San Francisco Medical Society I see *medical spokesmen so fearful that an all-encompassing, comprehensive national health plan will envelope them and their patients that they are willing to accept or promote diluted versions of national health programs.* In actuality, they do not actually favor the programs they espouse but feel it is better to seek the lesser evil.

As to how the *rank and file physician* feels in this regard I would like to cite a poll taken in San Francisco wherein physicians were asked their opinions regarding national health programs.

According to this recent poll taken in July of this year, *a vast majority* (almost 2 to 1) *are against a national health program, and feel that the American citizen would NOT receive better quality health care under such a system.* Almost 3:1 of all those polled were for *LESS* government supervision than for more.

Finally I would like to say a word about our youth. We are all concerned with what our youth are trying to say to us. Michael J. Halberstam, a young physician, in a recent article in the New England Journal of Medicine (284:21, May 27, 1971) pointed out that increased bureaucracy and centralization, increased impersonal dehumanization is the very thing that the young are protesting. He indicates that youth has discovered the common illness of Western man which is alienation, with the individual citizen having little power over his own immediate surroundings.

As he so ably points out—*We, in the USA in our present health care have this great tradition of our concern over the individual patient as a person; and of mutual trust between physician and patient. He asks if all this is to be substituted for a computer, a faceless burcaucrat, an assembly-line type of medical care with no confidentiality?*

What then is *the alternative* to all these national health plans?

It is the *system of free enterprise medicine,* which is so familiar to most of us that we seldom stop to marvel at its classic simplicity. Yet, despite its simplicity, it *is* a system—and a system which has worked to provide high quality health care to the American people at a reasonable cost.

The heart of the system is *individual responsibility* and *initiative* of both the patient and the physician. The backbone of the system is *free-choice* and *fee-for-service,* and the *freedom of the individual to choose,* and this last *is, after all, the essence of man's spiritual nature. The system, based on value given for value received between equal men giving mutual respect to each other, is ethical, fair, and the product of long experience.*

As Vice Chairman of the California Chapter of the Association of American Physicians and Surgeons I wish to thank the Chairman and members of this committee for the opportunity to present my views on behalf of our organization.

EDITOR'S NOTE.—We are prohibited from duplicating or quoting the unrevised stenographic minutes of the questions and answers that followed, but it is interesting to note that *Dr. Solari had a good opportunity to explain to the committee that the poor have been and would be well taken care of without Medi-Cal* in accordance with our Judeo-Christian tradition in America; that when government steps in, charity tends to be pre-empted. He also had a chance to show how *competition in the free enterprise system* prevents a doctor from charging all the traffic would bear. If he tries to overcharge, he loses patients and referrals. Dr. Solari also clarified the long recognized place *peer review* has had in medicine, in the form of tissue committees, chart committees, medical society committees, etc., but *not for control of fees which are better handled by the free market.* He *cautioned against underrating the value judgments of the Congressmen's constituents* in deciding whether a physician is giving proper care or whether they should find a better doctor. Both the presentation and the questions and answers must have been an exciting experience. The California Chapter of the Association of American Physicians and Surgeons expresses its appreciation to Dr. Rafael Solari for taking the time and effort to appear before the Ways and Means Committee.

The Case Against National Health Insurance

by Marvin Henry Edwards

The idea of national health insurance," according to Rep. Richard Fulton (D-Tenn.), "is an idea whose time has come. The question is no longer whether or not we need a national health insurance plan. The question is what plan?"

Since everyone who is saying much of anything seems agreed that some type of national health insurance should be adopted, that does indeed appear to be the question. Unfortunately, from the perspective of this study, it shouldn't be. The point which needs to be raised is not, "what plan?" but whether we should have any such plan at all.

There is an overwhelming body of evidence before us suggesting quite strongly that national health insurance, in any one of several modulations, would be calamitous to our nation. If that evidence were fully brought before the American people, it is extremely doubtful they would support such a departure. But so long as the fundamental issue is not even discussed, these crucial data remain hidden from view. This paper is an attempt to make them available to the public.

What has brought national health insurance – that perenially resurrected Harold Stassen of political issues – to such vigorous life in the '70s? A number of factors seem to be responsible.

The first is the political attitude of the day. Advocacy of national health insurance rests on the base of a claim that "all Americans have a right to health care." The current campaign for national health insurance rides the same wave which has brought forth such programs as Urban Renewal, the Food Stamp program, the War on Poverty, and proposals for a Family Assistance Plan or guaranteed annual income. A politics of vicarious altruism has led, in its inexorable way, from a concept of welfare to a concept of extra-constitutional "rights." Welfare recipients, social workers and politicians now proclaim that every citizen has a "right" to be provided with food, with housing, with income. It is a natural corollary that he should insist, also, upon the right to health care, financed by government.

The second major factor in the great comeback of national health insurance is the default of its traditional opponents. Stung by the passage of Medicare and Medicaid, stunned by a massive propaganda campaign, large segments of the medical profession have come to believe in Rep. Fulton's suggestion that some form of national health insurance is inevitable. The prophecy may well be self-fulfilling: by accepting the theory that a government takeover is inevitable, and acting accordingly, the profession may prove it to be so.

Ironically, the particular plan offered by Congressman Fulton was drafted, not by the traditionally liberal-leftist spokesmen for organized labor (though they had a plan of their own), but by organized medicine itself. This represents an obvious, and distressing, reversal. During the Kennedy administration, it was organized medicine which spearheaded the opposition to, and prevented (temporarily) the passage of, Medicare – a limited program of national health insurance for the aged. Now that type of opposition no longer exists. *

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* As a caveat against any unintended implication that the nation's physicians have individually or collectively weighed the current medical situation against the merits and demerits of national health insurance, and found such a program to be in the best interests of their patients and/or themselves, it should be pointed out that there is some question as to whether or not "organized" medicine – in this case the American Medical Association – speaks for the profession. In fact, there is considerable reason to believe that it does not: as with most large organizations, the AMA is possessed of a large professional bureaucracy, composed chiefly of physicians who have long since left the active practice of medicine, and it is this staff which frequently provides the *de facto* leadership of such organizations, confronting elected leaders with incomprehensible mountains of material to be consumed somehow and acted upon at each brief session of the Board of Trustees or the House of Delegates.

Many in the medical profession – and on the Republican side of the aisle in Congress – have abandoned the struggle. The battle has become one for position only: "If we don't introduce a program, they will."

To a large extent, the apparent success to date of the campaign for national health insurance is simply a matter of the predictable success of any campaign which does not encounter opposition. Plainly put, nobody much is fighting it.

Finally, the campaign is enjoying some preliminary success because of a widespread public frustration. Government economic policies have created an inflationary spiral which has the average American on a disheartening treadmill and focused his attention on the highly visible increases in his cost of living. The cost of medical care has risen less in recent years than the cost of such other daily expenses as housing, transportation, and meat on the table. Yet the advocates of government medicine have utilized a highly successful media campaign to center public attention on medical cost increases.

It should be further emphasized that the surge of opinion in behalf of more governmental medicine has occurred only among certain segments of the populace. Recent public (Gallup and Harris) and private surveys seem to indicate that most Americans remain generally satisfied with the present free-market medical system. Indeed, the well-publicized cries for change seem to be coming primarily from a few politicians, social reformers, and journalists.

But the drive, limited as it is, will have its effect. Though the news media may not now be accurately reporting current public sentiment, they may well create the demand for change. They have certainly begun to sow the seeds of discontent. National health insurance is not, as its advocates contend, inevitable. But, unless a concerted resistance is mounted, it is imminent.

I. A Dubious Right

National health insurance is based on the philosophical concept that every citizen of the United States has an undeniable right to health care.

Yet the right is deniable. Every citizen has a right to health, which is to say that he may not be intentionally or accidentally deprived of his health by fault of another, and that if he is he may seek legal redress. To that extent, he has a right to health as he has a right to life – a right enforced by the statutes of the land and by the moral laws of the community.

From this, however, the advocates of national health insurance would extract a further right: the right to health care. This extension involves a concept not present in the right to health itself. Whereas the right to health requires only that second parties refrain from injury, a right to health care would require active servitude on the part of some citizens at the demand of others.

A physician, like other citizens, performs his service voluntarily and offers it as a salable commodity, or donates it. He does not, however, perform as servant. The concept of a right to health care could lead to that conclusion. But, as it is not the physician who will be most affected by the decreased quality of care and increased cost which invariably mark national health insurance, neither is it only the physician who will be placed in a position of servitude.

One victim of the concept that each citizen has a right to health care will be the taxpayer, for the "right" will be fulfilled, or guaranteed, by federal provision of the funds by which such care may be purchased.

Each of the plans introduced in the Congress will, in some form, take the financial resources of some for the benefit of others. The systems vary, of course. The Kennedy plan, for example, is a compulsory program to be financed by payroll withholding taxes and by general revenue funds (income taxes); the Nixon plan would be financed partly (Part A) by compulsory expenditures by employers, and partly (Part B) from general revenue funds (income taxes); the AMA, or Medicredit, plan, would be paid for by the portion a citizen contributes, through taxes, to the general revenue funds which would be used to subsidize the health care expenses of part of the population. In each case, because it is the taxpaying citizen who will be forced to surrender part of his earned income for the benefit of others – or for the benefit of himself, though he may prefer to spend the money elsewhere – the right to health care is dependent upon a concurrent loss of rights.

Proposals for national health insurance are also based upon a belief that a government health program will increase the quality of medical care available to the citizen, and reduce the costs of that care. Extensive experience in this country and abroad indicates that the results will be exactly the opposite. Wherever the national health insurance approach has been adopted, the effect has been deterioration of medical quality, shortage of facilities, and a constant upward pressure on costs. (For experience of other nations in this respect, see Appendix B.)

Government-sponsored health care has been a staple demand of collectivists in America and elsewhere. On the European continent, national health insurance came into effect in 1883 when a harried Bismark, hard-pressed by the growing power of the German Socialists, tried to check the movement by adopting a number of the key Socialists programs as his own. By 1911, Lloyd George had pushed a similar program through the British Parliament and the movement was beginning to pick up steam in the United States. Agitation for government medicine has continued intermittently ever since.

From these observations, it is apparent that the health care "crisis" – officially so named by President Nixon – is not new at all. Advocates of government health insurance programs have been complaining about medical "crises" – high costs, inadequacy of care, unavailability of service, etc. – for many years, each time claiming a sudden deterioration which necessitates emergency solutions. No matter what the costs of health care, they have been "too high"; no matter what the medical progress, care has been "inadequate."

Essentially, the current attack has followed these lines: (1) There is a health crisis in the United States; (2) America ranks

very high in infant mortality comparisons with other nations – evidence of a low general quality of medical care; (3) medical bills are outrageously steep; (4) doctors are dishonest, as shown by extensive cheating on income tax returns; (5) there is a critical doctor shortage; (6) there is no efficient "system" for delivery of health care in the United States. In the passages which follow we shall examine each of these assertions in turn.

II. There Is No Crisis

As a matter of demonstrable fact, it simply is not true that there is a "crisis" in private medical care or that free enterprise medicine has failed to deliver quality care. Look at the record.

In 1900, the life expectancy of the average American at birth was just over 49 years; today it is more than 70 years, with half of the babies born this year likely to live to be at least 74 years old. In 1850, one fourth of the newborn died before the age of five. At the beginning of this century, one of every four babies died before the age of 25. By contrast, only one of every four babies born today will die before the age of 62.

The annual infant mortality rate in 1900 was 124.5 per 1,000. Today the rate is less than 20 per 1,000. The same improvement in health care is true at all ages: as an example, of every 1,000 persons who reached age 35 in 1900, nine would fail to survive to age 36; today that figure is down to approximately two per 1,000.

Critics of the free enterprise system claim there is a wide disparity between the quality of medical care available to the rich and the poor, the white and the black.

It is true that the mortality rates are higher and longevity figures lower for black Americans in most categories – a fact largely attributable to non-medical factors, such as diet, income, employment at hard labor, and lower-quality housing. Yet the statistics reveal that even among black Americans there is, rather than a "crisis," significant progress in terms of maintained health and sustained life.

For example:

In 1920, the average Negro male had a life expectancy at birth of 45.5 years, and the average Negro female had a life expectancy at birth of 45.2 years. Today, the Negro male has a life expectancy of 61.1 years and the Negro female has a life expectancy of 68.2 years.

In 1940 the infant death rate among Negroes was 73.8 per 1,000 live births; in 1967 the rate was 35.9 per 1,000 live births. The maternal death rate for Negro women in 1940 was 773.5 per 100,000 live births; in 1967 the rate was 69.5 per 100,000 live births.

In addition, the "gap" between the life expectancies of the white and black populations has narrowed to less than seven years (64.6 overall for Negroes, 71.3 overall for whites).

In these items, there is no more of a medical or health care "crisis" for blacks than for white Americans. (One can only apologize for the brevity of such "proof" within the confines of such a study as this. The above examples are accurate representations of a total longevity and mortality report in the 1971 Statistical Abstract of the U.S., published as "The American Almanac," pp 53 and 54, tables 65 through 69.)

For a medical "crisis" to exist only for the black community would imply that there is a marked difference in the care available to the white and black American – or, as it is stated by advocates of national health insurance, between the rich and the poor. If that were the case, there would be substantial differences in life expectancy at all stages of life, particularly in the later years, when health depends more and more upon medical care. The facts reveal just the opposite:

From age 40 on, the difference in life expectancy between white males and Negro males is very slight; at age 40, the difference is 3.5 years; at age 55 it is 1.5 years; at age 60, there is a difference in continued life expectancy of .8 years; at age 65, of .3 years. In fact, from age 67 on, at the time when life expectancy is most dependent upon the quality of health care, the Negro has a greater expectancy of continued life than does the white of the same age.

Tuberculosis and polio have been practically eradicated; the cancer survivorship rate shows some improvement (the uterine cancer death rate, for example, has been cut in half since 1940); open heart surgery is commonplace and saves many lives each year. Many can still remember the sight of children in braces from polio, signs tacked to front doors, warning of the case of "whooping cough" inside; formaldehyde-soaked bedsheets isolating the suffering victims of scarlet fever. Those days are gone forever.

There is yet another indicator of significance: one might expect that in a nation which is allegedly suffering a "crisis" in health care, and in which medical care is said to be unavailable to large segments of the public, the population would be stunted in growth and small in frame. Just the opposite is true in the United States. A 1971 report by the Department of Health, Education and Welfare revealed that American children are taller and heavier, on the average, than the children of any other population. According to the HEW study, American children have increased in height and weight for the last 90 years. The average eight-year old American boy of today, the report said, is almost 4.5 inches taller and up to 19 pounds heavier than the eight-year-old boy of 1880. And adults are correspondingly taller and heavier.

Nutrition, of course, is a major factor in the increased size of Americans, as it is in the increased longevity of life. Yet it seems irrefutably clear that nutrition improvements or not, if Americans were receiving a low grade of medical care, the health of Americans would be much lower; and conversely, if Americans are generally fit, as seems to be the case, that a good part of that fitness is due to the health maintenance provided by American physicians and the medical system in this country.

The argument that American health care is inferior is frequently based on the claim that the infant mortality rate in the

United States is higher than that in other nations. This argument employs figures taken from a report by the World Health Organization, published in the United Nations Demographic Yearbook for 1968. Page 28 of that report clearly indicates the reported figures are not comparable – for a number of very good reasons.

First, the standings compare nations with liberal abortion laws (in which poorly developed fetuses are prevented from reaching term and being delivered) with other nations, including the U.S., in which such fetuses are delivered and recorded as neo-natal deaths.

Second, each nation maintains its own requirements for recording a viable birth. Minimum required weights and survival periods vary widely. In a nation which requires a longer period of sustained life, or a heavier weight, before a live birth is recorded, the infant mortality rate will tend to look much better than if such nations followed U.S. standards.

In some nations, birth reports are not required until years after the event. Obviously if an infant dies before that time, the death may never be reported. This is especially true in those nations which relegate the duty of reporting births and deaths to the parents themselves, rather than to physicians. (Indeed, in many European nations, most births occur with the assistance of a midwife, while almost all American births take place within a hospital.)

Clearly, the infant mortality indictment rests on a comparison of apples and oranges. *

III. What Medicine Costs

Plainest of all the misrepresentations advanced by foes of private medicine is the argument that something inherent in free enterprise keeps driving medical costs continually higher. This rise in costs is directly traceable, not to free enterprise, but to the interventions of government. The most obvious culprit is government-spawned inflation.

In the period, 1956-1968, the average annual increase in physician fees was 3.7 percent; the average annual increase in general wages was 4.2 percent. Physicians fall further behind each year. What's more, physicians' earnings account for less than 15 percent of total health expenditures.

Department of Labor statistics released at the beginning of 1970 indicated that in the preceding two years the costs of all medical care had increased 12.9 percent, less than such other items as meats, poultry and fish (up 13.6 percent), home ownership (up 18.2 percent), transportation (up 13 percent) and insurance (up 21.4 percent). The increase in medical costs was about the same as the increase in clothing, shoes and restaurant meals.

A report in *Changing Times* magazine for April, 1971, pointed out that the average commodity and service price increase between December, 1967, and December, 1970, was 17.2 percent, and that the average increase for the past decade was 33.3 percent.

Although physicians' fees have risen, the survey revealed that the 10-year increase was approximately the same as or less than the increase in such items as lettuce, apples, cabbage and tomatoes; domestic help; paint; roof shingles; property insurance; transit fares; auto insurance; movie admissions; college tuition; newspapers; haircuts; and women's shampoos. The cost of a tonsillectomy has risen less than the cost of cheese, colas, men's suits and women's dresses.

In other words, the rise, though noticeable and painful to the purchaser, has been a part of the general increase in all prices and wages due to federal inflationary policies, not the free enterprise medical system.

The most substantial escalation of health care costs has not been in the charges of physicians, but in the daily room charges of hospitals. Most of this increase has not been due to the medical system, but to the political system and, in large part, to government itself.

For example, hospitals are large-scale consumers of many goods ranging from bed linens to the beds themselves, and to television sets, telephone equipment, food, serving trays, silverware and complicated medical equipment. As a result, inflation – a direct outgrowth of government economic decisions – has had a significant effect on hospital charges.

As just one example, H.E. "Sandy" Hamilton, director of New Orleans' famed Ochsner Foundation Hospital, has pointed out that it now costs approximately $500 to replace a hospital bed purchased 10 years ago for $150.

In addition, scientific progress has led to the development of sophisticated new equipment with life-sustaining or diagnostic capabilities unavailable a short number of years ago. The modern hospital, if it is to be adequately equipped to provide its patients with the greatest potential for recovery and early discharge, must purchase such equipment, and must, if it is to remain in business, pass along the charge.

It has been contended that overall hospital charges would be reduced if the cost of using such expensive equipment were directed only against the bill of the patient who uses the equipment. In the case of particularly expensive machinery, used for only a small percentage of a hospital's patients, such a procedure would make the cost of use prohibitive, whereas a slight apportionment of the cost among all patients, as part of the hospitals' total overhead, makes such equipment – and such

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* It is interesting to note, if one does wish to compare apples and oranges, that the WHO report shows the United States with the fourth best record among 11 major nations in preventing TB mortality, and the best record in preventing bronchitis mortality. Is it safe to assume, therefore, that the United States has (a) the best health care in the world; (b) the fourth best health care in the world, and (c) some of the worst health care in the world? If such comparisons are meaningful, all three of the above statements are equally and simultaneously true.

vital but costly facilities as the maternity ward and obstetrical and nursing services – feasible and available.*

Ironically, though it is organized labor which provides the most vocal criticism of hospital charges, much of the recent increase is directly attributable to the dramatic hike in hospital wages during recent years.

At Pennsylvania Hospital in Philadelphia, for example, wages for service workers, such as maids and cooks, went up by 43 percent between 1969 and 1971. Salaries for x-ray technicians increased by 39 percent, as did the pay for licensed practical nurses. Wages for registered nurses went up 25 percent; the pay rate for clerical help increased by 42 percent. The effect of such increases on hospital room charges is obvious when one considers that wages account for about 70 percent of the hospital's budget.

In addition, union-forced wage increases in the construction industry have sharply increased overhead costs for the many hospitals which are engaged in expansion programs.

Most interesting of all, in view of the demand for government to "solve the problem" of medical costs, is the manner in which existing Federal programs have sent such costs on an upward spiral. Experience proves a point apparent enough on reflection – that "free" medicine supplied by government is the most expensive medicine of all.

Unlike the patient in a free enterprise system, who is required to pay only for his own needs, the patient treated under a government health program must pay *as a taxpayer* a sum determined by (a) the total costs of the program and (b) his own income. Therefore, in addition to his own medical expenses, he must also pay for (a) persons who require (or demand) more medical attention than he does, and (b) persons who have smaller incomes and thus contribute less to the program.

Under the free enterprise system, excessive or frivolous demands for medical attention result only in increased medical costs for the person who receives the care; under a national health insurance program, with all of the nation's taxpayers footing the bill, all would suffer increased taxation. The taxpayer forced to pay more to support the program will in turn conclude he should get all he can from it and will be tempted to increase his own demands for medical attention. This increased utilization of services takes many forms: more frequent calls to a physician's office for trivial complaints; stocking up on prescription items; increased purchase of such items as dental braces and eyeglasses.

Senate testimony in 1970 by the American Association of Councils of Medical Staffs revealed that the average stay in private New Orleans hospitals, in which patients paid their own bills, either directly or through private insurance, ranged from 6.1 to 10.4 days, with an average of 8.11. By contrast, the length of stay in the U. S. Public Health Service Hospital was nearly 18 days and the average stay in the Veterans Administration Hospital was 22 days. As a result, even though the per diem charge in the government hospitals was lower, the total cost of treatment was considerably higher. The average stay in the private hospital cost the patient $527; the average stay in the PHS hospital cost the government (taxpayers) $922, and the average stay in the VA hospital cost $1,093.

The same tendency toward over-utilization has been occurring under Medicare. Robert J. Myers, chief actuary of the Social Security Administration in the 1960's, has reported that disbursements for the hospital insurance portion of Medicare in 1966-69 ran 41.1 per cent above estimates – due to the increased costs "which, however, were consistent with the general upward trend in prices" and due to "the higher utilization of services than had been assumed." Add to this the increased overhead in hospitals and physicians' offices from the need to hire additional personnel to process the time-consuming paperwork required by Medicare, plus the financial strain on other patients from such accumulated costs.

In 1969, the administrator of a large Texas hospital wrote to officials of the Social Security Administration that his hospital was being forced to withdraw from the provision of services under the Medicare program, because the program was threatening to ruin the hospital financially.

The problem arose over a Medicare policy of compensating participating hospitals only for actual care costs. The Texas hospital, like others, charged on a basis of actual cost plus a pro rated share of the overhead for providing such essential services as maternity and nursing facilities, costly equipment, etc. Because of the lower payment for Medicare patients, the hospital was faced with the necessity of increasing the overhead cost borne by other, non-Medicare, patients. Located in the Rio Grande Valley, with a large number of moderate-income patients, the hospital decided it could not increase the costs to its other patients (and could not absorb the loss), so it simply pulled out of the program. Other hospitals have undoubtedly elected to pass the buck, literally, in the form of higher day charges for non-Medicare patients (meaning, of course, for the great majority of Americans).

Project the Medicare experience into a full-blown "national health insurance" program and the outlook is forbidding. A massive superstructure of bureaucracy and governmental paperwork would be required to oversee the largest federal program

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* It has also been contended that the cost of such equipment would be reduced if hospitals avoided duplication by centering such equipment in one central hospital for each area. This proposal has two fallacies: first, by limiting the number of such units available, patients in need of the equipment's aid would likely find themselves placed on waiting lists to receive the care. In the case of many such appliances, the wait might be at a very high cost to the patient in terms of life or health; second, the suggestion flies in the face of the contention by NHI advocates that medical care is today too scattered, too unavailable, too distant from the patient. The proposal of centralization – usually offered by the same critics – would compound the problem of which they complain. A third proposed solution is simply that payment of such costs by government would ease the financial burden on the patient. This argument overlooks the obvious fact that the patient is also, usually, the taxpayer.

in the nation's history – one that would cover more than half a million health care providers and more than 200 million potential patients. Some idea of the immense cost of such a bureaucracy can be obtained by noting that the administrative expenses for the hospital insurance portion of Medicare – a program which pays out "only" $4.8 billion a year – totaled nearly $150 million in fiscal 1970.

The Social Security Administration has estimated that if reimbursements are made according to the standards followed in the Medicare program – that is, paying physicians, dentists and other participating health care providers their reasonable costs and charges – the program proposed by Senator Kennedy would cost approximately $77 billion a year, more than the entire national defense budget. (Other programs would cost less, but would also be expensive. For example, it is estimated the Nixon program would cost $12 billion.)

Professor Myers has calculated that the Kennedy program – the health care plan which has received the biggest buildup – will have an income of approximately $57 billion a year. Leaving aside the consideration of the $20 billion annual deficit this would produce, and how such deficits are made up, we can calculate what the $57 billion income to the government will mean in terms of outgo from the taxpayer.

That amount represents an average payment of about $265 per year from each person in the United States (compared to $172.38 private per capita spending for health care under the current system - see below). It would represent $660 a year from each worker, or taxpayer (compared to about $430 under the present system). If revenues are increased to meet the estimated costs, the amounts would be about one-third higher, or about $900 per year from each worker/taxpayer, compared to the current $430.

From considerations such as these, it is estimated the Kennedy plan would cost the average taxpayer up to 80 per cent more each year to maintain his family's health, with proportionate increases down the line for each of the other programs. (For details on costs and other features of these programs, see Appendix A.)

It is amazing to note, despite government pressures, that the average American still enjoys a bargain in health care. According to the Bureau of Labor Statistics, the average middle-income family of four in the United States now pays approximately $543 a year for *all* health care, including hospitalization, insurance premiums, doctor's visits, dental care, eye care, eye glasses, prescription and over-the-counter drugs, etc. – only about seven percent of what the family spends each year for goods and services.

The average family of four, however, includes two minor children, with relatively small health maintenance bills, and no aged persons. A more accurate picture, therefore, is obtainable from the Social Security Bulletin for January 1971 (page 5) which reported a per capita private expenditure of only $172.38 per year for health care services.

Critics of medical care costs frequently talk in terms of an increase in total health care expenditures – a figure which has grown from $26.4 billion in 1960 to $67.5 billion in 1970. In fact, it was this increase which led President Nixon to proclaim the existence of a "massive health crisis" in the United States.

Talk of a multibillion-dollar increase in total health expenditures is meaningless, however, in terms of whether or not the individual American is able to meet the cost of staying well. In that regard, the vital figure is the low $172.38 per capita. It should also be noted that there were 22 million more Americans in 1970 than in 1960. At a per capita expenditure of $172.38 per year, the population increase alone accounts for nearly $7 billion of the additional expenditure – while inflation and other government pressures, as observed, account for even more.

Finally, it should be recorded that while increased costs have raised out of pocket health expenses, 83 percent of all Americans are protected in varying degrees by private health insurance, which is usually adequate to meet a large part of most health expenses. In addition, many Americans are insured for supplementary medical costs.

IV. Defending the Doctors

Claims that physicians are commonly dishonest are based on reports that an investigation by the Internal Revenue Service found fraud in half the physician tax returns checked. According to Robert Myers, this is what actually happened:

The Social Security Administration compiled a list of medical services *providers* who had received $25,000 or more in Medicare payments. The list totaled only 11,000, including doctors, dentists, clinics, and commercial suppliers of medical equipment. Only 3,000 of the 11,000 returns required IRS auditing. Of these 3,000, only 1,500 showed as much as a $100 discrepancy, the basis for further investigation. Thus, "half" the returns (1,500 out of the 3,000 audited) were reported as "fraudulent." The truth is: 1,500 of the returns checked contained either possible fraud or possible error – 1,500 out of the 325,000 physicians and untold number of dentists, clinics and medical appliance suppliers.

In fact, out of the 325,000 physicians in the United States, only five have been convicted of fraud in the five-year history of Medicare, and only five more are under fraud indictment. Even if all five doctors currently under indictment are found guilty, the number of dishonest physicians comes to one in 32,500, or one for every five-state area.

Critics of free enterprise medicine contended that the system permits the available supply of medical personnel to become so poorly distributed that many areas are drastically short of practicing physicians.

It is true, of course, that there are areas which need more physicians – particularly in rural communities and the run-down sections of large cities. But even in the most rural areas of the most predominantly rural states it would be most unusual to find any area in which there was not a competent physician either within the county or, at worst, within an adjoining county.

In the large cities, while physicians may not be willing to work in areas with high crime rates or street violence, or in unattractive decaying slums, there are, in all such areas, *some* physicians – and even where there are only one or two doctors to care for thousands of people, there are some of the world's greatest medical institutions nearby: Johns Hopkins in Baltimore; Massachusetts General in Boston; New York Hospital in New York City, etc.

It is often maintained that many people who might use such facilities are unaware of them. If so, that is another problem altogether. It may reflect on a public relations failing of organized medicine (if it is medicine's job to let people know its presence), but government, too, would have to let people know of the existence of a government-financed facility.

Advocates of national health insurance frequently promote large, centralized group practices and mammoth comprehensive care institutions – which, if anything, will compound the problem of physical distance between patient and physician.

Free men may be given tax incentives, or bonuses, or other "lures" into undesirable areas of practice. Government can do no more than dangle such carrots, and hope the bait works, unless physicians are to be subject to compulsion. In this society, one would hope it would not be necessary to argue against such a proposition.

At the present time there are just under 325,000 physicians in the United States–a ratio of approximately one physician to every 630 citizens. Britain and France, on the other hand, have one physician for each 900 citizens. Both countries are frequently cited as possessors of exemplary national health programs.

It has been established that the United States is approximately 50,000 doctors short of present requirements. This estimate has been the basis for most of the contention that the United States is in the midst of a severe shortage.

It may be interesting to consider how the critics came to arrive at such a figure. Eli Ginzberg, in *Men, Money & Medicine*, reports on a week-long conference of medical educators at Fort Lauderdale, Florida, in 1966 which projected a serious "doctor shortage." This Conference assumed a population growth of two percent per annum. In fact, in 1968, the Census reported a population growth rate of only one percent. Using a rate of 1.2 percent per annum (apparently the rate at the time of his report), Ginzberg concluded: "To postulate a 2 percent rate of increase means an error of more than 50 percent in the demand predicated on this crucial error."

The Conference also based its estimates of a doctor shortage on (a) rising income ("more income, more demand for medical care"); (b) the desirability of having doctors available to send overseas to help disadvantaged nations; and (c) the desire to allow physicians to work shorter hours.

Ginzberg, a liberal who advocates government medicine, can only conclude with "skepticism, not about the desirability of increasing the supply of physicians, but at defining the situation as crisis and calling for a forced increase of large magnitude."

It is, and will always be, desirable to have more qualified physicians; there is not, by any stretch of the imagination, a doctor shortage of "crisis" proportions, nor even one which requires anything more than reasoned attempts to increase the number of physicians (a) graduated and (b) put into practice.

Under President Nixon's health insurance plan, medical schools would receive a capitation grant based on the number of physicians graduated each year. There is an inherent danger in such a proposal that the administration and faculty of such schools – now increasingly dependent on federal research subsidy – will lower the standards for graduation and return medicine to the days of the easy diploma. Indeed, one reason for the restricted number of physicians graduated each year is the comparative stringency of graduation requirements which has replaced the diploma mills of past generations and thus increased the caliber of physicians caring for the ill in this country.

As with the matter of costs, government itself has been a major inhibitor in the number of physicians "put into practice." Many doctors have been drawn *away* from patient care by government inducements into research and administrative work. For example, of the nearly 325,000 physicians in this country, less than 200,000 are engaged in office-based patient care. There are now nearly 30,000 doctors working for the government; more than 6,000 of them – enough to serve the entire state of Maryland (or any of 38 other states) – are not involved in patient care.

Clearly, there is good to be gained from an increase in the number of physicians treating patients. There is *not*, however, a doctor shortage which would justify the imposition of new federal regulations.

V. The Issue Is Freedom

It is a basic contention of the advocates of national health insurance that American medicine *must* be inadequate because of its obvious lack of centralized planning.

Most Americans now pay for a rather simple system of private medical care. They select a personal physician and pay him whenever they use his services; if the doctor writes a prescription, the patient pays the pharmacist for the capsules or mixtures he provides; if the patient is hospitalized, he pays for the treatment he receives and the days he spends in the hospital. The bills are paid either by the patient or by a private third party, usually an insurance company.

It's a system so simple that critics derisively refer to it as a "non-system."

Under this system of private practice, the patient pays only for the care or service he receives. If he receives twenty minutes of a physician's time, that is what he pays for, regardless of how much service the physician renders to the other patients he sees that day. The customer at a drug store pays only for the number of pills he is given without concern for how many pills the druggist's other customers are purchasing. The patient pays only for his own time in a hospital, plus his pro rata share of the hospital's overhead; he does not pay for the time spent by other patients.

This system of private enterprise medicine is so familiar to most of us that we seldom stop to marvel at is classic simplicity.

Yet, despite its simplicity, it *is* a system – and a system which has worked to provide high quality health care to the American people at a reasonable cost. In its place, advocates of government medicine would erect a complex, highly structured – and highly expensive – system of mass medical treatment.

It seems axiomatic, however, that highly structured systems are not essential to all forms of endeavor; in fact, it is readily apparent that there are relationships which function more satisfactorily in a less rigid format. While supermarkets may bring wider varities of food, at quantity prices, to more people, the supermarket concept may be totally unsuited for the provision of services which require individual attention rather than rolling baskets and check-out lines.

Patients in European health systems often complain of mass, impersonal, assembly-line care, which is frequently cursory and without the privileges of privacy to which Americans have been accustomed. Such complaints are inherent in the nature of mass systems. Patients in large American prepayment groups often say they never know what doctor will see them, and rarely see the same doctor twice.

In point of fact, structured systems may *reduce* the quality of medical care. Dr. Sidney Garfield, a founder of the Kaiser Permanente prepayment group, in California, has recently admitted that the change from fee-for-service payment to fixed fee prepayment had created such excessive demands for attention by patients with trivial complaints that the facility could not adequately care for the patients who really needed attention. Add to this the fact that further intervention by government will mean a loss of freedom for both physicians and patients.

First, the physician loses the freedom to enter into a private contractual agreement with his patient. That is, he loses the right to sell his skills and services at a price agreeable to both provider and recipient.

Second, the physician loses the freedom to practice his profession to the "best" of his ability. Bureaucratic overseers supervise and second-guess treatment and prescriptions. British doctors have been forced to repay the government, out of their own pockets, for medicines which they prescribed for their patients, but which were (a) not adjudged by the overseeing administrator to be the correct treatment dictated by the "the book" or (b) not covered under the provisions of government "formularies." Such restrictions tend to limit physicians to "approved" treatments, though there is ample evidence to suggest that decrees of bureaucratic bodies (e.g., the FDA) may not be consistent with the best possible medical care. The physician also is forced to spend much of his time in filling out forms and government official reports. And when payment is based on the number of patients "registered" on a physicians' roster, as is the case in Britain, the physician must, to make ends meet, treat more patients than he has time to treat well.

Third, the physician loses the right to move about freely. When the British government instituted its National Health Service, doctors were forbidden, under penalty of fine and imprisonment, to sell their practices. A decision to retire from practice, to leave the country, or to move to another area meant severe economic loss.

Fourth, the physician loses the right to choose whether he shall work or not work. In Quebec, when doctors went on strike to protest provisions of a provinical Medicare program, the Canadian government ordered the physicians to return to their practices under threat of imprisonment and heavy fine, in effect making physicians servants of the state.

Fifth, the physician becomes the "servant" of his patient, forced to cater to the most trivial demands or be hauled before boards of government overseers and subjected to punishment.

The result of these losses is greatly to reduce the physician's income, to reduce his freedom to move about and sell his services as a free man, and remove the pleasure he derives from his work. But serious as these prospects are, they are not so frightening as the dangers which government health programs contain for the patient.

First, of course, there are several obvious losses of freedom to the patient/taxpayers – loss of control over that portion of his income which is confiscated as taxation to pay for national health programs; loss of the freedom to choose his own physician (in both Sweden and England the private practice of medicine is almost non-existent); loss of privacy (both in treatment and in confidentiality of medical records); loss of the freedom to purchase private health care insurance (the private health insurance industry will be effectively destroyed by the Kennody plan), and thus to choose whether to allocate funds for possible health needs or to spend the money for other purposes.

There are, moreover, a number of not-so-obvious dangers. Professor Theodore Roszak, of the University of California, recently wrote of the eventual implications of government control of a nation's health:

"The National Health Service would have to take greater responsibility for population planning – which would include administration of a program of 'voluntary euthanasia' for the unproductive and incompetent elderly. The National Health Service must have to enforce a program of compulsory contraception upon all adolescents, who would later in life have to apply to the Service for permission to produce children. It would then be the job of the National Health Service to evaluate the genetic qualities of prospective parents before granting clearance to beget."

Dr. Eliot Glanville Williams, speaking before a British television audience, stated that the problem (NHS) might reach the point "that would warrant an effort being made to change the traditional attitudes towards the sanctity of life of the aged." In June, 1968, the British Broadcasting Corporation aired a special documentary on euthanasia, described as representative of the "forward thinking" among the nation's health experts as they plan the future of Britain's government health program.

In 1969, a Voluntary Euthanasia Bill was introduced in the House of Lords. The bill would permit the British government to put an elderly patient to death if the patient consented. It is frightening to contemplate the elderly – often weak, in pain, depressed, reminded of their uselessness and of the burden they impose on their relatives and the state – wearily nodding approval of their own execution.

Euthanasia is not, of course, a part of any of the bills which have been introduced in America. But neither was it a part of the NHS adopted by Britain in 1948. Now, however, that government has found that it cannot cope with the costs of guaranteeing the health care of all its citizens. No new hospitals were built in Britain for many years; there are long waiting lines for hospital admission, and government investigators have angrily condemned the sorry condition of medical facilities. The British government must cut costs – it must cease to provide care for so many people. Its choices are simple: admit that it is not the government's role to care for the health of the people, or keep them under national health insurance and find some way to reduce the cost of caring for them. Great Britain has obviously been gravitating toward the latter position.

VI. An Alternative Plan

I am frequently asked by advocates of national health insurance to propose an alternative solution to the health care crisis.

The request is based upon a false premise. There is no health care "crisis." The American system of medicine has not yet created the medical Utopia envisioned by the planners, but it is doing a very good job of providing a high level of medical care to the American people at a reasonable cost.

However, there is another "crisis" – a crisis in terms of the arrival of a moment of decision for the American people.

The proper alternative is a private enterprise system of medicine. I propose this alternative for the following reasons:

1. Free enterprise is morally proper for a society of free men; statism is not.

2. The results of private enterprise are satisfactory to those who are served by the system; the results of government medicine are not. In contrast to the Gallup and Harris surveys revealing a high degree of public satisfaction with the medical care available in this country, a recent British survey revealed that seven of every 10 Britons are dissatisfied with that country's health system. Discontent with the French medical system has reached such a peak that each week an hour-long radio program is devoted to the airing of public complaints about the system.

3. Government has compiled a long record of failure in meeting the problems of farming, housing, postal delivery, welfare – and medicine. In fact, intrusion of government into these sectors has created additional problems. On the other hand, private enterprise has moved – and is moving – to create solutions to problems in the delivery of medical care: problems which were not created by the private sector, but which it can solve if permitted to do so without federal interference. Consider:

Private physicians have long advocated a reduction in the number of physicians employed in goverment work, in planning, in administration, in teaching. (In recent years the increase in numbers of medical educators has been higher than the increase in numbers of medical students.)

Private practitioners advocate a re-emphasis on education in the medical schools, many of which have, in effect, become research centers, as administrators compete for federal grants. Such a re-emphasis on education will permit the release of vast research facilities for teaching purposes, and enable schools to increase the size of enrollments.

Private physicians have worked to create new medical teaching programs – such as the one now being developed at Kent State University – to place new emphasis on training students for patient care rather than for academic, research, or government work. (A recent survey of three medical colleges in Boston, Massachusetts, revealed that none of the seniors interviewed intended to enter patient-oriented practice.)

Private physicians have advocated a return to the use of practitioners as part-time medical faculty, releasing large numbers of full-time teachers for the care of patients.

Private physicians have worked to rearrange medical curriculums to shorten the education process. In these ways, private practice will increase the number of physicians available to care for the public, without lessening the requirements for graduation and thus endangering the quality of medical care.

Private physicians at Memorial Hospital in Long Beach, California, have created a special "day care unit" which permits patients who need only short-term recuperative care, without expensive special equipment, to be hospitalized for a single day at a cost of only $18.

Private physicians in Phoenix, Arizona, have invested $400,000 of private money into a Surgicenter, a short-stay surgical center which provides both surgery and short-term recuperative hospitalization, at low cost.

Both of these solutions are typical of the way in which *private* medicine is moving to free acute care beds and lower hospitalization charges.

Private physicians are making more extensive use of paramedical personnel – nurses and technologists – to perform testing procedures and reduce the amount of time a physician must spend with a patient. This lowers the cost of the visit and enables the physician to see more patients.

Free men in a free market can work wonders. The same private enterprise system which has produced high quality medicine at reasonable cost is continually working to provide better care at lower costs. I therefore propose less, not more government involvement.

Both systems of medicine – free and regimented – have been given a test in major nations. To abandon the efficiencies and freedoms inherent in private medicine for the costly chaos of government medicine could hardly be called "progress."

I do not, therefore, propose any government program to solve the fictional health care "crisis." I propose instead that we allow the free market to continue to provide – and continue to improve – the high quality of medical care available in this country.

Appendix A: Proposals Before Congress

If national health insurance does come to the United States, it will probably come in the form of one of these plans (or some revised version of them):

HEALTH SECURITY ACT (S. 3, H.R. 22) – The Kennedy-Reuther bill. Introduced by Senator Edward M. Kennedy and Representative Martha Griffiths. Drafted by the late Walter Reuther's Committee for National Health Insurance the program would be compulsory for all Americans and would provide comprehensive health benefits, including unlimited coverage for physician visits and care (including surgery) and for hospital care; hospital psychiatric care (with a 45-day limit); skilled nursing home care (120-day limit per spell of illness); up to 20 visits (per spell of illness) to a fee-for-service physician for psychiatric care. The program would pay most of the cost, but not all, for eyeglasses, appliances (braces, artificial limbs, etc.), laboratory services, podiatry, optometry, ambulance service, physiotherapy and home health services.

The bill would create a separate bureaucracy, consisting of a National Health Security Board, with regional and local overseers.

Approximately 36 percent of the estimated income would come from payroll taxes, paid by employers on their total payrolls, with no maximum taxable earnings base; 12 percent would come from direct individual payroll taxes; two percent would come from taxes on the self-employed; 50 percent would come from general tax revenues. The employer payroll tax would be at a rate of 3.5 percent, the self-employed tax at a rate of 2.5 percent, the individual tax at a rate of 1.0 percent on income up to $15,000. Estimated total cost: $77 billion.

The remainder of the bills introduced so far are in some measure voluntary. They include:

NATIONAL HEALTH INSURANCE PARTNERSHIP, FAMILY HEALTH INSURANCE PLAN, and other proposals, sponsored by the Nixon administration and outlined in a Presidential message to the Congress on February 18, 1971.

The first section of the program would create a "National Health Insurance Partnership" plan (NHIP) under which employers would be required to provide comprehensive health insurance for their employees. Minimum benefits would include hospital and physician care, full maternity care, well-baby care, laboratory services, and a minimum of $50,000 in "catastrophic illness" coverage for physician fees and hospital charges. Employers would buy the insurance from private companies and would be required to pay at least 65 percent of the cost for the first 30 months and 75 percent thereafter, with the employee paying the remaining portion.

Employees may choose to enroll in a Health Maintenance Organization (prepaid group practice) rather than receive private insurance coverage.

Employers would be compelled to offer the health insurance coverage but employee acceptance of the offer (including the employee's commitment to pay the remaining 25-35 percent of the premium cost) would be voluntary.

The program would go into effect on July 1, 1973.

The second portion of the Nixon health program provides a Family Health Insurance Plan (FHIP), under which the government would buy basic medical coverage for the medically indigent (income of $5,000 or less for a family of four). Families with an income of $3,000 or less would receive all medical and health care free; families with income between $3,000 and $5,000 would pay part of the costs through a graduated schedule of premiums, deductibles and coinsurance.

The plan would be completely administered and financed by the federal government. It would replace Title 19 of the Social Security Act (Medicaid) which is administered by state governments and financed by the state and federal governments.

Estimated cost is at $12.4 billion.

THE HEALTH CARE INSURANCE ASSISTANCE ACT – "Medicredit." (S. 987, H.R. 4960), introduced in the House by Representatives Richard Fulton (D-Tenn.) and Joel Broyhill (R-Va.). It is patterned after a "Medicredit Tax Incentive Plan" devised by the American Medical Association and has been endorsed by the AMA.

The program would be offered on a voluntary basis to all citizens under 65. Minimum benefits would include physician services, and hospitalization up to 60 days subject to cost sharing (20 percent coinsurance on the first $500 of medical expense and on the first $500 of emergency or out patient expense), and deductibles ($50 per hospital stay). Coinsurance and deductibles would be waived for the poor. The program would also provide catastrophic illness coverage (major medical) after a beneficiary had expended a certain amount above the basic coverage, based on taxable income (10 percent of the first $4,000, 15 percent on the next $3,000, and 20 percent thereafter).

Under this bill, the federal government would pay 100 percent of the premium for low-income beneficiaries (an individual and his dependents whose combined annual income would not give rise to any income tax liability). For others the government would provide scaled participation ranging between 10% and 99%, in the payment of premiums for basic coverage, and would pay in full the premium for catastrophic coverage. The extent of federal subsidization for each individual would be based on that individual's income tax liability. Persons with higher incomes (thus higher tax liabilities) would receive less federal money for health insurance purchases. (In other words, the person who contributes the least to the federal government gets the most from it; the person who contributes the most gets the least.)

The AMA estimates total cost of the program at $12.1 billion in new money; HEW says it would cost $15 billion.

Several other bills have been introduced, any one of which may emerge as a compromise choice of the Congress, and Rep. Wilbur Mills is said to be considering a program of his own.

Appendix B: The European Experience

Government health programs throughout Europe are plagued by severe overcrowding, inadequate and often antiquated facilities, dangerously outmoded equipment, drastic shortages of personnel, lack of essential services, impersonal attention, lack of privacy, and long waiting lines for admission to government hospitals. National health systems have caused a disastrous upheaval in the medical care received by hundreds of millions of Europeans:

– The Philadelphia Inquirer, in a 1970 study of European medicine, concluded that American doctors are much more active in preventive medicine; that the average length of confinement to American hospitals is many days shorter than in Sweden, Germany, or England (all of which have national health programs), and that American doctors, on the average, spend more time with each patient than do their European counterparts.

– A recent British government report on mental health hospitals in that country revealed that 40 percent are more than 100 years old, and most of the remainder are more than 80 years old.

– Hospitals in England and other nations with national health programs are overcrowded to an extent unknown in the United States. When former Social Services Minister Richard Crossman visited Central Mental Hospital in Warwickshire, he inspected wards so full that patients had to climb over each other's beds. His report stated simply: "This hospital is overcrowded to a hopeless extent – but it's no worse than many other hospitals I've been to."

While touring a hospital near Birmingham, Mr. Crossman came to a ward crammed with 72 beds, twice the number it was built to accommodate. Beds in the ward were so close that their sides touched. Patients got into and out of their beds either by climbing over the foot of the bed or over patients in adjoining beds. None of the patients had space for a wardrobe or footlocker. Night clothes were kept on the floor, stuffed under the beds. The 72 patients shared eight wash basins and three old, chipped toilets.

– Between 1948, the year the British National Health Service was inaugurated, and 1962, there were no new hospitals built in England. Only three were built between 1962 and 1970 (in a nation of 55 million people).

– A fire which killed 24 patients at Sheldon Hospital in Shrewsbury was blamed on unsafe facilities, but the Regional Hospital Board, dependent on government allocations, reported that it lacked the necessary funds to make improvements which would remove the danger.

– A committee of distinguished British physicians and surgeons recently issued an urgent plea that something be done about the conditions of the country's inadequate emergency services. Only 30 percent of Britain's hospitals have adequate emergency facilities, the committee reported.

– The overcrowding has serious effects on the patients in hospitals, but its effect is most deeply felt by the patients who can't get in at all. Government figures in August, 1966, revealed that more than 100,000 elderly and chronically sick Britons were on waiting lists for hospital beds. In addition, there were 76,000 women waiting to get into hospitals for gynaecological treatment; 80,000 children waiting to have their tonsils removed; 30,000 patients awaiting opthalmic surgery; 22,000 awaiting plastic surgery. By the end of 1968, there were more than half a million British patients awaiting admission to hospitals, 71 percent of them in need of surgery.

– Dr. Edward McNeil, a New York surgeon who came to this country from England, reported that at the time he left Britian the waiting time for children to have their tonsils removed was 10 years.

– Harold Gurden, a Member of Parliament from Birmingham, has called for a public investigation into waiting lists for children to have ear operations. Gurden said 50 Birmingham children a year are going permanently deaf because they are unable to receive hospital treatment in time.

– When 66-year-old William Osbourne, of Surrey, was injured in an auto accident, he made his way on foot to a nearby hospital, only to be turned away. The casualty department was not equipped to give any care – not even bandaging – outside its posted hours (9 to 5 on weekdays; 9 to noon on Saturdays).

– There are long waiting lists to get into Swedish hospitals, too. It is estimated that more than 4,000 persons are waiting to get into hospitals in Stockholm alone, nearly half of them for surgery. Waiting periods for minor operations sometimes run as long as six months.

– Touring Kansas physicians found hospitals in Leningrad to be "unbelievably barren. . . .Laboratories were skimpily equipped and would compare with one of our laboratories about 30 to 40 years ago." During their tour, the Americans saw Soviet physicians giving a patient blood transfusions through an old, worn piece of rubber tubing – a dangerous practice which has been obsolete in the United States for 30 years.

– Overutilization causes patients in Germany to stay in the hospital an average of approximately 24 days – three to four times as long as the average stay in the United States. "According to our social insurance statistics," Dr. Klaus Rentzsch writes, "tonsillitis caused the average patient to be laid up for 21 days in 1927 – and in 1967. In those 40 years therapy developed from aspirin to sulfonamides to penicillin and the other antibiotics. Every medical progress shortened the process of tonsillitis. But not one day was cut off the time the average patient was out of work."

– In Britain, taxpayers now must pay for free wigs, for women who are going thin on top, and even for sex-change operations. In one London hospital alone, seven men have recently undergone operations to be changed into women at the taxpayer's expense. Each operation requires the services of a consultant psychiatrist, consultant endocrinologist, two surgeons, and a professor of obstetrics.

– Treatment is also hampered considerably by the severe doctor shortage which plagues countries operating under national health programs. During the 1930's, an average of 27 doctors a year left Britain to practice in Australia. In the last 10 years the rate has been about 225 a year. In 1960, 162 British doctors began practice in the U.S. – more than in the entire decade of the 1930s. When Dr. McNeil recently checked a list of medical school classmates he found that more than half had either left England or quit the practice of medicine.

– Professor John Jewkes, a member of a royal commission on health care, recently reported: "The average American now has more medical services than the average Briton, and the gap between the two has been widening since the inception of the National Health Service."

AMERICAN ASSOCIATION OF BIOANALYSTS,
St. Louis, Mo., February 17, 1972.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee, New Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: I am Chairman of the Committee on Governmental and Professional Relations of the American Association of Bioanalysts, which is affiliated with the American Institute of Biological Sciences and the American Association for the Advancement of Science, and I am pleased to have the opportunity to file the following comments on HR-1, the Social Security Amendments of 1971. These comments represent the views of the following organizations:

The American Association of Bioanalysts.
The Arizona Medical Laboratory Association.
The California Association of Bioanalysts.
The Connecticut Association of Clinical Laboratories.
The Florida Association of Medical Laboratories.
The Illinois Association of Clinical Laboratories.
The Maryland Association of Bioanalysts.
The Massachusetts Association of Clinical Laboratories.
The Michigan Association of Bioanalysts.
The New Jersey Society of Bioanalysts.
The New York State Association of Clinical Laboratories.
The New York State Chapter, American Association of Bioanalysts.
The Ohio Association of Bioanalysts.
The Oklahoma Association of Bioanalysts.
The Oregon Association of Independent Laboratories.
The Pennsylvania Association of Clinical Laboratories.
The Rhode Island Association of Clinical Laboratories.

The membership of the American Association of Bioanalysts is composed of individuals who have devoted their talents to the direction and application of the life sciences to clinical laboratory analyses, those who teach such curricula, and those who hold similar commissions in the armed services or governmental laboratories.

In passing, we may note our formal presentations on independent laboratory matters in 1965 and 1967 before the Senate Committee on Finance.

1. PRESENT STATUS OF HEALTH CARE

A review of many bills for national health insurance indicates that:

(*a*) The provision and delivery of quality health services is of critical importance, and of the highest national priority.

(*b*) Present programs do *not* provide for continuing, efficient, comprehensive, low cost health services to all citizens.

(*c*) There is not adequate emphasis on preventive medicine, the maintenance of good health, rather than the more expensive alternative of treatment of illness.

(*d*) The physician must retain the right to order tests he deems medically necessary. He, and his patient, must have free choice of qualified, available laboratory facilities.

(*e*) A way must be found to provide services outside the hospital, where medically indicated, as a less expensive alternative to in-hospital care. While the delivery of high quality laboratory services is not the largest sector of health care cost, it is, in our opinion, a significant part of the physicians' armamentarium in diagnosing and treating his patient.

2. FEDERAL AND STATE LEGISLATION

As recently as 1965, there were relatively few states with laboratory licensing laws. At present, approximately twenty-two states have some form of laboratory legislation. A recent summary available from the Center for Disease Control indicates that approximately one hundred bills have been introduced in the various state legislatures, for the purpose of establishing quality standards in personnel, facilities and laboratory performance. The Federal Government under the Medicare Law and the Clinical Laboratory Improvement Act of 1967, has set very high standards for clinical laboratory operations.

Bioanalysts, in every state, have made significant contributions in raising the quality of laboratory services to the citizens of the United States.

Recommendation.—That representatives of the independent laboratories (both physicians and non-physicians) be invited, at the outset, and not after the fact, to participate in the deliberations of Ad hoc and Advisory Committees which will draw up the Rules and Regulations which carry out Congressional intent with respect to health security. We welcome the opportunity to serve in this capacity with other professionals and with consumer and community representatives.

3. THE CHANGING ROLE OF THE INDEPENDENT LABORATORY

Independent laboratories are fully integrated into the health services system, and provide services to physicians, hospitals, nursing homes, extended care facilities, Veterans Administration facilities, Blue Cross and Blue Shield Plans, the Armed Forces, private insurance companies and innumerable health and welfare agencies. All of these rely upon the testing and home visit services of independent laboratories.

In many states, licensed, certified or approved laboratories are classified as community health facilities, and are undertaking public health duties which have previously burdened State health laboratory facilities. These involve broad ecologic relationship of the human and his environment.

Recommendation.—There should be due consideration in any national health security program for the expanded role of the community laboratory provider of health services in full participation with the State public health laboratories. With the state tax dollar already overburdened, it is logical to expect the independent laboratory to provide new services.

Further, that Congress implement the earned right of the independent laboratory to continue to provide reimbursable services under whatever new system the Congress develops.

4. EQUALITY OF APPLIED STANDARDS

As of this moment, only independent laboratories are subject to the stringent Federal Standard of Medicare and the Interstate laws in terms of personnel qualifications, on-site inspections, compulsory proficiency testing and adequacy of facilities.

The Health Insurance Benefits Council, in its first report to Congress, made note of a "double standard" where hospital laboratories and doctors office laboratories are not under equal control.

We're pleased to report that HEW has developed Medicare hospital laboratory standards which will appear in the Federal Register some time next year.

The doctor's office laboratory continues to operate under no constraint of Federal or State control.

Recommendations.—That under any new system of health services, the same standards apply to all who perform laboratory tests and who are reimbursed for such services by any governmental or private health insurance program. Consistent with the recommendation set forth on the previous item (#3), that the Congress consider the following amendatory legislation:

Following the words, "No diagnostic tests performed in any laboratory," after subparagraph (g) of Section 1861(s), of Title XVIII, Public Law 89-97, page 37 strike out the following: "which is independent of a physician's office . . ."

5. A CLARIFICATION OF THE TERM "LABORATORY"

Since the development of the conditions for participation for independent laboratories under Medicare, in 1965, the term independent laboratory has been generally accepted to mean those laboratories not associated with hospitals or doctors offices. In reviewing current legislation, we note use of the terms, "diagnostic laboratory" services, "pathology laboratory" services, and occasionally, "laboratory" services. Bioanalysts may construe use of some of these designations as restrictive and discriminatory.

Recommendation.—In all legislative language, the term "laboratory services" be routinely used, to cover all qualified facilities and personnel in the respective laboratory disciplines.

6. DECREASED COSTS OF INDEPENDENT LABORATORY SERVICES

Independent laboratories do not receive or request public funds and grants for equipment and facilities. They are taxpaying organizations and therefore carry their fair share of the burden of government.

In spite of the economic and competitive disadvantages imposed upon a majority of our members, as compared to the hospital laboratory facilities which under Medicare could purchase expensive automated equipment and apportion the cost of Medicare and other carriers, the independent laboratory was able to lower prices in the marketplace.

Hospital laboratory fees on the other hand increased steadily with the retention of a captive (patient) market.

Many independent laboratories have instituted advanced systems for cost control, management, automated analysis and electronic data processing. Much more data is available to the doctor today for the patients' test dollar, than was available ten or even five years ago.

Recommendation.—Every effort should be expended by Congress to insure fair competition in the marketplace. The independent laboratory director is confident of his ability to provide quality service at reasonable cost.

7. THE HEALTH MAINTENANCE ORGANIZATION

The Social Security Amendments of 1971, and the numerous House and Senate bills on health security promote the development of Health Maintenance Organization (HMO) as a less expensive alternative to our present system.

We believe there is great potential in this approach. In developing the HMO concept, attention should be directed to:

(*a*) Providing comprehensive prevention of specific disease, the early detection of persons at special health risk, the treatment of active disorders, the maintenance of optimum status in long term conditions, and the rehabilitation of the disabled.

(*b*) All of the above fully accessible to all, when and where they require services.

(*c*) The benefit package should include out of hospital testing, multiphasic screening procedures together with physician ordered laboratory studies.

(*d*) Significant emphasis must be placed on out-patient care, in nursing homes, rehabilitation centers and extended care facilities.

(*e*) The HMO must be publicly accountable and should have on its governing boards consumer and community representatives.

(*f*) The HMO must be subject to on-going quality control at all levels—services, costs, management.

(*g*) The HMO must utilize the full range of manpower available in the community.

Recommendation.—That Congress take note of the many presently existing independent laboratory, facilities so that HMO's will not needlessly expend taxpayers' funds in the planning and developing of new laboratory facilities where qualified facilities already exist. Further, that the HMO decision-making bodies include representatives of the independent laboratory.

8. CONTINUING EDUCATION; TRAINING

The rapidly moving front of laboratory technology has doubled the number of tests performed in the last five years. This number will probably double again in less than five more years. New systems of analysis, new tests, computerization of data, have created many new problems for all levels of laboratory personnel.

It is essential that programs and grants in continuing education be developed not only for those presently licensed in the fields, but also for those supportive personnel whose number is legion, and without whom the laboratory could not operate.

There must be full exploration of state and/or Federal licensing, means for vertical mobility of degreed and non-degreed personnel, and development of equivalency examinations at all levels, to meet the demands of the next decade.

Recommendation.—That Congress insure the continuing participation of all

interested group in the important deliberations which have already been initiated in the above area—a participation which the Bioanalyst has earned through his service in the laboratory field.

9. CONCLUSION

In conclusion we wish to emphasize the American Association of Bioanalysts' great concern over the delivery of health services to the American public, and we concur in the general concept of the HR–1 amendments. We do, however, wish to emphasize again the need for consideration of an equitable, representative, and all-inclusive system which utilizes the talents of the many professionals now in the health professions.

We join with you, Senator Long, the Members of the Senate Finance Committee, the Congress, and the Secretary of Health, Education and Welfare, in their efforts to provide a comprehensive, low cost, high quality system of health care to all citizens of this great country. We join all members of the health team in our deep concern for the health and safety of the public.

Very truly yours,

BERNARD DIAMOND,
Chairman,
Government and Professional Relations Council.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.,
PANHANDLE-SOUTH PLAINS, TEX., CHAPTER No. 748,
Amarillo, Tex., February 17, 1972.

TOM VAIL,
Chief Counsel, Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR MR. VAIL: This correspondence is in regard to Bill HR–1 currently being considered and discussed before the Senate Finance Committee.

The Texas Panhandle-South Plains Chapter No. 748, National Association of Social Workers, recognizes the drastic and urgent need for welfare reform. However, we believe that this Bill is inadequate as it now stands.

We have attached a Position Statement to this letter and we ask that it be included in the official printed record of the hearings held by the Senate Finance Committee.

Sincerely yours,

FRANK B. REYES, ACSW,
President.

POSITION STATEMENT

The members of the Texas Panhandle-South Plains, Texas Chapter No. 748, National Association of Social Workers, support the need for welfare reform. This is an urgent and drastic need, however, we believe that serious consideration and planning is needed prior to implementation of a new program.

We support the following:

(1) The formation of a single program for persons based on need without regard to other qualifications, such as age, ethnic group, marital status . . . to replace the existing categorical programs and be established as a Federal program.

(2) An effective social service system be organized which will enable all individuals to be assisted in becoming productive and self sufficient.

(3) While training and employment programs are expedient, it should be realized that many individuals who receive welfare assistance are unable to work due to health, age, or need to care for children.

(4) The working poor should not be excluded from the national welfare program.

(5) Adequate provisions should be made to allow for benefits to be increased in proportion to the cost of living.

(6) An adequate health care program should be available regardless of the ability to pay.

(7) The application, evaluation and determination of eligibility for the programs should be simple and expeditious with due respect to the dignity of the individual.

(8) We urge that social workers be used in an advisory capacity in the administrative implementation of this program.

We request your earliest consideration regarding this urgent matter and are hopeful that the legislation which you pass will provide the program and services needed to assist persons to be as productive as possible.

WRITTEN TESTIMONY SUBMITTED FOR THE MONROE COUNTY COALITION FOR WELFARE JUSTICE BY ROBERT A. CARLTON, CHAIRMAN, H.R. 1 TASK FORCE

CONTENTS

MEMBER ORGANIZATIONS IN THE MONROE COUNTY COALITION FOR WELFARE JUSTICE

Action for a Better Community.
Baden-Ormond Welfare Rights.
Baden Street Settlement.
Center for Community Issues Research.
Childrens' Convalescent Hospital.
Church Women United.
Coalition of Concerned Social Workers.
Community Organization-Family Services Staff of Montgomery Neighborhood Center.
Family Service of Rochester.
Hillside Childrens' Center.
Hilton Welfare Rights.
Ibero-American Action League.
Jewish Family Service.
Lewis Street Center.
Mental Health Center, University of Rochester Medical Center.
Monroe County Bar Legal Assistance Corporation.
Monroe County Chapter, National Association of Social Workers.
Monroe County Federation of Social Workers.
Montgomery Neighborhood Center.
Office of Human Development, the Catholic Diocese.
Rochester Action for Welfare Rights.
Rochester Society of Friends.
Social Services Division, University of Rochester Medical Center.
Southeast Area Coalition.
Southeast Area Welfare Rights.
Young Womens' Christian Association.

Above listing as of February 16, 1972.

WHAT IS THE MONROE COUNTY COALITION FOR WELFARE JUSTICE

STATEMENT OF PURPOSE

The Monroe County Coalition For Welfare Justice is a newly formed coalition representing social, health, and mental health agencies, social work organizations, citizens' groups, and church-affiliated groups in the greater Rochester area. They have organized to oppose repressive welfare legislation and rulings, and to work for initiation of legislation at the federal, state, and local levels which will provide equal and non-discriminatory treatment of impoverished families. Organizations are listed above.

Address: Monroe County Coalition For Welfare Justice, c/o Family Service of Rochester Advocacy Committee, 31 Gibbs Street, Rochester, N.Y. 14604.

BIBLIOGRAPHY

1. HR 1, 92nd Congress.
2. Summary of HR 1, House Ways and Means Committee, Committee Print, 1971.
3. Report Of The Sub-Committee On Welfare Reform, New York State Temporary Commission To Revise The Social Services Law. Special Committee Report, Albany, January, 1972.
4. Summary Of "The New Welfare Work Legislation In New York State", A Report By The League Of Women Voters Of The Rochester Metropolitan Area And The Center For Community Issues Research. Rochester, January, 1972.
5. Position Statement On HR 1. Monroe County Federation of Social Workers. Rochester, August 9, 1971.
6. Myrdal, Gunnar, "Objectivity In Social Research." New York, Pantheon Books, 1969.
7. Myrdal, Gunnar, "The Challenge Of World Poverty." New York, Pantheon Books, 1971.

SUMMARY OF TESTIMONY

This testimony presents:

(a) *Basic position of the coalition on H.R. 1.*—The position of the Coalition in opposition to HR 1 is presented in the form of four resolutions passed by Coalition representatives, with brief inferences.

(b) *Work reform and work relief.*—An appraisal, based on research on both programs in Monroe County (Rochester, N.Y.) done by two local community organizations. They found the programs in Monroe County to be unproductive of jobs, expensive to operate, and assaultive upon clients' rights.

(c) *Separation of services and eligibility.*—An appraisal based on a study of the experimental separation of services and eligibility in Monroe County. The study was done by a labor union at the Monroe County Department of Social Services. Insofar as HR 1 would preserve or extend separation nationally, the findings of this study may contribute to the thinking of legislators in avoiding structures which fail to serve clients or the public.

(d) *A special note on research in poverty programs.*—Based on the experience of the staff of the Monroe County Department of Social Services with the method of research carried out by the New York State Department of Social Services during the experimental separation of services and eligibility in Monroe County.

WRITTEN TESTIMONY ON H.R. 1 PRESENTED TO THE U.S. SENATE FINANCE COMMITTEE FOR THE MONROE COUNTY COALITION FOR WELFARE JUSTICE

Much of what we would like to say about HR 1, the Senate Finance Committee has doubtless already heard. The intent of this paper is to present information which may be new to the Finance Committee.

The Monroe County Coalition For Welfare Justice was formed in September, 1971, and now consists of 26 organizations in the greater Rochester area. The list of member organizations and the purpose of the Coalition are to be found on page two of this document.

BASIC POSITION OF THE COALITION ON H.R. 1

On December 16, 1971, the following four resolutions were passed at a special meeting of the Coalition to act on HR 1:

1. *Resolved, That the coalition oppose H.R. 1.*—This resolution passed unanimously.

2. *Resolved, That the coalition oppose the Ribicoff amendments because they fall short of a good welfare bill and because they preserve the poor structure of H.R. 1.*—This resolution passed 27 to 5.

3. *Resolved, That the following four principles guide the coalition in evaluation of welfare legislation.*—

(*a*) A guaranteed adequate income for all recipients of welfare plus a guaranteed adequate income for the working poor.

(*b*) An end to oppressive work registration, with the substitute of progressive work incentives including adequate day care.

(*c*) A workable administrative process which does not divide administration between HEW and the Department of Labor.

(*d*) A guaranteed right to due process including the right to a fair hearing with adequate representation and the right to appeal decisions in court, with no penalties prior to fair hearing and appeal decisions. This passed unanimously.

4. *Resolved, That this coalition send a telegram to President Nixon urging that he veto the "surprise" work reform bill passed by Congress in December.*—This resolution passed unanimously. (As we all know, President Nixon did sign that bill into law on December 28, 1971.)

One remarkable paradox is seen by the Coalition in H.R. 1. In a bill purporting to enact welfare reform, there is no consideration of what is an adequate income and how this can be provided to those who are unemployable or who cannot find work. Neither H.R. 1 nor the House Ways and Means Summary of H.R. 1 discusses the concept of adequate income.

WORK REFORM AND WORK RELIEF

The Talmadge Bill has already enacted work reform and work relief programs at the national level. H.R. 1 would reinforce this act. However, New York State legislation already initiated both programs in this state, beginning in July, 1971.

Two local groups, the League of Women Voters of The Rochester Metropolitan Area, and a member organization of the Coalition, the Center for Community Issues Research, conducted a study of both programs in Monroe County. A summary of their research, reported January, 1972, is attached.

As you see, they found those programs to be relatively unproductive, expensive, and indeed assaultive to clients' rights. Alternative recommendations made by the Center for Community Issues Research, are to be found on the last page of that research summary.

We also wish to point up a state-wide inquiry into the state work reform and work relief programs conducted by a body of the State Legislature, the Sub-committee of the New York State Temporary Commission To Revise the Social Services Law. That inquiry, found in the section titled "The Work Referral Program" of the Sub-committee's Report, attached, presents a concern about the "human" elements of the program even though the Sub-committee favors continuation of the programs. The flavor of their conclusions can be appreciated by quoting two of their conclusions:

1. Excludes from necessity to report and pick up checks at employment offices those engaged in approved training programs . . . and those engaged in regular full time employment.

2. Authorize local social service districts, in consultation with the employment service offices serving their areas, to set criteria with respect to hardship resulting from the absence of transportation.

Such conclusions imply basic lacks in quality of social service and public service in these state programs. This, to us, is the value of that inquiry and it deserves attention, as the same sort of lacks could develop in such programs nationally.

However, in work referral legislation, the first consideration should be the prevention of a program such as the current New York State program which fails to produce many jobs, fails to save money, and fails to humanize. We turn to the research study, above, done in Monroe County and note the recommendation by the Center for Community Issues Research for the ultimate alternative federal solution, a full employment act.

SEPARATION OF SERVICES AND ELIGIBILITY

The 1967 Amendments to the Social Security Act require that in order for states to claim partial reimbursement for services, they must clearly separate and define such services by July, 1971. It seems HR 1 would reinforce this development by further defining and limiting reimbursible services and also by further separating administration of public assistance from services; states would be strongly tempted to entrust administration of public assistance to the federal government by being relieved of administrative expenses if they permit "federalizing" of their categorical assistance programs.

Thus in New York State, counties had to undergo separation by July, 1971. In Monroe County, the separation was done experimentally and was done earlier than in most of the state, in November, 1970.

The 280 member Monroe County Federation of Social Workers, a labor union at the County Department of Social Services and a participating group in the Coalition, studied the separation process locally through a survey of the staff and through a two day institute with a Congressman, an HEW official, and officials of another county undergoing early separation. A general concern was felt as to what was happening to clients and to staff because it seemed that in many ways the new delivery system for services as well as for basic assistance was not working well. Admittedly Monroe County had been hit in 1970 with abnormally high unemployment so that delivering assistance and services was all that more difficult. However, there seemed to be many problems of administration, service, relationship with the State, with the clients, and with other community agencies. In the process of this study, the Federation developed a concern about what would happen in the way of Separation under HR 1. Consequently, an ad hoc committee of 17 social workers and supervisors from many divisions of the Department studied HR. 1. Their conclusions were ratified by the Federation in August, 1971, and the resulting position statement on HR 1 is attached to this document.

The basic position of the Federation on HR 1 seems quite consistent with the resolutions made by the Coalition and reported on page 5 of this paper. However, the Federation developed its position on services further in some respects. Notably, it calls for a welfare bill establishing day care programs to clearly designate responsibility to supervise those day care programs. HR 1 does not do this as it is now written. Also, notably, it calss for community review boards with client participation in appraising the local operation of programs under HR 1, or under any welfare auspieces. HR 1 as written does not do this. It only calls for state advisory committees and, perhaps, thoughtlessly fails to include clients in the make-up of those committees. (See House Ways And Means Summary, page 195.)

A SPECIAL NOTE ON RESEARCH

HR 1 provides that continuing research be done by the federal government while programs of HR 1 are being implemented. Yet, it says little about the nature and kind of research to be done.

While good research is valuable, we want to sound a strong note of cauti n based on this County's experience with State-instituted research conducted after separation of services and eligibility.

The New York State Department of Social Services requires that in the new system of separated services, every service social worker, aide, teaching homemaker, volunteer, or other helping person, every day, complete the Daily Report Form, DSS–1306, on every task undertaken, whether it be a one minute phone

call or a two hour interview. Three tasks fill one form the size of a sheet of typing paper, so that normally a staff member would complete several sheets of tasks each day.

A sample DSS–1306 is attached. There are other forms for summarizing the data, but this is the basic form.

The State Department of Social Services never supplied instructions, definitions of terms, or a statement of the scope or intent of this research. Requests for these things by both the County administration and staff failed to elicit them from the State.

The lack of definitions left staff to define for themselves such terms as "referral", "Counseling", "supportive casework", and "exploratory discussion". From November, 1970, to June, 1971, staff was reporting this data without guideline definitions and was indeed "comparing apples and oranges." Then staff developed its own internal definitions. However, we have no idea how this form is being treated in other counties where it is in use.

In the estimation of Federation representatives, staff members were averaging three hours a week each in completing these forms. If so, a staff member would be spending 150 hours or more than four work weeks a year completing the forms. Perhaps, more than 200 staff members in this Department were engaged in completing the forms, which a number of clerks checked them for accuracy before they were mailed to Albany each week.

After more than a year, in December, 1971, the County administration unilaterally suspended usage of the DSS 1306, stating among other things that that Department had not received feedback from the State.

What is to be gleaned from this?

1. Basic scientific principles were ignored. Definitions were lacking, instructions were lacking, and consequently, validity of the data must be non-existent. Sampling techniques were not used, and consequently much unnecessary time, effort, and cost must have gone into this research as it may still be in other counties.

2. Commonly accepted principles of relationship between researchers, doers, and subjects were ignored. Staff of the County Department of Social Services was given no chance for input or communication with State researchers in this experimental county either when the research began or as it went on. Consequently, there were confusion, unanswered questions, anxiety, and a sense of futility. Furthermore, clients were unaware of this research which may well be used in deciding what kinds and amounts of services will be available to them in the future.

The eminent economist, Gunnar Myrdal, has said, "as social scientists, we are deceiving ourselves if we naively believe that we are not as human as the people around us and that we do not tend to aim opportunistically for conclusions that fit prejudices markedly similar to those of other people in our society."—page 43, "Objectivity In Social Research".

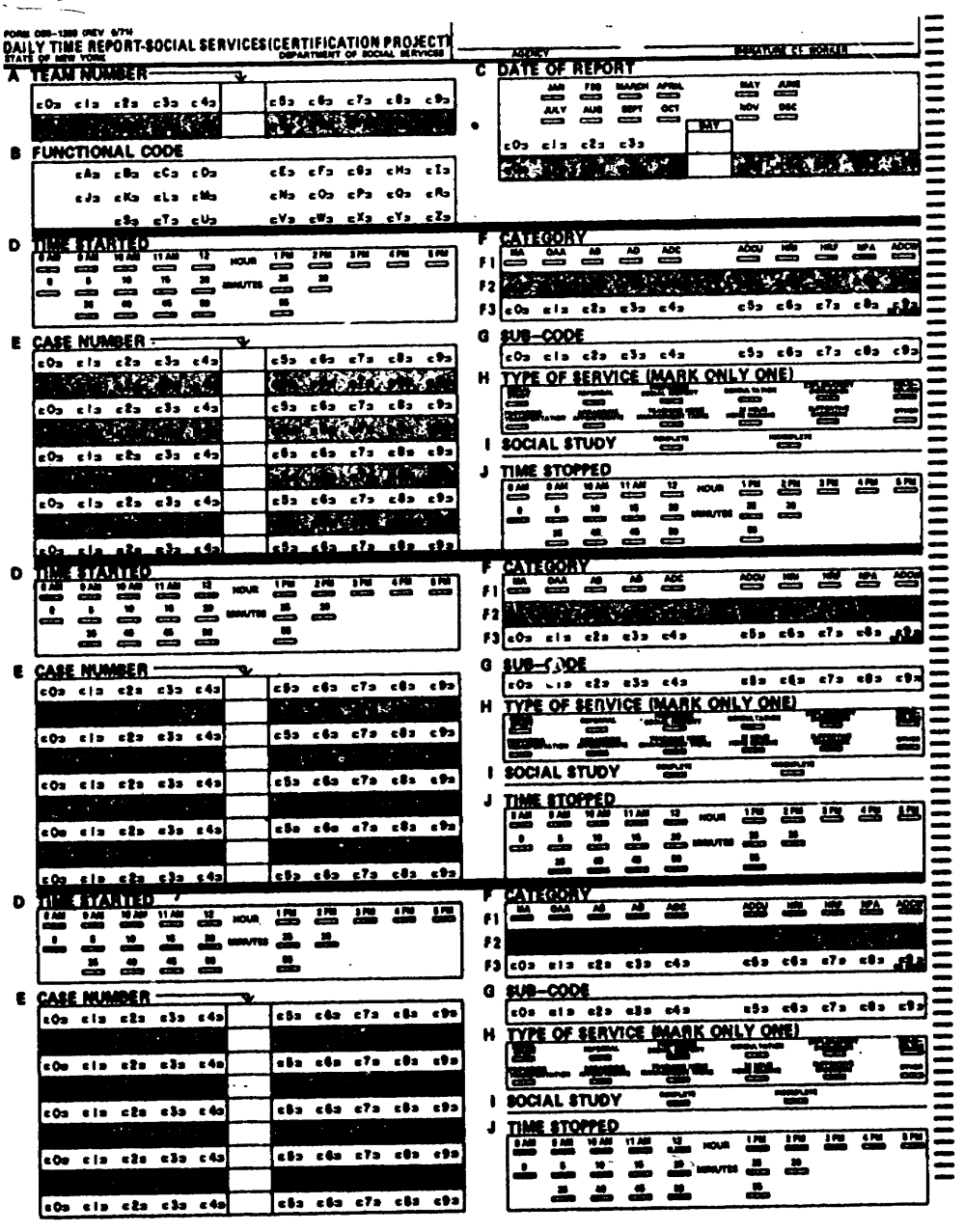
In his later book, "The Challenge Of World Poverty", Chapter I, Myrdal develops the point that research on poverty tends to go through three stages:

(*a*) Superficial research based on a power situation in which "the poor" have little power and "the rest of us" opportunistically have a need to deny the breadth and depth of poverty in a society.

(*b*) Research slanted in the direction of diplomacy and over-optimism when the "poor" gain some power—research slanted by "both sides". An example would be research done after an underdeveloped nation gains independence and seeks foreign aid from major powers.

(*c*) Possibly good research, based on openly expressed and acknowledged differences of interest and perspective between "the poor" and "the rest of us" but with mutual participation and a mutual need for facts with which to combat poverty together.

We fear that the research experience in New York State, the fact that HR 1 does not seek to define or discuss what poverty is, and the exclusion of clients, perhaps thoughtlessly, from taking part in advisory boards under HR 1, all suggest that HR 1 would cause us to settle for the first and worst kind of research—the most biased and repressed kind of research.


DAILY TIME REPORT-SOCIAL SERVICES(CERTIFICATION PROJECT)
STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
A TEAM NUMBER
B FUNCTIONAL CODE
C DATE OF REPORT
D TIME STARTED
E CASE NUMBER
F CATEGORY
G SUB-CODE
H TYPE OF SERVICE (MARK ONLY ONE)
I SOCIAL STUDY
J TIME STOPPED
D TIME STARTED
E CASE NUMBER
F CATEGORY
G SUB-CODE
H TYPE OF SERVICE (MARK ONLY ONE)
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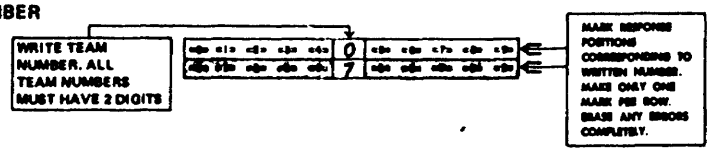
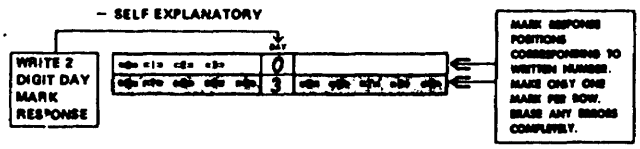
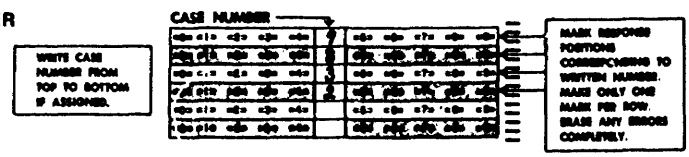
D TIME STARTED
E CASE NUMBER
F CATEGORY
G SUB-CODE
H TYPE OF SERVICE (MARK ONLY ONE)
I SOCIAL STUDY
J TIME STOPPED

INSTRUCTIONS

GENERAL

DO NOT MARK MORE THAN ONE BOX ON A LINE. USE NUMBER 2 PENCIL. ALL REFERENCES ARE MADE TO THE NEW SYSTEMS DESIGN FOR DELIVERING INCOME MAINTENANCE AND SOCIAL SERVICES MANUAL.

SECTION	ITEM	PROCEDURE
A	TEAM NUMBER	
B	FUNCTIONAL CODE	– MARK FUCTIONAL CODE LETTER (SEE MONITORING SECTION)
C	DATE OF REPORT	
	MONTH	– SELF EXPLANATORY
	DAY	
D. & J.	TIME STARTED AND TIME STOPPED	– MARK BOTH HOURS AND MINUTES. ROUND TIME TO NEAREST HOUR AND MINUTES. I.E., 8:58 IS 9 AM AND 0 MINUTES.
E	CASE NUMBER	
F. & G.	CATEGORY AND SUB–CODE	– SEE MONITORING SECTION APPENDIX A.
H	TYPE OF SERVICE	– MARK ONLY ONE SERVICE.

SUMMARY OF "THE NEW WELFARE WORK LEGISLATION IN NEW YORK STATE"

A REPORT BY THE LEAGUE OF WOMEN VOTERS OF THE ROCHESTER METROPOLITAN AREA AND THE CENTER FOR COMMUNITY ISSUES RESEARCH

The Work Reform Legislation of 1971 instituted two major changes in the administration of welfare in New York State. One, referred to as the *Work Reform Law*, requires all recipients designated as employable to report to the New York State Employment Services every two weeks to pick up their welfare checks and to report for employment interviews and job referrals. Failure to comply, by refusing to register with the SES*, refusing to take job interviews or to accept job offers, results in termination of the recipient's public assistance.

The other change, referred to as the *Work Relief Program*, and called the *Work Experience Program*, in Monroe County, stipulates that employable Home Relief recipients who are unable to find a job within thirty days will be assigned to public service jobs to "work off" their checks. The Work Relief Porgram applies only to recipients on Home Relief as current federal law prohibits the inclusion of ADC and U-ADC recipients in such a program.

The data for the study was derived from a variety of sources. Extensive interviews with administrative personnel in both the Department of Social Services* and the State Employment Service were held. An interview-survey of 212 welfare recipients, designated as employable by the DSS and referred to the SES was conducted. Also, surveys of recipients in the Work Relief Program and of recipients-who-had-been-dropped from the welfare rolls for failure to comply with the regulations, were carried out.

The major findings of the study are as follows:

(1) The new work regulations governing employable welfare recipients in New York State have not resulted in substantial numbers of recipients becoming self-supporting nor has the program resulted in reduced welfare rolls. Of the 2023 employable recipients in the program during October, 10% were placed in some kind of job or training but only 2.4% became self-supporting and able to leave the welfare rolls.

Out of 212 recipients in our survey, 7% had found jobs with the help of the SES while 6% had located jobs on their own. Less than half of these jobs were permanent, full time, or paying an adequate salary. A comparison of the percent of welfare cases closed in the first four months of the new program with a similar period in 1970 shows that the new laws have not resulted in a significant increase in the number of recipients becoming self-supporting. During this four month period in 1970, 33% of the cases closed monthly were for the reason of having found employment while one year later only 22% had been closed for that reason. In fact, in the first four months of the program, of the 1359 cases closed for employment, the work reform program accounted for only 141.

(2) The program is costly to administer and has not saved the tax-payer money. In October of 1971, the additional cost of administering the work program ($82,474) far outweighed the savings $44,690 realized from case closings.

(3) Even though the NYSES had seven employment offices in the Rochester area, it opened another branch to deal exclusively with welfare clients. Not only has this incurred extra administrative expense, but its location—six miles from the DSS offices—requires welfare recipients in the program to make frequent trips back and forth between the offices to maintain their eligibility. Failure to keep scheduled appointments is often due to illness or transportation problems but still results in termination of assistance.

(4) The vast majority (85%) of those employable recipients interviewed wanted to work. However, limited skills and unemployment records were severe handicaps. Those with skills could often locate jobs themselves, while SES had little luck placing unskilled workers. The program makes no additional provisions for job training and skilled counseling, leading to full-time and permanent jobs. The WIN program and government-sponsored training programs are oversubscribed.

(5) Recipients have no option to refuse unsuitable jobs except in the case of disability. The ambiguous wording of the law and the local policy of referring to Farm and Labor Office of SES forces recipients to accept jobs below the minimum wage of $1.85 per hour or face cut-off. Recipients are not informed of the rules which might protect them from arbitrary or illegal decisions.

(6) No concerted effort by DSS or SES has been made to determine what happens to persons cut off welfare under this program. Preliminary findings of a

survey done by the League and CCIR indicate that confusion about the program, rather than an unwillingness to work, has been the main cause of non-compliance. In addition, a majority of those dropped, whether for employment reasons or because of failure to comply, re-apply for and receive assistance within a few months. There is no question that the program is denying assistance to persons in need who are unable to cope educationally, physically, or emotionally with the complex, discouraging and expensive regulations.

(7) The Work Experience Program is providing governmental units with labor to perform work at no cost. Were these jobs not filled by the welfare recipients, some public agencies would be hard pressed to maintain the current freeze on hiring. Recipients placed in these jobs are paid at an hourly rate of $1.85, receive no formal training, and have no benefits, i.e. sick leave, vacation, health insurance. While WEP employees are supposed to have priority in any job opening in their line of work assignment, most WEP workers had little confidence in the provision and some have witnessed jobs filled from the "outside."

(8) Although federal regulations stipulate that no ADC or U-ADC recipients are to be enrolled in the WEP program, a survey of participants in Monroe County showed that between 15% and 20% of the enrollees in WEP were such recipients. A meeting of the DSS, the Welfare Rights Organization, CCIR and the LWV, however, resulted in the removal of all ADC and U-ADC recipients from the program.

(9) The entire program harasses the welfare recipient. He is shifted from the DSS office to the SES office and vice versa. No funds are provided recipients to cover the transportation cost necessary to comply with the law. They are often referred to jobs already filled or to temporary, underpaid, or part-time positions by the Farm and Casual Labor Office. Day care, job training, career counseling and other supportive services are lacking.

Notices of termination of grants are sent so routinely that in one month, October, almost half of those who received notices were able to prove their cooperation and remain on welfare. Others, not as able to "protect" themselves, were cut-off although still in need.

(10) Recipients are not informed of their rights and protection under the law. A pre-termination hearing procedure, guaranteed by the Supreme Court, has not been properly instituted to protect recipients from arbitrary cut-off.

The analysis of the new welfare work legislation in New York State as implemented in Monroe County raises serious questions about the law, its constitutionality, its administration and its implication for welfare reform.

THE FOLLOWING RECOMMENDATIONS ARE SUBMITTED BY THE CENTER FOR COMMUNITY ISSUES RESEARCH, ROCHESTER, NEW YORK

National

A. A full employment program should be enacted by Congress, providing real jobs at or above the national minimum wage.

B. Greater emphasis should be placed on supportive services in job training, day care, and medical care.

State

A. The Welfare Work Form and Work Relief laws should be repealed and replaced by a voluntary program, proviidng skilled guidance and job referrals.

B. The following recommendations are made *pending repeal* of the laws:

1. The work reform regulations of 1971 should be amended to exclude:
   (*a*) All ADC mothers.
   (*b*) Persons in full time Training programs.
   (*c*) All persons who do not have access to public transportation.

2. The allowances of the recipients remaining in the program should be increased to cover the monthly costs of transportation for check pick-up and job referrals.

3. The law should be amended to state clearly that no recipient may have his case terminated for refusing employment which pays less than the New York State minimum wage of $1.85 an hour.

C. The following administrative changes are recommended:

1. The DSS provide the services of at least one full-time social service worker in the office of the SES to act as liaison and assist clients.

2. All staff involved in the work program at both SES and DSS receive special training in:

(a) Counseling clients in understanding the work reform program.

(b) Determination of employability and non-compliance.

(c) Procedures of appeal, pre-termination hearings, and fair hearings.

3. The DSS prepares a pamphlet, for all recipients in the program, covering their rights and protections under the Work Reform Laws. (The DSS has agreed to hand out a brochure prepared by the Center for Community Issues Research, pending completion of their own pamphlet. The CCIR brochure will be available soon upset request from CCIR, 560 Joseph Avenue, Rochester, New York.)

4. The SES discontinue farm labor referrals pending investigation of the minimum wage requirements and labor conditions.

5. For the WEP program:

(a) That WEP work with educational and training programs to create job opportunities for recipients.

(b) That WEP officials monitor work assignments through site visits to assure that recipients are learning marketable skills and are not performing the work of regular employees.

ABBREVIATIONS

ADC or AFDC: Aid to families with Dependent Children. A 50% federally-subsidized category for one-parent families with minor children living at home.

U-ADC: Unemployed parent in an ADC family. A federal category for two-parent families in which the wage earner is unemployed or works less than 100 hours a month.

HR: Home Relief. A local category for unemployed and temporarily disabled adults and their families. Costs of the program are shared equally by the state and the county.

SES: State Employment Service.

WEP: Work Experience Program.

DSS: Department of Social Services.

WIN: Work Incentive.

POSITION STATEMENT ON H.R. 1 NOW PENDING IN THE U.S. SENATE BY THE MONROE COUNTY FEDERATION OF SOCIAL WORKERS, ROCHESTER, N.Y.

The Monroe County Federation of Social Workers is opposed to H.R. 1, also known as the Family Assistance Plan and the Welfare Reform Bill, in its current form. The bill, written by the House Ways And Means Committee, passed the House of Representatives on June 22, 1971. Presently the Senate Finance Committee is holding hearings on H.R. 1. That Committee may well amend the bill before reporting it to the floor of the Senate.

We urge you to write to the Senate Finance Committee and to the Senators from New York State to oppose this bill in its present form. Their names are listed at the end of this document.

Our Federation proposes the following 24 amendments to H.R. 1. They are organized so that the first 13 amendments deal with public assistance, the next 10 with services, and the last amendment with application of the bill to the U.S. territories.

1. Provide an income to all recipients of public assistance which gives an adequate standard of living. Such income would vary with the cost of living regionally and over the course of time.

We know that such income would be substantially higher than is now provided in New York State or any state, or would be provided under H.R. 1 either as now written or as it would be amended by the "Ribicoff" amendments. It would be substantially higher than "the poverty line"—$3760 annually for a family of four. We recognize that this proposal will be unpopular with the public. Nevertheless, the welfare of those citizens who must be recipients requires this. Furthermore, prolonged maintenance of persons at an inadequate level of income weakens families, damages physical and mental health, causes social unrest, stimulates vice, undermines programs of rehabilitation, and wastes the taxpayers' money.

2. Amend H.R. 1 so that it would be illegal for any State to reduce its present level of payments after July 1, 1971, until such them as amendment No. 1, above, is operative.

We know full well that states are suffering from a severe lack of funds. As a consequence, New York and other states have and may again cut back levels of payments in a time of rising costs of living. We believe that for the short-run H.R. 1 should be amended to stop this process immediately. However, we recognize the states' problems and we see the assumption of federal responsibility implied in Amendment #1, above, as the equitable solution to this dilemma.

3. Provide assistance for childless couples and those who are single, categories not now covered by H.R. 1.

These are the recipients now categorized as "Home Relief." Their assistance is now the total responsibility of the states and would remain so under H.R. 1. We concur with this Ribicoff amendment which asks the federal government to assume this function from the states.

4. Amend H.R. 1 to eliminate State residence laws.

State residence laws are an effort by representatives of the taxpayers to avoid the cost of dependent families who move across state lines. This is understandable but it does not work. These laws are proving to be unconstitutional. Moreover, many times there are valid reasons for families moving or traveling. Again, the equitable solution would be to adopte Amendment #1, above.

5. Amend H.R. 1 to eliminate the ceiling on assistance to families with more than eight children.

6. Make those who have not applied for other benefits for which they may be eligible, such as O.A.S.I. and U.I.B., eligible for help under H.R. 1 as long as they agree to apply for the other benefits within one week at the time of application for benefits under H.R. 1.

7. Provide the emergency assistance will not be limited to $100 but instead to whatever amount is needed to maintain the housing and nutritional needs of a family until their situation can be acted on.

8. Provide assistance (as now) on the basis of current need, with a simplified declaration of need; not on the basis of past earnings or projected earnings as H.R. 1 would provide.

H.R. 1, page 590, says that any person who, during the past nine months had earned (not saved) an amount that, if earned regularly, would make him ineligible for benefits, may continue to be ineligible for up to nine more months after earnings cease.

9. Expedite prompt revisions of receipients' budgets according to changes in family circumstances, rather than to provide for massive review of mandatory quarterly filings by recipients for the purpose of documenting their continuing eligibility for benefits.

We believe the effect of H.R. 1's present requirement of mandatory quarterly filings by recipients would build a new federal bureaucracy, create unnecessary administrative costs, and waste taxpayers' money. The more efficient and less costly procedure would be selective validation and recertification.

10. Eliminate medicaid deductibles for recipients.

11. Provide an adequate appeal procedure to that now used in New York State, except that appeal decisions should be rendered quickly, but notably giving clients the right to appeal before they are removed from the roles or transferred to other categories, and establishing qualifications for examiners.

12. Provide that own fathers of children shall be responsible for support of their children in accordance with their ability to support.

13. Provide that step-fathers *not* be responsible for step-children.

We believe that on balance, relieving step-fathers of financial responsibility for step-children will serve the interest both of recipient families and the general public. This amendment would strengthen families by removing an obstacle to remarriage. Moreover, we believe step-fathers generally will support as long as they can.

14. Provide that existing income maintenance personnel in the States be used to staff Federal income maintenance (when this function is transferred to the Federal Government) and that they not take a cut in salary, nor lose accrued benefits nor the right to collective bargaining.

15. Provide that existing service personnel in the States be used to staff Federal service programs initiated by H.R. 1, and that they not take a cut in salary, nor lose accrued benefits nor the right to collective bargaining.

16. Require that existing services be at least maintained in kind, quality and quantity, either at Federal or State and local levels, and that the Federal Government reimburse States 100% for services maintained by States.

17. Create or designate a coordinator with administrative responsibility over all three arms of the Federal Government which must work closely together to make the program work—Department of Labor, Department of Health, Education and Wlfare, and Social Security Administration.

We realize that the writers of H.R. 1 are confident that they have provided for the coordination of the various governmental divisions which must implement H.R. 1. Nevertheless we have profound concern that such a massive, national program as H.R. 1 will fail through inefficiencies, overlapping services, and gaps in service. For example, we note that the Secretary of Labor, in Paragraph 2112, and the Secretary of Health, Education, and Welfare, in Paragraph 2133, both will provide for furnishing of child care services to children of certain classifications of clients. It would appear that each Department will have staff and program for the same purpose. Furthermore, while the Secretary of Health, Education, and Welfare is designated to set standards of child care with the concurrence of the Secretary of Labor, we find no clear designation of who shall supervise implementation of the standards of child care throughout the program.

18. Provide qualified information and referral staff at the local level, readily available to applicants and clients, with ready access to case records at the local level of the various Federal, State and local agencies which will implement H.R. 1, to guide clients to proper services and troubleshoot inter-agency problems in rendering service to individual clients.

19. Provide for local review boards, representative of the community, to oversee the efficiency and equity of operation of the program at the local level. Review boards shall include significant representation of clients.

Page 195 of the Ways and Means Committee's Summary of this bill says that "local" committees would be established to evaluate effectiveness of "family plans" and "At least one such committee would be established or designated in each state. Representatives of labor, business, and the general public would be involved, as well as public officials who are not directly involved in administering the family programs." Why are not the clients to be represented? Why might a state have only one committee? We believe each community would require at least one such committee.

20. Registration for jobs, job training, or vocational rehabilitation shall be required of recipients selectively on the basis of careful study of their individual situations by staff.

21. Provide sufficient job training and actual job opportunities at the minimum wage, in the public and private sectors together, for all those able to work.

This amendment concurs with amendments offered by Senator Ribicoff. We also concur with his observation that the federal minimum wage of $1.60 an hour needs to be raised. Doing productive and useful work at low wages perpetuates poverty.

22. Provide greater work incentives by increasing the percentage of income earned that can be retained.

We concur with this Ribicoff amendment.

23. Provide expanded and enriched day care programs for those mothers entering the working force, with clear identification of reponsibility for supervision of programs according to clearly expressed standards of day care, provide for selective referral of children for child care services, and provide review boards for each day care program including significant representation by parents of children being served.

24. Amend H.R. 1 so that it applies equally to the U.S. and its possessions.

Again we urge you to express your view on H.R. 1 to the Senate Finance Committee and to the Senators from New York State. At this point the Finance Committee is responsible to decide whether and how to amend H.R. 1 before bringing it to the floor of the Senate. It is holding hearings on the bill. There are 16 Senators on the Finance Committee, any or all of whom would be good to write to. Neither New York State Senator is on the Finance Committee, but we recommend that both of them be written to. The Senators from New York State are James Buckley and Jacob Javits.

STATEMENT OF THE LEAGUE OF WOMEN VOTERS OF NEW JERSEY

The League of Women Voters of New Jersey, in its quest for welfare reform, urges that the Senate Finance Committee accept Amendment 559 and report HR 1 thus amended to the Senate. We feel that the provisions of the Amendment correct many deficiencies of HR 1.

New Jersey has a history of being conscientious in its attitude toward public assistance. It was one of the very few states who not only set a standard of need for welfare recipients, but met 100 per cent of that standard.

Recently, the welfare roles have swelled tremendously. In Essex County alone the number of new ADC applications rose from 365 a month in 1960 to 700 a month in 1970, and the gross expenditure for ADC rose from $8 million in 1960 to $82 million in 1971. Seeking fiscal relief, New Jersey cut back on many of its welfare allotments in July, 1971. Flat grants, reducing benefits for thousands of welfare recipients, were put into effect. The grant was so low in the adult categories that after only two months it was raised by $20 a month for single adults living alone. In addition, recognizing the hardships created, the state granted transitional rent allowances to those clients whose rents exceeded 30 per cent of their allotment in gradually decreasing amounts each month from July, 1971 to May, 1972. The theory was that these families would find less expensive quarters. In Essex County alone 16,000 cases have been receiving transitional payments and, in view of the acute housing shortage, cheaper quarters simply are not available.

Furthermore, the ADC–U program in New Jersey was abolished and the new Aid to Families of the Working Poor program was established in its stead. Under the provisions of AFWP, an intact family receives two-thirds of the grant of a family of the same size under ADC. In addition, the eligibility for the new program is more restrictive and many families formerly on the ADC–U rolls are showing up on the ADC rolls indicating the possibility that families have separated because of the incentive provided by the new legislation. The League of Women Voters of New Jersey looks forward to federal legislation which gives the same coverage to the working poor as it does to the ADC recipient.

With regard to the proposed federal legislation, the benefit level of HR 1, $2,400/year for a family of four, is considerably lower than even the present level of the flat grant in New Jersey, $3,888 for a family of four. This amount is also higher than that of the Amendment 559, $3,000. But the Ribicoff Amendment provides for increases to the poverty level (now about $4,000) and thereafter adjustments pegged to changes in the U.S. Consumer Price Index. We, therefore, consider these stipulations of Amendment 559 as an advantage over HR 1, but we realize that the cost of living in New Jersey is higher than that in most states and that a regionalization of the benefit level would be more advantageous to New Jersey and her recipients.

The fact that, in Amendment 559, states are required to maintain benefits will protect New Jersey recipients against future cuts. The fact that in the Amendment there will be a 30 per cent federal participation in the supplemental funds will benefit the state.

By extending benefits to individuals and childless couples, Amendment 559 would provide fiscal relief in New Jersey and a more uniform administration of public assistance which would benefit staff and recipient alike. General Assistance recipients in New Jersey are at present excluded from Medicaid, a benefit of categorical assistance recipients.

We object to the mandatory work requirement of HR 1 and of Amendment 559 because of the very high unemployment rate in New Jersey. Experience with the Emergency Employment Act has shown that it is difficult to fill public service job slots despite the fact that there have been a plethora of applicants. Because the work requirement of Amendment 559 applies to mothers with children over six rather than three as in HR 1, we favor the Amendment. Furthermore, Amendment 559 excludes from availability for jobs those mothers whose presence in the home is required "because of the unavailability or remoteness of suitable day care services." Day care services in New Jersey are at present sadly deficient. We think it abhorrent for a mother to be required to place her children in day care that is merely the custodial care provided in H.R. 1. We approve of the setting of standards for day care facilities as included in Amendment 559.

In conclusion, the League of Women Voters of New Jersey feels that Amendment 559 more nearly satisfies our goals of meeting the needs of the impoverished and of preventing poverty. We, therefore, support its passage.

STATEMENT OF THE LEAGUE OF WOMEN VOTERS OF ILLINOIS

The League of Women Voters of Illinois wishes to underscore the support of the League of Women Voters of the United States for the principles in Amendment 559 (Ribicoff) to H.R. 1.

Nearly 900,000 of our fellow citizens in Illinois are receiving public assistance. Our state, like many others, has been torn by the need to provide properly for its citizens in poverty and the need to balance the state budget.

We have seen our senior Senator work with other Senators and the administration to help provide emergency relief to hard-pressed states, which will mean some 60 million extra federal dollars for Illinois.

We have seen our Governor two years ago institute a state income tax (which the League strongly supported), the income from which has gone largely into public aid and schools in Illinois.

We have seen our Department of Public Aid attempt to implement a program of selective cutbacks which is now before the courts, rather than make an across-the-board cut in grant levels to those on public aid.

We have seen our state legislature stymied and ineffective in dealing with the problem of freeing up any state funds to transfer to the public assistance program.

In other words, we live in a major industrial state which has grappled with and—for the most part—dealt responsibly with the welfare problem. *But* all this has not meant any improvement in the bleak existence of our nearly 900,000 citizens who live in poverty.

Nor do we feel that, in its present form, H.R. 1 will improve that bleak existence. Yes, it may provide some fiscal relief to the states, and we regard this as an essential part of a welfare program. But only a *part*. We are also looking for some fiscal relief for our citizens in need.

Because the system of granting assistance to our citizens has become so cumbersome, expensive, complicated and widespread, it is no longer either a local or a state problem. The problem is national, and we feel that Amendment 559 more closely provides the kind of welfare program we would want for our citizens as well as for our state and local governments.

These are some of our reasons:

Income floor: Though this starts at a low $3000 for a family of four, it would rise by 1976 to the poverty level. Illinois benefits are currently comparatively high (averaging $3200 for a family of four), but this would give some hope of increase. H.R. 1 has no such built-in escalation.

Coverage: Amendment 559 would include individuals and childless couples as well as families and the working poor. Recent close scrutiny of the general assistance rolls indicated that approximately a third of the persons receiving general assistance in the city of Chicago are single persons.

Public Service Jobs: More than a billion dollars is authorized for this. Illinois is beginning now to provide public service jobs. While Illinois' unemployment rate generally is about 6 per cent, we have pockets in the city of Chicago and in rural downstate Illinois where the unemployment rate is more than 30 per cent. Recent statistics have shown, too, that unemployment has risen slightly in Chicago while it has decreased slightly nationwide.

Mandatory state supplementation with federal participation: This would assure as H.R. 1 would not, that our citizens in Illinois on public aid would not suffer a reduction in benefits. We also support the provision that such mandatory supplementation would increasingly be taken over by the federal government until 1977 when the program would be completely federalized.

Day care provisions: Twice as much money ($1.5 billion) is authorized for day care in the Ribicoff amendment as in H.R. 1, and federal standards must be met. The League in Illinois has recently completed a study of day care and, while we support the provision of day care for *all* children whose parents wish to use it, we recognize the priority need for low income families.

Determination of benefits: Major attention is given to the family's current need in Amendment 559. As our Cook County Department of Public Aid points out, it is unrealistic to base a family's current need on past income which it may no longer be receiving. This would result in such a family receiving no assistance or having to be placed on the general assistance rolls.

Residency requirement: None is permitted in Amendment 559. In Illinois we were pleased to see our Governor this past fall veto the residency legislation

passed by our state legislature. Such legislation is fighting at windmills, when legislators should be dealing constructively with the problems at hand.

If, in Illinois where benefits are comparatively high and where state officials and citizens have tried to deal meaningfully with the increasingly severe welfare problem, we still see seven per cent of our fellow citizens who need income assistance, it becomes obvious that the time has come—indeed is long since past—for the federal government to act. Not to *test*, but to *act*. We urge the Congress to deal responsibly not only with our state, but with our citizens in poverty.

We urge fiscal relief for those in desperate need.

Thank you for consideration of our statement.

Statement of the National League for Nursing, Council on Home Health Agencies, and Community Health Services

The Council of Home Health Agencies and Community Health Services of the National League for Nursing is the national spokesman for approximately 1,400 home health agencies and community health agencies. These agencies provide health services to people outside of hospitals; in other words, in patients' homes, in schools, public health clinics, and other community settings.

EXCESSIVE UTILIZATION

It is unfortunate that Medicare has perpetuated the problems created by voluntary health insurance programs that traditionally have given the highest priority to hospitalization as a covered service. This emphasis on hospitalization has increased not only the utilization of hospitals but also their costs. Between 1940 and 1965 the number of general hospital admissions on a per capita basis doubled. Over the past five years hospital costs have doubled. Under Medicare the financial incentive is for hospitalization even though care in the home would be more appropriate in the case of countless patients.

There are many elderly individuals with varying degrees of chronic illness, who could be maintained at home if reimbursement for broad home health services were provided. The denial of reimbursement for intermittent skilled nursing services and other therapeutic services to these individuals in their homes under Medicare has, in many instances, forced them into a hosptial or extended care facility at a much higher cost to the taxpayer. In the long run, it costs more in both human misery and hard cold cash to institutionalize our senior citizens than to provide an adequate program of home health services.

Senator Bennett on January 25, 1972, reported that a survey in New Mexico showed that 35 percent of the Medicaid population in nursing homes were not in need of institutional care. We have reason to believe these figures apply equally to Medicare patients.

RESTRICTIVE REGULATIONS

Furthermore, the limited benefits for home health services under Medicare have been curtailed sharply in the recent past through increasingly restrictive regulations of the Social Security Administration. Payment for needed services in the home is denied, frequently on a retroactive basis. Thus, the total reimbursements for home health services under Medicare are estimated to *decrease* from $79 million in 1969 to $50 million in 1971 while hospitalization reimbursements will *increase* from $4 billion to $4.5 billion in 1971. See below:

MEDICARE REIMBURSEMENTS FOR HOME HEALTH SERVICES AND INPATIENT HOSPITALIZATION, 1969-71

[In millions]

	Home health [1]	Hospitalization
Year:		
1969	$78.8	$4,039.5
1970	67.4	4,425.8
1971 [2]	49.5	4,538.5

[1] Includes parts A and B
[2] Estimated on the basis of data through Oct. 6, 1971.

Source: Social Security Bulletin, January 1972; vol. 35, No. 1. DHEW.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to—

Eliminate the three-day hospital stay requirement for home health benefits under part A; and

Authorize reimbursement for a comprehensive program of home health services to meet the health needs of the elderly and decrease the utilization of hospital inpatient care; and require providers of inpatient health services to coordinate with community-based home health agencies to reduce unnecessary hospitalization costs.

PROGRAM IMPROVEMENT

In many respects, the administration of Medicare as it relates to home health services is deficient. There has been little consistency in the regulations of Social Security Administration and a wide variation in their interpretation by fiscal intermediaries. Too frequently a home health visit that was reimbursable in the past is no longer a covered service today. When payments are denied retroactively the home health agency finds itself in financial difficulty. The development of regulations and their restrictive interpretations is based upon what has been described as "the intent of Congress." We ask Congress to—

Clearly state its intent for medicare to provide for the maintenance and improvement of the health status of the elderly with coverage of the broad program of home health services.

Home health services are a part of the programs of three major administrative units of the Department of Health, Education, and Welfare. They are the Social Security Administration, the Social and Rehabilitation Service and the Health Services and Mental Health Administration. There is little coordination among the three programs and no provision for obtaining consultation from non-Federal organizations and agencies in the field of home health services.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to—

Provide for the establishment of a home health advisory committee of representatives of home health agencies to assist the department of health, education, and welfare in the administration and coordination of its home health programs.

QUALITY OF CARE

To improve the quality of home health services, the National League for Nursing and the American Public Health Association sponsor a national program of accreditation for community health services. The criteria are more comprehensive than those required for certification in Sections 1861 (m) and (o) of P.L. 89-97.

Home health programs should be required to participate in utilization review programs. Such participation is now required for hospitals and extended care facilities. The utilization review process has a great potential for improving the level of services and monitoring utilization.

An important aspect of any program with the objective of measuring the quality of health services is the active participation of those most experienced and qualified in the provision of those health services. It is also important to involve the public as consumers of health services in such programs.

Accordingly, the NLN Council of Home Health Agencies and Community Health Services recommends that H.R. 1 be amended to—

Identify NLN-ALPHA as the national accreditation body for home health services with an agency's accreditation accepted in lieu of certification;

Extend the utilization review requirement to home health agencies participating in medicare and medicaid: and

Modify amendment No. 823 relating to professional standards review organizations to require that review activities in the case of home health services be the responsibility of a multi-disciplinary health team experienced in the field of home health services with representation from the general public.

In conclusion, the Council urges that the scope of Medicare be expanded from the narrow concept of the treatment of acute illness, primarily inpatient, to a program designed to promote and maintain health through the prevention of illness and the amelioration of chronic conditions through a comprehensive program of home health services. Such an expansion would provide better health care for the elderly at a reduced cost.

STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION, SUBMITTED BY JAMES L. JOHNSON, PRESIDENT

The American Clinical Laboratory Association seeks legislation that would eliminate the duplicate Federal enforcement activities affecting clinical laboratories in interstate commerce, and would lead to the establishment of coordinated and uniform laboratory standards both within and without the Federal government.

A relatively simple technical amendment to the Social Security Act (which is now being extensively amended by H.R. 1 in the Congress) could satisfy these objectives. The costly and burdensome overlap of Federal governmental programs results from the laboratory certification requirements imposed administratively under the Medicare program (Social Security Amendments of 1965, Public Law 89-97, 79 Stat. 286) on the one hand, and the laboratory licensure procedures established pursuant to the Clinical Laboratory Improvement Act of 1967 (CLIA) (Public Law 90-174, 81 Stat. 533) on the other. A brief amendment exempting from Medicare requirements those laboratories already licensed under the CLIA is all that is required. Such legislative action would have the effect of subjecting clinical laboratories in interstate commerce to only one Federal government authority, thereby saving tax dollars and providing relief for the affected laboratories, without sacrificing the protection presently afforded the public in any way. Significantly, the Association believes that such an amendment would measurably advance the cause of uniform standards.

By way of identification, the American Clinical Laboratory Association is an organization established last year to offer a collective voice on behalf of an important and growing segment of the laboratory industry not previously represented—the Federally-licensed interstate clinical laboratories. The underlying purpose of the organization is to speak out at both Federal and state levels on legislative and regulatory policies of significance to the clinical laboratory industry. Association members are dedicated to the support of legislative and regulatory policies that improve the quality of clinical laboratory testing and services, consistent with one of its stated purposes, i.e., to "encourage the enactment of uniform clinical laboratory legislation and administrative regulations and policies for the protection of the public."

Participation in the Federal Interstate program (administered since the enactment of the CLIA by the Center for Disease Control, HEW) is a prerequisite to ACLA membership. While the Association represents a relatively recent voice on laboratory matters, its members have long been involved. Several members offered testimony in support of what became the Clinical Laboratory Improvement Act, and many others have been active in working with various health personnel and regulatory officials within the Federal government and in various key states around the country. Members include both some of the larger laboratories and some of the smaller ones. All ACLA members participate in the Medicare, as well as the Interstate, program.

The ACLA has general concern as to the adequacy of regulation in the entire industry. It feels that present Federal regulation has been successful in improving the quality of the limited group of clinical laboratories which are subject to Federal jurisdiction. However, the ACLA fears that the passage of the CLIA, and the Federal enforcement policies developed pursuant both to it and to the Medicare program, have not achieved the hoped-for Congressional objective of encouraging a nationwide regulatory environment necessary to assure adequate laboratory services for the health care public throughout the United States. Whatever the long term solution to ACLA's general concern may be, however, its members are immediately concerned about the burdensome overlap they feel from the duplicative Federal programs.

The overlap of the CLIA licensure and Medicare certification programs has proven wasteful, costly and burdensome, whether viewed from the standpoint of the affected laboratories, the governmental agencies involved or the public. ACLA is not alone in this concern, as evidenced by the significant and relevant findings of the extensive Auerbach Report, a comprehensive study entitled "Clinical Laboratory Evaluation Programs", dated July 31, 1970, and submitted to the Community Health Service pursuant to contract with HEW. To date, the Association and industry members have not succeeded in their efforts to persuade HEW to accomplish administratively the results now sought by legislation. It is true, of course, that more coordination between the two HEW programs has been accomplished in recent years. However, ACLA members and other laboratories in interstate commerce still are confronted with two separate enforcement

authorities within HEW; laboratory standards and policies that differ in each program; duplication of inspection; and a general overlapping of enforcement policies. This continuing duplication of overall enforcement activity and policies is unfortunate.

By way of background, this problem arose from the 1967 enactment of the Clinical Laboratory Improvement Act on the heels of the establishment of requirements for participation in the Medicare program, without due recognition having been made for the need to coordinate the two Federal programs. In order for a laboratory to "participate" in the Medicare program, and thereby become entitled to reimbursement for laboratory services provided, a laboratory has to be certified by those HEW officials with Medicare program responsibilities as in compliance with the specific Medicare program requirements for coverage. The Medicare program operates in a manner that usually contemplates agreements between HEW and the states to utilize state services in determining whether a laboratory meets the requirements of the Social Security Act, including the standards promulgated by HEW. In all instances, the Department of Health, Education and Welfare reimburses the states for their costs in making inspections and performing other related activities pursuant to these agreements. Some 2,600 laboratories are certified as eligible under the Medicare program.

With the enactment of the Clinical Laboratory Improvement Act in 1967, the burdensome and costly duplication of activity arose. CLIA was intended to spawn a program which would "serve as the Nation's Federal standard-setting authority for independent laboratories" in the words of the House and Senate committees reporting out the bill. Yet, the Act provides for the separate inspection and regulation by the Center for Disease Control, HEW, of those laboratories that are engaged in interstate commerce and thereby subject to the Act, even though most of the laboratories are already qualified as Medicare-approved.

This CLIA provision for separation inspection and regulation of laboratories in interstate commerce, though otherwise qualified under Medicare, has resulted in the duplication of policy standards, inspections and testing programs. Although both Medicare and CLIA programs are conducted under the authority of HEW, and although both have the same objective of assuring high quality laboratory services, the two programs are quite different. The duplication has impact on some 350 to 450 interstate laboratories, licensed by CDC and subject to this overlapping attention.

As a result, ACLA members and certain other interstate program laboratories (1) will be inspected perhaps several times a year under the Medicare program by people representing the state agencies acting under delegation from the Bureau of Health Insurance, Social Security Administration, and will also be inspected during the same period by personnel from the Center for Disease Control; (2) are subject to proficiency testing programs administered under the supervision of CDC; and (3) are required to operate under regulations and policies that are not uniform as between the two HEW programs and Federal government agencies. Furthermore, Medicare policies are administered by the state authorities discharging responsibilities by delegation from the Social Security Administration. Administration of the same policies varies to such an extent in the different states as to create an unreasonable burden on the interstate laboratory. Thus, the approximately 350 to 450 licensed Interstate laboratories are subjected to burdensome and inconsistent duplication of Federal regulatory enforcement (as well as to state regulation in states where their laboratories are located), while virtually all other laboratories are subject to far less regulation, ranging from Medicare program requirements and state requirements to no regulation at all. Indeed, when a laboratory is not Medicare approved, or is Medicare exempt, or is located in a state that has no meaningful regulatory policy, that laboratory may escape all such regulation—a situation applicable to thousands of the nation's laboratories. Paradoxically then, the concentration of enforcement activity falls on the very laboratories which may require the least surveillance. Therefore, ACLA believes that it is a matter of legislative inadvertence that the Clinical Laboratory Improvement Act did not exempt from Medicare qualification requirements those laboratories meeting the exacting requirements of the Interstate program administered by CDC.

The previously-referred to Auerbach Report commissioned by the Community Health Service represents a recent and comprehensive evaluation of clinical laboratory regulatory programs in the United States. The Report's significant conclusion that state and local regulatory programs are inadequate suggests the need for a long-term solution. Its specific findings concerning the overlapping Federal programs, however, go to the heart of this ACLA statement and support

immediate action. The Report wisely credits the Federal government for what improvement has occurred in clinical laboratory licensing. However, it also details the present duplication of enforcement programs under Medicare and the CLIA, discusses the burdensome impact of the duplication, and notes generally the lack of uniformity between the two programs. It concludes that overall improvement in regulatory activities throughout the United States might start with the Federal government putting its own house in order.

The Auerbach Report goes on to recommend resolution of the question of overlap, better coordination of existing program activities, and determination of uniform standards and policies. In particular, over 18 months ago, the Report recommended that HEW take prompt action to formally coordinate activities of the Medicare and Interstate clinical laboratory evaluation programs, including coordination of inspections and testing, and harmonizing of the various standards of the two programs. ACLA, on the other hand, believes that such suggestions do not come to grips with the problem as well as its proposed amendment does. If passed, it would undoubtedly create a climate that would require uniformity of the two programs and policies.

The American Clinical Laboratory Association acknowledges that the Report's recommendations are worthwhile. It submits, however, that its requested amendment to H.R. 1 would cure the problem sooner and more efficiently. The very passage of the proposed amendment would create such a climate within HEW as to assure the ultimate promulgation of uniform standards and policies within both programs.

ACLA finally notes that the CLIA authorizes the Secretary to exempt a laboratory from the licensure provisions of the Act if it is accredited by a national accreditation body that applies standards equal to or more stringent than the provisions of CLIA and the rules and regulations thereunder. We note that there are some 275 laboratories holding an unrevoked letter of exemption issued by the Secretary under these provisions. ACLA believes that the technical amendment should extend as well to these laboratories.

In view of the foregoing, it is recommended that action be taken to amend the Social Security Act in order to eliminate the unnecessary and burdensome duplication hereinabove discussed. Specifically, H.R. 1 should add a new section to the Social Security Act, [similar to Section 1865 of the Act (42 U.S.C. § 1395 bb)] which would read as follows:

"A laboratory shall be deemed to meet the requirements of numbered paragraphs (10) and (11) of Section 1395 x(s) of this title (and should be considered as an eligible supplier of services and eligible for payment), if such laboratory is licensed pursuant to the Clinical Laboratory Improvement Act of 1967 (Public Law 90-174, 81 Stat. 533) or is an accredited laboratory that holds an unrevoked and unsuspended letter of exemption for that purpose issued by the Secretary pursuant to said Act."

U.S. SENATE,
COMMITTEE ON COMMERCE,
Washington, D.C., February 23, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The attached is a summary of recommendations which the Seattle Urban League has made in regards to the Social Security Amendments (H.R. 1) which the Finance Committee is currently considering. They asked that I bring this material to the attention of yourself and the other members of the Finance Committee.

Best personal regards.

Sincerely,

WARREN G. MAGNUSON.

SEATTLE URBAN LEAGUE, SEATTLE, WASH.—PROBLEMS IN TITLES I, II, AND XX OF H.R. 1 THAT ARE NOT ADDRESSED BY THE RIBICOFF AMENDMENTS

H.R. 1 is based on the premise that the poor are to blame for their poverty. The essential character of the bill is to use minimum income payments with detailed controls and conditions surrounding such payments as a means of controlling behavior. The Ribicoff amendments do not alter this basic character.

For this reason, time should be taken to develop an adequate income maintenance system, based on need, without categorical distinctions, and designed to be administered with dignity and simplicity.

If, however, one adopts the assumptions that H.R. 1 in some form will pass, the following are the features which need to be changed in order to make the bill at all acceptable, recognizing that, even with amendments, the essential character of the bill will remain unchanged in its retention of categories and imposition of restraints based on perjorative attitudes.

TITLE I—OLD AGE, SURVIVORS, AND DISABILITY INSURANCE

1. We question, the wisdom of increasing the tax rate payable by both employer and employees, to 5.4% in 1973–1974, 6.2% in 1975–1976, and 7.4% from 1977 on.
2. The bill rules out funding the benefits from general revenues. As the cost of living increases, the taxable wage base will automatically increase. There will be a point of no return where it is more advantageous for an individual to invest towards his own retirement rather than participate in the Social Security System. A tax revolt can be anticipated at that point.
3. The minimum benefits of $74 for a single person, and $111 for a couple are too low. Benefits should at least match the poverty level.
4. The cost-of-living clause raises benefits fastest at the highest payment levels instead of at the lower payment levels.

Strengthening this Title and reintroducing it separately would be a positive step.

NEGATIVE FEATURES OF TITLE II (MEDICARE, MEDICAID) OF H.R. 1

Medicare

1. Uninsured under Medicare can enroll but must pay full cost of $31 per month which will be prohibitive for many.
2. Medicare Part B deductible increased from $50 to $60.
3. Coinsurance of ⅛ of the inpatient hospital deductible imposed from 31st to 60th day. Previously started at 60th day.
4. Benefit period in respect to the deductible is not defined for Medicare as 1 year as is done for Medicaid.
5. No provision for adding drugs furnished out-of-hospital to the list of reimbursable services.
6. Hospital and extended care facilities can charge beneficiaries for costs of services in excess of those necessary, "even when not requested by the patient".
7. The Department of Health, Education, and Welfare will establish minimum periods after hospitalization for which a patient would be presumed to need extended care or home health care. This would be limited in duration and would not in many cases encompass the entire period the patient needed care, according to the "Report of the Committee on Ways and Means, House of Representatives, 92nd Congress, 1st Session, 1971", p. 98.
8. Does not eliminate the different methods of financing Parts A and B of Medicare as suggested in the Administration's Health Insurance Bill (S 1623).
9. Teaching physicians to be reimbursed on cost instead of fee for services basis unless a bona fide private patient relationship had been established, etc. May introduce a distinction between Medicare and other patients and encourage a differentiation in care.
10. Limiting cost increases in skilled nursing homes and intermediate care facilities to 105% of the cost in the preceding year may simply invite an automatic 5% cost escalation.
11. The requirement that extended care facilities provide professional social work services is eliminated.
12. Fair hearings are not allowed for claims under supplementary medical insurance for amounts under $100.

Medicaid

1. Decreases federal matching by ⅛ after 60 days in general and tuberculosis hospitals; and in skilled nursing homes unless there is an effective utilization review program.
2. Decreases federal match by ⅛ after 90 days in a mental hospital and eliminates federal match after a stay of an additional 275 days in a patient's lifetime, except for possibility of additional 30 days where it is shown the patient will benefit therapeutically.
3. Requires medically inidgent to pay an enrollment premium related to income.
4. Permits, in addition, States to impose deductibles and co-payment on the

medically indigent, *not related to income.* Secretary Richardson feels that "The imposition on the medically needy of cost-sharing charges which are neither nominal nor income-related would work a severe hardship". (Hearings before the Committee on Finance, United States Senate, 92nd Congress, First Session on H.R. 1, 1971, p. 45)

5. Permits states to impose on cash assistance recipients nominal deductible and cost-sharing charges for non-mandatory services such as drugs, anesthetics, blood, dental care, eyeglasses.

6. Cash assistance recipient families with incomes above the Medicaid eligibility level would have to incur medical expenses equal to the amount their income exceeds the Medicaid standard before receiving any medical coverage, i.e., they would have to spend their earnings over and above the $720 a year disregard for medical care.

The report of the Committee on Ways and Means on H.R. 1 indicated that this provision was expected to save $140 million in federal Medicaid funds in the family category by eliminating the medical costs of cash assistance recipients who earn above $720. p. 75.

7. States may reduce the Medicaid eligibility income ceiling, which would make many people now eligible, ineligible.

8. States have the option of operating programs for the medically needy who are not recipients of cash assistance, but are not required to. (Report of the Committee on Ways and Means, p. 75)

9. States are not required to make Medicaid available to persons newly eligible under the income maintenance sections of H.R. 1.

10. The requirement that states have a comprehensive Medicaid program by 1977 is repealed.

11. States may eliminate or reduce the scope and extent of non-mandatory services.

12. Statewideness or comparability of services not required.

13. Licensing requirements for nursing home administrators waived. Permits administrators who have functioned in this capacity for three years prior to establishment of State licensing standards to continue, without any reference to competence.

14. The emphasis on delivery of services through Health Maintenance Organizations may result in poor service, particularly if under profit making auspices as the bill allows, unless extensively monitored.

TITLE XX—ASSISTANCE FOR THE AGED, BLIND AND DISABLED

Many of the same restrictive, punitive provisions embodied in the Family Assistance Title of H.R. 1 are present in Title XX.

The following are sections which need to be changed:

§ 2011(a)(b) Eligibility and Amount of Benefits

1. The resource limitation of $1500 is too low.

2. The amount of benefits are to low.

By 1975 the benefit level for a couple will be $2400 per year. The Bureau of Labor Statistics low budget for retired couple in 1969 was $2902. The Consumer Price Index has risen 11.1% since then.

3. Determination of eligibility for and amount of benefits is to be made quarterly. It seems unnecessary to substitute quarterly review for the current annual review for this group.

4. The "Report of the Committee on Ways and Means, House of Representatives, 92nd Congress, 1st Session, 1971" (hereinafter Committee Report), specifies that an eligible individual and spouse will receive a couple's benefits instead of each receiving individual benefits ($200 instead of $300 per month), even if they live apart. (p. 150)

§ 2011(d) Special Limits on Gross Income

The Secretary may decide when gross income will be considered large enough to make a person ineligible, even though net income may be inadequate.

§ 2011(3) Limits on Eligibility

1. Inmates of public institutions ineligible.

2. Persons in public facilities which receive Title XIX medical payments may only receive up to $25 per month. This would result in additional state costs for institutional care.

3. Persons who fail to apply within 30 days for any other benefits for which they are eligible will be ineligible for benefits under this title. Any benefits already paid would be considered overpayments (Committee Report, p. 150)

4. Persons who are incapacitated due to alcohol or drug abuse will be ineligible unless they are in an approved treatment facility and subject to monitoring.

5. Residence (S 2011(f))—No person is eligible while outside the United States for any reason, and must be back in the United States for 30 consecutive days before becoming eligible for benefits.

§ 2011 (g)

Lower benefits to be paid to residents of Puerto Rico, the Virgin Islands, and Guam.

§ 2012 Meaning of Income

1. The blind and disabled are allowed to disregard a work incentive of $85 per month plus ½ of the remainder, plus amounts needed for achieving self support, while the aged are allowed only $60 per month plus ⅓ of the remainder.

2. The blind are allowed to disregard work expenses while the aged and disabled are not.

3. The earnings of a non-eligible spouse are considered in determining benefits, and treated as if earned by one person. Thus the income disregards are per couple, not per individual, even if both are working. (Committee Report, p. 151)

Support and Maintenance in Kind (Committee Report, p. 150)

Persons residing in the household of an ineligible person would have their benefits reduced by ⅓ even if the recipient pays room and board; while an individual livin gin a rooming or boarding house would have no reduction in his benefits.

§ 2013 Resources

1. The Secretary may determine what is a reasonable value for a home and household goods and personal effects. "These regulations . . . would not necessarily be as liberal as those now in existence . . ." (Committee Report, p. 182)

2. The Secretary is to prescribe the time periods and manner in which property must be disposed of in order not to be counted in determining eligibility for benefits.

"Assets such as buildings or land not used as the individual's abode . . . which are not readily convertible to cash must be disposed of within a time limit prescribed by the Secretary . . ." (Committee Report, p. 154)

Benefits paid during the period allowed for disposal of the assets will be considered overpayments if they would not have been payable had the proceeds been taken into account when the person started getting the benefits.

§ 2014 Definitions: Aged, Blind, and Disabled

1. The definition of disability is restrictive. A recipient must not only be "unable to engage in any substantial gainful activity" but also be unable to: "considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. . . ."

No funds are provided for finding jobs or for relocating persons to different regions. Substantial gainful work is not defined.

2. *Eligible spouse*—Spouse must be blind, disabled, or old aged to be eligible. Eliminates "essential person". Would eliminate approximately 1,000 persons in Washington State.

§ 2014 (f) Income and Resources of Individuals Other than Eligible Individuals and Eligible Spouses

The income and resources of a non-eligible spouse or parent are considered income to the recipient, whether or not available to him. Such income is subject to the ⅓ grant reduction for room and board, as well as reducing the recipient's grant by the amount of the non-eligible person's income.

§ 2015 Rehabilitation Services

1. Persons eligible because of blindness or disability must participate in vocational rehabilitation services, unless they can establish good cause for refusal. Services should be available but not mandatory.

2. Good cause is not defined. The Secretary will prescribe criteria for determining when an individual is employable. (Committee Report, P. 337–338)
3. No incentive or expense allowance is provided for participation.
4. Blind and disabled persons will have their condition reviewed quarterly.

§ 2016 Optional State Supplementation

1. The states may but need not supplement federal benefits.
2. States may not increase benefit levels or liberalize eligibility requirements above 1971 levels without losing the hold harmless protections.
3. States may impose residency requirements for supplementary benefits.
4. States not required to cover under Medicaid newly eligible persons.
5. Federal benefits would be reduced by the amount of state supplementation unless here was an agreement between the Secretary and the State.

Part B—Procedural and General Provisions

§ 2031(a) Payment of Benefits

1. The Secretary determines how often benefits are to be paid.
2. There is no provision for emergency grants for non-recurring needs except at time of initial application.
3. Payments may be paid to any interested third party without safeguard of a hearing to determine incompetence or without provision for appointment of a guardian or legal representative.

§ 2031(b) Overpayments and Underpayments

1. Recovery of overpayments permitted.
"An individual would not be found to be without fault if an incorrect payment which was made to him or on his behalf resulted from his statement which he knew or should have known to be incorrect or from his failure to furnish information which he knew or should have known to be material, or from his acceptance of a payment which he either knew or could have been expected to know was incorrect." (Committee Report, p. 187)
2. Underpayments would not be paid to the estate of a deceased individual. Overpayment could be recovered from the estate of a deceased individual. (Committee Report, p. 155)

§ 2031(c) Hearings and Review

1. Benefits may be terminated prior to a hearing.
2. Factual determinations by the Secretary are not subject to judicial review.

§ 2031(d) Hearing Examiner, Representation of Claimants

1. Hearing examiners need not meet the standards of the Administrative Procedures Act.
2. The Secretary may regulate who may represent claimants. He may require of such persons, other than attorneys, that "they shall show that they are of good character, and in good repute, possessed of the necessary qualifications to enable them to render . . . valuable service . . .

§ 2031(3) Applications and Furnishing of Information

1. No simple declaration system.
2. Failure to or delay in submitting reports of change in circumstances will result in reduction of benefits by $25 for the first incident, $50 for the second, and $100 for subsequent incidents, except for good cause.
Good cause is not defined.

§ 2031 (f) Furnishing of Information by Other Agencies

Heads of any federal agency shall provide information. No guarantee of confidentiality of records.

§ 2032 Fraud

Excessive penalty. Misdemeanor. $1,000 fine or a year in prison, or both.

§ 2033 Administration

While the Social Security Administration is to administer this program, there are to be separate applications and reports, and separation benefit checks.

§ 522

Statewideness not required for services.

SEATTLE URBAN LEAGUE—A COMPARISON OF H.R. 1 AND THE RIBICOFF AMENDMENTS

Summary

NEGATIVE FEATURES OF RIBICOFF AMENDMENTS

I. *Explanation*

Deals only with Title XXI of the act and does not address the problems in Titles II (Medical) and Title XX (Old Aged, Blind and Disabled Program).

II. *Work Registration Requirements*

1. Retains *work registration requirement* as a condition of receipt of benefits "Good cause" for refusal is determined by the Secretary and not defined.

2. Excludes mothers of children under six (6) from the work registration requirements. We think all mothers or caretakers of school age children should be exempted unless they volunteer.

3. Secretary of Labor retains discretion of determining whether "good cause" exists for failure to participate in manpower services, training or employment.

III. *Child Care*

1. Retains provision that Secretary of Labor decide which cases and for how long child care services shall be required.

2. Retains provision that child care services may be provided from any available sources including profit making day care centers.

3. Retains provision that parents may be required to pay for all or part of the cost of child care services according to a schedule to be prescribed by the Secretary, including those incapacitated mothers required to accept vocational rehabilitation services.

IV. Work Protections

1. Retains provision limiting federal match for public service employment to three years; but does increase third year match from 50% to 75% or more, if needed to prevent increasing unemployment.

V. Training Allowances

1. Retains provision excluding individuals participating in training to obtain a college degree from incentive allowances, or individuals receiving wages under a Department of Labor program, e.g. on-the-job training.

VI. Rehabilitation Services for Incapacitated

1. Retains provision that incapacitated persons accept vocational rehabilitation services or lose their benefits, and requires quarterly review of incapacity.

The amendment is more punitive than H.R. 1 in that it states that individuals who "are unable to accept or continue to participate in" rehabilitation services shall lose their benefits while H.R. 1 states that individuals who "refuse to accept or continue to participate in" such services shall lose their benefits.

VII. Benefits

1. While benefits are raised by the Ribicoff Amendments to $3,000 a year instead of $2,400 for a family of four, and the $3,600 ceiling on benefits for families of eight (8) or more is eliminated, the payment level is far below the goal of beginning at the poverty level and reaching the Bureau of Labor Statistics "low budget" standard by 1976.

The goal in the Ribicoff Amendments is to reach the poverty level by 1976.

2. Retains provision that the Secretary determines reasonable value of home and household goods in determining resource exclusions; that he decide the time and manner in which property must be disposed of not to be counted in determining eligibility.

3. Retains clause excluding from benefits any family whose rate of payment would be less than $10 a month; affects 191,000 families under H.R. 1. Not sure how many under Ribicoff payment levels.

4. Retains provision that benefits be paid on the basis of estimated income for a quarter.

5. Retains provision that Secretary may prescribe when gross income is so large as to make a family ineligible.

6. Makes individual ineligible if he fails to apply within 30 days for other payments to which he is entitled. Under H.R. 1 whole family was eligible.

VIII. Meaning of Family and Child

1. Retains provision that no one shall be eligible for benefits with respect to any month during all of which he is outside the United States except for seeking employment or engaging in employment.

IX. Optional State Supplementation (Sec. 2156)

Does not require state to supplement the working poor until 1973 (Sec. 2156, 507)

X. Supplementary Benefits

Requires that supplementary payments to individuals who refuse without good cause to register for manpower services, training or employment, or for vocational rehabilitation services, be reduced.

XI. Payment of Benefits

1. Retains provision that payments may be made to a third party where family members are unable to manage funds or when a member refuses to accept services or employment or to participate in training; or is unable to accept rehabilitation services.

2. No provision for emergency grants for nonrecurring needs except at time of initial application.

XII. Furnishing of Information by Other Agencies

1. Retains provision that head of any Federal agency shall provide such information as the Secretary needs for determining eligibility for or amount of benefits, or verifying other information with respect thereto.

XIII. Applications and Furnishing of Information by Families

1. Retains provision that the Secretary prescribe requirements for filing applications, furnishing data, reporting changes, etc.

XIV. Penalties for Fraud

1. Retains misdemeanor and $1,000. fine or one year in prison, or both.

XV. Obligation of Deserting Parents

1. Retains requirements that amount due shall be collected from amounts due or becoming due the deserting parent from the Federal Government *at any time.* No statute of limitations and no provision for a hearing.

XVI. Penalty for Interstate Flight to Avoid Parental Responsibility

1. Retains misdemeanor, $1,000 fine or a year in prison, or both.

XVII. Reports of Improper Care of Custody of Children

1. Retains provision that Secretary advise appropriate agencies if he has reason to believe a child is or has been subjected to neglect, abuse, exploitation, or other improper care. Improper care is not defined.

XVIII. Advisory Committees

1. Still only to evaluate the effectiveness of manpower and training programs. No committees are set up to evaluate the operation of the application and payment process or the delivery of services.

XIV. Hold Harmless (Sec. 503)

1. Does not apply to those who would have been ineligible for reasons other than income in 1971; i.e. single persons who are not aged, disabled, blind or childless couples.

XV. Services

1. Retains the provision that services need not be provided statewide, and provision that individual programs for family services are not required.

XXI. Enforcement of Support Orders—Public Assistance Amendments Effective Immediately

1. Retains provision including enforcement of support against step-parent although in the amendments to Title XXI, this is not required unless state law makes the step-parent responsible.

XXII.

Does not address question as to whether Indians must sell their reservation lands in order to be eligible.

XXIII.

Retains provision under Payment of Benefits that the Secretary may establish ranges of incomes within which a single amount of benefits under this title shall apply. It is not clear what this implies.

H.R. 1—A Special Report by the Seattle Urban League, November 1971

Welfare reform is widely regarded as the number one domestic priority in the nation today. The current welfare system is unsatisfactory both to the recipients, who find it inadequate and demeaning, and to the general public who regard the rising costs of ever increasing caseloads as excessive.

Since August 1969, six versions of Welfare Reform bills have been under consideration by Congress. The Mills' Bill, H.R. 1, passed the House on June 22, 1971 and is currently before the Senate Finance Committee. No public hearings have ever been held on the bill.

This latest version of Welfare Reform satisfies neither recipients nor business groups. The National Welfare Rights Organization calls it "a giant step backward." The United States Chamber of Commerce characterizes the bill as a "revolutionary" bill that has "the potential to destroy our private economy."

The National Urban League recognizes the need for a basic income floor for all Americans as the only means to appropriately compensate for the economic and social dislocations of an advanced economy. The NUL has set forth a list of requirements which it feels should be met by welfare reform legislation. The following is a comparison between the NUL requirements and what is proposed in H.R. 1.

National Urban League requirements are:

1. A new, unified and federally financed and administered program of assistance.

H.R. 1—provides the possibility of dual administration with respect to services, medical aid, special needs, and supplemental benefits.

2. Strong and clear legal requirements and guidelines to assure equitable and efficient administration, with a minimum of red tape. Use of simple affidavit to establish eligibility for all in need with no means test or case-by-case investigation.

H.R. 1 increases red tape.

No simple declaration process.

Every applicant must be interviewed in person and furnish birth certificates, income records, etc.

100% check of key application items.

Complete verification of every element of eligibility of a sample.

Biennial reapplication required to be filed and processed as though it were initial application.

Regular, periodic checks of information will be made against data files.

Field investigation prior to authorization of benefits if any question arises as to accuracy of information.

3. Federal supplements must be made available to enable states to maintain current benefits at least at present levels.

H.R. 1 does not require maintenance of current benefit levels.

It is estimated that without a state supplement, 90% of the recipients in 45 states would have their present benefits reduced.

In King County, Washington, a family of four which is receiving $3,240.00 a year from Public Assistance would receive $2,400.00 a year.

4. Coverage for all people equally in need, regardless of residence, reason for poverty, or current categorical distinctions.

H.R. 1 excludes—

All single persons and childless couples who are not Aged, Blind or Disabled.

The whole family if one member fails to apply for any other benefit for which he is eligible.

"Essential" persons who are currently eligible.

Any person who refuses employment, training or rehabilitation services.

Persons incapacitated by alcohol or drug abuses unless they are undergoing treatment in an approved facility.

Families whose head is a college student even if working full time.

A child living with a "non-needy relative" (now eligible).

Pregnant women with no children other than the unborn child (currently eligible for A.F.D.C.).

Self employed whose gross income is determined to be too large.

Families with no current income who would now be eligible for A.F.D.C. but who have earned too much in the three previous quarters. (Presumed to have saved any earned income in excess of H.R. 1 payment levels, e.g., over $200 per month for a family of four.)

Possibly those with no "fixed domicile," e.g., migrants.

Anyone whose benefit would be less than $10.00 per month.

Anyone who remains outside the U.S. for 30 days except for employment or military service.

H.R. 1 proposed

Benefit levels by category:

2 persons:	
Old aged, blind, and disabled	$2,340
1974	2,400
4 persons:	
Working poor:	
(Earned ceiling)	4,140
(Ceiling with supplement)	4,260
Family assistance	2,400

H.R. 1 permits a residency requirement for state supplementation.

States may exclude from the supplement—

Families with unemployed Father.

The working poor.

The guarantee that states' expenditures will not exceed their 1971 costs does not apply to supplementary payments to persons not required to be included—i.e., the families with unemployed fathers and working poor; or to payments to persons who would have been ineligible for reasons other than income in 1971.

Thus, state supplements to these groups would be at state expense and the benefits would be deducted from the federal allowance.

5. Assistance grants at the official poverty level at the outset with provisions for rapid and orderly steps to the lower level standard of living index as determined by the Bureau of Labor Statistics.

H.R. 1 grants levels and cost of living increases:

Family of 4:	
Urban—current	$3,800
Rural—Poverty index (OEO December 1970)	3,200
Bureau of Labor statistics "low budget, Seattle-Everett, Wash., spring, 1970	7,630
H.R. 1 benefit	2,400
Families of 8 or more: H.R. 1 sets ceiling of	3,600

6. We reject the concept of compulsory work requirements.

H.R. 1: Every person determined to be available for employment must register and accept available employment or lose their $800 annual benefit and have family payments made to a third party.

7. Incentives should be provided to encourage those eligible for public assistance to move into job training and full employment. Such incentives should include the right to keep enough earned income to make working more attractive than relying solely on public assistance.

H.R. 1: The work incentive allows persons to keep $60 per month plus ⅓ of the remainder. Out of this must be paid all work related expenses and day care costs. Currently the $30 per month plus ⅓ is in addition to child care and work expenses.

8. Insure the payment of minimum or prevailing wages, whichever is higher.

H.R. 1: Must accept work unless it pays less than 75% of minimum wage, i.e., $1.20/hr. or the prevailing wage, whichever is higher.

9. Suitable employment consistent with individual skills.

H.R. 1: Suitability of job to individual skills not a ground for refusal to accept employment.

10. Exemption from requirement to register for employment for mothers or other persons responsible for the care of school-age children if they chose not to work.

H.R. 1:

Mothers with children over 5 years of age must register. In 1974, mothers with children over 2 years old must register.

11. Provision of quality day care centers for those who do work.

H.R. 1:

A ceiling of $2,000 for a family of four is allowed as exempt income for day care. This does not cover the cost of day care for two children at the current $5/day rate.

$700,000,000 appropriation sufficient only for custodial care.

Only 875,000 day care slots for estimated 2.6 million registrants.

No standards for day care stipulated in the bill.

No guarantee of day care before employment or choice of facility.

12. Provide critically needed public service jobs where there is a shortage of private or other public sector jobs.

H.R. 1 provides for 200,000 public service jobs BUT these are intended to be "transitional" and no Federal monies will be available for them after the 3rd year.

13. Supportive services should be made available, but not compulsory.

H.R. 1 requires:

Incapacitated individuals to accept rehabilitation services or lose their benefits.

The Department of Labor is to provide those supportive services "deemed necessary" for persons registered for training and employment. However, there is a closed end appropriation for all services except day care and family planning.

The state share of monies for services will be proportionate to the Federal share in all states.

Calls for more services with possibility of less money to provide them.

14. Right of the recipient to a fair hearing, continuation of grant pending the outcome of hearings.

H.R. 1: Benefits may be terminated without prior hearing for failure to submit quarterly reports.

15. Right to representation at hearings must be clearly spelled out.

H.R. 1: The right to representation is restricted to attorneys or to persons "of good character and in good repute."

16. Notification of benefits and qualifications for entitlement must be publicized by federal administering agencies.

H.R. 1: Public Information.—Not spelled out in the bill.

17. Such legislation must preserve all rights now held under current public assistance laws.

H.R. 1—rights eliminated:

States may impose residence requirements for receipt of supplemental benefits.

Benefits may be terminated without prior hearings.

Determinations of fact by the Secretary on the basis of fair hearings not subject to judicial review.

Representation restricted.

Excessive penalty for failure to report.

18. Such legislation should include a realistic opportunity for participation by recipients in influencing the administration and general nature of programs.

H.R. 1 eliminates recipient representation on local advisory committees. Committees will be set up to evaluate employment and training programs. They shall be composed of "representatives of labor, business, the general public and units of local government."

19. Protections must be written in to assure American Indians and migrants, and citizens of Puerto Rico and the Virgin Islands full and equitable participation in all assisting programs.

H.R. 1:

Question arises whether Indians must sell their land and use up the resources before being eligible.

Because of the "fixed domicile" requirement there is some question whether migrants will be eligible.

There is also a question whether the Bureau of Indian Affairs can supplement another federal program to provide supplement for unemployed fathers as they currently do in Alaska.

H.R. 1 sets grants in Puerto Rico, Guam and the Virgin Islands at a lower level, based on the ratio of the per capita income in those areas to the per capita income of the lowest of the 50 states. This could be only 3/5 of payment made in mainland U.S.A.

SEATTLE URBAN LEAGUE—A COMPARISON OF H.R. 1 AND THE RIBICOFF AMENDMENTS

Summary

POSITIVE FEATURES OF RIBICOFF AMENDMENTS

I. Child Care

1. Adds protections relating to suitability or remoteness of child care services as grounds for refusing work.
2. Requires transportation be included as part of child care services.
3. Makes Secretary of H.E.W. responsible for providing child care services instead of Secretary of Department of Labor.
4. Eliminates provision that not more than $100 million be appropriated for child care services.
5. Requires that day care standards be no less comprehensive than the Federal Interagency day care requirements.
6. Increases sums for development of day care facilities from $50 million to $100 million.
7. Provides that up to $25 million a year shall be used for training personnel for employment in providing child care services.

II. Wage and Work Protection

1. Adds provision that *work must suit* individuals interests and *proficiencies* and hold reasonable promise of making the person self-supporting.
2. Requires payment of at least the higher of the applicable Federal, State or local wage rate or the prevailing wage, or the *minimum* wage.
3. Requires that work be covered by Workmen's Compensation and considerations of health, prior training and experience, etc.
4. Changes priorities for work and training from mothers and pregnant women under 19 to give priority to unemployed fathers or volunteer female heads of family, etc.
5. Provides that no one be given an employability plan until the necessary services and employment opportunities are available. Family assistance benefits will be paid to individuals pending availability of necessary programs.
6. Redefines purposes of public service employment to provide employment for eligible individuals, not just those otherwise unable to find work or to be effectively placed in training.
7. Requires any employer receiving federal funds and all public service jobs in the private sector to list job vacancies with the Department of Labor.
8. Redefines goals of public service employment to develop new careers.
9. Eliminates review every six months of each public service employee and substitutes periodically.
10. Raises sum for manpower services, training and employment programs other than public service employment, from $540 million to $1 billion.
11. Increase from $800 million to $1.2 billion amount for public service employment.
12. Requires estimate of additional funds needed if 5% or more needy employable people have no reasonable job prospects.
13. Requires Secretary of Labor to consult regularly with representatives of employers and recipients and specifies equal opportunity requirements.
14. Requires Secretary of Labor to ensure eligible Opportunities for Families individuals priority in participating in other Federal programs designed to promote employability or employment opportunities.

III. Benefits

Increases benefits but not sufficiently (See VII (1) under negatives).

1. Provides that no one shall receive less benefits than he did previously.
2. Provides for redefinition of poverty to take account of rises in cost of living and to require a more adequate definition of poverty.
3. Allows $1500 in exempt resources the first year and $2000 beginning July 1, 1973. Too low.
4. Requires studies to establish variations in living costs and recommendations for adjustments in light thereof. Such recommendations are to apply to any programs aided under the Social Security Act providing payments to individuals or for their medical care.
5. Eliminates taking into account income from preceding quarters in estimating benefits.
6. Provides that aid be furnished with reasonable promptness based on current needs.
7. Eliminates requirements that families reapply biennially. Substitutes provision for study of a sample of families who have received benefits for 24 consecutive months.
8. Provides same benefits for Guam, Puerto Rico, and the Virgin Islands as for the 50 states.

IV. Income

1. Increases from $1500 to $2000 the amount of the proceeds of any life insurance policy which is expended for illness or burial which can be disregarded.
2. Increases from ⅓ of net income to 40% of gross income the amount of earned income which can be disregarded.
3. Adds "other educational expenses" to income which can be disregarded in the way of grants etc. for educational purposes.
4. Changes from ⅓ to 40% the amount of child support or alimony which can be disregarded.
5. Adds "the net amount of any income taxes paid in a month" to excluded income.
6. Deletes provision limiting total income which may be disregarded to the lesser of $2000 plus $200 for each additional member over 4, or $3000.
7. Raises from $1500 to $2000 the total face value of all life insurance policies which may be excluded.

V. Meaning of Family and Child

1. Add proviso that definition of residence shall not be interpreted to exclude migrant families or others of unfixed domicile.
2. Deletes proviso that a person who has been out of the U.S. for 30 consecutive days must have been back for 30 consecutive days before he is eligible for benefits.
3. Includes in definition of eligible family single persons and childless couples who are not aged, blind, or disabled.
4. Deletes exclusion of families whose head of household is a college student.

VI. Income and Resources of Noncontributing Individual

1. Excludes stepparents' income unless applicable State law makes the stepparent responsible for the support of the child.

VII. State Supplementation

1. Eliminates provision that states may establish a residence requirement.

VIII. Supplementary Benefits

1. Specifies that the supplement is to be excluded in determining the income of the family and that it must be an amount that assures they receive no less in benefits than they were receiving in January 1971, including the bonus value of food stamps. However, does not cover newly eligible.
2. Where the state makes its own supplementary payments it must agree not to impose any liens against the property of any member of a family or his estate on account of such payments, and that there will be no adjustment of or recovery of such benefits.

3. The Federal Government will pay 30% of the State's supplementary payments during the first year and by 1976 the payments will be 100% federally funded.

IX. Payment of Benefits

1. Adds proviso that benefits be paid no less often than monthly.
2. Changes emergency provision for paying a cash advance of up to $100 to be counted against benefits to a cash payment in an amount the Secretary finds appropriate to protect the family's welfare. However, there is no provision for emergency grants for non-recurring needs except at time of initial application.

X. Overpayments and Underpayments

1. Changes recovery of incorrect benefits from "shall be made" to "may be made".

XI. Hearing and Review

1. Greatly strengthens protections for recipients with respect to fair hearings, judicial procedures and appeal.

XII. Representation of Claimants

1. Eliminates waiver allowing hearing examiners not to meet the specific standards prescribed.
2. Provides for free choice of representation and eliminates restriction on who may represent clients.

XIII. Applications and Furnishings of Information by Families

1. Eliminates requirements that recipients file quarterly reports.
2. Eliminates the $25, $50 and $100 penalties for failure to report.

XIV. Administration

Adds employee protection provisions.

XV. Advisory Committees

Recipients are included on the Advisory Committees to evaluate the effectiveness of manpower and training programs.

XVI. Initial Appropriation for Child Care

Raised from $700 million to $1.5 billion.

XVII. Services to Needy Families with Children

Working poor not excluded in the definition.

XVIII. Appropriations for Services

1. Eliminates ceiling of $800 million for the first year and provides such sums as may be necessary.
2. Eliminates allotment of money for services to states on basis of ratio of their expenditures to the total federal share in all States with service deficit being taken into account.

U.S. SENATE,
OFFICE OF THE MAJORITY LEADER,
Washington, D.C., January 17, 1972.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is a letter I have received from Theodore Carkulis, Director of the Department of Public Welfare for the State of Montana.

Mr. Carkulis offers several constructive comments regarding welfare reform legislation, and I thought perhaps the Committee would like to have the recommendations of Montana's chief officer in the area of welfare.

With best personal wishes, I am,

Sincerely yours,

MIKE MANSFIELD.

STATE OF MONTANA,
DEPARTMENT OF PUBLIC WELFARE,
Helena, Mont., January 11, 1972.

Hon. MIKE MANSFIELD,
Senate Majority Leader,
U.S. Senate, Washington, D.C.

DEAR SENATOR MANSFIELD: Now that the time for a decision on welfare reform (H.R. 1) is drawing near, I feel I must bring to your attention the concern of a number of state welfare administrators with respect to the administration of the welfare system. We believe that whatever plan is finally adopted it should include provision for optional administration by the states without penalty. An earlier version of the bill included such a provision but penalized the states if they chose to administer the program.

State administration is not necessarily inconsistent with the idea of a uniform national program with full federal funding. I believe that the concept of full federal funding may be maintained even though individual states would have a voice in determining the level of assistance payments in the state. In my opinion, state determination of the payment level, above a relatively low national minimum floor, is desirable in any program which is based on need. It is also important that the payment level in a state be established in relation to economic indicators so that assistance payments would not be disruptive of other elements of a state's economy.

Another important consideration is that the recipients in the national assistance program will be required to receive services from a number of other agencies which are essentially state agencies such as the Employment Service, Vocational Rehabilitation, Child Care Services, Social Services, and Medical Assistance. If the program is to succeed, close coordination of all of these programs will be imperative, and it seems to me that a state agency would be best able to achieve this coordination with other state agencies.

The claim has been made that states have failed in the administration of public welfare programs, a condemnation that many of us do not accept. In fact, in the last few months a number of states have taken significant steps toward welfare reform in spite of federal restrictions. This is not to say all of the states are necessarily working in the right direction but only to indicate that states can take measures to solve their problems if they are permitted and if they are provided the resources.

In view of the above arguments I would respectfully urge you to bring this suggestion to the attention of Senator Long—who I believe is receptive to the idea—for the consideration of his committee when they again consider this bill.

And finally, as you are already aware, Congress has been discussing and debating welfare reform for almost two and one-half years while the welfare burden on states has been increasing. So the matter of immediate fiscal relief has become extremely urgent. We know that proposals to meet this problem have been made by the administration and others but we want to take this opportunity to re-emphasize the urgency and to express Montana's concern.

With kindest personal regards, I am,

Sincerely yours,

THEODORE CARKULIS, *Director,*
Social and Rehabilitation Services.

NATIONAL GRANGE,
Washington, D.C.

Re H.R. 1.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter will bring up to date the views of The National Grange regarding the subject legislation. In brief, we endorse the amendments in Social Security laws and improvements in benefits under such laws

which are contained in H.R. 1, but while we recognize the need for reformation of our presently unsatisfactory welfare system and believe that some aspects of H.R. 1 could well result in improvements in that system, we have serious reservations about the present provisions of the bill relating to family assistance.

The National Grange represents 7000 local community Granges across the nation, with a total membership of over 600,000. The Grange is more than a farm organization. Our purpose is to serve the total interest of rural communities and the nation.

Social Security legislation has drawn considerable attention at the Annual Sessions of the National Grange throughout the last decade. Without any question, the cost of Social Security falls most heavily on the self-employed. This includes the total of our farm population. In the midst of a continuing cost-price squeeze on farmers, we are naturally and rightfully concerned over the amount they can earn while collecting Social Security payments.

At the Annual Session of the National Grange in 1965, the delegate body adopted the following resolution:

"Resolved, that the Grange favor *raising the number of hours a farmer can work before forfeiting Social Security* in proportion to the 25% raise given other occupations."

Of almost equal, if not greater, concern to the Grange, especially if we look at the recurrence of this concept in our resolutions, has been the objection of the Grange to the low amount people other than farmers are permitted to earn while drawing Social Security benefits.

The following two resolutions were adopted at our 1967 Annual Session:

"Resolved, that the National Grange go on record as being in favor of changing the Social Security law, whereby the *breadwinner of the family could earn the same amount while receiving Social Security benefits, as he or she and their spouse could earn collectively* at the present time and *still qualify for Social Security benefits.*"

"Resolved, that a change be made in the present law that would *allow the combined income of a married couple, over and above the Social Security, to be $3,000 and same could be earned by either spouse or a combination of their two incomes, thus removing the present discrimination against the one breadwinner.*"

It seems logical and reasonable that in the present period of relatively high employment, plus increased higher costs of living, that considerable flexibility should be written into the law to permit elderly retired people to retain a combination of Social Security benefits and earned income that would place them a couple of steps above the poverty level.

Thus, the Committee will understand the Grange's concern with the low level of Social Security which is available to many of our elderly citizens, and which does put them in a rather precarious situation unless they have other income to fall back on. We would hope that you could see fit to consider the increase in the allowable earnings of those who are limited to an unreasonably low earning and total income level during their declining years. It would permit them to live with increased decency and dignity—*the real objectives of this legislation in the first place.*

The Grange has also expressed its concern over the amount of benefits paid to a surviving widow. At the Annual Session in 1965 the delegate body adopted the following resolution:

"We recommend the *widow's survival pay be increased to an amount equal to the husband's primary insurance payment.*"

The other major concern of the Grange regarding Social Security legislation pertains to the number of years over which a person's earnings are averaged for the purpose of determining Social Security benefits.

At the 1969 Annual Session of the National Grange the delegate body adopted the following policy position:

"Resolved, that the National Grange urge Congress to . . . Change the period by which benefits are computed to the three (3) highest years of earnings."

The number of years over which a person's earnings are averaged for the purpose of determining Social Security benefit payments may be a crucial factor in computing the amount of such benefits. Certainly in a great many cases it is at least as important as the level of maximum benefits. Lowering the number of years that must be used could well mean more than increasing the maximum benefits by some publicized percentage such as 15 percent.

A man born in 1929 or later must average 38 years of earnings *on which Social Security taxes were paid.* A man retiring upon becoming 65 in 1970 would have to use 14 years of such earnings. It may well be that they would have to include years in which they had no "creditable" earnings, thus cutting down the average yearly amount of such earnings. Much government employment at all levels, and self employment in past years, would not count towards Social Security benefits. Also, earnings creditable in any year are of course limited viz. $3600 for any year 1951 through 1954, $4200 for 1955 through 1958, $4800 for 1959 through 1966, $6600 for 1966 and 1967, and $7800 for 1968 and later.

Other examples of necessary years of "creditable" earnings are shown by the following table furnished by the Social Security Administration:

	Number of years you must count in figuring your average earnings	
	Men	Women
Year in which you were born:		
1896 or earlier	5	5
1897	6	5
1898	7	5
1899	8	5
1900	9	6
1901	10	7
1902	11	8
1903	12	9
1904	13	10
1905	14	11
1906	15	12
1907	16	13
1908	17	14
1909	18	15
1910	19	16
1911	20	17
1912	21	18
1913	22	19
1917	26	23
1921	30	27
1925	34	31
1929 or later	38	35

(If you have not earned enough Social Security credits to be insured at 65 (62 for women), you must count more years than those shown in figuring your average earnings.)

We fully realize that the entire area of Social Security, Medicare, Medicaid and family assistance is indeed complicated and we by no means claim any expertise on the subjects. However, we would like to take this opportunity to call to the Committee's attention resolutions passed by the National Grange in recent years that reflect the Grange's position on many of the issues under consideration by your Committee:

HOSPITAL AND MEDICAL CARE

"Whereas, hospital and medical expenses are continually increasing; and

"Whereas, the average income is not sufficient for individuals to meet these expenses; and

"Whereas, many people who need medical and hospital care cannot afford adequate insurance to cover these expenses; and

"Whereas, the Department of Health, Education, and Welfare has recently completed an intensive investigation in these areas: Therfore, be it

"*Resolved*, That steps be taken to halt the rise in cost of hospitalization and medical care and that this matter be under constant review to the end that all people may be assured of adequate medical care at reasonable costs.

"WELFARE

"Whereas, we are greatly concerned about the continued increased cost of the Public Welfare Program: Therefore be it

"*Resolved*, That the National Grange recommend that employable welfare recipients be required to work at gainful employment, when given an opportunity, for at least a part of their income to be eligible for welfare payments, and that welfare payments shall not be correspondingly reduced to the point where it erases their incentive to work. We feel that this principle of reduced welfare payments should be applied in such a manner that it will encourage welfare recipients to seek gainful employment; and be it further

"*Resolved*, That every effort should be made to reduce Welfare costs through skillful administration and staffing in the various Welfare Departments and Social Services."

"WELFARE AND POVERTY PROGRAMS

"Whereas, many people now availing themselves of assistance through existing State and Federal Welfare and Poverty programs are believed to be abusing the privilege of programs which were set up for people who cannot care for themselves; and

"Whereas, the abuse of present Welfare and Poverty programs is producing generations of welfare dependents; and

"Whereas, the function of Public Welfare is important both in terms of human services and in terms of money, and should have influence and control from local government; and

"Whereas, while we do not oppose those who are in need of help from Welfare or Poverty programs, we do oppose misuse of welfare funds; and

"Whereas, Welfare recipients who are able-bodied and able to work should be required to work for their aid; and

"Whereas, some local welfare agencies have been weakened over the years by increasing centralization of authority at the State and Federal levels: Therefore be it

"*Resolved*, That greater latitude be granted to the local authority, however it may be designated, to provide the necessary care for illegitimate children and the impoverished, and at the same time to regulate, in fairness to the taxpayer, those who abuse the various welfare, ADC and poverty programs, and further that local welfare authorities refuse welfare grants to recipients who are not domiciled residents of the political subdivision granting the assistance.

"FAMILY INCOME"

"*Resolved*, The National Grange is in support of changes to the social services program that provide improved work incentives, provide a uniform national scale of eligibility standards and benefits, provide for job training and child care services and hold the promise for more effective program administration."

At the 105th Annual Session of the National Grange, held in Charleston, West Virginia in November of 1971, the delegate body adopted resolutions which we here reproduce in pertinent part:

"SOCIAL SECURITY TAXES FOR RETIRED WORKERS

"Whereas, retired workers up to age 72 are at present required to pay Social Security taxes on their earned income; and

"Whereas, due to inflation and rising living costs, many retired persons badly need some employment income to supplement their social security payments, and can ill afford any reduction in their earnings: Therefore be it

"*Resolved*, That the Grange favors legislation eliminating Social Security taxes for those persons receiving direct Social Security benefits."

"*Family Assistance*

"We believe that the provisions of Title IV of H.R. 1 in the 92nd Congress—which would establish new programs for needy families with children, and which has been passed by the House of Representatives and is now being considered by the Senate Committee on Finance—is a considerable improvement over H.R. 16311 in the 91st Congress which this delegate body opposed for reasons stated at the 104th Annual Session, page 168 of the Journal of Proceedings. One of the principal improvements in Title IV of H.R. 1 is its requirement that family members found to be available for work would be required to register for manpower

services, training and employment—and also to accept available employment—upon penalty of loss of benefits.

"Our study of H.R. 1 has not satisfied us that enough improvements have been made in the proposed legislation to overcome the reservations which we have had heretofore."

"*Welfare Reform*

"Whereas, public welfare is an increasing cost to taxpayers; and

"Whereas, there are those receiving welfare who are able-bodied; and

"Whereas, we believe the dignity of the recipient is enhanced if he can feel that he has worked to earn his payments, rather than to receive charity, even though the work available may not be the kind preferred by the worker; Therefore be it

"*Resolved*, That we urge revision of our welfare laws to accomplish this purpose; and be it further

"*Resolved*, That welfare agencies work with the vocational and rehabilitation services and other similar organizations to help train welfare recipients in useful work in order that they become self-supporting; and be it further

Resolved, That employable welfare recipients be required to work at gainful employment for at least a part of their income to be eligible for welfare payments, thereby reducing welfare payments in part, that the National Grange encourage action at both Federal and State levels to make it necessary that all able-bodied men and women under the age of 65 (except those persons who are required for sufficient reason to stay at home) work for the welfare which they receive or train for such work; and be it further

Resolved, That the National Grange endorse any revision or additional regulations that would cancel all or part of welfare benefits to able-bodied men and women who refuse to accept available employment for which they are qualified; and be it further

Resolved, That students who drop out of school and apply for welfare be required to attend a vocational school."

We appreciate this opportunity to present the views of the National Grange on these important matters to the committee.

Sincerely,

JOHN W. SCOTT, *Master.*

LAW OFFICES,
SURREY, KARASIK, MORSE & SEHAM,
New York, N.Y.

Hon. RUSSELL B. LONG,
Senate Finance Committee, New Senate Office Building,
Washington, D.C.

DEAR SIRS: We are writing to you on behalf of the Allied Pilots Association, the collective bargaining representative of the pilots in the employ of American Airlines. We were disconcerted to discover that your Committee has voted to provide extra Social Security benefits—after they retire—to persons who stay on their jobs past the age of 65.

As you may know, a regulation promulgated by the Federal Aviation Agency in 1960 requires all commercial airline pilots to retire at age 60. Since the present Social Security laws do not entitle a man to benefit until he reaches the "normal" retirement age 65, the effect is to create a period of five fallow years in which a pilot may not work at his profession or receive Social Security benefits. Moreover, the omission of the potentially productive years from age 60 to age 65 could adversely affect the calculation of benefits due forcibly retired pilots.

Since the bonus provision you approved is intended to benefits employees who elect to continue to work after 65 it is only equitable that individuals who are forced to retire early pursuant to Federal regulations should not be penalized. Thus, the amendment to the Social Security laws adopted by you should be extended to apply to any individual who, by force of Federal law or regulation, is required to retire at an age earlier than that established by the Social Security laws as the "normal retirement" age. Of course, this inequity could and should be eliminated by simply amending the Law to provide that the normal retirement age for such individuals shall be their Federally forced retirement age—

in the case of pilots, age 60. We have urged this change upon Congress a number of times in the past, and bills have been introduced to accomplish the result. In light of the "bonus" amendment which you have adopted we think this is a particularly appropriate time for you to act on this proposal.

We would appreciate it if this letter were made a part of the record of any proceeding being held relating to the subject matter treated.

Very truly yours,

MARTIN C. SEHAM,
General Counsel,
Allied Pilots Association.

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION,
THE FIRST CHURCH OF CHRIST, SCIENTIST, IN BOSTON, MASS.,
Washington, D.C., February 14, 1972.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: We are writing to offer some suggestions for improvements in the welfare reform program on which your Committee has recently been holding hearings. Specifically, we direct your attention to two matters in the Family Assistance Plan.

A. CHILD CARE CORPORATION

A number of proposals have been offered as solutions to the problem of care for the children of working mothers under the proposed welfare reform program. Some of them provide for health examinations and immunizations. They also provide for medical treatment in certain situations for children enrolled under day care programs. There is no exemption from these health services for those whose religious beliefs would prevent them from accepting medical services. Unless one is added, many children, such as those from Christian Science homes, will be prevented from enrolling.

Christian Scientists do not seek exemption from examination and immunization without consideration for the health of others. If a public health problem, such as an epidemic of communicable disease arose, we would yield to the public need. However, it has been our experience in other programs that even in normal times some local health administrators treat the language of Federal support for a program as compulsory—whether it was intended to be or not. That is why a clearly stated provision in the statute is necessary to protect the religious rights of all the people.

Your Child Care Corporation Act, S. 2003, contains a splendid exemption which covers this situation (Sec. 2004(d)(1)). This paragraph as it was worked out with your staff during the 91st Congress is quite satisfactory. Unfortunately, two pairs of unnecessary parentheses were added along the way. The exemption would be much clearer without these additions. We hope your Committee will remove them. Senator Ribicoff, in his Senate Amendment No. 318 to H.R. 1, has accepted this language.

B. REPORTING OF NEGLECTED CHILDREN

H.R. 1, sec. 2177 (page 384 line 19 to page 385 line 6) provides for reporting by Federal welfare workers of cases of child abuse or neglect which come to their attention. This is an effort to end the tragedy of mistreatment of children by their own parents. It reflects the trend in many State legislatures. We applaud every effort to correct this terrible problem in American society. But the language of this section might encourage welfare workers who do not understand the long and broad acceptance of Christian Science as a healing method to report Christian Science treatment of children as neglect because no medicine is used.

Most neglect reporting laws in the individual States have clarified this point by specifically exempting instances of reliance on such religious beliefs from the reporting requirement. Congress included a good provision of this kind in its Child Abuse Reporting Law for the District of Columbia (Public Law 89-775, sec. 6). A similar exemption was added to the definition of "neglected child" in

the District of Columbia Court Reform and Criminal Procedures Act (Public Law 91-358, sec. 16-2301(9)).

We are asking that you add to section 2177 of H.R. 1 a new subsection (b) similar to the two above mentioned Federal statutes as follows:

"Notwithstanding any other provision in this Act, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be neglected within the purview of this section."

We hope that you will understand that we have no desire to weaken this legislation in any way. We are not experts on the subject of welfare reform, but we are concerned with the people's right to the free exercise of religion. If you have any questions about these recommendations, please do not hesitate to call on us.

Cordially yours,

H. DICKINSON RATHBUN, *Manager.*

NATIONAL CONFERENCE OF CATHOLIC BISHOPS,
Washington, D.C., February 9, 1972.

HON. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: In behalf of the United States Catholic Conference I write to advise you of the position of the Roman Catholic Bishops of the United States regarding the proposal of Senator Claiborne Pell which would permit clergymen to be covered under Social Security as an employee rather than as a self-employed person as provided under existing law.

This matter was given careful consideration at the Bishops' Administrative Board Meeting in mid-February, 1971. The proposal which would permit a priest to choose an employer-employee relationship for Social Security purposes is incompatible with both the theological concept of the priesthood and long-established tradition and practice in the Roman Catholic Church. Neither the bishop nor a parish is the employer of a priest. Rather, a priest accepts an assignment to pastoral duties from his bishop and the parish or some other unit of the Church pays his sustenance. These relationships are essentially different from those of a conventional employer-employee relationship. A bishop accepts deep moral obligations for the welfare of priests which are wholly unlike those included in an employer-employee relationship. In practice, a bishop does not relieve a priest of his pastoral duties without his acquiescence, another circumstance wholly incompatible with the concept of employment.

For these and other reasons, the Bishops unanimously concluded that the proposal clashes with the relationship of a priest to his bishop and in his pastoral functions. Accordingly, they strongly oppose Senator Pell's amendment to the Social Security bill now pending before the Finance Committee.

I kindly ask that our position be made a part of the Committee record.

With cordial good wishes, I remain

Sincerely yours,

The Most Reverend JOSEPH L. BERNARDIN,
General Secretary.

STATEMENT BY MRS. SHERMAN ROSS, CHAIRMAN, LEGISLATIVE PROGRAM COMMITTEE, AMERICAN ASSOCIATION OF UNIVERSITY WOMEN

The American Association of University Women appreciates this opportunity to express our views on the H.R. 1 amendments to the Social Security Act dealing with revision of public assistance programs and relating to OASDI programs.

We have been alarmed by the increased cost of welfare without, seemingly, doing much to alleviate the persistent poverty of far too great a percentage of the country's population.

We are of the opinion that a 5% increase in social security benefits is not adequate in terms of present living costs and, in view of the low income level, of those living on pensions that relate to a quite different dollar than that of 1972. We urge that an escalator clause keyed to increases in the cost-of-living index be a part of the bill passed by the Senate. Fluctuation in the value of the dollar should be covered.

We also support the proposed increase to 100% of the deceased spouse's benefits at age 65 for widows.

We believe allowance should be made for inflation—or note taken of the dollar increases in wages without an increases in purchase power—when new earning exemptions for OASDI beneficiaries are adopted. In other words the old $1200 ceiling is probably now the equivalent of an $1800 to $2000 earning exemption. In view of today's inflated prices, we think it probable that the ceiling should be higher than $2000.

While we are pleased that it is proposed to include the disabled under Medicare we are of the opinion that the two year waiting period for coverage is far too long and we urge elimination or substantial reduction of this provision.

We believe prescription drugs should be made available and that medicare premiums for those living at the substance level—on social security plus little else—should be eliminated.

In supporting increases in benefits we recognize that an increase in the wage base must be made and that eventually it may be necessary to supplement these trust funds annually from the general revenues of the United States.

We are extremely anxious to see progress made in reform of our welfare assistance programs. The present system has a tendency to contribute to fathers leaving homes in order that mothers and children be cared for. It also discourages rather than encourages individuals to risk leaving the welfare rolls. Therefore we support a basic family income, work training and income supplements.

We do not support forcing mothers of small children into work training or jobs unless adequate child care provisions are enacted. A report just released by the Labor Department reveals that employment among the residents of poverty neighborhoods increased in 1971 by 2.1% over 1970 from 7.6% to 9.7%, while the overall unemployment figure increased by 1% or from 4.9% to 5.9%. The same report also states that the biggest increase by unemployment was among adult women where the percentage increase has been from 5.7% in 1970 to 8% in 1971. In the face of this data we believe that job training unless it leads somewhere—unless jobs are made available through a federally subsidized program—may result in the further deterioration of the spirit and the morale of the poor.

We believe many of the poor and unemployed, or underemployed, would prefer employment—even if their wages did not reach the poverty income level set for a family of four—to any form of welfare, if some form of income supplement were enacted.

On the other hand we are aware of the dangers of creating a class of low wage workers subsidized by the taxpayer for the benefit of private employers.

We urge that restrictions against this danger be written into H.R. 1. We also hope that the provisions of the bill which now seem punitive—or could be implemented in a punitive way—be drafted in such a manner as to be somewhat less humiliating or demeaning to those who have no alternative but to accept public help.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., February 14, 1972.

RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This letter presents our views on portions of H.R. 1, the Social Security Amendments of 1972.

Our comments on H.R. 1 are directed to the "Health Maintenance Organization" (HMO) provisions of the bill, and to proposed amendments relating to catastrophic insurance and professional standards review (PSRO).

The Kaiser Foundation Medical Care Program provides most of the health care services required by more than 2,350,000 members in the metropolitan areas of California, Portland, Oregon, and Vancouver, Washington, Cleveland, Ohio, Denver, Colorado and on the Islands of Oahu and Maui in Hawaii. Over 75,000 of our members are Medicare beneficiaries. As the largest group practice prepayment plan in the United States, our program represents a fundamentally different health care system which organizes direct medical and hospital services to meet the health care needs of a defined population comprised of its members.

This organized system and the utilization and cost data derived from it constitute a yardstick by which other health care delivery methods can be measured. Consumer acceptance of the program in the areas where it operates has been impressive. Membership is limited largely by the ability to finance facilities and to staff them with professional and management personnel.

HEALTH MAINTENANCE ORGANIZATION PROVISIONS

Your Committee recognized in 1967, in its report on H.R. 12080 (90th Congress), that group practice prepayment plans might offer one alternative to the growing problems of cost and lack of organization of health care services.

In 1970, in the Senate-approved version of H.R. 17550 (91st Congress), your Committee approved provisions creating a new HMO reimbursement option.

H.R. 1 once again contains provisions for an HMO option under Medicare, as well as provisions which would allow Medicaid payments to be made to HMO's. We support the HMO provisions of H.R. 1, as they were approved by the Ways and Means Committee and passed by the House of Representatives.

The major thrust of these new provisions represents in our view a constructive effort to seek new alternatives in a search for solutions to the problems of cost, quality, and accessibility of health care. The provisions are open-ended and this is appropriate. They do not dictate any one form of organization. For many years, we have said that the needs of the country can best be served by a pluralistic system for providing health care—and we continue to believe this is so. These provisions, now clearly endorsed by the administration, will, of course, offer encouragement to group practice prepayment plans such as ours; but they also offer the opportunity for the development of many new variants sharing only the common features mandated by H.R. 1.

There remain in the House-passed version of H.R. 1 a few items which we feel require some brief comment, without detracting at all from our support.

(1) Open Enrollment Periods (Section 1876(b)(7))

It is obviously desirable to require some form of open enrollment period, and necessary to avoid manipulation of enrollment for adverse selection. However. Section 1876(b)(7) of H.R. 1 (and the corresponding provision of H.R. 17550) are written in such a way that they could be construed to require an HMO to give absolute priority to Medicare beneficiaries over other members of the community up to 50% of its enrollment (Section 1876(b)(5)) within the limits of its capacity. This would be undesirable. For the benefit of the elderly and the entire community, a comprehensive health care organization should serve a genuine cross-section of the population in its service area. If Section 1876(b)(7) is interpreted to require enrollment of the elderly up to 50% of membership (no matter what percentage of the community they constitute), the high rate of utilization by the elderly would soon absorb an excessive proportion of the available capacity of the facilities and services of a community-based comprehensive health care organization. Furthermore, an unbalanced medical practice is less attractive to physicians.

We suggest that Section 1876(b)(7), page 442, line 1, should be amended to read:

"(7) Has an open enrollment period of at least every year under which, consistent with maintaining a membership that represents a cross-section of the population in the area served by the HMO, it accepts eligible persons (defined under subsection (d)) without underwriting restrictions in the order in which they apply for enrollment to the limit of its capacity (unless to do so would result in failure to meet the requirement of paragraph (5))."

(2) Evaluation of Performance

A variety of types of health care organizations are likely to elect reimbursement under the HMO option. For example, not only group practice prepayment plans, but individual practice prepayment plans such as the Foundation for Medical Care of San Joaquin County, are likely participants, in addition to other new forms of organization. We believe it would be highly valuable to measure the performance of various categories or types of health care organizations over the course of a number of years operation under the HMO option. Evaluations should also compare HMO's with other methods of providing health care.

We suggest that H.R. 1 be amended to add a new section, 1876(k), at page 446, between lines 18 and 19, to read as follows:

"(k) The Secretary shall periodically evaluate the performance of health maintenance organizations as compared to other sources of health care services and shall separately evaluate group practice prepayment plans, individual practice prepayment plans and other distinct categories of health maintenance organizations. Each such category shall be defined by the Secretary in regulations."

In this connection, while we strongly believe comparative evaluation is essential, we suggest that it will be necessary to proceed with a measure of caution. Because health care has been predominantly characterized by a distinct lack of organization, the tools of comparative analysis are not fully developed. Thus, for example, determinations related to whether health services are received "appropriately" (Section 1876(b)(6) will be difficult to make. And, we know of no standard under which "promptness" could be divorced from the overall concept of "appropriateness" of medical care (Section 1876(b)(6)).

It is of paramount importance that the rate basis for reimbursement of health maintenance organizations as provided in the House version of the bill be retained. Conversion to a cost basis would make this legislation meaningless. The House version avoids excessive retention by providing that any excess retention must be repaid unless it is used on behalf of Medicare beneficiaries either to provide additional benefits or to reduce the rates they pay to the health maintenance organization.

Consideration should be given to removing the limitation that health maintenance organizations can receive only 95% of the cost of covered services if such services were furnished by other than health maintenance organizations. The intent should be to compare various systems of delivering health care services for the purpose of determining the approach that can provide the best package of services for Medicare beneficiaries at the least cost. The answer to this question will be prejudiced if health maintenance organizations are compelled to start with a 5% competitive disadvantage.

Concluding our remarks with respect to the HMO provisions, Mr. Chairman, we fully appreciate the caution expressed by this Committee when it reported H.R. 17550 in 1970, that the interests of Medicare beneficiaries and the integrity of the trust funds be well protected. We would point out that the broad authority contained in Section 1876(i) to closely regulate the terms of and performance under contracts with health maintenance organizations seems well designed to achieve that objective. It is important that sufficient flexibility be left in the law to allow room for the innovation which is vitally necessary to the improvement of health care in this country. For the long run, that objective should be given a very high priority.

CATASTROPHIC ILLNESS INSURANCE

We understand that you plan to introduce your catastrophic illness insurance proposal as an amendment to H.R. 1. We appreciate your interest in protecting people against catastrophic health costs, but we have some concern with regard to the details of this proposal.

We believe that enactment of catastrophic illness insurance without provision for comprehensive basic coverage would bring additional inflationary pressures on health care costs and would tend to divert health care resources from primary care and noninstitutional care toward increased emphasis on institutional care and esoteric health services. We are also concerned about the impact of this proposal on low income workers because its deductible and co-insurance features would create significant barriers to medical care for such persons and would result in a subsidy to middle and upper income families which would be paid by poor families.

Catastrophic illness insurance also raises special probelms for direct-service, group practice prepayment plans such as the Kaiser-Permanente Medical Care Program. The members of a comprehensive plan that emphasizes preventive and outpatient services will receive less benefits from a mandatory, tax-supported catastrophic insurance program because they will use less hospitalization. Furthermore, a direct-service pain that provides comprehensive physicians' services has difficulty in integrating its coverage with a dollar deductible (such as $2,000). Such plans and their members would have to bear substantial administrative costs in order to price out physicians' services to determine whether or not members had met the $2,000 deductible. Furthermore, itemizing fees would recast such plans into the fee-for-service mold.

These problems can be met in a manner which results in equitable treatment for the members of such plans, encourages such plans and their providers to continue to implement cost savings characteristics, and produces substantial savings in administrative costs, by authorizing per capita payments to such plans on behalf of their members.

The following amendment which would authorize the Secretary to make per capita payments to such organizations is submitted for your consideration:

"Section 2004(a)(4). In the case of organizations which provide or arrange comprehensive health care services for a defined population, the Secretary shall authorize per capita payments to such organizations on behalf of eligible individuals enrolled in such organizations. A combined per capita payment may be made to such organizations for the services set forth in subsections 2004(a)(2) and 2004(a)(3), which are provided or arranged by such organizations. Such per capita payments shall equal the average payments made on behalf of eligible individuals residing in the general geographic area served by such an organization and shall be based upon the undertaking by such organizations to provide or arrange services to eligible individuals enrolled in such organizations and shall not be based upon specific services rendered to each eligible individual."

PROFESSIONAL STANDARDS REVIEW

We would like to comment briefly on the professional standards review provisions that we understand Senator Bennett will offer as an amendment to H.R. 1. We are pleased that this amendment has been modified to help assure more equitable treatment for physicians who are not engaged in traditional fee-for-service practice. However, we are still concerned that professional standards review organizations may, for various reasons, not apply their standards in a sound or objective manner to group practice prepayment plans.

Substantial costs resulting from duplication of functions could be avoided if the Secretary were authorized to waive review and control activities required under this amendment if he finds, on the basis of substantial evidence, that a health maintenance organization is effectively performing such review and control activities.

We believe that Sec. 1170 of the proposed amendment is in conflict with the health maintenance organization provisions of H.R. 1. Potentially this approach could establish professional standards review organizations as the sole insurers of health care in the geographical areas they serve. We believe that diverse approaches should be permitted and encouraged.

We would like to suggest one specific amendment to Sec. 1156(b)(1) which would help to assure equitable treatment of organized health care systems:

"(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment *and methods of organizing and delivering care*, are considered within the range of appropriate treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;"

We look forward to the results of your Committee's deliberations on H.R. 1.

Very truly yours,

KAISER FOUNDATION HEALTH PLAN, INC.,
By ROBERT J. ERICKSON, *Counsel.*

THE PHYSICIANS FORUM, INC.,
New York, N.Y., February 15, 1972.

Senator RUSSELL LONG,
Chairman, Senate Finance Committee, U.S. Senate Office Building, Washington, D.C.

DEAR SENATOR LONG AND DISTINGUISHED MEMBERS: The Physicians Forum, a national organization representing practicing physicians concerned with changing the system of distribution of medical care in the United States, regrets that it was not given the opportunity to present its views on HR-1 directly to your Committee. In lieu of this we wish to have these views incorporated in the record of the Committee's hearings.

We believe that any bill dealing with the health of the Nation must recognize the need for the federalization of welfare benefits, such benefits to provide

sufficient income for adequate food, clothing and shelter. The base of $2400 for a family of four is far below the subsistence level.

We welcome the inclusion of the disabled in the Medicare program. However, the inclusion and increase of coinsurance and deductible requirements in this program is retrogressive and can only serve to limit the availability of medical services to those who can least afford to pay for them.

Likewise, permitting the States to reduce the scope of care by eliminating outpatient drugs, eye glasses, etc., is indefensible in anything but monetary terms.

The need for long term care is not met by any of the bill's provisions and can only serve to worsen the predicament of the chronically ill.

Eliminating social services under medicare from extended care facilities is cruel and indefensible. Patients in such facilities need all the supportive services that can be provided in order to maintain them in a state of dignity. Anything less is degrading. Similarly, to allow nursing homes to function without a single registered nurse, even in rural areas, degenerates the term "nursing home". What kind of a place is a nursing home without a nurse?

And finally we view with great concern the possibility that your Committee is preparing to recommend catastrophic illness coverage as an addition to HR–1. Such plans are designed to protect middle to upper income level groups but deny protection to those who are poor.

We hope you will give serious heed to our objections to HR–1 as it currently stands, so that needed changes will be made that begin to provide adequate medical care to the poor and near-poor of this Nation.

Sincerely,

VICTOR W. SIDEL, M.D.,
Chairman.
PAUL W. SPEAR, M.D.,
Former Chairman.

STATEMENT OF GORDON R. MEYERHOFF, M.D., LONG ISLAND, N.Y.

A CAPSULE ON PEER REVIEW

The current basis of physicians selling peer review to physicians is that if we don't police ourselves government will police us. It is further pointed out that we can do it benignly to each other as an educational procedure. The review process thereby even improving our own ability to care for our patients.

In actual practice, all those already engaging in it acknowledge that it turns into a punitive process for those who do not measure up. That it has to be such is obvious if one approaches it with the view of a mature person.

For a mature person even enforced education is punitive. A mature person is always and continuously self-educating. It behooves society, for its overall, long-term benefit, to structure itself on the basis of mature relationships between its members. This serves both as instruction for the young in the mature ways and as soil in which maturity for its adults can thrive.

Much as good soil also allows for some weeds to grow, the freedom and liberty required for maturity will allow at times a lack of supervision for the immature and license for the delinquent and incompetent. Except for obvious gross unethical and incompetent practices, it is one of the costs that society *is gladly willing to pay for the overwhelming benefit* of an encouraging, free, maturity-cultivating interrelationship among its members. The alternative is the demoralizing imposition of a police state.

Such an insuring of professional freedom is the counterpart of what we sacredly guard in law as "innocent till proven guilty." There our structure of "due process" is a much more freedom preserving mechanism than a criminal catching device. There we have for centuries now recognized the far greater value to ourselves to have our formal structure of society geared to preserving freedom, which may at times have us *suffering being exposed* to criminals at large, than to subject ourselves continually to the crushing structure of a regimented, police state.

The current pinch of economics is tending to make us forget that we have also evolved this wisdom, for centuries now, insuring for professional freedom. We must always remind ourselves, and thereby exercise our own maturity, that the few dollars that freedom costs has, for centuries now, provided *the best buy any of us has ever made.*

PHARMACEUTICAL MANUFACTURERS ASSOCIATION,
Washington, D.C.

HON. RUSSELL B. LONG,
Chairman, Senate Finance Committee, U.S. Senate, Old Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The purpose of this letter is to outline the position of the Pharmaceutical Manufacturers Association on certain proposals currently pending before the Senate Finance Committee.

These proposals include S. 936, 92nd Congress, a bill introduced by Senator Joseph M. Montoya and other co-sponsors, and Amendment 824 to H. R. 1 introduced by Senator Abraham A. Ribicoff. As we understand it, the testimony and statements received by the Senate Finance Committee on these measures will be considered when H. R. 1 is discussed in Executive Session.

These measures are similar in most respects. They would extend Medicare benefit coverage to include out-of-hospital prescription drugs with a $1 co-payment requirement on each prescription to be paid by the patient. Both measures would establish a Federal Formulary Committee and both would authorize the use of a restrictive Federal Formulary coupled with a pricing mechanism based on maximum allowable costs for drugs listed by the Committee.

The Pharmaceutical Manufacturers Association is a voluntary, nonprofit trade association composed of some 115 companies engaged in the research, development and production of prescription medicines. Our member firms account for approximately 95% of these products made and sold in the United States.

The innovative efforts of our members are primarily responsible for making available the great number of new life-saving and life-sustaining medicines that have proven valuable to medicine during the past 30 years.

These companies have research laboratories, manufacturing plants and other facilities in nearly all of the 50 states and employ more than 130,000 workers, including a high percentage of scientists and researchers. They have an annual payroll of more than $1 billion and pay taxes of approximately $700 million annually to Federal, State and local governments.

Our member companies vary greatly in size. Many have annual sales of less than $200,000, while others have sales of $200 million or more. Approximately one-half of the PMA member companies would qualify as "small business" as that term is defined by the Small Business Administration.

Our Association appeared before the Senate Finance Committee in 1967 and 1970 to testify on proposals similar to the subject bills. In light of our two prior appearances, we felt it apropriate to submit our views by letter to you as Chairman, with copies to all Committee members. Our position today is essentially the same as spelled out in our earlier testimony, however, we believe the arguments we presented then, in support of our position, have even greater validity today.

Before restating our views on the pending legislation, we would like to outline our position on the philosophy which attends the use of the Social Security system to provide out-of-hospital drug benefits to Medicare beneficiaries. The pharmaceutical manufacturing industry does not oppose using the instrumentalities of the Federal Government or the Social Security system to make health care more broadly available. What we have always maintained is that whatever drug or other health benefits Congress decides are necessary for the well being of our aged population, should not bring in its wake, lesser quality or utility than are available to other segments of our population.

SCOPE OF THE PROBLEM AND POSSIBLE ALTERNATIVES

Recently published data reflects that the approach offered in the Montoya and Ribicoff proposals is not the most practical, economical or efficient method of helping the elderly meet necessary expenditures for prescription drugs. In our opinion, the approach in these proposals exceeds the requirements of the aged for assistance.

It is clear that the elderly, as a group, require a significantly larger number of prescription medications than any other age group. In 1971, preliminary Social Security Administration figures indicate that the aging spent $52.49 per capita on outpatient prescription drugs—nearly four times the rate for the under-65 group.

Nevertheless, it is also apparent that the great majority of the aging can manage the cost of their medications, because they are fortunate enough not to incur the major prescription expenses that are such a burden to a few.

The pharmaceutical industry believes that the rational, effective and administratively sound way to meet the prescription needs of the elderly is to construct a program that is keyed to the *medical* considerations involved. Doing that, in our judgment requires that the prescription drug system become an integral part of the medical benefits program, together with *its* deductible features.

That would mean adding the prescription benefit program to the overall scheme, in a manner that makes clear the contextual relationship that in fact exists between medical and pharmaceutical services in every well-established major medical plan now offered in the private sector. In short, any new Medicare prescription drug coverage benefit should be part of the overall program in a fully integrated sense.

We know that every experienced nation has found it wise to require all but the medically indigent to pay something toward the cost of their prescription drugs, and we believe that a flat payment shoud be employed in any American plan. As for record-keeping, we would observe that the Medicare Part B system, now in its seventh year of full operation, has worked reasonably well; we can see no reason why the addition of pharmaceutical benefits, handled by the nation's 55,000 pharmacies would not also work well, with sufficient lead time.

An additional approach to minimizing costs is that of utilization review combined with better sources of information for prescribers on comparative drug costs. In that way cost, as well as quality, may enter into the physician's choice of medication. Some modest utilization review mechanism would seem desirable to apply constraints to over-use, since there might be a tendency to increase usage because a partial reimbursement plan had become available.

THE LIMITATION OF A NATIONAL FORMULARY

Proponents of a national formulary have placed great reliance on its alleged ability to solve problems associated with the reimbursement of prescribed drugs, rational drug use and governmental economies in drug programs. What they overlook is the fact that the operation of a hospital formulary is very unlike any proposed national out-patient formulary. They fail to recognize that hospital pharmacy stocks are selected by a committee of physicians and pharmacists who practice in that hospital; and that the hospital formu'ary committee, of its own personal knowledge, is aware of the preferences of the hospital physicians and of the quality differences among the so-called chemical equivalents. The committee also knows what products are available, the reliability of their sources and what products are stocked in the hospital pharmacy.

Importantly the hospital formulary reflects the opinions and desires of the prescribing doctors themselves. It considers price, but it does not do so at the expense of quality. A final major distinction is the fact that under a hospital formulary, physicians are free to veto the purchase of drugs manufactured by firms of uncertain or unknown reputation and they may, whenever their judgment dictates, prescribe non-formulary products.

By comparison, the proposed national formulary would give the individual doctor no effective voice in the decision to exclude certain medications. Similarly it would not give him the opportuntiy to prescribe non-formulary drugs without imposing an economic penalty on the patient whom the program is supposed to help. In brief it restricts prescribing to medicines listed by the formulary committee and perpetuates the myth that the lower priced product is equivalent in quali'y and activity to all others on the market. Such a practice, clearly would tend to lower standards, penalizing innovation, and rewarding the less conscientious producers.

Recent critical review of governmental use of out-of-hospital formularies indicates that they have been tried and found wanting in a number of states. They are simply not producing the results that their supporters thought they would. Newly issued HEW medicaid guidelines for state administrators of Title XIX programs now cautior against the use of highly restrictive formularies.

Studies comparing the results of state drug welfare programs utilising restricting formularies, open formularies, and no formularies suggest that the most successful and economical programs are those without restrictive formularies.

They also show that the ratio of administrative costs to total medical care cost under Medicaid is significantly lower for the nonrestrictive states.

A similar conclusion emerges from a study of foreign programs. Italy, one of the member nations of the Common Market, has the most rigid system of price control for the reimbursement of drugs under social security programs. Nonetheless, it also has the highest drug prices. On the other hand, Germany, a Common Market country without control on manufacturers' prices, but with an effective system of utilization review, has the lowest prices.

PRICE CONTROLS—A DETRIMENT TO COMPETITION

The Montoya and Ribicoff proposals would establish a method of reimbursement for dispensing pharmacists based on a "maximum allowable cost" for each drug listed in the formulary. This cost would be the "acquisition cost" determined by the Committee plus a reasonable dispensing fee, or the actual, usual or customary charge at which the dispenser sells the product. The formulary committee, it should be noted, would also list the maximum allowable cost for given strengths, quantities and dosage forms at which the listed drugs are generally available for sale to dispensing pharmacists.

As a consequence of this sweeping grant of economic power to a small group of appointed "authorities," a price control system would be established over the entire drug industry—manufacturers, wholesalers, and retailers. Each would be faced with fixed price ceilings and a system that would inhibit prompt and flexible price adjustments to meet changing material, supply, labor or other costs.

But even apart from the manner in which this drastic price control system would be imposed on the products of this industry, the Montoya and Ribicoff proposals would require the pharmaceutical industry to accept administrative decisions—without any workable right to administrative review or hearings. It would be bad enough if these were temporary controls, but the proposals in question call for a permanent system of price fixing. We believe such action is without precedent in this country. Whatever price controls have been established have been in wartime or extreme national circumstances. But even then they were only for temporary periods.

MEDICAL PRACTICE LIMITED BY THE FORMULARY

To continue to provide a high level of medical care, the physician must have the necessary freedom of choice in making those judgments which his training and experience tell him are best for his patient. This includes drug selection.

We support the proposition that physicians should seriously consider price in selecting products as well as any other medically indicated procedure, device, service or treatment. But physicians must remain free to make that decision without substantial Government interference. If the spectrum of drugs available to physicians can be arbitrarily limited by a federal committee, then every medical procedure, device, service or treatment is subject to the same limitations.

It is basically self-defeating to restrict the physician's choice of drugs. When price considerations are applied vigorously, many first and second choice drugs are not available for patient treatment, and medical care is prolonged unnecessary because of the use of less preferred and less effective drugs.

THE FALLACY OF THE SO-CALLED GENERIC EQUIVALENCE ASSUMPTION

The center piece of the Montoya-Ribicoff proposals is an assumption—and it is no more than an assumption—that drugs with the same generic name, which meet USP and NF standards, are chemically and therapeutically equivalent. There is no support in science for this belief, nor have we found responsible authority in Government or industry making such claims.

Studies by recognized experts have established that chemical equivalency does not equate with therapeutic equivalency. They also show, in nearly all the products examined to date, that variations in formulations produce important differences in biological activity. The FDA, the Academy of Pharmaceutical Sciences of the American Pharmaceutical Association, the pharmaceutical industry, the National Academy of Sciences and many independent investigators have validated differences in drug products of the same generic name made by different manufacturers.

No one today, no not even the FDA, can hold out any assurance of the equivalence of the same-named generic products. Nor does it appear that anyone will be able to do so in the foreseeable future.

ADMINISTRATIVE COSTS

Unquestionably, the Federal Government has a legitimate interest in holding down health care costs for Medicare, or any other federally financed program. No one would deny that responsibility. However, as we have attempted to develop in this letter, whatever economies can be effected should not be achieved at the expense of the aged by skimping on the quality of their health care services. This is not only false economy, but bad health care as well.

We believe that there are suitable alternatives to S. 936, and Amendment 824; ways by which federally assisted programs can be structured to reduce costs without reducing the quality of health care. Both of these proposals, since they adopt the same approach, inevitably involve high administrative costs because so many claims would be involved. Even with a nationwide network of electronic computer equipment, there would be tremendous administrative problems in dealing with the large number of individual bills and the more than 55,000 pharmacies.

Recalling the dispute that occurred in the 91st Congress over the actual administrative costs of the National Formulary and other attendant features, it would seem clear that additional information is still badly needed. We do not believe that existing data has sufficiently identified administrative costs, including those related to the policing of restrictions requiring physicians and pharmacists to suppress their professional judgments and select products solely on the basis of cost.

In conclusion, therefore, the PMA opposes S. 936 and Amendment 824 because:

They would reduce the quality of medical care for Medicare beneficiaries;

They would interfere with the physicians' right to choose what in their judgment are the best medications for their patients;

There are suitable alternatives which are more practical, economical and efficient;

The heartstone of these proposals, the assumption of generic equivalence, cannot be scientifically supported now or in the foreseeable future; and lastly

There is no sound data base establishing the administrative and other costs of the proposed program.

It would be appreciated if you would include this letter in the record of the hearings on H.R. 1.

Sincerely yours,

C. JOSEPH STETLER.

STATEMENT OF KEITH KNUDSON, PRESIDENT, INTERNATIONAL SOCIETY OF CLINICAL LABORATORY TECHNOLOGISTS

My name is Keith Knudson, RMT, Supervisor of Clinical Laboratories, Hiawatha Community Hospital, Hiawatha, Kansas. I am President of the International Society of Clinical Laboratory Technologists, a professional Society of some 3500 Medical Laboratory personnel staffing Clinical Laboratories throughout the United States. Our members work in Government Laboratories, Private Hospitals, and Independent Laboratories. As Medical Laboratory Technologists and Technicians, our membership has a great interest in upgrading the services provided by Clinical Laboratories throughout the United States, and we are particularly concerned with any legislation which will affect the operation of such Laboratories.

With the enactment of Medicare legislation in 1966, the Federal Government has become involved in prescribing regulations for the qualifications of Laboratory personnel as well as the Laboratories. The Clinical Laboratory Improvement Act regulating Laboratories in Interstate Commerce enacted in 1968, also projects the Federal Government into the Laboratory field. After Medicare was passed in 1966, our Society felt that there were many inequities in the original regulations. Unfortunately there were no available statistics, and experience on which to assess these inequities. There now has been adequate opportunity to gain much needed experience in determining what the short-comings of the existing

regulations have been, and we now have the opportunity of implementing the Medicare program with revised regulations that will be of benefit to the general public.

Probably more important than the inequities in the regulations has been the record of inequitable representation and repeated instances of prejudicial conduct which can be documented. It is to this matter that we wish to address ourselves. Section 1123. (a) HR 1, is of special concern in view of the experience and history of the past six years—we refer to "Program for Determining Qualifications for Certain Health Care Personnel". Line 17 through 21 of the bill states "The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) . . . ."

We will cite just two recent incidents which point out our concern over this language. Our Society is a member of the Intersociety Committee for Health Laboratory Services which is composed of organizations which represent all groups involved in the Clinical Laboratory Service. Our Society is also a member of the Association of Schools of the Allied Health Professions. We refer to these memberships because we wish to emphasize that our organization is known to all of the professional organizations and government agencies in the laboratory field.

In June of 1971, the Secretary of HEW submitted a report on "Licensure and Related Health Personnel Credentialling" as required under Section 799A, Public Law 91–519. The report was prepared by the Secretary's Licensure Report Task Force, Mr. Ronald J. Wylie, Chairman. Our Society was not accorded an opportunity to be present at a meeting called by Mr. Wylie to hear discussions on this matter. As a result, we could not provide input. Therefore, in our opinion, the report is not based upon complete information reflecting all views.

Once again in September of 1971, a conference on credentialling was conducted by the Association of Schools of Allied Health Professions under a United States Government grant. Once again our Society along with such other groups as the Clinical Chemists, the Microbiologists, and the Bioanalysts, were not given an opportunity to participate. It is, therefore, with a real sense of deep concern that we must point out the inherent dangers in the language "in consultation with appropriate health organizations and State Health and Licensure Agencies." Who is to select the "appropriate health organizations?"

Since the inception of our Society in 1962, we have been a leading proponent for career mobility and proficiency examinations. We believe we were the first Professional Society in the field to advocate levels of laboratory personnel such as Technologists, Technicians, Directors, etc. We have continually championed the proposals that competency of performance should be the essential criteria for Medical Laboratory personnel rather than self serving private organizational certification. This policy has been met with determined objections of organized medicine, specifically the American Society of Clinical Pathologists, and the American Medical Association. Although it is gratifying to note that many of the policies which our Society initially proposed as long as 8 to 10 years ago, are now being adopted by many in the field, we still feel there is a very grave danger that the same obstructionist groups which have created sky-rocketing costs are being placed in positions of authority. They are instrumental in making recommendations for implementation of laboratory services under governmental programs, and are predominant on all advisory boards.

It is, therefore, with a deep sense of urgency that we ask the Congress of the United States to enact amendments to the Social Security Act which insure that there will be a system of review based on equitability, justice, and impartiality. We are aware that a peer review system is being suggested by other organizations, and we heartily endorse such a concept.

Rest assured the primary concern of our Society is to be of greatest service to the Government, to the field of medicine, to the patient public, to the Laboratory Community, as well as to our members. We believe the record of the past six years will attest to the fact that continuing the policy of having Physician and Hospital dominated Advisory Boards and Commissions will not only perpetuate the inequities that now exist, but will insure the continuation of high cost health care, and that not every American will have the benefit of adequate health services.

TESTIMONY OF JOAN FOLEY, REPRESENTING THE COMMITTEE ON INCOME MAINTENANCE

I am Joan Foley. I speak here today for the Committee on Income Maintenance. We are a Committee of American citizens from all walks of life who are interested in the welfare of the American people as a whole and especially in the present system of welfare which was created over 30 years ago as a temporary measure and has not proven successful.

Our Committee has been functioning for the last four years, has held three conferences, and has been instrumental in having numerous bills introduced in the House by Congressman William Fitts Ryan and Congressman Leonard Farbstein, to wit: H.R. 13025, H.R. 586, H.R. 1634, H.R. 14773, and H.R. 4801.

The provisions which we feel must be included in a meaningful income maintenance bill have been sent to all members of the House, the Senate, and to the Governors of every state and have received very favorable reactions from all. Based on the favorable support we have received, not only from our legislators but also from the public as a whole, our Committee has adopted the following resolutions.

RESOLUTION

We believe that the time has come for this nation to end poverty, and realizing that the present, inhumane welfare system has been a tragic failure for millions of families, our Committee has resolved:

1. Congress should enact during the present term a meaningful income maintenance law.
2. Such a law should include the following provisions:

(*a*) Maintenance payments of at least $4,000 a year for a family of four, payment of $2,500 for single persons as well as families, including senior citizens.

(*b*) Members of a family of an individual should be able to earn up to $8,000 a year on a sliding scale and not forfeit maintenance payments.

(*c*) Job requirement provisions should not be used to interfere with the bargaining efforts of a labor organization nor should they undercut the prevailing wage structure in a particular type of employment, nor should they undercut minimum wage standards.

(*d*) Under no circumstances should a mother be required to be separated from her young children or face the prospect of losing maintenance payments.

(*e*) Income maintenance legislation should be linked to a good job-training program and to a massive program to provide day care centers.

(*f*) In the event that a person cannot secure employment in the private sector of the economy, the federal government should be the "employer of last resort".

No more important problem confronts Congress this year than the reform of the destructive welfare system. The Committee on Income Maintenance urges that income legislation be the first order of business before the current Congress.

Very truly yours,

MRS. BELLA ALTSHULER,
Chairman.
MR. FREDERICK NORTON,
Vice-Chairman.

THE COUNCIL

RES. NO. 644, NOVEMBER 16, 1971

Resolution Calling Upon the Congress to Enact a Meaningful Income Maintenance Program During the Current Term

By Mr. Weiss, Mrs. Greitzer and Messrs. Silverman, Thompson, Friedland, Katzman, DiBlasi, Clingan, Sadowsky, Haber, Postel, Burden, Sharison and Mrs. Ryan—

Whereas, The present welfare system has failed in its original purpose of attempting to maintain an adequate standard of living for the unemployed and their families, and is utterly unable to provide a decent standard of living for the poor and the chronically unemployed; and

Whereas, It is inhumane, frequently forcing the separation of families and subjecting recipients to invasions of privacy and numerous other indignities; and

Whereas, It does not address the problems of the underemployed, the working poor and the near poor and fails to confront the overriding question of poverty itself; and

Whereas, The continued existence of poverty in the United States is morally repugnant, incompatible with democratic ideals and unnecessary given America's great wealth and resources: Now, therefore, be it

Resolved, That the Council of The City of New York calls upon the Congress of the United States to commit itself positively to ending poverty in the United States by enacting a meaningful income maintenance program during the current term; and be it further

Resolved, That such a program shall include the following provisions:

1. An income floor of at least $4,000 per year for each family of four;

2. Payment for single persons as well as families;

3. Incentive pay on a sliding scale permitting a family of four to work without losing benefits under this program, until the total family income reaches $8,000 per year;

4. Classification of all benefits under this program and the conformance, with due process, of all administrative procedures relating to benefits;

5. No job requirements should (a) interfere with the rights or bargaining position of any labor organization or (b) undercut any prevailing wage rate in the particular industry or occupation;

6. Any job requirement should guarantee each beneficiary any rights granted to or held by any other worker in the particular industry or occupation, including, but not limited to, social security, unemployment compensation, union representation and collective bargaining, severance pay and seniority;

7. No job requiremet should force the separation of a mother from her young children by threatening her with the loss of maintenance payments; and be it further

Resolved, That any income maintenance legislation be linked to:

1. Adoption as public policy the theory of the Federal government as the "employer of last resort," guaranteeing the right to a meaningful and productive job to any individual willing and able to work who cannot secure such employment in the private sector;

2. The provision of a massive and free program of vocational training and day care centers for all those desiring these services; and be it further

Resolved, That copies of this resolution be transmitted immediately to the President of the United States and the officers, floor leaders, appropriate committee chairmen and New York City members of each house of the Congress.

Referred to the Committee on Finance.

KEMPER INSURANCE,
1511 K STREET NW.,
Washington, D.C.

DEAR SENATE FINANCE COMMITTEE MEMBER: We do not believe S. 1376 is an appropriate compromise between those interests which favor nationalization of the health insurance industry in America and those who favor minimal change.

In our opinion S. 1376 has two defects in its present form. S. 1376 does not allow for existing health financing systems. First, it finances catastrophic health care for everyone, whether or not a person can afford to purchase the coverage in existing private markets. The situation with regard to catastrophic health care is different from the situation which existed when Medicare was enacted. At that time, coverage for illness was difficult to obtain if one was elderly, whether a person could afford coverage or not. However, today, anyone who can afford catastrophic health and accident coverage, can purchase it.

The second defect is that S. 1376 does not allow for existing casualty insurance systems. A principle which has been central to America's economic life is that those who engage in an activity should shoulder the costs of that activity—if they can afford to do so. S. 1376 would have the government and taxpayers pay for all illnesses and injuries, regardless of source. Where guaranteed medical benefits already exist for illnesses and accidents arising from distinct activities, those benefits should pay medical bills. Otherwise, the costs of these

activities are obscured and the social and economic pressures for a safe workplace and highway safety, for example, would quickly dissipate.

We hope that whatever legislation you support, you would seriously consider these comments.

Cordially,

STEVEN H. LESNIK,
Washington Manager, Corporate Relations.

COMMENTS BY KEMPER INSURANCE ON S. 1376—AMENDMENT TO H.R. 1

1. Catastrophic Illness Insurance is the first step in total nationalization of the health insurance field:

(*a*) It contains no controls to prevent reduction of hospitalization and medical care deductibles in ensuing years.

(*b*) Will superimpose a government operated and financed mechanism on existing private programs.

(*c*) Government should provide insurance only (a) if no coverage is available in private market or (b) to those people who either cannot afford private insurance or do not have access to it.

2. Further fragmentation of health care delivery and financing systems:

(*a*) Will create duplicative and conflicting administrative systems between the private insurance industry and Social Security System. For example, private insurance would administer basic benefits system, Social Security would administer catastrophic system with a good possibility of the private carriers also reimbursing the deductibles and co-insurance amounts. This would create a maze of red tape for hospitals, doctors and administrators.

(*b*) Diverts attention from a national goal of a coordinated comprehensive approach to ambulatory and preventive care through an integrated system of intensive manpower development, community health planning with coordinated private-government health care financing.

(*c*) Will remove economic restraints on excessive health care. This will compound the problem of rising medical and hospitalization costs due to newly created demands on specialized high cost services.

3. Conflicts with casualty insurance systems:

(*a*) Role of insurers as providers of total trauma care management for automobile insurance and workmen's compensation system cease to exist to its present extent.

(*b*) Wou'd end a set of financing systems organized that allocate the costs of injuries and illnesses arising from specialized activities to those activities—such as industrial accidents and illness through the workmen's compensation system, and auto injuries through auto insurance.

(*c*) The American Mutual Insurance Alliance Automobile Guaranteed No-Fault Protection Plan with $50,000 no-fault medical care coverage would provide adequate medical coverage for 99.9% of all injured in auto accidents. Also, in nearly all states full medical benefits are provided by workmen's compensation. Catastrophic Illness Amendment doesn't contemplate payment of these benefits.

NATIONAL HEALTH INSURANCE

I. Two basic issues:

A. Improving healthcare in America.

B. Financing healthcare:

1. Government should provide financing only for the poor and medically indigent. Others should pay their own way.

2. Private sector is the most efficient and economical vehicle for financing.

3. Providers of care should be encouraged to operate economically.

4. The financing of medical care for injuries arising out of special circumstances should be handled separately.

II. The importance of improving the organization and capacity of the healthcare delivery system before restructuring the financing mechanism:

A. Avoid added inflation.

B. Prevent further mal-distribution.

C. Avert disillusionment of public.

D. Forestall another Medicare fiasco.

III. The importance of phasing-in increased benefits:

A. Facilitate effective management of the program.

B. Minimize the potential of encountering the pitfalls of II A, B, C and D.
C. Make improvements available to the public as soon as feasible.
D. Effect a *gradual* increase in taxes and cost to employers.
IV. Why workmen's compensation and automobile insurance should be primary:
A. Medical costs of industrial injuries should be borne by the industrial community and not by the taxpayers.
B. Workmen's compensation is an efficient financing mechanism.
C. Almost all states have full medical coverage for employees injured on the job.
D. The federal government is now studying workmen's compensation. We should await findings and recommendations before integrating WC into a national health insurance program.
E. Present approach maintains pressure and stimulates incentive for providing safe working conditions for employees and for safe driving by motorists.
F. Costs of automobile accident injuries should be borne by those who derive the primary benefits of the travel which causes them.
G. It would be socially undesirable to "bury" the horrendous costs of automobile accidents. These should be kept in the forefront.
H. If automobile and WD were made excess, states would lose substantial income now received from premium taxes.
I. If automobile and WC were made excess, considerable new competition for health insurance could be expected. This would throw the health insurance market into a turmoil.
J. Keeping WC and automobile insurance separate reduces the cost of national health insurance.
V. Weaknesses of catastrophic programs:
A. Increase demands on delivery system without improving it.
B. Further fragmentation of the delivery system.
C. Likelihood that the benefits of the program and, therefore, the costs will rapidly increase as has been the case with social security.
VI. Disadvantages of federal regulation:
A. Unnecessary replacement of state regulation which is established and working well.
B. If federal government regulates at all, it should only be over that portion utilizing public funds. Even there, state authorities should administer using federal standards.
C. Unusually and unnecessarily expensive to duplicate state regulatory system.
D. Stifling effect of federal regulation on competition.

JOINT COMMITTEE ON ATOMIC ENERGY,
Washington, D.C.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee, New Senate Office Building, Washington, D.C.

DEAR SENATOR: I thought I ought to call to your attention the enclosed correspondence which I received from Wade C. Johnson, Executive Director of the Hospital Association of Rhode Island, in opposition to the proposed Bennett amendment to H.R. 1.

I would appreciate it very much if you could make this letter a part of your record on this bill and call it to the attention of the other Committee members.

With best wishes, I am,
Sincerely yours,

JOHN O. PASTORE, *U.S. Senator.*

HOSPITAL ASSOCIATION OF RHODE ISLAND,
Providence, R.I.

Hon. JOHN O. PASTORE,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR PASTORE: Senator Wallace Bennett has proposed an amendment to H.R. 1—Social Security Amendments for 1971. Senator Bennett's amendment, as we understand it, would take the responsibility for health care quality control and utilization review out of the hospital and its medical staff and place it, improperly, with the county medical society. In November, 1970, we wrote to you expressing our concerns with and opposition to Senator Bennett's amendment.

It is our understanding that the Senate Finance Committee, which is presently considering H.R. 1 (about which we wrote you in February), has tentatively voted in favor of Senator Bennett's amendment. The final vote, within the Committee, on the entire piece of legislation is expected within the new few weeks.

We continue to be concerned about the Bennett amendment which would establish Professional Standards Review Organization (PSRO) outside of the hospital to monitor the quality of care and utilization of resources within the hospital.

Placing quality and utilization review in the hands of local medical societies bypasses the medical staffs of hospitals. Local medical societies have no experience in the delivery of health care and only a team approach involving hospital trustees, medical personnel, administrators and trustees can achieve the desired results.

In this regard it is important to note that the hospital medical staff concept of utilization review has as its objective optimal utilization, not overutilization and not underutilization, of hospital facilities and resources.

Thus it cannot be separated from a complete *medical audit* of the care the patient receives, which is a medical staff function by *peer review*. It simultaneously evaluates utilization of facilities and services and identifies problem areas requiring planning for and services based on patient needs and use. From it evolves our continuing education program for the medical staff, including the family practitioner in the community, which has the goal of continually improving patient care. Utilization review also acts as a management tool for evaluating policy as it affects patient care.

In addition, the amendment raises serious questions with regard to the legal responsibility which boards of trustees of hospitals have for patient care. Removal of legal liability for actions taken by PSROs would simply mean the PSRO's norms would likely become federal standards for malpractice. Such standards or norms could become absolute rather than guides and, thus inhibit innovation and change in patterns of patient care.

Even the courts have recognized that the governing authority of the individual institution has ultimate responsibility for patient care—responsibility which cannot be delegated to any *outside agent*.

All hospitals in Rhode Island have established utilization review committees to help assure that costly hospital beds are used only by those patients who could not be treated adequately elsewhere. Utilization review enables a committee of physicians to examine the admission and length of stay of patients and thereby oversees the utilization of hospital beds and services.

The voluntary, short-term general hospitals in Rhode Island participate in PAS (Professional Activities Studies), a computerized system of summarizing all medical records of utilization review and quality appraisal.

According to the latest statistics available, for the twelve-month period ending June 30, 1971, Rhode Island's short-term general hospitals collectively had reduced the average length of hospitalization by one-tenth day, when compared with the national average for hospitals of comparable size.

In a two one-half year period, from January 1, 1969, to June 30, 1971, hospitals in the state had reduced the average length of stay by one-half day, proving that the hospitals had taken enormous strides in improving their utilization through internal attention to length of stay.

Various forms of utilization review in Rhode Island's hospitals are now shortening hospital stays throughout the state and saving money for individual patients and third-party payers. A net reduction of one-half day in overall hospital stays in the state has meant a potential savings of nearly $8 million to health care purchasers.

A check by the Hospital Association with those hospitals in the state who have exhibited the greatest reduction in length of say during the last two and one-half years has shown that stepped-up and more extensive efforts have been taken by utilization review committees in those hospitals.

It is our opinion that the fine work undertaken voluntarily by the hospitals in Rhode Island regarding quality control and utilization review will be minimized if PRSO's are mandated by law.

We urge that PSRO's be permitted as experiments in those locales where such a system might prove effective. In this way the PSRO concept can be tested as to its viability and effectiveness.

As we indicated during our recent visit to Washington, it is the very strong opinion of the Hospital Association of Rhode Island and its member hospitals that passage of the Bennett amendment as it is presently written would be deleterious to the delivery of health care to all Rhode Islanders. We understand that the Rhode Island Medical Society is also opposed to the Bennett amendment.

Sincerely,

WADE C. JOHNSON, *Executive Director.*

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

Hon. RUSSELL B. LONG,
Senate Finance Committee
Senate Office Building
Washington, D.C.

DEAR SENATORS I have received the enclosed letter from Mr. Wilbur J. Schmidt, Secretary of the Wisconsin Department of Health and Social Services, regarding certain provisions of Section 507 of H.R. 1. I would be most appreciative if you would arrange to have Mr. Schmidt's letter inserted in the official hearing record of H.R. 1.

Thank you for your courtesy.

Sincerely yours,

GAYLORD NELSON, *U.S. Senator.*

STATE OF WISCONSIN,
DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
Madison, Wis.

Hon. GAYLORD A. NELSON,
U.S. Senate,
Washington, D.C.

DEAR SENATOR NELSON: We have recently received a copy of the Proposed Amendments to H.R. 1 in the Senate and wish to share with you our concerns and recommendations on several areas covered by the amendments.

We have reviewed the summary of Proposed Amendments to Section 507 of H.R. 1 in the Senate and find it quite comprehensive. There are, however, several areas that we think should be modified in order to make the transfer of county and state employees to the federal system more equitable.

One area that concerns us is that separation of income maintenance and social services has resulted in the arbitrary assignment of some income maintenance staff to service functions. Some of the former income maintenance staff now in the social service area prefer to return to income maintenance functions and will do so when income maintenance positions become available. We recommend that *all* public welfare staff, not just those performing the income maintenance function, be permitted to transfer to HEW with the special considerations provided in the bill. Otherwise, some people with a strong income maintenance interest and competence will be artificially excluded. Expanding the coverage to all public welfare staff will not likely burden HEW, because many staff will prefer to remain in local or state service or to perform social service functions.

We are concerned, too, because the proposed amendments state that ". . . a department or agency of the United States may appoint . . ." It would be far more desirable to say ". . . a department or agency of the United States must offer and appoint to perform its authorized functions under this act any individual . . ." It appears in the proposed amendments that the federal government could choose not to offer employment to some or all income maintenance staff. If that should happen income maintenance employees would find themselves unemployed at the expiration of the ninety day period. The federal government should be required to offer positions to all income maintenance staff and appoint those who wish to be employed by the new program.

Another area, credit for prior service, creates a special problem for state supervised, county administered programs. The problem is ". . . credit shall be given for service with the state or political subdivision of the state by which the appointee was employed on the last day of his employment described in paragraph (1)(B) prior to his appointment under paragraph (1). We believe that employees should be given credit for their total uninterrupted service as it is

not unusual for county and state employees to transfer from one county to another or move from state to county and county to state employment. These employees are now covered under a common retirement system and all counties are under the same merit rule. We believe, then, that it would be far more equitable to recognize their total uninterrupted service in a state's public welfare program or even, ideally, within public welfare programs anywhere in the country.

The other provisions for the transfer of state and county employees appear comprehensive and fair. If you can assist in bringing about the changes in the areas we have specifically stated you will help to provide fair and equitable treatment of Wisconsin residents currently employed by Wisconsin public welfare agencies and also help insure the success of the federal income maintenance system.

Sincerely,

WILBUR J. SCHMIDT, *Secretary.*

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