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SOCIAL SECURITY AMENDMENTS OF 1967

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETIETH CONGRESS
FIRST SESSION
ON

H.R. 12080

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

PART 3

SEPTEMBER 20, 21, 22, AND 26, 1967

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SOCIAL SECURITY AMENDMENTS OF 1967

WEDNESDAY, SEPTEMBER 20, 1967

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

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

Present: Senators Long, Gore, McCarthy, Hartke, Metcalf, Williams, Bennett, and Curtis.

The CHAIRMAN. The hearing will come to order.

On yesterday we had a group of people speaking for welfare persons who are not working and do not want to work, who came here and refused to obey the law, and eventually they left.

I must say that, as chairman of this committee, my reaction to those kinds of people is that if they can find time to march the streets and if they can find time to picket congressional committees, and if they can find time to sit all day in committee hearings when they had been heard, and deny other people their right to be heard—people who have that much time available to them should have time to do some work. I think they very much hurt the case for those who would like to draw welfare payments and decline to work, all at the same time.

It seems to me folks like that have plenty of time to work. In the future we may find it necessary to decline to permit certain people to be in this committee room, just as today we are not inviting those people back. If we hear them before this committee again, it will be after everybody else has been heard so they can just sit here until midnight if they want to.

It is the first time, may I say, since I have been a member of this committee that we have had to have any problem of that sort with people of that kind. I hope that that kind of event will not plague this committee or any other in the future.

We are pleased to have with us today the Honorable Phillip Burton, U.S. Representative from the Fifth District of California.

STATEMENT OF HON. PHILLIP BURTON, A U.S. REPRESENTATIVE IN CONGRESS FROM THE FIFTH CONGRESSIONAL DISTRICT OF CALIFORNIA

Mr. BURTON. Thank you, Mr. Chairman.

I was not here yesterday, so I am in no position to make any observation with reference to that situation but I would like to state that it is my own personal view that the chairman of this committee is responsible for helping more poor people receive some measure of economic security than any Member of either this body or the other body. Without the efforts of the distinguished chairman of this committee, a great many of the aged and handicapped and poor families in my own State would be a good deal worse off but for the continuing and, in many instances, magnificent efforts of the distinguished Senator from Louisiana.

The CHAIRMAN. I thank you very much, Mr. Burton.

May I say that in years gone by I have been the principal sponsor of a number of amendments to increase welfare payments both for mothers and dependent children and for the aged, so much so, that the late George McLain, who came from your State, brought me a little plaque to put on my mantel which said "Friend of the Poor," some such thing as that. I rather cherish that because I did regard myself as being an advocate of those who, through no fault of their own, need some help from their Government.

But I have some doubt about it when I see people who can find time to do a lot of things that are not right, a lot of things that are improper, and cannot find time to do something proper such as help themselves insofar as it is reasonably within their capabilities to do so.

I appreciate your situation, Congressman Burton. You represent a very great State, and I appreciate your interest in this matter.

Mr. BURTON. Thank you, Mr. Chairman.

I will attempt to quickly and specifically indicate some recommendations I have for the committee's consideration.

First, let me state that I would hope—as a minimum—the committee would support the administration's recommendation with reference to increases in the taxable wage base, the percentage of taxes applied to that base, and the minimum and other benefit amounts to social security beneficiaries including the extension of medicare to the disabled OASDI beneficiaries.

Secondly, I would like to urge the committee to retain the administration proposal and the House action making the aid to families with dependent children where the father is unemployed a permanent provision of the law.

There is one aspect of the House action I would hope would be reversed by the Senate, and that is the proposed January 1, 1967 freeze. This action most unfairly discriminates against the growth States such as California. Its provision will create, in my view, unmanageable administrative problems as well as denying, on the basis of an irrelevant yardstick, assistance to those who need it.

Third, I would hope that the Senate would enact a provision, apart from the basic matching program for child aid, that would permit a 50 percent open-end matching to children living under foster care in a foster home or child-care institution.

Fourth, I support the administration proposal with reference to permitting AFDC families to retain a portion of their earned income.

Fifth, I would hope that the Byrnes-Prouty proposals which blanketed in older persons without adequate wage credits—be reduced from the age of 72 to 70 and this amount be paid on an actuarial basis out of the general fund rather than the trust fund.

There is one point that I believe to be most important. That is that a cost-of-living factor be included in the basic law of the Social Security Act even if this would mean for purposes of the first year there would be a less apparent real percentage benefit increase than otherwise would be permitted. I would recommend that all social security cost-of-living increments be borne out of the general fund rather than the trust fund.

As the chairman is aware and the members of the committee are aware, the public assistance recipients received, by and large, no consideration in the House bill. I assume this in no small measure is a tribute to this committee and to the Senate in that it was assumed that this oversight in terms of the public assisance recipients would be taken care of on this side.

I would hope that the aged, disabled, and blind public assistance recipients would be given the same increase in permitted earnings as is contemplated for social security beneficiaries. This is at the rate, as I understand it, of an increment of some $15 a month.

I would hope that the disabled public assistance recipients, who currently are not permitted to retain any earnings, be permitted the same earnings rights as blind public assistance recipients. I would hope that these earning provisions be made mandatory so the States must permit these earnings, rather than permissive as is the case today.

There is another important provision of the law that was established a few years ago permitting under certain circumstances blind and disabled persons whose assets exceeded that which otherwise would permit them to be eligible for public assistance. This provision permits each State for a period of 3 years to have a special training program aimed at helping these people become self-supporting. I would urge that the 3-year limitation be increased so that it is without limit so long as the potential recipient is in an earning or vocational setting. More particularly, I am thinking of a blind person or a post-polio victim who is starting on his way to college, and this may be a 4-year course or perhaps a 7-year course if he is going to law school. Currently the States are limited to a maximum of 3 years Federal matching.

I would hope that—on a permissive basis—the old-age assistance Federal matching would be provided to those States that chose to reduce the OAA age of 65 to 60.

Also, I would urge that the matching formula for all the public assistance titles be increased.

I would urge that the increase take place primarily at the lower end of the Federal contributions scale, and I would require that this increase be passed along to the recipients of public assistance.

We are faced with the lamentable fact that the bill as it left the House does not provide a single nickel for any aged blind, disabled public assistance recipient in the country, not a nickel. We are faced with the further fact——

Senator CURTIS. May I ask a question right there?

Mr. BURTON. Yes, sir.

Senator CURTIS. What programs, if any, were discontinued?

Mr. BURTON. None whatsoever.

Senator CURTIS. That is all.

Mr. Burton. The bill, as the distinguished Senator knows, is divided basically into two elements: one is the basic social security mechanism and the other is the supplemental public assistance titles. There were increases in the wage rate and the taxes and the benefits on the social security side. There was no increase whatsoever to the public assistance recipients.

In that respect I urge that the committee consider two actions: One, to increase by an amount of $5 to $10 the public assistance side of this bill.

Secondarily, to require rather than permit a passing on an amount of $10 of the social security increase. The law currently—thanks to the efforts of the chairman of this committee—permit States to ignore $5 of outside income which, in the main, is social security income. I am not aware of any State that has taken advantage of this. We are going to find that the greatest number of low-income social security beneficiaries whose amounts are going to be increased this year are going to have a corresponding dollar for dollar reduction in their public assistance grant. So I would urge that the committee require that the States ignore $10 of outside income. This is another way of saying to those on the low income side of the social security scale that they will be permitted to retain, in fact, if they are also dependent on public assistance, at least $10 of that social security increase. Otherwise we find the lowest income people will have their benefits raised on the social security side, their public assistance decreased on the other side, and be without a penny increase as a result of the action of this Congress. I don't think that is our intention. I know this is the effect of the legislation in its present form.

I want to deal for just a moment with the residence problem. The courts have recently ruled, I believe this matter will be sustained by the highest court—that residence requirements are in violation of the Constitution. Either on a contingency basis or recognizing without regard to how the highest court will rule, I would urge that in order to ease the impact of the decision on those States in the adult categories that have a 5-year durational residence requirement at this time, that the Federal Government increase its contribution in a declining rate so that at the fifth year it is at the current rate of Federal contribution with reference to the various States, and the proposal I would consider as a basic point of beginning would be for those recipients who are in the State the first year the Federal contribution, 90 percent, decline to 80, 70, 60, and then 50 percent for States like California and correspondingly for States with different income characteristics, where the Federal contribution varies because their income is less than the Nation's average.

There is another small point that has been overlooked in the Byrnes-Prouty proposal. That point is this: The conference committee last year in adopting a variation of the Prouty proposal eliminated anybody who has any pension rights from any public source. I think if the staff and the committee will look into the matter they will find out that they are unfairly discriminating—repeat, unfairly discriminating—against those who receive veterans' pensions or the widows of those who receive veterans' pensions.

Without belaboring the relationship of public assistance, veterans' pensions and social security, the committee arrived at an objective just the opposite to that which they were intending to arrive at, and I would urge that the exclusion for veterans or widows of veterans be eliminated from the impact of the Prouty amendment.

I support the House version increasing very modestly the Virgin Islands and Puerto Rico contributions, and I think that those increases not only be in order, but even further increases in the Federal contributions should be adopted.

There are only two other points, Mr. Chairman, I would like to make. The first point is that it is proposed in the House version of title XIX benefits—the medical care benefits, the extended version, if you please, of Kerr-Mills—be very seriously limited based on a national income standard—in effect—the standard to be decreased in stages, in two or three stages.

Now, I don't quarrel with the concern of the Congress in terms of modifying or reducing the level of Federal commitment in many areas and in developing a scale of priorities in that regard. I do decry that the House version has the effect essentially, of telling to my State and New York and a half dozen of the high-cost, high-income States, "the Federal Government is going to reduce its level of commitment in this area at your expense only." This is not an across-the-board national reduction of Federal commitment. It is a big State, high-income reduction only, and I think that that is not the best way to legislate; particularly considering that these are also the States that receive the smallest percentage, if you please, of Federal matching in title XIX. Title XIX was an extension of Kerr-Mills. As the members of this committee know full well, Kerr-Mills was developed as a supplement to the medical care provided the welfare indigents. It was a program designed for those who were not on welfare, but whose income characteristics were such in the light of their health needs that they should have made available to them some kind of a publicly supported health program.

The House version completely reverses the thrust of Kerr-Mills extended through title XIX—making the low middle income and the near poor no longer eligible in many instances for medical care, reverting right back to the old notion of medical care for welfare recipients only. I submit if we buy the House version we are hastening the day when the cry in the country will be medical care under social security for everyone in our society.

I can't understand this complete and radical departure from the clear legislative history of Kerr-Mills. The language of the testimony in the report of this committee and on the floor for Kerr-Mills and title XIX is at complete variance with the justification for this cutback in title XIX. If we chose to cut back on title XIX funds let us cut back across the board on a percentage basis, let us cut back the distinguished chairman's State from 80 to 75; California 50 to 47, the other States as you please, but let's not make the cutback in the form that uniquely cuts back Federal contributions to the big, high cost of living States.

My final point is this: I personally have introduced legislation, and I look forward to the day when we will bring order out of chaos to these income maintenance programs of the aged and the physically handicapped. By that I mean this: Legislation I have introduced provides that we shall, as national policy, establish an income-guarantee program geared to the wage level of the minimum wage. Income from all sources will be considered, gaps, between that income and this minimum wage annualized would be made up by the Federal Government. There would be no public assistance income maintenance matching programs at all. We would either set this minimum wage Federal standard or a lesser amount if that be the collective judgment of the Congress. Then the States, if they chose, could increase this amount if they had the resources and the will. But we would eliminate this variety of matching formulae, Federal standards, and all the rest of the unnecessary complications in meeting our national responsibility to provide an income—minimal though it may be—to those who are 60 and over and to those who are blind and physically handicapped.

The day will come when we will reach the conclusion that this is the rational way for us to deal with this problem rather than with this hodgepodge of income maintenance programs. The present confusion of programs really leads us, and large, to taking care of some people to a greater extent than we otherwise might intend and leaving those who don't fit into the neat definitions of these various programs without any income at all.

That, Mr. Chairman and members of the committee, are the suggestions that I would hope that you would consider in marking up this bill.

The CHAIRMAN. Thank you very much, Congressman Burton.

Senator Williams?

Senator WILLIAMS. Congressman, I gathered that you are endorsing the administration's recommendations for additions to the House bill, plus a few other recommendations of your own?

Mr. BURTON. That is correct.

Senator WILLIAMS. Now, the administration put a price tag on their increased recommendations of around $3¼ billion, and I assume yours would go, well it would go beyond that—that is an annual cost.

Would you recommend an increase in payroll tax to finance that?

Mr. BURTON. First, as the distinguished Senator knows, the administration proposal only affects in the main the social security beneficiaries. There is nothing for the public assistance recipients—the aged, blind, disabled, and family program—nothing at all. I would recommend an increase in the taxable wage base, sir, not an increase in the taxable percentage applied to the base.

Senator WILLIAMS. Part of it, I understand you recommend, it be financed out of general funds, general revenue?

Mr. BURTON. Just the cost-of-living factor. I think the cost of living is highly desirable and useful for those on fixed incomes, but I do not think this is an obligation—nor should it be—of the trust fund.

Senator WILLIAMS. We were advised that out of this $3 billion that each percentage point increase in income taxes yields the equivalent in revenue of approximately a billion dollars, and we were advised that about 3 percentage points of a 10-percent tax increase of the administration was to take care of these increased benefits of this category. Would you endorse at least that much of his recommendation for increasing income taxes?

Mr. **Burton**. I would support opening up the ceiling on the taxable wage base, gear the revenues available on that and then take a look at, very cautiously, any increment, if any, in the percentage of taxes applied to the wage base.

Senator **Williams**. Well, we are advised that that would not take care of it, all of it, increased recommendations, and what I was asking the benefit of your advice is whether you would endorse an increase in income taxes to pay for it.

Mr. **Burton**. Oh, yes.

Senator **Williams**. You would?

Mr. **Burton**. Oh, yes.

Senator **Williams**. Thank you.

The **Chairman**. Senator Gore?

Senator **Gore**. No questions.

The **Chairman**. Senator Bennett?

Senator **Bennett**. I didn't get here in time to hear the testimony.

The **Chairman**. Senator Curtis?

Senator **Curtis**. No questions.

Mr. **Burton**. In general, I am suggesting two things: the public assistance side be given equitable treatment and that they not lose the benefit of the social security increase; secondly, to pay the cost-of-living proposal out of the general fund rather than the trust fund—if the committee decides, as I hope it will—that a cost-of-living factor should be in the basic Social Security Act for the social security beneficiaries.

Thank you, Mr. Chairman.

Senator **Curtis**. Mr. Chairman, I would like some memorandum obtaining the basic utilization and cost information which underlie the basis for the tax rates in the health insurance proposals of 12080, to have it reduced to a memorandum form and I would ask unanimous consent of the committee that we might request this from the Department.

The **Chairman**. All right.

(The above-referred to appears at p. A201.)

The **Chairman**. Now, the next witness is the Honorable George K. Wyman, commissioner of the State of New York Department of Social Welfare.

We have requested that the witnesses limit themselves to 10 minutes in their principal presentation. I believe, Mr. Wyman, if there are some questions why, you may answer them.

STATEMENT OF GEORGE K. WYMAN, COMMISSONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Mr. **Wyman**. Mr. Chairman, and members of the committee, my name is George K. Wyman. I am the commissioner of the New York State Department of Social Services. I welcome this opportunity to present this statement on behalf of the department and of the New York State Board of Social Welfare, our citizen policymaking board, which is celebrating its 100th anniversary this year.

H.R. 12080, which you have under consideration, is a very broad piece of social legislation, but I intend to confine my remarks to those portions of it which are most pertinent to New York State.

With regard to the social security benefits, the House bill, while increasing payments to social security beneficiaries by 12½ percent, does not go nearly far enough in meeting the income-maintenance requirements of those persons at the lowest end of the scale. It proposes to increase minimum benefits from $44 to $50, when in reality the minimum benefit should be at least $70, as proposed by the Federal administration. If the minimum benefit is increased, a substantial number of old-age assistance recipients who must be supported now through the welfare program, can have their income-mainteance requirements met under the social insurance program. For example, more than 50 percent of our old-age assistance recipients require such help because their social security benefits are inadequate to meet even minimum needs. To make two separate payments for income maintenance represents needless duplication and overhead. We could discontinue this supplementation if the minimum social security benefits were increased to a reasonable amount.

The argument is raised that to do so would call for an unwarranted increase in the social security tax. As a former deputy commissioner of social security. I think it is high time that general tax revenues are used to support the social security trust fund, at least in small part. Precedent for this recommendation is found in the financing of every social insurance system in the civilized world and in the fact that our own system now draws on general tax revenues to pay benefits to persons over age 72 who have not had sufficient covered employment, and to match the $3 per month contributions paid by beneficiaries under part B, title XVIII of the act.

Title XVIII, medicare: The Federal administration's proposal to cover about 1 million disabled beneficiaries under title XVIII should be adopted.

The CHAIRMAN. Let me just ask one question about that. If we put this minimum high enough to take those people off State welfare by existing standards, as a practical matter wouldn't that result in the States simply boosting their standards higher than that and continuing those same payments in addition to it?

Mr. WYMAN. Only if the necessity for raising the standards was quite apparent and it is apparent, Mr. Chairman, when the cost of living has gone up 3½ percent this past year.

The CHAIRMAN. Well, I understand that. But my impression is that when we reduce these welfare payments in Federal matching if the States have the money they just take the money they have and allocate that through their welfare departments to people who are applying for help, the people on the existing caseload, so if they had been getting by with, let's say, a maximum of $60 and we make $25 or $30 more available to a State per capita then they just boost their standard up to a hundred dollars and go right ahead dividing the money they have available to them on that basis. It tends to be the case because they have administrative discretion to do it and they have the money there and rather than setting to some other program the welfare administrators just say "well, let's adopt this new regulation in a hurry, otherwise the State legislature might spend it on highways or something else."

Now, it might well be a good idea for the Federal Government to so raise its social security standards that you would have very little requirement for State welfare programs, but I wonder if we would, by just simply raising the welfare payments without achieving that objective if we just raised it, without doing something about the State programs?

Mr. WYMAN. Well, I certainly agree with you that, Mr. Chairman, that States should not rely upon increased benefits, social security benefits, as a windfall to offset State expenditures.

On the other hand, I think the great advantage to the recipients themselves is they would be able to look forward to having one payment, one check. I seems to me there is quite a bit of needless duplication in our present situation which could be remedied if the minimum benefit, at least, were substantially increased to take care of this minor supplementation which we have to now perform.

Senator HARTKE. Mr. Chairman, let me ask the Commissioner: When you make your determination of the amount that is needed do you take into consideration the amount of cash you have on hand in the State fund or is the determination of need based on the requirements for taking care of a family or whoever is involved?

Mr. WYMAN. Our situation in New York State, Senator, is some different from many States. We have an open end appropriation, and we have no limit on the individual grant of assistance for any of these programs. So that if an individual needs $200 a month on a needs basis we will grant that.

Senator HARTKE. Yes.

Mr. WYMAN. Naturally we have an appropriation, but within that appropriation we have no ceilings on individual payments.

Senator HARTKE. Yet for each one of these cases you have to make an individual determination as to need; isn't that true?

Mr. WYMAN. That is correct.

Senator HARTKE. If you have a person, for example, who comes in and makes an application and there is a determination by the investigator that he has sufficient need, then at a later date it is determined that his need has ceased to exist under your standards, and an investigator makes that finding then he will be dropped from the rolls; isn't that true?

Mr. WYMAN. Correct.

Senator HARTKE. How does he come back on the rolls?

Mr. WYMAN. Whenever he reapplies.

Senator HARTKE. He has to reapply; isn't that true?

Mr. WYMAN. Oh, yes.

Senator HARTKE. So in effect what you are saying here, and what I want to congratulate you for saying it, is that it is preferable to provide a system whereby these people can receive individual maintenance of needed income from a social security system which is based on a regular procedure rather than utilizing investigations and then having this constant thought of "Big Uncle" looking over your shoulder, and if you would provide him $100 a month minimum, as I have suggested in my bill, rather than the $50 as given by the House or the $44 as it is now or the $70 as given by the administrator, you would have a multiplying effect. First you would take a group of people off the investigator rolls. You would reduce the amount of money involved in welfare payments. You would also make it possible for these people to come off the welfare rolls. A $100 minimum would take a lot off, won't it?

Mr. WYMAN. Yes, sir.

It would take more than 70. I recommend 70 because that was the proposal from the administration.

Senator **Hartke**. Just for your information it would take over 1,400,000 off the rolls nationally if you take $100 and that is a very, very conservative estimate, and I hope you keep on pressing it and putting pressure on all of us good Finance members to recognize the need for taking care of it in this way.

Mr. **Wyman**. Thank you, Senator.

Turning now to title XIX, Mr. Chairman, and members of the committee, the proposal before you would drastically reduce Federal participation in the payment of medical assistance on behalf of medically needy persons in New York State and in 13 other States. Under the present law, States are authorized to establish their own standards for medical assistance, just as they are permitted in all other public assistance programs. New York State, acting in good faith, established its standards in accordance with the provisions of the present Social Security Act when title XIX was implemented in our State in May of 1966. We have had a program of comprehensive medical care for medically needy persons since 1929. Since 1936, all medical services have been made available without durational, monetary or therapeutic limitations of any kind. Prior to the adoption of title XIX our standard of eligibility for a family of four needing hospital care was $52 and $47 for all other medical services. In order to meet the Federal requirements for "maintenance of State effort" and not to substitute Federal funds for State and local funds, it became necessary to raise the income standards. We would have raised these standards to $5,700 for a family of four in any event because the previous standard was based upon 1963 pricings. In the course of legislative consideration of the program in New York State, agreement was reached to set the standard at $6,000 for a family of four where there is one employed person. If there is no employed person the level is $5,150.

The proposal before you would reduce this standard to 150 percent of the cash assistance standard for a similar size family (without income and resources) on July 1, 1968, 140 percent of the standard on January 1, 1969, and 133 percent on January 1, 1970. This proposal, if enacted, will eliminate medical benefits for 600,000 potentially eligible persons in the first 6 months' period, 750,000 persons in the next year, and 900,000 persons the third year. It will jeopardize help for employed families. It will reduce Federal contributions to the program by at least $15 million the first 6 months, $70 million the second year, and $50 million the third year. But this is not all the harm this proposal will do. If our legislature finds it necessary to conform the New York program to the reduced Federal level, program expenditures will be reduced by $45 million the first 6 months, $130 million the second year, and $150 million the third year. The reason for this very substantial reduction is that when one Federal dollar is eliminated from the program, one matching State and one matching local dollar are also reduced, that is in New York State. Therefore, the real impact of the Federal reduction will be tripled.

This proposal seems utterly unrealistic to us in New York State. It is unrealistic because it proposes to reduce the eligibility standard at the same time the cost of medical care is escalating at a very rapid rate. It went up 8 percent last year, while the cost of hospital care increased

16 percent. In addition, the general cost of living has increased at least 3 percent since the inauguration of this program. No one predicts a future leveling off of these costs, let alone a reduction in them.

The major cause of dependency in the United States is illness. Everyone agrees that the "poorest of the poor," those who receive public assistance, should have their medical care needs met. Also, most people believe we should prevent dependency if at all possible. Therefore it makes good, common sense to help those persons who are able to support themselves with food, clothing, and shelter but who need assistance with their medical care bills. This means we should help the workingman who is faced with a sizable medical bill, in order that he will not have to mortgage his home, sell his car, or go into debt, in order to pay the medical obligation, or, even worse, deplete himself of his resources to the point where he becomes a welfare recipient. The health of the Nation is one of, if not the most important of our concerns. Any effort to deny needed medical care to low-income people is poor economy, in my opinion.

The Congress need not be concerned with limiting Federal participation in medicaid, because there is a built-in restriction on costs. That is the requirements for State and local matching funds. In New York these matching funds represent almost two-thirds of the total costs. Very few other States have this fiscal capacity. In fact New York is the only State which has met the 1975 deadline established by Congress in title XIX which requires all States by that time to have provided comprehensive medical care for all needy persons. The fears expressed last year over possible runaway costs just haven't materialized. Therefore we urge title XIX remain unchanged in this respect.

The CHAIRMAN. Let me ask you about that for just a moment——

Mr. WYMAN. Yes, sir.

The CHAIRMAN (continuing). To see how it works out.

We were warned for many years if we didn't pass medicare that the cost of the Kerr-Mills program, which is medicaid, as I understand it, that was the genesis of it, was going to skyrocket.

Now, we have medicare and we also have this medicaid program. As I understand the House bill tried to hold the cost of the medicaid program down. The House is moving toward a program where you provide medical care to those who can't pay, and expect people to pay it if they are working and can earn income.

Now, does this House bill mean that you are going to be insisted on peope paying for medical care who cannot afford to pay for it or who can't find ways to pay it over a period of time if one advances credit to them and that sort of thing?

Mr. WYMAN. Well, sir, the House proposal would reduce the standard of eligibility in our State in which there will be Federal participation for this same family of four from $6,000 to $3,900 by January 1, 1970. So what it really does is penalize the employed person.

The CHAIRMAN. $6,000 to what, $3,900?

Mr. WYMAN. $3,900, yes, sir.

What it really does, you see, is continue, of course, to take care of the person who is receiving cash assistance the poorest of the poor that I mentioned earlier. Everyone agrees we should meet their medical needs, but what we in New York tried to do——

The CHAIRMAN. In regard to this family making $6,000, could you have some sort of a sliding scale so that they would pay perhaps the first 10 percent of that medical expense, or pay up to maybe $300 or $400, and then the State or the State, with Federal matching, perhaps, pay the additional part of it?

Mr. WYMAN. Yes, sir.

In fact we do have that arrangement for other than in-hospital care in our State, where if the income of the family is above $4,500 they pay a deductible representing, in effect, 1 percent of the income. There is no deductible required for in-hospital care because the Social Security Act prohibits such deductibles.

The CHAIRMAN. Well, now why should we do that? Why should we prohibit a deductible? Why should we, at the Federal level, prohibit you from having a deductible that would relate to someone's ability to pay?

Mr. WYMAN. It pertains only, you understand, to in-hospital care and I assume the Congress felt——

The CHAIRMAN. Why should we have that?

Mr. WYMAN. Congress felt this was the most expensive kind of medical care and, therefore, people shouldn't be expected to contribute toward their own hospital care.

The CHAIRMAN. Sitting as one member of this committee every once in a while, I run into a ridiculous Federal law, and when I ask about it no one on this committee or on the House Ways and Means Committee knows about it but we find that some bureaucrat on the Hill proposed it and we enacted it without knowing what it was.

What possible sense is there in the Federal law saying you can't have some deductible for hospital care when the States are paying for it? All we are doing is matching you to go along with your standards.

Mr. WYMAN. Sir, I hope that is a rhetorical question. I am not able to answer that.

The CHAIRMAN. You can't answer. Well, that is all right. To me it just doesn't make any sense. I would think that if a family comes in here and they have $7,000 of income, that the answer shouldn't be that you can't ask them to pay any part of it, but if they come in here and the bill is $1,000 I would think you might be able to ask them to pay all that exceeds $700, for example, or pay the first $300 or $400 of it, and then that the State would pay the rest of it for them.

Mr. WYMAN. Yes, sir.

We do that where the income exceeds this exempt level of, say $6,000.

Let me give you an example. Suppose the man——

The CHAIRMAN. But you say you can't do it inside the hospital?

Mr. WYMAN. No.

The CHAIRMAN. For hospital care.

Senator Curtis?

Senator CURTIS. I want to ask now, what is the income limitation in New York at the present time?

Mr. WYMAN. For a family of four a net income of $6,000.

Senator CURTIS. How do you define net income?

Mr. WYMAN. Income less State and Federal income taxes, health insurance premiums, and any court-ordered payments makes net income.

Senator CURTIS. So that would probably represent wages of considerably more than that?

Mr. WYMAN. Wages of what, sir?

Senator CURTIS. I say an individual has to have considerably more than $6,000 to have $6,000 net after?

Mr. WYMAN. Gross income, yes, sir.

Senator CURTIS. Now, also this coverage takes care of any member of the family who becomes sick, not necessarily the breadwinner; is that right?

Mr. WYMAN. Yes, sir.

Senator CURTIS. So in order to be eligible you not only can have this net income of $6,000, you do not have to be aged do you?

Mr. WYMAN. No, sir.

Senator CURTIS. You do not have to be unemployed?

Mr. WYMAN. No, sir.

Senator CURTIS. And the breadwinner does not need to be disabled?

Mr. WYMAN. No, sir.

Senator CURTIS. How many of these people are you taking care of who have or have available at reasonable group rates hospital and medical insurance?

Mr. WYMAN. Our initial statistical information indicates that between 40 and 45 percent of the people who are qualifying for this program in New York State have health insurance. It is either of a contributory—I mean most if it, however, is of a noncontributory type.

Senator CURTIS. Do they draw those benefits in addition to the medicaid?

Mr. WYMAN. They draw those benefits first. In fact under our statute they must avail themselves of these resources before we will step in and pick them up.

Senator CURTIS. All right.

Now, what incentive is there for an employer to continue those?

Mr. WYMAN. Actually there isn't as much as there should be.

Senator CURTIS. There isn't any, is there?

Mr. WYMAN. Very little, for this reason, Senator: The only—the very interesting thing about it, however, is that no one, to my knowledge, has actually dropped health insurance in New York State by reason of this program. There were many fears expressed that this would happen, that people would convert life insurance or they would drop health insurance coverage, and this hasn't happened. One of the reasons for that is that many of these health insurance coverages are of a union negotiated type, or they are of national contract type, and the unions are not about to have their membership drop their insurance coverage.

Senator CURTIS. So it seems, now, for instance, a family of four in New York State could have $6,000 left after they paid their Federal income tax, the State taxes, which no doubt include the taxes on their home.

Mr. WYMAN. No, sir; just State income taxes.

Senator CURTIS. Just the State income tax?

Mr. WYMAN. Yes, sir.

Senator CURTIS. Also their medical insurance?

Mr. WYMAN. And their health insurance premiums; yes, sir.

Senator CURTIS. How about their social security payments?

Mr. WYMAN. No.

Senator CURTIS. If they have even $6,000 net as defined by your law and one of their children had to have their tonsils removed you pay the entire bill?

Mr. WYMAN. Yes, sir.

Senator CURTIS. Do you realize that there are very, very many citizens over the country who pay some Federal tax who have nowhere near $6,000 to live on who are taxed to pay that bill, and here the breadwinner is neither unemployed, he isn't aged and he isn't disabled?

Mr. WYMAN. In Nebraska, Senator, I am sure that that is the case. In New York City I don't think that is the case. It costs more to live in New York than it does in Nebraska.

Senator CURTIS. It isn't worth any more, it isn't worth as much. [Laughter.] And there is absolute freedom of movement in the country.

Mr. WYMAN. I think another thing you have to keep in mind, Senator, is that New York, for example, pays 13½ percent of Federal income taxes and gets back 10 percent in the form of grants in aid and benefits so when it comes to the standpoint of a State taking advantage of the Federal Treasury, I don't think that is the case. After all, New York is putting up $2 to get $1 Federal here.

Senator CURTIS. You must have quite a good tax base there.

Mr. WYMAN. We have a forward looking Governor and legislature and electorate who are——

Senator CURTIS. I am satisfied all are looking forward to Washington in more ways than one. [Laughter.]

The CHAIRMAN. While you are talking about all of New York's entitlements, if I were draining money out of the other 49 States in interest charges the way Manhattan Island is I wouldn't go around complaining. We are paying something else on poorer States too, but you are not testifying against the program as a whole, I take it. You just think that New York ought to be able to continue this program that they presently have that is what you have in mind.

Mr. WYMAN. Yes, that is it exactly.

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

The CHAIRMAN. Yes.

Senator GORE. Mr. Commissioner, you just made a statement that the cost of living is higher in New York State than in Nebraska. I am not as familiar with Nebraska as I am with Tennessee and Washington. What items in the cost of living would you say, are higher in Washington, D.C., than in Tennessee?

Mr. WYMAN. I should imagine the rents, sir, the homeownership costs are probably higher. I thing food and clothing, these items are pretty much the same throughout the country.

Senator GORE. As a matter of fact, my wife tells me that groceries are higher in my hometown in Tennessee than in Washington.

You have named rent. What else might be higher?

Mr. WYMAN. Perhaps transportation, perhaps utility costs. I am not familiar with the Washington facts in this case. But I believe these are the things that make for the various differences. Certainly the cost of medical care in New York City is among the highest in the country.

Senator GORE. Why would that be? Are drugs higher in New York?

Mr. WYMAN. No. I think labor costs, which represent a very substantial part of hospital operation, for example, are one of the major factors here.

Senator GORE. Let's take some of the items in the cost of living. Food would be no higher, would it?

Mr. WYMAN. I believe there wouldn't be very much difference. I do not think clothing represents much of a difference, but I do think in areas of homeownership, rental, and transportation and utility costs. In the northern part of our State, certainly clothing costs because of more acute winter conditions would be a factor. But these would make for some difference.

Senator GORE. Does an automobile cost more?

Mr. WYMAN. I don't imagine so.

Gasoline is about the standard rate throughout the country.

Senator GORE. Gasoline, as a matter of fact, might be higher in Tennessee, the automobile would be higher in Tennessee, food would be higher in Tennessee. What about State and local taxes?

Mr. WYMAN. I really have no knowledge about that, Senator.

Senator GORE. What I am trying to illustrate to you is that you have dismissed the question of Senator Curtis of the justice of taxing a person in Nebraska who has an earning of $4,000 a year to pay the medical expenses of a citizen in New York who earns $6,000 a year. You dismiss that by saying that the cost of living is higher, but some of the principal items in the cost of living will be higher in Nebraska than in New York City.

Mr. WYMAN. Well, Senator, I wouldn't want to leave the impression that I was dismissing Senator Curtis' question cavalierly. I gave that as a reason. I can't—I am not an economist, I don't have available to me the information that you are asking with respect to comparison of cost-of-living factors throughout the country, but I am just drawing on a conclusion that may be erroneous. I do think, however, perhaps a more thoughtful answer to Senator Curtis' question would be on the basis of the per capita income in these various States, and the ability of the State to meet its obligations with respect to its own needs or medically needy persons. I think there isn't any question that New York State has a greater fiscal capacity to accomplish this, and in view of the fact that we are already spending almost two-thirds from State and local funds, it would indicate the willingness of the citizens of New York to support this program.

My point is simply that I don't think the Congress would want to place a greater burden than having two-thirds of the costs already paid by local and State taxpayers stepped up by dropping the Federal share of the program when New York State pays a very substantial part of the Federal taxes to begin with.

Senator GORE. The Members of the Congress must, it seems to me, seek to deal as equitably and fairly and equally as possible with the citizens of Nebraska, New York, and any other State. And I must say to you that it is very difficult for me to justify the situation which Senator Curtis describes levying a tax upon a citizen in Nebraska with one-half the income of another citizen in New York, while the citizen in Nebraska must pay all of his medical expenses and be taxed to pay the medical expenses of the citizen in New York with an earning capacity of much more. How would you justify that?

Mr. WYMAN. Well——

Senator GORE. Not as a commissioner from New York, but as though you were a member of the Senator Finance Committee with an obligation to deal equitably with all citizens in whatever State they may live.

Mr. WYMAN. I would have to look at it from the standpoint of what the State itself believed it could support. Nebraska evidently doesn't feel that it can support a program of the scope that New York feels that it can. But I think proportionately you would find that the amount of money, Federal funds that are being channeled to New York either per capita or on a relationship to the per capita income or in relationship to the income taxes that the source of which resides in New York State residents, would all point to the issue I am making and that is that this is not charging Nebraska or Tennessee residents for a program in New York State.

Senator GORE. Why isn't it?

Mr. WYMAN. Simply because the New York State origination of the funds is so much more substantial than it is in Tennessee or Nebraska or anywhere else in the country.

Senator GORE. Well, you know, Mr. Commissioner, you are really making an argument here to the effect that to him that hath shall be given and to him that hath not shall be taken away.

Mr. WYMAN. Well, let me put it a little differently, if I may, Senator Gore. I think that New Yorkers generally support the concept of the variable grant, the Federal grant in aid program, variable according to the per capita income or the capacity of the State to carry its own burden.

Senator GORE. Yes, I understand.

Mr. WYMAN. Now, in New York State these Federal grants in aid formulas invariably work on the basis of giving New York, California, and other relatively high income States a lower return and a much higher return to Mississippi and Alabama and places where the capacity is not so great.

Now, we have not, as I understand it, have not objected to this concept the haves helping the have-nots, and that is all that is being said here.

Senator GORE. What you are pleading for is for the have-nots to help the haves?

Mr. WYMAN. I think that in order to get you the answer to the question that you are talking about, you say that the have-nots would be helping the haves here, I just don't think that is the case and it won't be under this program. It hasn't been so far under this program.

Senator GORE. Let me make this observation about the income of the State of New York. I think a great deal of that income is derived from interest payments from and profits from sales into various other States. I don't think you can entirely dismiss the inequitable treatment of citizens on the basis that one man lives in a State that has a small per capita income while another lives in a State with a large per capita income. True we must deal with States, but this must be modified by the fact that we are dealing essentially with the individual American. And it is unfair, inequitable treatment when you say that because a certain citizen lives in a State that is rich, you give him more. Why? Merely because he lives in a State that has a large income. Should you penalize a man, a citizen, an American, because he lives in Nebraska, a State with a low per capita income?

Mr. WYMAN. No, of course not.

Senator GORE. Are his need, are his pains any less severe? Do his groceries cost less, do the drugs cost less? This is a harsh rule we are attempting to apply here.

Mr. WYMAN. I think really what you are saying, Senator, is that we need a national standard and not necessarily of income, but a national program of care for people who need medical care.

Senator GORE. I think we are approaching agreement on that. Mr. Chairman, I didn't mean to interrupt you.

The CHAIRMAN. Thank you.

Here is an article, and I will be glad to put it in the record at the conclusion of your statement. I am sure you have seen it. It is from the New York Times, September 17, this year.

"Upstate areas fear bankruptcy from rising cost of medicaid," and they just say that is their statement, and those people say that they just can't carry the county part of this medical aid expense. They say that the poorest counties are those being hurt the hardest because they have the highest percentage of medicaid patients, and the people are quoted here as saying that the costs of this thing have just skyrocketed. It would seem to me there is a burden on both you and us to see how we can keep the costs of this thing on some manageable basis.

Now, we will not let a person deduct from income taxes his medical expenses unless they exceed 3 percent of his income, the theory being that everybody had some medical expenses and unless he has unusually high medical expenses he ought to take care of them out of his own pocket. Now why shouldn't we put that principle in here? I am not talking about the welfare cases, but about some one who is making enough money to paddle his own canoe. Why can't we say that he is going to pay at least 3 percent before we start paying for it through public funds?

Mr. WYMAN. That is a possibility, Senator, and as I explained in the New York statute there is such a deductible.

The CHAIRMAN. Would it help you if we would repeal this section of the Federal law that says—how it got there I can't figure out—we would have no deductible if he were in a hospital drawing or receiving hospital care? Just strike that out?

Mr. WYMAN. If I had a choice I think from an administrative standpoint administering a deductible is a very difficult thing to do, and the public health people hold that anything that stands as a bar for the person, particularly in low income situations, from getting needed medical care early can, you know, be a detriment to his eventual health recovery.

Given an alternative between a deductible and a lowering of eligibility I would prefer a lowering of the eligibility limit without a deductible for the reasons I give.

The CHAIRMAN. You are talking as an administrator?

Mr. WYMAN. Yes, sir, solely as an administrator.

The CHAIRMAN. But so far as social justice is concerned wouldn't a deductible related to income be more fair?

Mr. WYMAN. Oh, certainly.

The **CHAIRMAN**. I realize the tremendous administrative problems you have in handling this and I know what the hospital administrators' problems are, so we will have to think about that.

But I would just ask if that isn't one way to help keep the costs of this thing down.

Here is a story today, Wednesday, September 20, that should also be in the record. Here is Governor Reagan of California saying that——

Senator **GORE**. One of the forward-looking Governors.

The **CHAIRMAN**. But I suspect he is quite right on this. [Laughter.] He declares that the public welfare system must be judged a failure in this country. He is talking about medicaid and he says down here:

> In California alone, hastily drawn legislation in this field can bankrupt our State unless we have major revisions.

Now, the House is moving to provide some revisions. I think you would agree that really as a public expense we are just not trying to pay everybody's medical bill. But we are trying to pay the bill of people who have great difficulty in paying out of their own resources. We are just not trying to take care of everybody and providing for everybody's medical bills at State expense, are we?

Mr. **WYMAN**. No, sir, and neither are we. We just want to keep them from becoming welfare recipients because of medical illness.

The **CHAIRMAN**. It seems to me somebody receiving $6,000 ought to pay some share of his medical expenses and I would hope we could work something out along that line. You don't oppose that if it is administratively feasible, I take it?

Mr. **WYMAN**. Yes, sir, that is right.

The **CHAIRMAN**. Your answer should be no, you don't oppose it.

Mr. **WYMAN**. Yes, I concur with your statement, is the way I should clarify the record, Senator.

The **CHAIRMAN**. Thanks very much.

Mr. **WYMAN**. May I proceed?

The **CHAIRMAN**. Yes, go right ahead.

Mr. **WYMAN**. With regard to title XIX and supplementary medical insurance benefits, the actuaries of the Social Security Administration are concerned that people over age 65 will discontinue their $3 per month payments under part B, title XVIII of the act, in order to obtain benefits under title XIX, medicaid. To counteract this possibility the House bill contains a provision (section 222 of the bill) authorizing States to "buy in" on behalf of all medically needy aged persons in the State by paying the $3 per month contribution not later than January 1, 1970. The penalty for not doing so is that States will not be able to claim under title XIX, medicaid, for medical benefits that would have been made available under part B, title XVIII. We estimate there are 1,400,000 medically needy aged in New York State who are potentially eligible under title XIX. To "buy in" for this group would cost $50 million per year. However, the bill before you will not permit States to claim one-half of this cost, as we are permitted to do now when we "buy in" for old age assistance recipients. This proposal is really an unwarranted penalty on States that wish to make certain all their medically needy senior citizens are adequately covered under the supplemental medical insurance benefits program. We recommend full Federal reimbursement in this situation.

Turning now to public assistance, Mr. Chairman, in 1935 when the Social Security Act was adopted, it was thought that most of the problems of dependency, except for those of the aged, the blind, widows and orphans, could be solved as soon as the economy recovered and the 15 million persons then unemployed—out of a labor force of 45 million—could be returned to jobs. Thus the public's concept of the welfare function was one of alleviating temporary problems. It wasn't until the 1950's that the basic causal factors of welfare dependency were generally recognized. These stem from poor health, lack of education, poor housing, racial discrimination, mental deficiency, unemployment, old age, youth, and other factors—and obviously their solution is not easy. While welfare departments do what they can—in conjunction with other Government and private agencies in health, welfare, education, and allied fields—to prevent, alleviate, and eliminate those hazards that threaten the well-being of individuals and families, they have not been able to eradicate the basic causes of poverty in our society and economy. To do so will require, under Government leadership, the massive support and participation of industry and private agencies, and by the whole spectrum of civic and community organizations.

Because the people who require public assistance represent the failures elsewhere of society, and because public welfare highlights the social and monetary cost of these failures, it is often faulted for its inability to solve all the problems for all the people, all of the time.

In 1956 Congress adopted a set of goals and objectives for public welfare. Simply stated, these are to encourage self-support, self-care, and, in addition for AFDC families, the strengthening of family life. I think it would be well to evaluate H.R. 12080 in the light of these goals and purposes.

Society has found that the best way to motivate an individual or an institution is to offer either an inducement for accomplishment or to prescribe a punishment or loss of privileges for failure. In other words, this is the "carrot and stick" approach. Therefore in 1962 Congress offered an inducement to States to provide social services for recipients by reimbursing them for provision of defined services, at a 75-percent rate, as compared with the 50-percent rate for regular administrative costs. The bill before you now proposes that the "carrot and stick" approach be used with regard to individual recipients and families. This technique must be used with discretion because too much "carrot" or too much "stick" can have an adverse effect upon the individuals who are to be motivated. The alleged "get tough" policy in H.R. 12080 is a case in point.

Aid to families with dependent children. The bill proposes that each adult and each child over 16 in an AFDC family would be provided with employment counseling, testing, and job training. This is a laudable purpose. Certainly every male recipient who is physically able should accept training and take appropriate employment. However, mothers should be offered employment opportunities only when the best interests of their children would be served in so doing. To this end the proposal for expanded day-care services is a very positive one. But all mothers should not be forced to work outside their homes.

In a similar fashion, the offering of family planning services should be safeguarded, as it is in New York State, by proscribing any coercion in connection with the offering of such services.

The CHAIRMAN. Let me ask you this while you are on this subject. Yesterday this whole room was filled with mothers who sat around this committee room all day and refused to go home. Why can't those people be told that if they can find time to impede the work of the Congress that they can find time to pick up some beer cans in front of their house.

Mr. WYMAN. Precisely, I agree with you.

The CHAIRMAN. If they are able to work, have work right in front of them, but can't find time to so much as catch the rats in their own house, I don't see why we ought to have them on the public payroll.

Now, it seems to me as though they ought to be able to find something to do if they can find time to go demonstrate or wrap a chain around a city hall or come in here and demonstrate in the streets and impede the work of the Congress. Those people ought to be offered the opportunity to work and if they don't want to do something constructive then we just shouldn't pay them, period.

Mr. WYMAN. Mr. Chairman, I had the pleasure of hearing your opening remarks this morning, and I concur with them a hundred percent, and I certainly concur with the idea that wherever it's possible and feasible and in the best interests of those children these people should be expected to accept training and take counseling, job counseling, and accept employment when it's offered.

The CHAIRMAN. We have a program for unemployment insurance. The people who draw that unemployment insurance have earned that right. They worked under covered employment, gainfully employed, and there was a tax on that payroll so that when they were no longer employed because the boss didn't have a job for them, there would be an unemployment insurance check waiting for them after they had been without employment for 2 weeks.

Now, that had to be suitable employment, too. That is the way the law reads as I understand it.

So if a person has been a steelworker or a pipefitter he doesn't have to go to work on a job that doesn't pay a minimum wage. He would take the view he is accustomed to doing a higher caliber of work than that and the kind of work that he does is not available to him.

But those people cannot turn down suitable employment and still draw that unemployment insurance check. Would you mind telling me why a welfare client who has never done a day's work in his life ought to be put above a man who works for a living and pays to support those people?

Mr. WYMAN. Oh, I wouldn't. In fact in our State a refusal to accept a valid job offer just the way you have described it means discontinuance of assistance and, further, all employable persons are referred to the State employment office regularly in order to make themselves available for employment opportunities.

The CHAIRMAN. Then do I understand in New York State now that you don't provide public welfare payments to people who have a job available to them but won't take it?

Mr. WYMAN. Yes, sir; that is correct.

The CHAIRMAN. Well, then, I dont' see where you and I have much to argue about.

Mr. WYMAN. No, I don't, Mr. Chairman.

My only argument is that I don't think all mothers, you know, willy-nilly, so to speak, should be expected to take employment without considering the impact of being absent from the home or the children. If there is proper supervision for the children and day-care facilities and things of that kind, then I think that is fine. But I wouldn't like to see a meat ax approach to this.

The CHAIRMAN. Let me say, I don't know of anybody, including the members of the House Ways and Means who have suggested that a mother be required to leave a chlid without care in the home or without even appropriate care in the home in order to go to work somewhere.

Mr. WYMAN. This is the thing I think we have to guard against.

The CHAIRMAN. I had the good fortune to have a number of good mothers working for me either in Louisiana or here who do very fine work and are very fine people. They have found ways to provide for their children. It is proposed here that we find ways to help welfare mothers to take care of those children while they do something worthwhile and something constructive. I am frank to say I am not impressed with the idea that those welfare mothers are doing something constructive sitting around those homes. Part of the time perhaps so, but all he time I rather doubt it.

But other mothers are supporting their families and it seems to me those welfare mothers could strive to do the same thing.

Does it seem fair to you for those mothers who work in my office and in Louisiana to pay taxes to support welfare mothers who don't feel like working?

Mr. WYMAN. No, sir; I agree with you.

The CHAIRMAN. Thank you very much.

Mr. WYMAN. We support the Federal administration's proposal which is not contained in H.R. 12080, to require States to meet the full standards of need as determined by each State. The Advisory Council on Public Welfare last year said that low public assistance payments contribute to the perpetuation of poverty and deprivation that extends into future generations.

New York is one of the States that meet 100 percent of need. In addition we revise and reprice our standards annually. Therefore, this proposal will have no effect in our State, but it is essential if the poor in many States are not to be cheated of the minimum essential of life.

Work incentives: We certainly support the proposal to have an earnings exemption and also to have this uniformly applied regardless of the source of such earnings. It appears to me that exempting the first $30 of earned family income plus one-third of any additional earnings is a step in the right direction. But it might be better to have a scale of exemption which would provide more of an inducement to the recipient to take himself completely off the welfare rolls. Such a scale could provide a progressively smaller exemption as the earnings increase.

The CHAIRMAN. Do you think this is administratively feasible?

Mr. WYMAN. It is more difficult, but I think it would provide a greater inducement.

The proposal to assist only the children of unemployed fathers who have had a recent work experience is an unnecessarily rigid requirement. Some parents, mothers as well, have not had a recent employment opportunity, and their children should not be discriminated against. Similarly, it should not be necessary for the parents to exhaust their unemployment compensation benefits before assistance is made available. We have found it necessary to supplement these benefits when they are inadequate to meet the needs, especially in larger families.

Federal payments for foster home care: The proposal in H.R. 12080 to make payments up to an average of $100 per month per child for those placed in a foster home under court order is another move in the right direction. Unfortunately this would aid only 5 percent of the 40,000 children which New York State now has in foster care. The cost of their care is approximately $100 million per year, paid entirely from State and local funds. We believe there is a valid Federal interest in the well-being of these unfortunate children who can certainly be classed as ones who are in the greatest need of assistance and care. The mere fact that they do not have a relative within the Federal classification who is able to care for them should not prevent the Federal Government from meeting its obligation to these youngsters. We recommend that coverage be expanded to include all needy children in foster care.

Limitation on number of children in AFDC classification: We are strongly opposed to the proposal that the proportion of children in each State receiving AFDC due to the absence of a parent be frozen at the level of January 1967. If this ceiling is imposed, approximately 25,000 needy children and their dependent parents in New York State would not be eligible for help. The loss in Federal reimbursement would be approximately $20 million per year.

The purpose of this amendment, as I understand it, is to restrict the number of illegitimate children that the Federal Government will aid. I think this is basically unsound because certainly an illegitimate child is as much in need as a legitimate one and he should not be punished for the sins of his parents.

Beyond this, however, is the fact that included in the category of absent parents are U.S. servicemen stationed overseas, including Vietnam. When their allotments are inadequate to meet the needs of their families, or when they do not make an allotment, their children, under present law, are eligible for AFDC payments.

The CHAIRMAN. Why shouldn't we find ways to make those fathers contribute something to the support of their children?

Mr. WYMAN. I think you could, Senator, through the appropriations for the Defense Department or some other legislative means. But that still wouldn't meet the problem where the man does make an allotment but he has a large family and this is inadequate, this allotment, large as he can make it is still not adequate to meet the needs of his family back home.

The CHAIRMAN. I am not concerned about the man who is making a substantial effort, but it seems to me there are tremendous resources available in this Federal Government which are not available to a private client to see that fathers contribute something for the support of those children. In fact, we have resources available to us that are not available to you. We can tax that father wherever he happens to be, and if he is anywhere in the United States or anywhere within the reach of this Government we have the authority to reach out and lay the heavy hand of the Federal Government on him.

I am not in favor of undue Federal interference in any case where it is not justified, and where it is not necessary, but if we can work out some way to reach that father who owes support to those children, and is refusing to do anything about it, would you favor that?

Mr. WYMAN. Yes.

The CHAIRMAN. As a general principle.

Mr. WYMAN. As a general principle, and something we are actively doing all the time is seeking to obtain contributions from the absent father. In fact, as you know, there is a reciprocal, Uniform Reciprocal Support Act, that all States have now adopted, that permits us to reach across States lines, but it doesn't permit us to reach to the man overseas and under these conditions.

The CHAIRMAN. We could help you with that, couldn't we?

Mr. WYMAN. Yes, you could. But in the meantime I don't think that an arbitrary limitation on the number that the Federal Government is going to help under this absent-parents classification is going to help the children back home either.

The CHAIRMAN. We are not just asking you to come up here and tell us why you don't think something will work. We are asking, you ought to be looking at the problem, coming in and saying here, "It seems to us we might have a better answer for this problem." After all, you are an administrator.

Mr. WYMAN. Well, I concur in your comments, Senator, that a way would be to put a little teeth into the servicemen's side of it.

The CHAIRMAN. One way we could do it with regard to these absentee fathers, once we determine they are the father and they are not supporting the child is to place some kind of a tax on them which would have the same effect as if you had garnisheed their salaries wherever they go. We would take part of their check and pay part of the expense.

Mr. WYMAN. We want to make certain it gets back home for the benefit of those children.

If this proposal is adopted, many of these servicemen's dependents will be eliminated from the rolls, with all the unnecessary hardship and morale problems resulting.

My final point, Mr. Chairman: New York favors the proposal to authorize $5 million for the next 4 years for grants to colleges and universities to develop programs for training social workers. Unfortunately the sum is woefully inadequate to do the job, and we would recommend that $50 million per year be authorized and appropriated.

That concludes my remarks, Mr. Chairman. If you have any further questions I would be glad to answer them.

The CHAIRMAN. Thanks very much.

Senator Williams, Senator Bennett?

Senator BENNETT. Mr. Chairman, I think you have pretty thoroughly explored for the committee all of the witnesses' points of view and I have no questions.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. No further questions.

The CHAIRMAN. Thank you very much, sir.

Mr. WYMAN. Thank you.

(Articles referred to previously by the chairman follow:)

[From the Washington Post, Sept. 20, 1967]

PUBLIC WELFARE SYSTEM A FAILURE, REAGAN SAYS

(By William Champan, Washington Post staff writer)

SAN FRANCISCO, September 19.—Gov. Ronald Reagan declared today that the public welfare system "must be judged a failure in this country today."

The goal of welfare, he told a group of newspaper editors and publishers, is to reduce the number of people getting public assistance and yet the welfare rolls continue to mount.

The California Governor, who is in a struggle with his State's courts over welfare policies, also suggested that welfare should no longer be considered an "inalienable right" of the poor.

"Isn't it something of a gift granted by people who earn their own way to those who cannot, or in some cases even to those who will not?" he asked.

Answering editors' questions, Reagan once again insisted that he hopes to discourage supporters in other states from starting Reagan-for-President campaigns.

"I'm doing everything I can to discourage this by contacting these people and I won't lift a finger to campaign," he said. He intends to lead the California Republican delegation as a favorite-son candidate to the GOP convention next summer.

Reagan's comments on welfare follow the general line laid down in his gubernatorial campaign last fall, although they seemed more broadly directed at the entire national public assistance system.

"The goal of welfare should be to make recipients independent of welfare," he said. "It is one government program whose success can only be measured by a decline in the necessity for continuing it . . . By these standards, welfare must be judged a failure in the country today."

The Governor was especially critical of Medicaid, the federally supported system of providing medical care for those who cannot afford it. Like other governors, Reagan has found that the states' Medicaid bills are much higher than had been anticipated.

In California, he said, Medicaid costs are rising at the rate of 50 per cent a year and the state went $130 million into debt to fund the first 16 months of its operations.

"We are in deep trouble when in this phase of our welfare programs," Reagan told the conference, which is sponsored by United Press International.

"In California alone, hastily drawn legislation in this field can bankrupt our state unless we have major revisions."

A conference of officials from large states opens here tomorrow to consider changes in the Medicaid program. The meeting was once billed as a political gathering of Reagan, Michigan Gov. George Romney and New York Gov. Nelson A. Rockefeller. However, Rockefeller has said he is not coming and Reagan and Romney will not meet personally at the sessions here.

[From the New York Times, Sept. 17, 1967]

UPSTATE AREAS FEAR BANKRUPTCY FROM RISING COST OF MEDICAID

(By Martin Tolchin)

Upstate counties are facing bankruptcy, increased taxes and mounting frustration because of the vastly increased costs of the Medicaid program.

Sleepy villages with tree-shaded greens and Civil War monuments have awakened to stormy debates over how to pay their burgeoning Medicaid debts. Merchants on two-block-long Main Streets fear that proposed local sales taxes will drive their customers across borders to tax-free counties and states.

County officials in steepled, red-brick buildings complain that although localities pay 25 per cent of the Medicaid costs, they have no voice in setting fees, which the state has steadily raised.

Nor do localities set eligibility standards for recipients, despite the growing rolls of patients and their general conviction that a dollar goes much further upstate than downstate, and hence a poor man in New York City may be middle-class in the Adirondacks.

Ironically, the poorest counties bear the greatest expenses under the program, because they have the highest percentage of Medicaid patients. They are consequently being compelled to levy sales taxes on clothing, meals, appliances and entertainment, which will be paid by those least able to afford it.

Impoverished Franklin County, on the Canadian border, has a per capita income of $1,500, the lowest in the state. Eighty per cent of the population is eligible for Medicaid, and 10,500 of the county's 44,000 residents already are enrolled.

The county voted a 2 per cent sales tax Sept. 1, effective Dec. 1, to cover the costs of Medicaid. An original appropriation of $840,000 was bolstered by an additional $500,000 appropriation July 1, and "this may not take us through the first of the year," according to Orra Langdon, Jr., county director of social services.

A resolution was passed by the county's Board of Supervisors asking that eligibility standards be made more stiff, making $3,900 the maximum that a family of four with one wage-earner could earn to obtain free medical care, instead of $6,000, the present maximum. The board also resolved to publish lists of practitioners paid by the program, with the amount each has received, "to show where the money is going," according to Bill Southworth, chairman of the Board of Supervisors.

INCENTIVE TAKEN AWAY

Like many upstate officials, Mr. Southworth believes that Medicaid "takes the incentive away from people."

"If they wanted to budget their incomes, they could pay more of their medical bills—at least part of them could," he said.

The county's three hospitals each received last July increased reimbursement rates, raised by the state, although the county must pay the bills. Mercy General Hospital was increased from $34.74 to $49.08 for ward patients; General Hospital of Saranac Lake was raised from $37.48 to $41.39, and Alice Hyde Memorial Hospital was increased from $30.15 to $33.32.

In adjoining Clinton County, which borders Canada and Lake Champlain, an original Medicaid appropriation of $1.5-million was raised to $2.5-million last spring, when the county borrowed $325,000 to pay its quarter share. Last month, the county was authorized to borrow $600,000 more, "and it still won't be enough," said Richard Duquette, County Welfare Commissioner.

Clinton County, a predominantly Catholic county with large families and a per capita income of $1,900, has 20,800 persons on Medicaid, out of a population of 72,000, with an estimated 50 to 70 percent eligible.

"A lot of people are getting it who don't deserve it," said James F. Barnes, a farmer who stood in front of the silo on his 249-acre beef farm five miles north of Plattsburgh, the county seat.

But a welfare administrator in the county Medicaid office looked up from a desk littered with forms and said:

"Here are 1,422 dental patients for the month of April, of whom 819 are less than 21 years of age. It's our youth we're taking care of. When you consider that we send busloads of boys to take their physicals, and half aren't physically fit . . . People want to spend money on beautiful schools. Do you want to send sick youngsters to school?"

The county has appointed a committee to discuss a sales tax with the city of Plattsburgh, which is legally entitled to six month's notice before a tax is imposed. The city itself enacted a sales tax two years ago, which has provided $750,000 "without hurting business," according to Joe Mosier, the editor of The Plattsburgh Press-Republican.

A sales tax was defeated by a single vote at the last meeting of the Board of Supervisors of Essex county, just south of Clinton. The county's original Medicaid appropriation was $780,000, and the county borrowed $350,000 last spring. "And we don't know how long that will last," said John Oren, County Welfare Commissioner. Between 70 and 80 percent of the county population is eligible for Medicaid, and 10,000 of the 35,000 already have enrolled.

"If we don't adopt a sales tax, we'll have to raise the land tax," said Hugh Morrison of Keene, N. Y., chairman of the Finance Committee of the Board of Supervisors. "You can't carry a deficit note beyond the next budget."

WARREN COUNTY PROBLEMS

Warren County, on Lake George, borrowed $400,000 last spring to finance a Medicaid budget that was increased from $825,000 to $1.5-million. "We might be another $800,000-$850,000 short," said H. Russell Harris, County Welfare Commissioner.

Mr. Harris, an elected official who has served 30 years in local government, will not be a candidate for an appointment this fall because "I don't believe in the program."

"It's just avalanched," he said. Noting that last year the total appropriation was $450,000, he said: "We were paying $32 a day for ward services at Glens Falls General Hospital, and this included physicians' and surgeons' fees. Our newest rate is $48 and does not include any physicians' or surgeons' fees."

The borrowed money must be paid back next year. Earl H. Bump, chairman of the county Board of Supervisors, said:

"We can't live with this. Our real property tax is high now. The only alternative we have is the sales tax. Perhaps if eligibility could be set by each county, we could work with it."

Saratoga County had an original Medicaid appropriation of $450,000, borrowed $225,000 more last spring, and last week the County Welfare Department asked for an additional $300,000 "to carry us though November," according to Joseph V. Gemmiti, County Welfare Commissioner.

The county is studying a real estate tax. "Taxpayers are going to have to decide whether a $30 pair of glasses is worth the $100 increase in tax rates," Mr. Gemmiti said.

"They're all worried about money," said George K. Wyman, State Commissioner of Social Welfare. The total cost of the program has increased from $460-million in the first fiscal year to $738-million this year. Nearly 3 million patients are enrolled in the program, out of 6 million potentially eligible.

More than 65 percent of the state's physicians are participating and "that's a pretty good average, when you consider that many are in teaching positions and have specialites," Mr. Wyman said.

The CHAIRMAN. The next witness is Dr. Ira C. Layton, vice chairman of the National Association of Blue Shield Plans.

STATEMENT OF DR. IRA C. LAYTON, VICE CHAIRMAN, BOARD OF DIRECTORS, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS; ACCOMPANIED BY JOHN W. CASTELLUCCI, PRESIDENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS; AND JOHN C. McCABE, PRESIDENT OF MICHIGAN BLUE SHIELD

Dr. LAYTON. Mr. Chairman, and members of the committee, I am Dr. Ira C. Layton, a practicing physician in Kansas City, Mo., and vice chairman of the board of directors.

I am vice chairman of the national association.

With me on my left is Mr. John W. Castellucci, president of the National Association of Blue Shield Plans and on my right Mr. John C. McCabe, president of Michigan Blue Shield, which is one of the large part B carriers and he is also cochairman of the part B carrier advisory group.

Mr. McCabe will assist me in answering questions relating to the operational aspects of medicare.

The national association——

Senator CURTIS. May I ask one brief question?

In what States, if any, are you the intermediary?

Dr. LAYTON. There are 33 Blue Shield plans involved as intermediaries for medicare. I think perhaps Mr. Castellucci can tell you.

Senator CURTIS. For section B?

Dr. LAYTON. Yes, sir, that is what I am referring to, sir.

Senator CURTIS. Would you submit those for the record, those States?

Dr. LAYTON. We would be happy to.

Senator CURTIS. All right.

(The information referred to follows:)

BLUE SHIELD PLANS WHICH ARE CARRIERS UNDER PART B, TITLE XVIII

Alabama
Arkansas
California (all but two counties)
Colorado
Florida
Illinois (5 counties)
Indiana
Iowa
Maryland
Minnesota (50% of state)
Michigan
Massachusetts
Kansas
Missouri (western counties)
North Dakota
New Hampshire
New York (Buffalo,[1] Rochester,[1] and New York City[1] areas)
Ohio (northeastern counties)
Pennsylvania
Rhode Island
South Carolina
South Dakota
Texas
Vermont (New Hampshire Blue Shield)
Washington, D.C.
Washington State
Wisconsin (2 plans)
Montana
Delaware
Utah
Puerto Rico

Dr. LAYTON. The National Association of Blue Shield Plans coordinates the activities of 84 Blue Shield plans in the United States, Puerto Rico, and Canada, which provide prepaid medical and surgical coverage for 60.5 million persons.

An additional 11.5 million persons who do not have regular Blue Shield protection or supplementary coverage to medicare are served by Blue Shield under various governmental programs including titles XVIII and XIX, the civilian health and medical program uniformed services, and various State and local government welfare programs.

Thus, Blue Shield is today serving some 72 million persons—66.5 million of whom are residents of the United States.

BLUE SHIELD AND THE TITLES XVIII AND XIX PROGRAMS

Mr. Chairman, it is a privilege for me to appear before you today to present Blue Shield's views on those portions of H.R. 12080 which relate to the titles XVIII and XIX programs.

As you are aware, after the passage of medicare, 33 Blue Shield plans were selected to serve as part B carriers under the title XVIII program for 60 percent—roughly 10 million—of the aged beneficiaries. Speaking frankly, the past 14 months of medicare—which saw the new, complex, and massive program get underway—have been by far the most trying period in the history of Blue Shield.

It was also a period which brought to Blue Shield the satisfaction of a challenge well met. Today, the 33 Blue Shield part B carriers are processing medicare claims at a rate of 30 million bills a year.

As for title XIX, 12 Blue Shield plans are serving under this Federal-State program thus far, and the majority of other plans have applied for title XIX roles in those areas where efforts are being made to put the program into operation. Presently, Blue Shield plans are processing title XIX claims at a rate of 25 million bills a year.

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[1] Individual Blue Shield plans.

We are especially pleased to note that the recently implemented title XIX program in one State has been purchased on a premium basis from one of our plans.

As you can readily see, Mr. Chairman, Blue Shield's involvement in titles XVIII and XIX have been both direct and extensive. And because Blue Shield has played a role in which it has been placed at a central point between the public, the medical profession, and the Government, it is in a unique position to become attuned to the desires and special problems of these three groups.

It was for these reasons, I am sure, that Blue Shield was encouraged to present testimony on March 6 of this year before the Committee on Ways and Means on its experience with medicare and on H.R. 5710—the forerunner of H.R. 12080.

To avoid repetition, we should like to direct your attention to our statement on H.R. 5710 in which Blue Shield stressed the need to simplify administrative procedures, and to utilize the capability and experience of part B carriers to the full extent of the law. We believe that Blue Shield is beginning to be used in this manner under title XIX, and urge a continuation of this trend. Only in this way can Blue Shield plans serve the public under Government programs with the same degree of efficiency, economy, and satisfaction that we have achieved in serving our more than 60 million regular subscribers.

It must be emphasized, however, that maximum service to the public cannot be attained without the cooperation of the medical profession and allied groups, and without the dedicated effort of the staff members of the Department of Health, Education, and Welfare, and various State agencies.

We are pleased that a number of recommendations made by Blue Shield were incorporated into H.R. 12080 now before you. We are also pleased to note that some of the administrative changes we urged are being considered.

H.R. 12080 contains a number of revisions that will improve the administration of title XVIII, and we would like to express our appreciation at this time to the authors of this legislation. At the same time, we must point out that title XVIII is still a complex program, and that a "comprehension gap" continues to exist on the part of many beneficiaries.

With the firm belief that every effort must be made to make the program as simple as possible, the following comments and recommendations are made on specific provisions of H.R. 12080.

In our testimony on H.R. 5710, Blue Shield pointed out that the receipted bill requirement "is causing considerable dissatisfaction and some hardship to beneficiaries" and that this matter "is in urgent need of correction." We applaud the effort made in H.R. 12080 to rectify this problem, but do not understand fully why a third method of payment for physicians' services is necessary.

From an administrative point of view, we believe the objectives contained in section 125(a) can be accomplished effectively and efficiently by amending (2)(i) by changing the word "receipted" to "itemized" and by placing a period after the word "service" in (2)(ii) and deleting all that follows.

These changes still permit either the physician or the beneficiary to submit his itemized bills. Moreover, the beneficiary may include either itemized or receipted bills when he files his claims, and this will assist us greatly in speeding up our processing time. We are presently receiving many itemized but nonreceipted claims which must be separated and returned.

In addition, this will enable carriers to adapt existing procedures to process all claims whether assigned, itemized, or receipted. Existing procedures will also be adequate to safeguard against duplicate payments.

Section 126 eliminates both the requirement for initial physician certification for hospitalization of medicare patients and the requirement for physician certification for outpatient hospital services. We strongly supported this proposal in previous testimony, and continue to support this amendment because there are existing procedures which obviate the certification requirement.

Section 131 authorizes payment under part B of full "reasonable charges," without a deductible or coinsurance, for radiological and pathological services furnished by physicians to hospital inpatients. While we advocate the inclusion of the services of these specialists under the part B program, we are concerned with the potential impact this may have on hospital admission.

In our testimony on H.R. 5710, Blue Shield supported an amendment which would permit payment for the purchase of durable medical equipment, when this would be more economical than rental. We are pleased to note that this amendment is embodied in section 132 and we continue to support it.

Section 134 would include under part B, diagnostic X-ray tests provided in the home under the supervision of a physician. We support this proposal.

Under section 133, physical therapy furnished in the patient's home under the supervision of a hospital would be covered by part A of title XVIII. This does not include the independent physical therapist who has no arrangements with a hospital, but may be requested by a physician to provide services at a patient's home. We urge that a provision be added to cover this situation.

As for section 140 on an advisory council to study the need for coverage of the disabled, there is little question that there are disabled persons who need financial assistance to meet health-care costs. However, as stated in our testimony on H.R. 5710, we believe very strongly that the title XIX programs should be utilized to provide the disabled with the type of coverage they require.

Blue Shield notes that section 162 would increase the membership in the Health Insurance Benefits Advisory Council from 16 to 19 members and expand its scope to assume the duties of the National Medical Review Committee. Since Blue Shield is a major force in the financing of medical-surgical care, it also participates in studies and makes recommendations on the utilization of medical care services.

We believe that the effectiveness of HIBAC in its new role could be enhanced with Blue Shield representation. We urge that section 162 be amended by inserting the following phrase after the word "medicine," on line 17 * * * "persons who are representatives of organizations and associations directly involved in mechanisms for financing medical care services".

Mr. Chairman, H.R. 12080 would bring about many needed changes in the administration of title XVIII. These amendments will not only be of assistance to carriers, but also to the providers of service and the public. We are pleased that thought has been given to provide the carriers with leadtime to prepare for the new procedures on itemized bills as proposed in section 125. We urge the same consideration be given to other substantive changes. Our experience has shown that a tool-up period of 3 to 6 months is essential when major changes are to be implemented. We also urge that sufficient advance notification of the changes be given to the public and the providers of service. Only in this way will we be able to avoid the difficulties that cause public concern and hardship.

As for title XIX, section 220 provides that Federal matching funds would be available if the income level of a family does not exceed either (1) an amount one and a third times the highest amount payable under the aid for dependent childrens program for a family the same size or (2) an amount one and a third higher than the State per capita income for a family with four members and comparable amounts for families of different sizes.

It is our understanding that application of the proposed formula in some cases may deprive title XIX benefits to some individuals who are destitute to the point of receiving monthly cash assistance. This would change the character of the title XIX program of aid to the "needy" and "medically needy" and we recommend that consideration be given to a more flexible approach.

Because Blue Shield has been working with individual States to implement title XIX, we are well aware that this is primarily a State matter and that verification of eligibility is indeed one of the most pressing problems in title XIX programs.

As indicated earlier, Blue Shield is strongly in favor of utilizing the private sector in the administration of title XIX. Since many of the Nation's needy are already receiving cash assistance under titles I, IV, X, XIV, or XVI, we would like to pose this question: If these individuals are receiving cash benefits to purchase the basic necessities of life, why can't assistance be provided by participation in the purchase of needed health-care coverage for those who cannot afford it?

We strongly recommend that there be a study to determine the feasibility of this approach, which could dramatically change the concept of providing health care for the needy and medically needy of this Nation. We are convinced that this would effect significant economies; simplify administrative procedures; and bring the needy back into the mainstream of society in the provision of health care.

Blue Shield also supports section 226 which would establish an advisory council to assist the Secretary of HEW on matters relating to the administration of the title XIX program. Because of the major role of Blue Shield in medical-surgical prepayment, we offer our full cooperation and willingness to participate on this advisory group.

As in the past, we strongly endorse the principle embodied in section 227, permitting the individual eligible for medical assistance to have free choice of physicians and medical facilities. On behalf of the Blue Shield plan and the medical society in Puerto Rico, we urge that there be no deferment of the effective date of this provision with respect to Puerto Rico.

Blue Shield supports the intent of section 224 to provide greater flexibility in the basic services to be provided under title XIX. However, we believe that by allowing the States to have an option of selecting any seven of 14 benefits, certain problems may arise. For example, it is conceivable that this would enable a State to qualify a title XIX program devoid of such basic items as physicians' services or inpatient hospital services. We urge these two benefits be a prerequisite of all title XIX programs.

Mr. Chairman, this concludes Blue Shield's recommendations and comments on H.R. 12080.

Our principal goals have been twofold. First, to simplify the title XVIII program as much as possible so that the elderly can obtain the benefits they are entitled to in an orderly, uncomplicated fashion. And, secondly, to express our concern and strong interest in the title XIX program.

Mr. Chairman, we are pleased to discern a growing conviction in the Congress that many of the social problems we face cannot be solved by government alone. These problems also need the vigor, expert knowledge, and capabilities of the private sector, which is the basic strength of our Nation.

As pointed out in our previous testimony on H.R. 5710 and in some of the recommendations we made today, we believe that the complications in title XVIII can be lessened by allowing the private sector—as represented by part B carriers—to play its full role as envisioned in the medicare law.

We also urge your close study of the feasibility of utilizing the private sector in the title XIX program to minimize the establishment of new government systems and inefficient outflows of government spending. We are convinced that this can be accomplished by participating in the purchase of health-care protection from private carriers for those persons who cannot afford this coverage themselves.

We would welcome the opportunity of meeting with the committee and its staff if additional information or clarification on any of the items we presented is needed.

Thank you again for the privilege of appearing before you. On behalf of Blue Shield, may I express our best wishes to you on your important deliberations.

The CHAIRMAN. I appreciate your statement, Dr. Layton. There is only one thing I would like to ask about.

You have urged a greater usage of Blue Shield under title XIX. Many doctors, and particularly those in Louisiana, have been insisting on the right of direct billing of their patients under title XIX. Would that have the effect of further removing Blue Shield from the scene?

Dr. LAYTON. I would doubt it, sir.

The CHAIRMAN. In other words, I would like to see greater usage of Blue Shield if that did not interfere with the doctor's desire to bill directly under title XIX.

Dr. LAYTON. I know of no plan—virtually all Blue Shield plans pay directly to doctors but I know of no plan—that doesn't have provisions also to pay to the patient when such is indicated.

The CHAIRMAN. When the doctor bills directly?

Dr. LAYTON. Yes, sir; this can be accomplished.

The CHAIRMAN. In other words, I think the reason doctors want direct billing so much is because they don't want the Federal Government seizing upon the Federal activity in this area to tell them how to run their medical practice or what they can do and can't do with regard to treating patients. I don't suppose they would have the same objection to trading with Blue Shield.

Dr. LAYTON. I am sure not. Such problems are virtually nonexistent when we are treating with patients who are Blue Shield subscribers.

The CHAIRMAN. So far as you know, you are still getting along all right with the doctors?

Dr. LAYTON. Not as well as we were. But we are getting along well.

The CHAIRMAN. Thanks so much.

Senator WILLIAMS. No questions.

Senator CURTIS. At the top of page 3, Dr. Layton, you say—

> We are especially pleased to note that the recently implemented title XIX program in one State has been purchased on a premium basis from one of our plans.

Without taking too much time, could you give us a thumbnail sketch of how it is handled and a little bit about the costs?

Dr. LAYTON. If I may, I would like to refer that to Mr. McCabe.

Mr. MCCABE. Senator, I think what is being attempted, and it is being explored, as a matter of fact, in Michigan as well, what is being attempted is the development of a system under which some of the characteristics of insurance can be incorporated into this as a Government-financed program, so that, for instance, we can arrive at some actuarially sound monthly cost estimate for those who are eligible, those who are identifiably eligible—the medically indigent create a difficult problem because we don't know and the State or county don't know who is eligible until they appear and ask for the service.

In the case of those who are on cash assistance, they are identifiable and you know on an operable basis who they are.

What we are looking for is a system where these costs can be identified, not unlike group insurance, so that State legislators could be told that this is the amount we estimate it will cost for the next period. While none of us, as private organizations, are in position to finance a Government program out of our own reserves, we hope that we can do something that will give these short term guarantees with adjustment, if necessary, in the future.

As I say, these are at an embryonic stage.

Senator CURTIS. But you actually have a plan operating in one State?

Mr. MCCABE. That is right.

Senator CURTIS. And you charge the State a lump sum?

Mr. MCCABE. Charge the State a lump sum, with an identifiable amount for administration, and there is provision for that particular monthly charge to be adjusted when it proves to be either too high or too low.

Senator CURTIS. Now, on page 6 with reference to the pathologists and radiologists, the last sentence of the first paragraph:

> While we advocate the inclusion of the services of these specialists under the part B program, we are concerned about the potential impact this may have on hospital admissions.

My question is "Why?" Will you spell out your concern a little bit more? I am familiar with the fact that they want to be treated as physicians and not as hospital employees and with that I agree.

Dr. LAYTON. This is not our specific reference and concern. Our concern is hospital utilization. Where there is 100 percent coverage rather than a coinsurance factor involved pressures are brought to bear by patients on doctors for admission to the facility where they get the greatest coverage.

Senator CURTIS. In other words, the House bill, as it stands, there is a coinsurance provision that applies for these specialist services if they are treated outside the hospital but not if inside?

Dr. LAYTON. That is correct.

Senator CURTIS. And any part of the program that does that tends to put an additional load on the hospital.

Dr. LAYTON. That is correct.

Senator CURTIS. Now, on that same page 6, purchase of durable equipment, I take it you are referring to such things as at the present time medicare can pay a monthly rental for a wheelchair but they can't buy it.

Dr. LAYTON. Yes, sir.

Senator CURTIS. You would make that permissive to fit the individual case?

Dr. LAYTON. When it is economically more feasible to purchase rather than rent.

Senator CURTIS. Now, on page 10 referring to title XIX, you urge the use of the private sector, including Blue Shield, and you say:

> If these individuals are receiving cash benefits to purchase the basic necessities of life, why can't assistance be provided by participation in the purchase of needed health care coverage for those who can afford it?

Why limit it to title XIX? I won't take a great deal of time but you might be interested in knowing when medicare was adopted I offered an alternative, but time was such that it was not developed maybe as fully as it should have been. But it would have enabled every aged person to buy hospital and medical insurance.

Isn't it true that one situation where hospital and medical insurance from the private sector is very expensive is when the aged person does not have the benefit of group insurance?

Dr. LAYTON. Yes, sir; very expensive.

Senator CURTIS. Yes. Because there is a tendency for those about to need the services to take it, and so on.

But the premiums have been quite reasonable where you have insured a group, have they not?

Dr. LAYTON. Yes, sir.

Senator CURTIS. I think we missed a very good bet. The Government employees have group hospitalization and medical insurance, the Government doesn't do the insuring. It is purchased from a pool of private carriers. The Government, on its civil servants pays a portion but that is because it is the employer. It is also true that upon retirement a civil service employee can carry his own—can continue to carry it, hospital and medical insurance, and he still gets the benefit of the group.

My alternative to medicare, when it passed, was that all aged persons in the United States be deemed eligible for the group hospital, medical insurance pool, as civil servants, and that the Federal Government be authorized to pay from general revenues premiums for those people who could not pay or those people who could not pay all of it.

Just by rule of thumb, I assume that the upper one-third, those living in the upper one-third, income bracket could pay for their own, where we got the group rate because there would be a tremendous group if we got everyone. That the lower one-third couldn't pay anything and that the middle third could pay half of it, I think we would have saved about $5 billion a year from the beginning.

I am very much intrigued that you have suggested to buy this service from a private source should be explored.

Dr. LAYTON. Senator, a review of the records will show the Blue Shield presented testimony at the time in strong support of your position.

Senator CURTIS. I know it is true.

That is all, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Curtis.

The next witness is Mr. Wallace Smith, speaking for the American Mutual Insurance Alliance, American Insurance Association, and National Association of Independent Insurers, and accompanied by Andrew Kalmykow and John Nangle.

Mr. Smith, we appreciate the fact that your group has joined together in representing a number of people who have a very direct interest in this matter. You are well known to the committee and we know you have done some very fine work here representing the association, and you just proceed as you think best.

STATEMENT OF WALLACE M. SMITH, REPRESENTING THE AMERICAN MUTUAL INSURANCE ALLIANCE, ACCOMPANIED BY ANDREW KALMYKOW, REPRESENTATIVE OF THE AMERICAN INSURANCE ASSOCIATION; AND JOHN NANGLE, REPRESENTATIVE OF THE NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

Mr. SMITH. Thank you, Mr. Chairman.

As you stated, Mr. Chairman, this statement is presented as a joint venture on behalf of the American Insurance Association, the American Mutual Insurance Alliance, and the National Association of Independent Insurers.

My name is Wallace M. Smith, and I am representing the American Mutual Insurance Alliance.

To my left is Mr. Andrew Kalmykow and he is here as the representative of the American Insurance Association; and, to my right, is Mr. John Nangle, who is here as a representative of the National Association of Independent Insurers.

The American Insurance Association has a membership of 169 stock insurance companies, the American Mutual Insurance Alliance has a membership of 120 mutual insurance companies and the National Association of Independent Insurers has a membership of 350 stock, mutual, and reciprocal insurance companies. These three associations represent member insurance companies which write approximately

90 percent of the total automobile, general liability, and private workmen's compensation insurance written in this country.

Our purpose in appearing before the committee today is to call attention to an emerging problem and suggest possible solutions which we consider of major importance to the general public as well as to our industry.

THE PROBLEM—DUPLICATION

The Federal Government and the private insurance industry have legitimate and responsible positions in the providing of health care for our Nation's citizens. The programs of each should not compete, overlap, or duplicate, but should be coordinated so as to complement each other.

Over the years, in the development of the social security program, the significant contributions made by the casualty insurance industry generally have not been adequately recognized. We particularly would emphasize that very substantial medical payments are made under the liability system. Such payments are required of our policyholders and of our companies as their insurers as a result of legal obligations over which neither policyholders nor their insurance carriers have any control. We call your attention to the fact that duplication of medical or disability payments presently exists in the medicaid, medicare, and disability programs.

MEDICAID

The administration and the Congress both have indicated serious concern for the need to bring about greater control and economies in the medicaid program. As this program has been developed it has provided health care to a considerable number of families of moderate income. These people generally are reached by private health care programs; and to the extent that their health needs are met through a legal or contractual obligation of another party they should not be considered medically indigent.

Programs available to these people in addition to medicaid are: the veterans programs, State workmen's compensation programs, recoveries under the liability system, and private medical insurance.

The committee is probably aware that more than 80 percent of our civilian population under age 65 is covered by some form of private health insurance which in 1966 made payments in excess of $10 billion.

What is often overlooked is the role played by the casualty insurance industry in providing medical loss coverage to the American public.

In 1966, more than $5.5 billion was paid out by liability insurers. Approximately 100 million policyholders and their families are covered under liability insurance policies, most of which also include medical pay premiums. Under these coverages, approximately $1,028 million was paid out specifically for medical payments.

Approximately 60 million working people are covered under workmen's compensation programs at the State level. Under these programs more than $500 million was paid specifically for medical benefits.

General liability payments under other insurance coverages would add to the amount, so that the total medical benefits provided by the casualty insurance industry would approach $1.8 billion a year.

Overall in 1966 the total amount of insurance industry benefits the health insurers and liability insurers paid for medical care amounted to approximately $12 billion.

Unquestionably, many beneficiaries will be paid twice through receipt of benefits under the medicaid program, and from obligations imposed upon the insurance industry by the liability system. To the extent that the medcaid program is intended to assist the medically indigent, it is not consistent to apply medicaid benefits to those whose needs are being met by a third party under a legal or contractual obligation. To the extent that health care protection is being provided from sources other than under the social security program, the resulting duplication is discriminatory and a wasteful, inefficient used of public funds.

Additionally, such duplication results in prolonged hospitalization, delayed rehabilitation, and excessive recourse—overutilization—to the country's medical personnel and facilities. All of these results create additional costs and problems under the health care program.

The House of Representatives has recognized this problem and provided under section 229 for the coordination of benefits to preclude overpayment in the medicaid program. We strongly support this provision of the bill and urge this committee to concur with the House action.

MEDICARE

What has been said regarding medicaid, concerning insurance industry payments under the liability system, is equally applicable to the medicare program. The House in its consideration of this matter gave as a reason for not including a provision similar to that in medicaid, title XIX, within the medicare program, title XVIII, the fact that most health insurance companies already had modified their policies to prevent duplication. The casualty industry cannot similarly modify its liability policies.

The liability of our policyholders, and their insurers, to all injured parties, including medicare beneficiaries, is controlled by the common and statutory law. The only practical solution to prevent duplication in these situations is to amend title XVIII.

Such a coordinating provision already exists with respect to workmen's compensation medical payments. The rationale underlying that provision applies equally to liability medical payments. We respectfully urge the committee to adopt a similar provision with respect to liability recoveries by medicare beneficiaries.

The importance of adopting such a provision would be magnified even further if medicare were extended to disabled persons under age 65. In the event that such a move is decided upon, we will be happy to cooperate with the Advisory Council study recommended by the House to deal with the coordination of medicare benefits to disabled persons under 65.

DISABILITY OFFSET

In 1965, this committee made a major contribution toward coordination of social security and workmen's compensation insurance benefits through the inclusion of an offset provision in the Social Security Disability Act. Under that provision social security and workmen's compensation disability benefits are not allowed to exceed 80 percent of a beneficiary's current earnings prior to disablement. A worker's current earnings is considered to be the larger of either the average monthly wage used for computing his social security benefits or his creditable average monthly earnings during his 5 consecutive years of highest covered earnings after 1950.

For example, 1967 earnings which exceed $6,600 would be excluded in computing this maximum, since amounts over that figure are not taxed for social security purposes. If combined benefits from social security and workmen's compensation exceed this maximum, social security benefits are reduced.

H.R. 12080 would amend this offset provision by specifying that the amount of combined benefits that can be paid may be computed without regard to the limitations established for annual creditable earnings. That is, all earnings would be counted not just those subject to social security taxes.

Reasonable arguments can be made for the House amendment. However, we are greatly concerned that if it is allowed to stand without further modification, it will destroy the necessary incentive needed for successful rehabilitation. We believe that rehabilitation of the disabled is a primary goal of both the social security disability and workmen's compensation programs.

The tax free nature of the 80-percent formula applied to a person's full wages comes very near or at times may even exceed his take-home pay while working.

For example, a single man earning $125 a week would pay $23.60 weekly in social security and Federal income taxes thus leaving his take-home pay of $101.40. Under the House amendment such persons would be entitled to combined benefits up to $100 per week. This $1.40 difference does not create a sufficient financial incentive for the effort required to achieve successful rehabilitation with such persons.

Another example, a family of four, parents and two children, earning $125 per week would pay $16.90 in social security and Federal income taxes thus leaving a take-home pay of $108.11. Under the House amendment the family would be entitled to combined benefits up to $100 per week. This would leave a net difference of $8.11 between his benefits and net take-home pay.

Considering the deduction of necessary expenses connected with employment, such as transportation, lunches, special work clothing, union dues, etc., for a disabled person, the 80-percent formula under the House amendment is clearly excessive as compared to recognized standards in this field. Authorities generally urge that the standard of disability benefits should be 66⅔ percent of wages. Such a standard has been endorsed by the Council of State Governments and the International Association of Industrial Accident Boards and Commissions (the National Association of State Workmen's Compensation Administrators). As a matter of fact, the U.S. Department of Labor, in its bulletin, No. 212 of June 1, 1967, urges this standard.

Our Nation can ill afford to lose the talents of good workers, particularly those possessed of highly developed skills. Yet, under the House amendment, it is these highly skilled, high-paid workers who will be most affected. We cannot believe that Congress knowingly would destroy rehabilitation incentives when it so willingly votes hundreds of millions of dollars in Federal assistance for both physical and vocational rehabilitation programs for the disabled.

Accordingly, Mr. Chairman, we respectfully urge the committee to substitute the 66⅔-percent figure for that of 80 percent in the House amendment.

In conclusion, we believe that as a nation we are fast approaching the day when first-rate medical care will be within the financial means of everyone. To encourage progress toward that goal we urge that full use be made of all available resources, private as well as public. Only through careful coordination and cooperation between private and public agencies can this national objective be achieved, which will result in a total cost basis that is not unduly burdensome to the public. As an industry, we pledge ourselves to work with Congress and the administration in doing whatever is within our power to establish and make effective this kind of cooperation.

Mr. Chairman, this concludes our statement.

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

I am going to take your statement along and study it. I think you made a very fine statement here on behalf of your group and I will certainly see to it, and I am sure other committee members will, that your suggestions here are carefully considered by the committee in executive session.

Mr. SMITH. Thank you.

The CHAIRMAN. It is good to see you back before us again.

Senator Bennett?

Senator BENNETT. No questions.

Senator CURTIS. One question.

On page 5, the second paragraph, you say:

> The House of Representatives has recognized this Problem and provided under Section 229 for the coordination of benefits to preclude overpayment. We strongly support this provision of the bill and urge the Committee to concur with the House action.

Now, that is in reference to ——

Mr. SMITH. Medicaid.

Senator CURTIS. Medicaid?

Mr. SMITH. Title XIX; yes, sir.

Senator CURTIS. Will you explain how that works?

Mr. SMITH. Senator Curtis, in simple language that amendment which was adopted by the House provides that where a person is receiving medicaid benefit and that person, for example, is involved in an automobile accident where one of our company insurers, would have to pay for the injuries, the hospital care, the doctor's care, all of the medical attention and needs of that person, then, such person could not receive medicaid benefits, or in other words, collect twice.

Senator CURTIS. Is this limited to casualty insurance?

Senator BENNETT. No.

Senator CURTIS. You referred to an automobile accident?

Mr. SMITH. No. This would be primarily to liability payments involved in the casualty field, but it would apply equally to liability, to the liability of any person involved that had to meet that liability for the person or the beneficiary under the medicaid program.

Senator CURTIS. It would not apply to the individual citizen who had purchased hospital or medical insurance?

Mr. Kalmykow. I would like to comment, if I may, on that particular point.

I think our language would be broad enough to include that although I think it is primarily directed at the problem which Mr. Smith covered, and that is liability insurance.

Senator Curtis. As it applies to the purchaser of hospital and medical insurance who incomewise might be eligible for medicaid, to eliminate the duplication then he would drop the private insurance?

Mr. Kalmykow. That would be a matter for an individual.

Senator Curtis. Wouldn't that be the practical results?

Mr. Kalmykow. It could possibly be, yes.

Senator Curtis. I can see your point.

Mr. Smith. I might point out that what this——

Senator Curtis. Clearly when it is paid on a liability payment by a third person.

Mr. Kalmykow. I don't think this particular amendment, Senator, does affect that particular situation one way or the other as to availability or not availability of private insurance. In other words, this would not induce him to drop it any more than the general situation as it exists at the present time.

Senator Curtis. Mr. Smith, you were about to add something.

Mr. Smith. I was about to say that perhaps I could clarify this a bit by stating that although I don't know that this would get around the problem that you mentioned, Senator Curtis, the amendment states, that where a person, a medicaid beneficiary, is entitled to receive his medical assistance from any other source, then he would be prevented from receiving similar or duplicative benefits under the medicaid program. In answer to your question, the medicaid program undoubtedly will cause some persons to drop their private coverage.

Now, the gentleman here this morning from New York as a witness, you will recall, stated where benefits are received—I think he mentioned the figure of 45 percent of the medicaid applicants in New York have private health coverage, and where those people receive such liability benefits, insurance companies are required to pay these first, and then the governmental medicaid benefits come on top of that, if needed.

There are six States that have such a requirement in their laws in the country. This leaves 44 other States that would allow duplication of such benefits that is those benefits received from any other source and also the medicaid benefits.

This was the purpose of our supporting such a provision to prevent that duplication and to save the taxpayers at both the State level and the Federal level the cost to them where we, the insurance industry, would be meeting the costs of that health need. In the case of liability payments, our companies are compelled to pay these under our policy contracts.

Senator Curtis. Certainly when an insurance carrier pays the cost of an illness, the individual is not immediately indigent.

Mr. Smith. This is our contention, Senator Curtis.

Senator Curtis. That is all.

The Chairman. Thank you very much, Mr. Smith, and also your associates.

Mr. Smith. Thank you, Mr. Chairman.

The CHAIRMAN. The Senate is in session and as we continue this hearing, I would like to ask witnesses to keep in mind that we do have a good staff.

Senators are required to participate in debate on the floor, but we will see to it that the suggestions that are made here by the witnesses are all considered by the committee—even though there may only be a few Senators, sometimes as few as one presiding Senator, here to hear their statements. I would like to see them summarize their statements as best they can and stay within the 10-minute rule, as closely as possible.

The next witness is the Honorable Norman A. Erbe, executive director of the American Chiropractic Association and also the former Governor of Iowa, accompanied by Dr. Sidney C. Birdsley of Salt Lake City, Utah, president of the American Chiropractic Association and Dr. Robert L. Thatcher, president of the Minnesota Chiropractic Association, and Harry N. Rosenfield, Washington counsel of ACA.

I am going to leave the room but I am going to ask that Senator Bennett be recognized to introduce his constituent.

Senator BENNETT. Thank you, Mr. Chairman, I am happy to welcome Dr. Birdsley here today representing the profession of which he is an honored member, and representing the State of Utah of which he is an honored citizen.

Apparently he won't have too much to say, but I am sure he will give support and encouragement to the spokesman for the chiropractic association.

Thank you.

The CHAIRMAN. I have discussed your recommendations with our staff, and I believe that for the most part they will receive very sympathetic consideration before the committee. I am going to have to leave at this time, but I am going to ask Senator Metcalf to take the chair.

Thank you very much.

STATEMENT OF NORMAN A. ERBE, EXECUTIVE DIRECTOR, AMERICAN CHIROPRACTIC ASSOCIATION; ACCOMPANIED BY DR. SIDNEY C. BIRDSLEY, PRESIDENT; DR. ASA J. BROWN, LIAISON GOVERNOR, BOARD OF GOVERNORS; DR. ROBERT THATCHER, PRESIDENT, MINNESOTA CHIROPRACTIC ASSOCIATION; AND HARRY N. ROSENFIELD, WASHINGTON COUNSEL

Mr. ERBE. Mr. Chairman and members of the committee, I thank you very much.

My name is Norman A. Erbe, and I have served as attorney general and Governor of Iowa. I testify to urge the inclusion of chiropractic care and services within the medicare bill.

I appear here today as executive director of the American Chiropractic Association of Des Moines, Iowa, a national professional body with a membership of 6,972 chiropractors who are licensed by their respective States to provide health service.

My colleages with me today are Dr. Sidney C. Birdsley of Salt Lake City, Utah, on my right, president of the American Chiropractic

Association; Dr. Asa J. Brown, of Alexandria, Va., liaison governor, board of governors, ACA; Dr. Robert Thatcher, of St. Paul, Minn., president of the Minnesota Chiropractic Association; and Harry M. Rosenfield, Esq., ACA's Washington counsel.

Mr. Chairman, 2 years ago this committee favorably reported, and the Senate approved, amendments to H.R. 6675 to include chiropractic services in the medicare program (S. Rept. 404, 89th Cong., 1st sess., pp. 41-2, 185). We respectfully suggest that such action by this committee and the Senate was—and still is—in the public interest. We urge this committee again to take this same action; we trust that the conference committee will this time accept the Senate's version on this matter.

Medicare's purpose as expressed by Congress was to provide an insurance protection to America's senior citizens against the financial uncertainties and hardships of ill health. In so doing, the Congress mandated two overriding principles in the very first two sections of the medicare title of the Social Secuirty Act, as follows:

(1) "Prohibition Against Any Federal Interference," (sec. 1801).

(2) "Free Choice by Patient Guaranteed," (sec. 1802). In fact, so adamant was this committee and the Senate as a whole about effective free choice that it amended H.R. 6675 so as to guarantee to everyone freedom of choice in obtaining health services from any qualified institution, agency or person. This amendment, which was accepted by Senator Long for this committee, was described thus:

> The choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans.

(Congressional Record, vol. 111, pt. 12, pp. 15790-15791.)

I regret to say that in its present form the medicare law violates both of these principles in at least one important respect, its failure to enable medicare beneficiaries to choose the State-licensed health services provided by chiropractors.

First, a few words about chiropractic:

Chiropractic is a recognized health service licensed in 48 States, the District of Columbia, and in Puerto Rico. Each of these States or jurisdictions have specific laws defining the practice of chiropractic, prescribing requirements for licensure, and authorizing chiropractic services and care. To become licensed in many States, the new doctor of chiropractic must take the same basic science examination required of medical doctors and osteopaths. Many State laws also require that annual license renewal is permissible only after the doctor of chiropractic has taken a specified number of hours of approved postgraduate study, thus assuring the chiropractic patient of professional currency with the latest scientific progress.

Chiropractors have been classified by the U.S. Public Health Service in a 1966 study as among "medical specialists and practitioners" including pediatricians, obstetricians, and ophthalmologists, among others.

Claims for chiropractic care are paid by several hundred insurance companies throughout the various States and by workmen's compensation boards of 41 States and the District of Columbia. All Federal agencies accept sick leave certificates signed by chiropractors, and chiropractic care is, of course, a recognized medical expense under internal revenue regulations.

Chiropractic is a science which utilizes the inherent recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health. Chiropractic practice is the specific adjustment and manipulation of the articulations and adjacent tissues of the body, particular of the spinal column, for the correction of nerve interference and includes the use of recognized diagnostic methods as indicated. Patient care is conducted with due regard for environmental, nutritional, and psychotherapeutic factors as well as first aid, hygiene, sanitation, rehabilitation, and related procedures designed to restore or maintain normal nerve functions.

Chiropractic is based on the premise that the relationships between the spinal column and the nervous system are the most significant, since the normal transmission and expression of nerve energy is essential to the restoration and maintenance of health.

Chiropractic is the largest drugless healing profession. It does not include the practice of surgery.

Chiropractic professional colleges require a minimum of 4 academic years of professional resident study, including clinical experience under strict supervision. In addition, 2 years of preprofessional education are required. Eight chiropractic colleges are affiliated with the American Chiropractic Association which spends a very considerable portion of its income for improvement of the Nation's chiropractic educational program. The accepted validity of a doctor of chiropractic (D.C.) degree is attested by the U.S. Office of Education in its publication entitled "Academic Degrees," page 169. This is the accepted authority on the legitimacy of academic degrees. Appendix I, attached to this statement, sets forth a short description of the extensive professional and scientific education in health sciences required before licensure as a chiropractic doctor.

Freedom of choice and States rights:

I respectfully submit that the present medicare law violates the basic principles of section 1801 and section 1802 of the Social Security Act by its failure to provide coverage to America's senior citizens for chiropractic health services. Let me be specific:

I. STATES RIGHTS ARE ABRIDGED BY FEDERAL LAW

The assurance seemingly provided by section 1801's "Prohibition Against Any Federal Interference" is vitiated through interference with the States freedom effectively to make available to their elderly citizens the health services of licensed chiropractors.

This is a serious matter since, as I have already noted, 48 States, Puerto Rico, and the District of Columbia, all have licensing laws which recognize the practice of chiropractic and authorize its health services for their citizens. Therefore, the Federal medicare law, by denying coverage of chiropractors, penalizes the citizens of these States and interferes with the operation of such State laws within the respective State boundaries.

As a former Governor of the State of Iowa, I feel especially sensitive about abridgment of States rights by the Federal Government. And this denial of effective States rights in title 18 (medicare) is all the more strange because true States rights (and the coverage of chiropractic services) are allowed in title 19 (medicaid). Our latest survey shows that of the 28 States which have federally approved medicaid programs 14 already include chiropractic services. These 14 States are:

California, Idaho, Illinois, Massachusets, Michigan, Minnesota, Nebraska, New Mexico, New York, North Dakota, Ohio, South Dakota, West Virginia, and Texas.

In addition, six States, Iowa, Kansas, Montana, Nevada, New Hampshire, and Oregon have medicaid plans in operation but not yet approved. Of these six States, Iowa, Kansas, and Oregon provide chiropractic coverage and New Hampshire is awaiting an opinion from the Attorney General authorizing coverage.

Thus we have the following odd results under the present Social Security Act:

1. The medically indigent can obtain chiropractors' services under medicaid (title 19).

2. But the medically self-sufficient cannot obtain chiropractors' services under medicare (title 18).

This is an unjust and unfair discrimination against the self-sufficient senior citizens of our Nation who should also be entitled to exercise their right of selection of health care. We respectfully urged this committee to amend H.R. 12080 (Just as it did with the 1965 bill) so that medicare eligibles may be entitled to State-licensed chiropractic services under title 18.

II. FREEDOM OF CHOICE IS DENIED TO PATIENTS

America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of State-licensed chiropractors.

If there was one continuing thread during the entire congressional debate on medicare, as well as in the prior 20 years of discussion, it was freedom of choice by the patient to obtain health services from any qualified institution, agency, or person. This was the guarantee intended by section 1802. This is what the voluntary insurance premium in title 18 was intended to buy. This was the objective of this committee's and the Senate's amendment in 1965. When such "freedom of choice" is denied, medicare in effect denies protection for the individual health, comfort, and well-being of each and every senior American.

Let me hasten to say that as a former Governor, I am fully aware of the need for compromises that often have to be made before major laws are enacted. This, of course, was equally true in 1965 with the medicare bill. But I respectfully submit that the time has now come for restoring the amendment approved by this committee and the Senate in 1965, to allow coverage of chiropractic health services authorized and licensed under State law. Freedom of choice of health care is the basic right of all Americans.

I believe it fair and just to say that the coverage of chiropractors' services under medicare is a test of the genuineness of our dedication to the principles proclaimed in sections 1801-2 of the medicare law—

"Prohibition against any Federal interference."

"Free choice by patient guaranteed."

A moment to dwell on medicare costs. We are aware, of course, of congressional concern with the mounting costs of the medicare program. However, we believe that inclusion of chiropractic in medicare will not increase costs. Such inclusion adds no new benefits to the program whatsoever, but merely an alternative health service for obtaining the benefits already legislated by the Congress and still continued in H.R. 12080. For example, a beneficiary with a lower back ailment who chooses a medical doctor for treatment is covered, whereas the same beneficiary must pay out of his own pocket if he chooses a doctor of chiropractic to treat him for the same ailment. The ailment is the same, but medicare now pays for an M.D.'s treatment, but not for the doctor's of chiropractor treatment for the same problem.

In fact, the available evidence from four States shows that treatment by chiropractors may actually reduce costs under medicare. Appendix II includes data collected from official sources in California, Colorado, Florida, and Minnesota, illustrative of this cost reduction in fact in existing programs which authorize chiropractic as an alternate health service. There is every reason to believe the same cost reduction experience would prevail in medicare.

Since budgetary considerations were stated in the House to be responsible for noninclusion of the services of other health practitioners, we believe this rationale to be inapplicable to chiropractic. Consequently, although we appreciate the thought and motivation that are behind section 141 of H.R. 12080, and offer our full cooperation if such study be undertaken, we respectfully suggest that there appears to be no valid reason to defer inclusion of chiropractic for a feasibility study as proposed in section 141. In passing it might be noted that nowhere is assurance given that either the health services to be included in such study or the State bodies that license such health service practitioners will be adequately and fairly represented in the study group or staff upon which the HEW Secretary must rely for his findings and recommendations.

PROPOSED AMENDMENT

The committee and the Senate have already indicated their belief in the right of medicare patients to select chiropractic care and services under title 18. The particular statutory manner in which this is accomplished is of lesser importance, provided, of course, it be effective to achieve its full purpose.

Two major different means have been suggested to include chiropractic in medicare, and either one would serve the public welfare:

I. The House-approved H.R. 12080 would amend section 1861(r) of the Social Security Act so as to provide for podiatrists with respect to services which they are legally authorized by the State to perform. This same approach can be followed with chiropractors, as indicated in appendix III.

II. In 1965 this committee and the Senate sought this objective through amending 1861(s). Appendix III includes a proposed amendment to this same end.

What this committee proposed in 1965 on chiropractic services now seems within reach if this committee reaffirms its former well-considered judgment. We respectfully suggest that this committee was wise and its action well-conceived when it accorded the right to choose chiropractic care and services as part of the health services provided under the medicare program (title 18) just as it is already authorized under medicaid (title 19). Anything less in the current bill, H.R. 12080, would be an injustice to medicare eligibles, an abridgment of States rights, and a denial of freedom of choice by American citizens. We respectfully urge this committee to amend H.R. 12080 so as to include chiropractic in medicare.

Mr. Chairman, I have abbreviated my statement to some extent in the interest of time for the committee, and I would respectfully request that the entire statement be included as part of the record.

Senator METCALF. Your entire statement will be in the record of the committee.

Governor Erbe, we had a very thorough statement from you and a very objective one and we enjoyed it.

Do you have any questions, Senator Bennett?

Senator BENNETT. Just a comment. The problem here is very simple. We faced it before and I see no questions that need to be asked to clarify it.

Senator METCALF. Senator Bennett, as a very junior member of this committee, we have been over this track many times and I see no reason why we should have a study or reverse the previous procedure in committee.

Thank you very much for abbreviating your statement and staying within the time.

Mr. ERBE. Thank you.

(Mr. Erbe's prepared statement with appendices follows:)

PREPARED STATEMENT OF NORMAN A. ERBE, EXECUTIVE DIRECTOR, AMERICAN CHIROPRACTIC ASSOCIATION

My name is Norman A. Erbe, and I have served as Attorney General and Governor of Iowa. I testify to urge the inclusion of chiropractic care and services within Medicare.

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SENATE POLICY

Mr. Chairman, two years ago this Committee favorably reported, and the Senate approved, amendments to H.R. 6675 to include chiropractic services in the medicare program (Sen. Rep. 404, 89th Cong., 1st Sess., pp. 41-2, 185). We respectfully suggest that such action by this Committee and the Senate was—and still is—in the public interest. We urge this Committee again to take this same action; we trust that the Conference Committee will this time accept the Senate's version on this matter.

PURPOSE OF MEDICARE

Medicare's purpose as expressed by Congress was to provide an insurance protection to America's senior citizens against the financial uncertainties and hardships of ill health. In so doing, the Congress mandated two overriding principles in the very first two sections of the medicare title of the Social Security Act, as follows:

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(2) "Free choice by patient guaranteed," (sec. 1802).

In fact, so adamant was this Committee and the Senate as a whole about effective free choice that it amended H.R. 6675 so as to guaranty to everyone freedom of choice in obtaining health services from any qualified institution, agency or person. This amendment, which was accepted by Senator Long for this Committee, was described thus:

"The choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans." (*Congressional Record* Vol. 111, Part 12, pg. 15790–1)

I regret to say that in its present form the medicare law violates both of these principles in at least one important respect, its failure to enable medicare beneficiaries to choose the State-licensed health services provided by chiropractors.

CHIROPRACTIC, A RECOGNIZED HEALTH PROFESSION

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Claims for chiropractic care are paid by several hundred insurance companies throughout the various States and by workmen's compensation boards of 41 states and the District of Columbia. All Federal agencies accept sick leave certificates signed by chiropractors, and chiropractic care is, of course, a recognized medical expense under internal revenue regulations.

NATURE OF CHIROPRACTIC

Chiropractic is a science which utilizes the inherent recuperative powers of the body and the relationship between the muscoloskeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health. Chiropractic practice is the specific adjustment and manipulation of the articulations and adjacent tissues of the body, particularly of the spinal column, for the correction of nerve interference and includes the use of recognized diagnostic methods as indicated. Patient care is conducted with due regard for environmental, nutritional and phychotherapeutic factors as well as first aid, hygiene, sanitation, rehabilitation and related procedures designed to restore or maintain normal nerve functions.

Chiropractic is based on the premise that the relationship between structure and function in the human body is a significant health factor and that such relationships between the spinal column and the nervous system are the most significant, since the normal transmission and expression of nerve energy is essential to the restoration and maintenance of health.

Chiropractic is the largest drugless healing profession. It does not include the practice of surgery.

Chiropractic professional colleges require a minimum of four academic years of professional resident study, including clinical experience under strict supervision. In addition, two years of pre-professional education are required. Eight chiropractic colleges are affiliated with the American Chiropractic Association which spends a very considerable portion of its income for improvement of the nation's chiropractic educational program. The accepted validity of a Doctor of Chiropractic (D.C.) degree is attested by the United States Office of Education in its publication entitled "Academic Degrees", page 169. This is the accepted authority on the legitimacy of academic degrees. Appendix I, attached to this statement, sets forth a short description of the extensive professional and scientific education in health sciences required before licensure as a chiropractic doctor.

FREEDOM OF CHOICE AND STATES' RIGHTS

I respectfully submit that the present medicare law violates the basic principles of sec. 1801 and sec. 1802 of the Social Security Act by its failure to provide coverage to America's senior citizens for chiropractic health services. Let me be specific:

I. States' Rights are Abridged by Federal Law

The assurance seemingly provided by Section 1801's "Prohibition Against Any Federal Interference" is vitiated through interference with the States' freedom effectively to make available to their elderly citizens the health services of licensed chiropractors.

This is a serious matter since, as I have already noted, 48 states, Puerto Rico, and the District of Columbia, all have licensing laws which recognize the practice of chiropractic and authorize its health services for their citizens. Therefore, the Federal medicare law, by denying coverage of chiropractors, penalizes the citizens of these states and interferes with the operation of such state laws within the respective state boundaries.

As a former Governor of the State of Iowa, I feel especially sensitive about abridgement of States' Rights by the Federal Government. And this denial of effective States' Rights in Title 18 (medicare) is all the more strange because true States' Rights (and the coverage of chiropractic services) are allowed in Title 19 (medicaid). Our latest survey shows that of the 28 states which have Federally approved medicaid programs 14 *already* include chiropractic services. These 14 states are: California, Idaho, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, New Mexico, New York, North Dakota, Ohio, South Dakota, West Virginia, Texas.

In addition, six states, Iowa, Kansas, Montana, Nevada, New Hampshire and Oregon have medicaid plans in operation but not yet approved. Of these six states, Iowa, Kansas and Oregon provide chiropractic coverage and New Hampshire is awaiting an opinion from the Attorney General authorizing coverage.

Thus we have the following odd results under the present Social Security Act:

1. The medically indigent can obtain chiropractors' services under medicaid (Title 19).
2. But the medically self-sufficient *cannot* obtain chiropractors' services under medicare (Title 18).

This is an unjust and unfair discrimination against the self-sufficient senior citizens of our nation who should also be entitled to exercise their right of selection of health care. We respectfully urge this Committee to amend H.R. 12080 (just as it did with the 1965 bill) so that medicare eligibles may be entitled to State-licensed chiropractic services under Title 18.

II. Freedom of choice is denied to patients

America's self-supporting elderly are denied effective freedom of choice to obtain the needed and beneficial health services of state-licensed chiropractors.

If there was one continuing thread during the entire Congressional debate on Medicare, as well as in the prior 20 years of discussion, it was *freedom of choice by the patient to obtain Health services from any qualified institution, agency or person.* This was the guarantee intended by Section 1802. This is what the voluntary insurance premium in Title 18 was intended to buy. This was the objective of this Committee's and the Senate's amendment in 1965. When such "freedom of choice" is denied, medicare in effect denies protection for the individual health, comfort and well-being of each and every Senior American.

Let me hasten to say that as a former Governor, I am fully aware of the need for compromises that often have to be made before major laws are enacted. This, of course, was equally true in 1965 with the medicare bill. But I respectfully submit that the time has now come for restoring the amendment approved by this Committee and the Senate in 1965, to allow coverage of chiropractic health services authorized and licensed under State law. Freedom of choice of health care is the basic right of all Americans.

I believe it fair and just to say that the coverage of chiropractors' services under medicare is a test of the genuineness of our dedication to the principles proclaimed in Sections 1801–2 of the medicare law

—"Prohibition Against Any Federal Interference"
—"Free Choice by Patient Guaranteed."

MEDICARE COSTS

We are aware, of course, of Congressional concern with the mounting costs of the medicare program. However, we believe that inclusion of chiropractic in medicare will *not* increase costs. Such inclusion adds no new benefits to the program whatsoever, but merely an alternative health service for obtaining the benefits already legislated by the Congress and still continued in H.R. 12080. For example, a beneficiary with a lower back ailment who chooses a medical doctor for treatment is covered, whereas the same beneficiary must pay out of his own pocket if he chooses a doctor of chiropractic to treat him for the same ailment. The ailment is the same, but medicare now pays for an M.D.'s treatment, but not for the D.O.'s treatment.

In fact, the available evidence from four states shows that treatment by chiropractors may actually reduce costs under medicare. Appendix II includes data collected from official sources in California, Colorado, Florida and Minnesota, illustrative of this cost reduction in fact in existing programs, which authorize chiropractic as an alternative health service. There is every reason to believe the same cost-reduction experience would prevail in medicare.

Since budgetary considerations were stated in the House to be responsible for non-inclusion of the services of other health practitioners, we believe this rationale to be inapplicable to chiropractic. Consequently, although we appreciate the thought and motivation that are behind Sec. 141 of H.R. 12080, and offer our full cooperation if such study be undertaken, we respectfully suggest that there appears to be no valid reason to defer inclusion of chiropractic for a feasibility study as proposed in Sec. 141. In passing it might be noted that nowhere is assurance given that either the health services to be included in such study or the State bodies that license such health service practitioners will be adequately and fairly represented in the study group or staff upon which the HEW Secretary must rely for his findings and recommendations.

PROPOSED AGREEMENT

The Committee and the Senate have already indicated their belief in the right of medicare patients to select chiropractic care and services under Title 18. The particular statutory manner in which this is accomplished is of lesser importance, provided, of course, it be effective to achieve its full purpose.

Two major different means have been suggested to include chiropractic in medicare, and either one would serve the public welfare:

I. The House-approved H.R. 12080 would amend Sec. 1861 (r) of the Social Security Act so as to provide for podiatrists with respect to services which they are legally authorized by the State to perform. This same approach can be followed with chiropractors, as indicated in Appendix III.

II. In 1965 this Committee and the Senate sought this objective through amending 1861 (s). Appendix III includes a proposed amendment to this same end.

What this Committee proposed in 1965 on chiropractic services now seems within reach if this Committee reaffirms its former well-considered judgment. We respectfully suggest that this Committee was wise and its action well conceived when it accorded the right to choose chiropractic care and services as part of the health services provided under the medicare program (Title 18) just as it is already authorized under medicaid (Title 19). Anything less in the current bill, H.R. 12080, would be an injustice to medicare eligibles, an abridgement of States' Rights, and a denial of freedom of choice by American citizens. We respectfully urge this Committee to amend H.R. 12080 so as to include chiropractic in medicare.

APPENDIX I

EDUCATION REQUIREMENTS FOR LICENSURE AS DOCTOR OF CHIROPRACTIC

1. CHIROPRACTIC EDUCATIONAL REQUIREMENTS

The chiropractic doctor is educated in chiropractic principles and practice, anatomy, biochemistry, microbiology, pathology, physiology, public health, diagnosis and x-ray, clinical disciplines, and related health sciences. Beginning with these basic subjects, a chiropractic student spends a major part of the first two years (of a four-year course—not less than 4200 clock hours) in master-ing these fundamentals. The remaining two years are devoted to practical or clinical studies dealing with the diagnosis and treatment of disease, and working with patients in applying chiropractic principles and gaining experience of practice. Approximately one-half of the time of the last two years is spent in the clinics of the college of his choice.

2. STATE EXAMINING BOARDS

Each state has a State Examining Board composed of doctors of chiropractic. In a few states, there are composite boards of doctors of chiropractic and doctors of medicine.

APPENDIX II-A.—SUMMARY OF AVERAGE COST PER CASE UNDER CHIROPRACTIC CARE AND ALL PROFESSIONS

Source of information	Cost under chiropractic care	Medical cost, all professions
California:		
Old-age security	$33.31	$76.67
Aid to the blind	39.14	81.32
Aid to needy disabled	45.12	121.68
Auto injuries	131.29	166.97
Florida: Back injuries	51.00	61.77
Colorado: Back injuries	20.82	31.67

Source: H. G. Higley, "Cost of Chiropractic Services" (unpublished, September 1966), p. 8.

APPENDIX II-B

FLORIDA INDUSTRIAL COMMISSION DATA ON COMPARATIVE COSTS OF SERVICES BY CHIROPRACTORS AND MEDICAL DOCTORS

1. In 1960 a study was made of the workmen's compensation records of the Florida Industrial Commission. The report was entitled "A Survey and Analysis of the Treatment of Sprain and Strain Injuries and Industrial Cases."

2. The purpose of the research was to compare the—
   (1) average treatment costs
   (2) worktime losses. and
   (3) services rendered.
per case for back injuries, as treated by chiropractors and medical doctors.

3. The study covered 19,666 individual cases, and was checked at each stage by the First Research Corp., a nationally recognized and independent research organization.

4. The findings are that as to sprain and strains of the neck, spinal column-vertebrae, and back.

(A) The cost of the average case was as follows:

	Handled by—	
	Chiropractor	Medical doctor
Total treatment costs	$51	$65
Compensation costs	9	37
Total	60	102

(B) The Average Worktime lost was:

Handled by:

Chiropractors	3 days
Medical doctors	9 days

5. *Thus*, when a sprain and strain case was handled by a medical doctor rather than a chiropractor:
   (A) *Treatment costs*—averaged 27.5% more
   (B) *Compensation Costs*—averaged 311% more
   (C) *Work Time Losses*—averaged 300% more

6. Benefits from Chiropractic Care in such cases:
   (A) Reduced medical costs
   (B) Reduced compensation cost
   (C) Reduced loss of salary and pain to employee
   (D) Reduced loss of manpower to employer.

APPENDIX II-C

MINNESOTA—RESULTS OF A SURVEY OF 10 000 INDUSTRIAL ACCIDENT CASES IN MINNESOTA

1. In 1958, Associated Insurance Research of Owatonna, Minnesota, released the results of a survey of 10,000 industrial accident cases in Minnesota in the period 1954–1958. The claims all dealt with back injuries incurred in industrial employment. (No cases of permanent injury were included.)

2. The Survey revealed the folowing facts:

(a) Average Cost Per Claim:	
Medical doctors	$64.60
Chiropractic doctors	35.64
(b) Off-the-Job Time Loss, Case Average:	
Medical doctors	10.2 days
Chiropractic doctors	.9 days

APPENDIX III

PROPOSED AMENDMENT TO H.R. 12080 TO INCLUDE CHIROPRACTIC SERVICES IN MEDICARE

Alternative I—*Amendment to § 1861(r) of Social Security Act*, by amending § 127(a) of H.R. 12,080.

1. Section 127(a) of H.R. 12,080, p. 50, line 22:

After word "chiropody," insert the following: "and a doctor of chiropractic or a chiropractor."

Alternative II—*Amendment to § 1861 (s) of Social Security Act*, by adding a new § 127A to H.R. 12,080.

1. Section 127A, H.R. 12,080, p. 50, after line 20:

Between lines 20 and 21, add the following new section:

SEC. 127A. (a) Section 1861(s)(1) of the Social Security Act is amended by adding before the semicolon and after "services" the following: "or chiropractors' services"

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Chiropractors' Services

"(z) the term 'chiropractors' services' means services performed by a chiropractor, but only with respect to functions which he is legally authorized to perform as a chiropractor by the State in which he performs them."

Senator METCALF. Our next witness is Mr. Frederic W. Richmond, who is chairman of the Citizens Committee for Medicaid, accompanied by Harrison Brody of the Citizen's Emergency Committee To Save Medicaid.

We are delighted to have you before the committee. You have a prepared statement and go right ahead.

STATEMENT OF HARRISON BRODY, CHAIRMAN, CITIZENS EMERGENCY COMMITTEE TO SAVE MEDICAID

Mr. BRODY. Mr. Chairman, U.S. Senator Russell B. Long, and distinguished Members of the U.S. Senate Finance Committee, may I take this opportunity to thank your committee for the generous invitation which it has extended to the Citizens Emergency Committee to Save Medicaid to present testimony in opposition to certain provisions of H.R. 12080, which if not revised, would tend to cripple and devitalize the operations of New York State's medicaid program.

On August 17, 1967, the House of Representatives passed H.R. 12080, which abrogated the intent and spirit of title XIX of the Social Security Act. Title XIX provided that New York State could set up its own minimum qualifications for medicaid eligibility without excessive restrictions. The antimedicaid provsions of H.R. 12080 provided that by July 1, 1967, a medically needy New York family of four would be cut off from lifesaving medical assistance if its annual net income exceeded $3,900, an amount actually below New York State's poverty level.

In substantiation of the above fact, we offer in evidence the statement of Mr. George K. Wyman, New York State Commissioner of Social Welfare, who declared early in 1967 that a New York family of four could qualify for cash welfare payments if its income fell below $3,931.

Without public hearings or prior announcement, the House of Representatives passed certain provisions of H.R. 12080, which would abolish the present equitable New York State exemption of $6,000 net annual income for a family of four, and replaced it with a repressive means formula under which the income of such a family, in order to remain eligible for medical assistance, could not exceed:

$4,400 after July 1, 1968
$4,100 after July 1, 1969
$3,900 after July 1, 1970

In other words, a family of four in New York State, would then have to become progressively impoverished to qualify for medicaid under the House's new legislative restrictions. The minimum net annual income exceptions for other groups of applicants for medical assistance would likewise be downgraded to mendacity.

The chart appended below, perhaps, illustrates more graphically than words the mendicancy level to which H.R. 12080 would reduce medicaid in New York State:

FAMILY OF 4 PERSONS—ANNUAL NET INCOME EXCLUSION ABOVE WHICH MEDICAID ELIGIBILITY CEASES

Medicaid roulette	Yearly	Weekly	Daily	Daily per person
New York State Level, Present	$6,000	$115.38	$16.48	$4.12
H.R. 12080, July 1, 1968	4,400	84.06	12.00	3.00
H.R. 12080, July 1, 1969	4,100	78.84	11.26	2.82
H.R. 12080, July 1, 1970	3,900	75.00	10.71	2.68

If the discriminatory provisions of H.R. 12080 are allowed to go unchallenged, they will exclude hundreds of thousands of medically needy families and over 1 million New York citizens from the benefits of the New York State medicaid program—a program which is legally designed to give essential medical and health care to low-and limited-income families.

The virtual progressive abolition by H.R. 12080 of essential doctor, dental, surgical, and hospital care under medicaid—to all families except those who are poverty stricken or on the relief rolls—has much greater humanitarian and national implications than the empty statistics with which Congress seeks to balance the books of human sickness, misery, pain, and suffering. Antimedicaid legislation is part of the same congressional thinking which made some House Members deride legislative proposals to exterminate rats as a libel on the efficiency of cats. As in the reluctance of Congress to pass rat-control legislation, certain Members of the House have oversimplified the facts about the medicaid program and covertly hidden the truth. The truth is that medicaid applicants are "medically indigent"—not so much because of the lack of weekly income, but because of the lack of immediate resources of "cash on hand" to meet the crises of sudden medical emergencies.

New York State and its legislature has understood the urgent need of its indigent families for emergency medical care and is being punished for its foresight and compassion by the House of Representatives. In initiating and signing the New York State medicaid bill into law, Gov. Nelson A. Rockefeller affirmed that a citizen with "an empty pocketbook" could not pay catastrophic medical bills. Governor Rockefeller also declared, and this citizens committee concurs, that "an enlightened medicaid program represents the medical emancipation of America."

Make no mistake about it. The immediate effect of H.R. 12080 on medicaid is not simply to raise the income requirements for medical assistance eligibility, but to restructure drastically the whole equitable system of New York State's medicaid program and to progressively render it supine and inoperative. A New York congressional member of the House Ways and Means Committee, who vainly tried to stop the antimedicaid juggernaut, has called the repressive features of H.R. 12080 "completely disastrous."

To further increase the income requirements for medicaid eligibility from its present, modest, realistic, actuarial, carefully thought out levels, on which the bipartisan New York State Legislature spent months of agonizing appraisal, would defeat the entire purpose of the New York medical assistance program for the medically indigent—which is honestly and faithfully administered by the New York State Department of Social Welfare under Commissioner George K. Wyman, whose record and achievements in this field are well known to the Members of the U.S. Senate.

The antimedicaid provisions of H.R. 12080 have spawned a hybrid monster—a federally dominated medical assistance program of planned chaos which we hope, trust, and pray the U.S. Senate Finance Committee—in its good sense and beneficence—will thrust aside, and reinstate, in its stead, the original provisions of title XIX of the Social Security Act as they relate to medicaid.

Medicaid payments in New York State, for its fiscal year starting on April 1, have been estimated at $739 million. Of this amount, the estimated contribution of New York State and its localities has been some $450 million. The rest of the money has been borne by the Federal Government. Under the circumstances, shouldn't New York State be allowed to administer its own medicaid program? Is it fair for the House Ways and Means tail to wag the body of the New York State medicaid dog?

Two years ago, title XIX of the Social Security Act, establishing the present equitable medicaid program, without excessive restrictions for any State, was passed by the Congress of the United States. To date, over 2 million needy New York citizens have been given medical assistance under medicaid. Under H.R. 12080, over 1 million medically indigent New York State residents would be eliminated from the present medical assistance essential health and medical services programs. Such a result would be the equivalent of a legislative atomic time bomb dropped on the medical services of the needy.

Overwhelming testimony in favor of the medicaid program has been presented, not only by distinguished Members of the Congress, but also by qualified experts in the fields of preventive medicine, law, sociology, economics, labor, social services, government, and human relations. Among those who have supported this program of "medical emancipation," and their names are legion, are George K. Wyman, John Gardner, Wilbur Cohen, Mitchell Ginsberg, Victor Gotbaum, Joseph Rogoff, Harry Van Arsdale, Frederic W. Richmond, Jacob Gilbert, Jonathan B. Bingham, James Scheuer, Daniel Greenberg, Irving Blumberg, Joseph H. Louchheim, Dr. Howard Rusk, and many, many others. Their arguments in favor of the restoration of title XIX's original medicaid program are even more persuasive today with rioting in our cities, enormous population growth, and ever-increasing medical and living costs everywhere.

The present shortsighted antimedicaid provisions of H.R. 12080, directed mainly against the 17 million citizens of New York State, would, therefore, be inordinately socially and economically unsound—for the following reasons:

1. WELFARE RECIPIENTS RECEIVE AUTOMATIC MEDICAID

Of the estimated over 2 million persons on medicaid in New York State, 50 percent automatically receive medicaid benefits, without a means test, because they are on welfare rolls.

2. EIGHTY PERCENT EXCLUSION OF NONWELFARE MEDICAID APPLICANTS

Of the remaining 1.2 million or more persons on medicaid in New York State, but not on relief, 80 percent of those presently eligible would be excluded by H.R. 12080.

3. SEVENTY-FIVE PERCENT OF MEDICAID ELIGIBLES CARRY HEALTH INSURANCE

Furthermore, the congressional H.R. 12080 cutoff program for New York State eligibles is completely unrealistic—because of those families of four or more who would be excluded—75 percent are covered by private medical insurance plans such as Blue Cross, Blue Shield, HIP, GHI, major medical—and medicaid picks up only the catastrophic portion of their medical assistance, when required, which is nominal.

4. H.R. 12080 OPENS DOOR TO POSSIBLE 3,000 PERCENT INCREASE

Of the 25 percent who would be declared ineligible for medicaid under H.R. 12080, who have no health insurance, they might recede to the welfare rolls entirely if they don't receive medical assistance when they require it, with a consequent enormous increase in the expenditure of public funds for their total maintenance.

5. MEDICAID IS NOT A GIVEAWAY PROGRAM

The present New York State medicaid program is not a "giveaway program." The New York State Department of Social Welfare's means test for medicaid is strictly interpreted and uniformly applied as follows: "Any family applying for medicaid, which has a surplus of cash resources in excess of 50 percent of its net income exemption, is ineligible." In simple language, New York State now says that if a family unit of two people, with a net income exemption of $4,000 has over $2,000 in the bank or in mutual funds, it is out of the medicaid ball game.

Likewise a pensioner, for example, subsisting on a marginal standard of $2,300 per year, or $6.30 per day, is also currently excluded from medicaid benefits by present New York State criteria if he has resources above that amount in unearned income. In addition, if an applicant earning $4,500 gross income does not meet his mandatory 1 percent deductible requirement, as having been spent on medical care, he is also declared ineligible in New York State under present requirements.

6. NEW YORK STATE MEDICAID HAS BUILT-IN SAFEGUARDS

The applicant for medical assistance undergoes scrupulous screening as to the extent of his financial resources. If a family has resources in excess of 50 percent of their minimum net exclusion, even to the $1,000 insurance policy allowed them for each member's burial expenses, they may be excluded under New York State's criteria.

7. H.R. 12080 WILL PRODUCE EXPENSIVE REDTAPE

The projected new legislation will tear down the old medicaid system and attempt to build up a new system. The cost of a new bureaucracy superimposed on the old will far exceed the expenses of the past and present. The economy drive will turn into a new nightmare of useless expenditures. Parkinson's law will prevail.

8. H.R. 12080 CONSTITUTIONALLY VIOLATIVE OF STATE SOVEREIGNTY

On constitutional grounds, discriminatory attacks against New York State control of its own medicaid program violate the spirit of constitutional government and destroy solemn contacts between the Federal and State Governments, which have as their sole purpose the general welfare of the people of the United States.

In conclusion, the Citizens Emergency Committee To Save Medicaid fervently believes that the deferred death sentence which has been passed against New York State medicaid by certain provisions of H.R. 12080, should be rescinded by the Senate of the United States—and that the pending regressive antimedicaid legislation should be replaced by the original fair provisions of title XIX of the Social Security Act under which medicaid has operated so successfully and humanely up to the present.

It is certain that as the brightest day follows the darkest night, a wise and humane Senate would not desire to have on its conscience the tragic responsibility for a course of action which might deny to the outstretched arms of its less fortunate brethren the healing medical help and surcease from needless and wanton suffering. With the potential strangulation of the medicaid program—for all but the unfortunate needy on relief rolls—hundreds of thousands of innocent children may be excluded from general medical care under medicaid—from dentistry to correct crooked teeth and jaws, from surgery to heal their bodies, and from the ministrations of preventive medicine, which might make them, in God's good time, healthy and productive citizens.

We must not allow a misshapen medicaid produce a misshapen America. Never again must we permit our great Nation to produce generation after generation of youthful Americans—70 percent of whom couldn't pass the minimum health standards of Selective Service or of the President's Committee on Physical Fitness. A healthy American is a strong America. With the medical emancipation of our great Nation under medicaid, this Nation can have a new birth of national health. We know that there is not the slightest doubt in the minds of this great Senate committee that the health and well-being of our citizens, young and old, is America's most precious heritage.

Thank you for your patience and consideration. God bless you for your good will.

STATEMENT OF FREDERICK W. RICHMOND, CHAIRMAN, CITIZENS' COMMITTEE FOR MEDICAID

Mr. Richmond. Senator Metcalf, first may I take this opportunity on behalf of more than 200 organizations representing labor, business, social service and health associations, and civic groups which compose the Citizens' Committee for Medicaid, and on behalf of the Citizens Emergency Committee To Save Medicaid—both committees which I have the honor to represent—to express our deep appreciation to your distinguished chairman and the members of this great senatorial committee for the privilege you have given me and our citizens' committees in allowing us to come before you to express our point of view in favor of New York State's medicaid program, and to present our arguments in opposition to those sections of H.R. 12080, which would effectively destroy New York State's present successful program of medical assistance under title XIX.

My statement shall be brief and, I hope, to the point. In a single year, New York State has established a landmark in our Nation's history of health care by providing voluntary, lifesaving medical services to over 2 million needy New Yorkers. This figure includes hundreds of thousands of families, over a half million children and a large number of senior citizens past 65. This humane achievement could not, however, have been accomplished without the good will, guidance, and compassionate cooperation of legislators like yourself and of the Federal Government. However, I have not come here simply to praise you, but to plead for your help in nullifying the antimedicaid provision of H.R. 12080, which seeks to set aside the original nonrestrictive enabling legislation of title XIX and substitute a system of regressive restrictions on the administration of New York State medicaid. In our opinion, these restrictions are both unwise and unjust.

It is our conviction that a Federal law which prohibits the sovereign State of New York from administering its own medical assistance program, that prevents it from setting up its own standards and qualifications for medical eligibility for its own citizens within its own borders, is impractical in its application and approaches legislative tyranny in its philosophy.

It is likewise our belief that it is clearly inequitable to grant medical assistance under medicaid only to those families who have virtually a welfare status—and deny it to low-income families, even though they have been declared "medically indigent" and eligible for medicaid under the present criterion of the New York State Department of Social Services. Yet, that is exactly what H.R. 12080 would do.

H.R. 12080 has been rightfully called the New York State Medicaid Exclusion Act because it would, within a year or two, disqualify nearly 2 million medically needy New Yorkers, now eligible for lifegiving medical assistance, from receiving this care. This kind of legislation—which would take back in 1967 that which was given in 1965—is unconscionable. And, I submit further, it will add more fuel to the fires—real and otherwise—set by those who argue that Congress has little concern for those trying to break a cycle of poverty that has continued for far too long.

For make no mistake, if H.R. 12080 passes in its present form, it will strike hardest at those families who have managed to pull themselves up from the lower depths of poverty, who are just beginning to see daylight and learning to become productive members of society.

If New York State medicaid is going to be destroyed by being watered down, it would be better if it had never been started. But it has been started and, in my humble opinion simple justice and good sense require that the medicaid program for 17 million New Yorkers should continue to be equitably and fairly administered, without prejudice and discrimination of any kind—not public, nor private or even legislative.

We cannot rationalize the anguish of the medically needy with the unrealistic formula of H.R. 12080 which, in three successful annual bombshells, sets levels of 150 percent of poverty, then 140 percent and finally 133⅓ percent in order to receive medical care under medicaid.

In New York State, the impact of such a formula will be to reduce eligibility levels by over 30 percent during the next 3 years while, if present trends continue, the cost of medical care will rise by over 40 percent. To play these games with human misery is to out-Nero Nero.

You know as a businessman and a taxpayer, I have been keenly aware of the dollar pressures building up against the New York State medicaid program. In the fiscal year that began April 1, medicaid payments in New York State are estimated at $738 million. However—and this is the crucial argument for those who claim New York is out to break the Federal bank—New York State and its subdivisions will make their own contribution of $450 million. In other words, for every dollar of Federal reimbursement, New York itself will spend nearly $2.

Under these circumstances, isn't it fair, isn't it equitable, that New York State—which bears the major part of its medicaid costs—should be allowed to continue to apply its own standards of medicaid eligibility for its own citizens? Does it make sense for a congressional committee of the House of Representative to mandate, at long range, which New Yorkers must go without vital medical services?

As you distinguished gentlemen know, and as the record shows, the New York State Legislature spent long, tiring months in the preparation of rigid qualifications, standards, and criteria for medicaid eligibility. There are many built-in safeguards. The State legislature acted upon the good faith of a Congress which, in 1965, passed the medicaid provisions under title XIX of the Social Security Act.

Are we now to ignore the conscientious labors of the bipartisan New York State legislature? Is its fair and equitable medicaid program now to be thrown out the window? Shouldn't each State be master of its own work for its own program of medical assistance? Hasn't New York State proven its fiscal integrity and responsibility in its administration of its own medicaid program?

To establish, as H.R. 12080 seeks to do, an arbitrary poverty standard for medical assistance in New York State flies in the face of reason. It destroys the fundamental justification for the original title XIX act which contained no regressive limitations. Title XIX established a fair uniform standard for medicaid eligibility in New York and all other States. That standard was—Is the applicant medically indigent? If the applicant qualified for medical services by reason of being financially unable to secure them, then the State stepped in and extended a remedial, medical helping hand. Would we now strike down this hand of medical mercy?

Mr. Chairman, distinguished members of this great committee, the life or death of New York State's medicaid program rests in your hands. If some of my remarks have sounded unduly harsh, I know you will understand that they were made without personal malice, but in the service of the medical future of the people of the State of New York. There is no need here to recount the great need for medicaid. For as Dr. Charles Mayo has so ably expressed it, "Sickness makes people poor; poverty makes people sick."

But I do respectfully, though urgently, request you to set aside those destructive portions of H.R. 12080 which relate to medicaid, and to reinstate the spirit and substance of title XIX of the original social security legislation. And allow New York State and all States to establish their own honest criteria for medicaid eligibility.

The cost to the Federal Government for an entire year of New York State medicaid is less than the cost of 7 days' conflict in Vietnam. Surely, the medical survival of our citizens is one portion of our domestic program which we can sustain in spite of demands elsewhere. For what can we value more than human life, lived under dignity, freedom, and democracy? What we are discussing here is not so much a program of medical aid, but a program of "freedom from medical want."

The United States, which has dedicated and rededicated itself to the emancipation of all mankind, now, through the efforts of this great senatorial committee, has the historic opportunity to establish the "medical emancipation" of 17 million citizens of New York State and, inevitably, the medical emancipation of our entire Nation.

Thank you.

Senator METCALF. Thank you, Mr. Richmond.

Senator Hartke?

Senator **Hartke.** I would like to congratulate Mr. Richmond for a very fine statement. His record for public service is well known throughout the Nation, and I think it is important we recognize his contribution in the past and also recognize his contribution to this committee at this time.

Mr. **Richmond.** Thank you, Senator Hartke.

Senator **Metcalf.** Senator Bennett?

Senator **Bennett.** I have no questions.

Senator **Metcalf.** I want to thank you, Mr. Richmond, for your very eloquent and persuasive testimony, and I know all members of the committee will give very serious consideration to the points that you have made.

I want to ask Mr. Brody a question which was suggested by the staff. I note that Mr. Richmond says the cost to the Federal Government for an entire year of New York State medicaid is less than the cost of 7 days' conflict in Vietnam. Many of us who deplore the cost of any conflict in Vietnam have suggested that perhaps we should eliminate that. I don't like to equate some of these other things with that. Many of us are vitally concerned with the rising cost, my State as well as yours, of the medicaid programs. Is there some action that we can take that you think would be fair, specific action that the Federal Government can take to reduce some of these medicaid expenditures on an equitable basis?

Mr. **Brody.** Thank you, Mr. Chairman, for that question.

My committee sent here not to argue or fight with the Members of Congress, but to cooperate with them, and what we want is a viable modus vivendi medicaid program for the State of New York, a program that will comply with the best thinking in the United States of America, and it's useless for the State of New York to be out of line. If you are going to set standards and criteria for 50 States and New York State is going to insist on banging its head against a stone wall, we are not going to get anywhere.

Now, I have taken the position in my statement which is in the record, that we want the title XVIII reinstated. But perhaps the status quo cannot be maintained. Therefore, in the interest of this compatibility and in the interests of saving money, and through the coincidence of your distinguished chairman, Senator Russell Long's statement this morning, I have the honor of presenting a specific recommendation, is not just generalizations about why we are against something or why we are for something, but this is specifically a recommendation for an amendment to H.R. 12080, and it takes the form of an exemption, to wit: "That in those States where a 2-percent deductible is required for any eligibility, beginning at 150 percent of AFDC, the Federal income medical assistance criteria need not apply."

Now, this will save the New York State medical assistance program because it will enable us to establish our own qualifications and to keep the 3 or 4 million eligible people on the rolls, whereas under the House Ways and Means formula, which we respect and we respect the opinion of Mr. Wilbur Mills who has handled trillions of dollars, but the fact is that Mr. Wilbur Mills and the House Ways and Means Committee have strapped the medicaid program of New York State to the electric chair, and July 1, 1968, the first lethal charge of electricity will eliminate all of those persons in New York who are on the medical eligibility lists except for those who are on relief, on the welfare rolls. That is the net effect. We don't need any more electrical charges after 1968. By 1969 only welfare recipients will be alive.

Senator METCALF. With the price that Con Ed has for electricity up there, I hope we can save the electric charges.

Mr. BRODY. Yes, sir.

Now, the practical effect, I know Mr. Wilbur Mills will be happy to accept this, will be to produce a deductible prerequisite in medical expenditures as a prerequisite of medicaid of between $100 and $105 million a year on which the Federal share on a matching basis will be approximately $75 million a year, and I think on the basis of salvaging and saving and enabling the medicaid system of New York State to survive, this is a suggestion which I know the chairman had in his mind, and it is very essential that a deductible be enforced, not only for outpatient care, which is a small item, but the inpatient care which is a financial hemorrhage when you consider, gentlemen, that upstate there are hospitals which charge $45 to $60 a day, and downstate New York, in New York City, the hospital charges from $60 to $80 a day. So that we must have a medical deduction as a prerequisite for medicaid assistance, especially in New York City, and based on an income, a net income exemption of $6,000 a year, that will be about $120, it might go up to $150. Multiply that by a million you get the net aggregate total of $150 million a year and this will show New York State's willingness to cooperate with Congress, willingness to brake the program, as Mr. Wilbur Mills says, and also to show that it does not want to get more than its fair share of the medical funds. Thank you, Mr. Chairman, for your consideration.

Senator METCALF. Do you have a comment?

Mr. BRODY. I would like to enter into the record a certification of medical expenditures in order to show you it is a simple operation. Mr. Wyman has said that it is difficult. It is not difficult, and I would like you to see the W-668 form which is utilized by the New York City Department of Social Services for one page and its says "certification of medical expenses incurred during the current year." It is a simple operation, it doesn't take more than 30 seconds to fill out, and it will make the program completely viable.

Senator METCALF. Without objection it will be included in the record at this point.

(Form referred to above follows:)

Certification of Medical Expenditures Incurred During the Current Year

(PRINT IN INK OR TYPE)

Name of Applicant ______________________________

Address of Applicant ______________________________

Print in ink or type the information required on this Certification, sign and date it in the space provided, then attach and submit it with Form MA-11, Application for Medical Assistance.

Name of Person Receiving Services	Type of Service	Name of Provider of Services	Month and Year of Payment	Amount
				$
			TOTAL	$

I hereby submit this supplemental information regarding my Application for Medical Assistance and certify that all of the information above is true and correct to the best of my knowledge and belief.

Signature ______________________________ *Date* __________

Senator **Metcalf**. Did you have a comment, Mr. Richmond?

Mr. **Richmond**. No, Senator, just to bring to your attention the fact that with living costs as they are in New York City we recently participated in a survey made by the Community Council of New York which shows a family with a net income of $6,000 a year, a family of four, has a total sum of $9.37 a week after it has paid for its food, clothing, and shelter. In other words that $9.37 has to cover everything else, education, theater, books, beer, the movies, vacations, everything.

Now we really believe that in New York City a family with an income that low is actually medically indigent because they can't afford, especially they can't afford, preventive medicine. The more preventive medicine we can get across the country the cheaper our total medical bill will be because preventive medicine keeps people out of the hospitals.

Senator **Metcalf**. I want to thank both of you and I know the committee thanks you for your appearance, for a very persuasive statement and for a constructive proposal that will be given serious consideration.

Thank you very much.

The next witness is Dr. E. J. Felderman, who is president of the New York State Association of Physicians and Dentists, Inc.

Dr. Felderman, we are pleased to have you before the committee.

STATEMENT OF E. J. FELDERMAN, M.D., PRESIDENT OF THE ASSOCIATION OF NEW YORK STATE PHYSICIANS AND DENTISTS; ACCOMPANIED BY MARTIN H. BERNSLEY, ATTORNEY

Dr. **Felderman**. Mr. Chairman, I would like to introduce my counsel, Mr. Bernsley.

Senator **Metcalf**. Go right ahead.

Dr. **Felderman**. OK, thank you.

Mr. Chairman, I am E. J. Felderman, president of the Association of New York State Physicians and Dentists; and on my right, as I said before, Mr. Bernsley, who is with me, my counsel. I represent approximately 5,000 practicing physicians and dentists of the State of New York, and I am here to discuss the impact that the word "qualified" may have on section 227 of 12080, "Free choice by individual eligible for medical assistance."

During the past year the New York State's implementation of the medicaid program resulted in considerable confusion within the professional community, due in part to the distorted interpretation of the word "qualified."

New York State, and I believe it is the only State, of all those who are participating in the medicaid program, has created arbitrary requirements in excess of State licensure for the purveyor of professional services.

In a booklet prepared by the U.S. Department of Health, Education, and Welfare entitled "Questions and Answers—Medical Assistance and Medicaid," a question is posed (No. 45). The reply is—

"that the medicaid program unlike medicare includes no provision that requires States to allow free choice of physician. The basic intent, however, is to provide for everyone who needs assistance in meeting medical care costs—care that will be equal to that available to the general population. Freedom of choice is provided in most States."

The report of the Committee on Ways and Means on H.R. 12080, House Report 544, Union Calendar 207, under the broad heading of general discussion of the bill, on page 122, (par. i), states—

> Under the current provisions of law, there is no requirement of the State that recipients of medical assistance under the state title XIX program shall have freedom in their choice of medical institutions or medical practitioners. In order to provide this freedom, a characteristic of the medical care system in this country, a new provision is included in the law to require states to offer this choice.

Further along in the opinion, it states "it is possible that some providers of services may still not be willing or considered, and I emphasize the word 'qualified,' to provide the service included in that State plan."

I must, at this time, refer you to a memorandum that was submitted to the Honorable John W. Gardner, Secretary of Health, Education, and Welfare, date June 26, 1967. Attached thereto are several pages marked as exhibits with a further memorandum on rule 85.10 of the State Board of Social Welfare of the State of New York. As you can readily note, the word "qualified" is causing the confusion and in part is contributing to the failure of proper implementation of the medicaid program in New York State.

I must refer you to section 1802, of Federal title XVIII, section 85.10 of New York State Board of Social Welfare Rules, and to the present amendment before you, section 226. In all instances, the language is identical in the substantive part of the paragraph.

Title XVIII is federally administered and free choice is really guaranteed to all participants in the medicare program.

Title XIX is a State-operated program, and using the language of 1802 and the interpretation of the word "qualified" has been altered to mean qualifications beyond licensure. The new amendment, if unchanged and passed into law, would only further substantiate the State of New York's thesis that qualified should mean additional qualifications—as has been arbitrarily implemented by New York State administrators of the medicaid program.

There are any number of instances where purveyors of services are denied the opportunity to render such service by the discretionary ruling and connotation of the word "qualified."

First Deputy Health Service Administrator of New York City—James J. Haughton, in a letter to all physicians dated October 10, 1966, states—

> shall be guaranteed the free choice of the person qualified to participate in the Medical Assistance Program. Accordingly, the New York State Department of Health has established qualifications for participation of physicians and dentists—

It becomes rather apparent that in a program of wide scope as is medicaid—involving great numbers of people, maximum utilization of purveyor would be the goal in an already small numbered professional group.

Today, and for the forseeable future, the medical manpower shortage is acute. Plans are readied to train the unskilled in paramedical areas to alleviate the shortage.

Within New York, a large segment of professional personnel are being deprived the right to participate by the administrators of the medicaid program. This action is well documented in the accompanying memorandums.

There is no doubt that not all purveyors were delighted to participate—and in an already narrowing horizon of numbers, it is further cut back by an interpretation which if unchecked, we believe will be a misrepresentation of the basic intent of the law.

A headline of the New York Times of Thursday, May 18, 1967, "Ten Health Groups Shut to Medicaid." "Health Insurance Plan Centers Say They Are Loaded Down With Poor." On May 12, 1967, a New York Daily News report stated that 13,000 poor died in a year for lack of good care.

Gentlemen, the foregoing facts are self-evident. Therefore, I respectfully submit for your consideration a suggested amendment to section 226(a), section 1902(a) 23 "to provide that an individual eligible for medical assistance may obtain such assistance from any institution, agency or person, legally authorized (duly licensed) by that State wherein he practices, performs those services, or actions required, including an organization which provided such services, or arranged for their availability on a prepayment basis, who undertakes to provide him such services." Further, I respectfully request that this amendment may state that it be effective immediately. The New York State Departments of Health, Social Services, and Education, have been for the past year and several months exploiting the medicaid program for a projected modification of the State education laws. I feel that this policy is unjust and is depriving many needy of a basic requirement, which is not only a privilege, but a fundamental right.

I hope, Mr. Chairman, and gentlemen of the committee, that you may consider in your written opinion, the possibility of further amplifying the concept of free choice in its true and intended manner.

Thank you for your courtesy.

Senator **Metcalf.** Thank you very much, Dr. Felderman. Senator Bennett?

Senator **Bennett.** Mr. Chairman, this is a very interesting statement, but it misses the thing the committee needs to know most. What is the basis on which these people have been disqualified?

Dr. **Felderman.** The basic concept that is reinforced by the administratve bodies is they say they have to—if they are going to give away money—they have to know that it is given to the best qualified performers of this particular action, and they have set up arbitrary standards and they are consistent with the Workmen's Compensation Board of the State of New York.

Now, in New York City alone, and this is authenticated, approximately 6,000 to 7,000 physicians are—have not got hospital facilities. They have arbitrarily set up AAGP, which is an American Association of General Practitioners.

Senator **Bennett.** Yes, but there must be two or three very simple rules on which you are disqualified.

Dr. **Felderman**. Well, if you don't belong to the private country club of AAGP, if you don't have your certificate by the American Board of Pathology, if you don't have a hospital staff appointment then you are disqualified from participating in that program.

Now, the general practitioner as the foundation and backbone of American medicine doesn't have to belong to the American Association of General Practitioners or any other group.

Senator **Bennett**. All right.

Is the requirement that you must have all of these conditions or one of them?

Dr. **Felderman**. You have to belong to AAGP and have a hospital staff appointment.

Now, you may not have a hospital staff appointment because of a very complex situation of New York City medicine. In New York City medicine there are—well, let's put it this way—back in 1949-50, one of the big voluntary hospitals or proprietary nonprofit hospitals says, "We are not going to allow general practitioners on our staff any more. You will have to get a specialty rating, become a specialist within 2 years. If you fail to comply in 2 years with a specialty rating you won't be on that hospital staff whatsoever."

So they took these men who were on the hospital staff as practitioners and put them aside and they weren't allowed to have hospital facilities.

Senator **Bennett**. Now, these people who do not have hospital staff ratings, there are still some hospitals to which you take your patients—there must be.

Dr. **Felderman**. Well, a lot of these men have been discouraged from undertaking entrance into these hospitals because it has been basically a conspiracy of specialization that has been going on for a number of years.

Senator **Bennett**. I am not interested in that. I am interested in the simple basic facts of the problem. If they can't take their patients to hospitals where do they take their patients?

Dr. **Felderman**. They refer the patients over to somebody else.

Senator **Bennett**. They refer the patient to someone else?

Dr. **Felderman**. Yes, that is right.

Senator **Bennett**. No further questions, Mr. Chairman.

Senator **Metcalf**. Well, Dr. Felderman, I have had an opportunity during the course of your testimony and Senator Bennett's interrogation to glance through the supporting statements in the brief that you have, and I think that you have, in response to Senator Bennett, outlined the problem involved. The committee still stands by the quotation from the chairman that was made by Governor Erbe that the choice of one's own doctor and other provider of health services is a right which should be enjoyed by all Americans, as the chairman of this committee opened the debate years ago, several years ago——

Senator **Bennett**. That is right.

Senator **Metcalf** (continuing). And we still stand on that. So we thank you for your testimony, your appearance. The brief that you have submitted as a part of your statement will be analyzed both by the staff and the members of the committee, and it sets forth this special problem in which you are involved.

Dr. FELDERMAN. Thank you very much, sir.

Senator METCALF. Thank you very much.

(The brief referred to above follows:)

ASSOCIATION OF NEW YORK PHYSICIANS & DENTISTS, INC.,
Plainview, N.Y., June 26, 1967.

Memorandum to: The Honorable John W. Gardner, Secretary of Health, Education, and Welfare.

From: E. J. Felderman, M.D., president, Association of New York State Physicians & Dentists, Inc.

On behalf of: The Association of New York State Physicians & Dentists, Inc.

Re: New York State's compliance with title XIX of the Social Security Act, Welfare, Medical Assistance (sec. 1904 Public Health Law, 89-97).

The purpose of this Memorandum is to raise on behalf of the above named Association, a specific question of stautory compliance of the State of New York, with the purpose and intent of Title XIX of the Social Security Act.

This Memorandum is not to be interpreted as an attempt to create confusion in the administration of this noteworthy program, but on the other hand, to correct an overextension of powers that is being exercised by the State Administrative Departments in executing the Medicaid Program.

In accordance with Section 1904, we are requesting the Secretary to exercise the powers herein contained to functionally alter the varied and somewhat chaotic orders that appear to be evolving from the State of New York Department of Health (exhibit #1).

Title XVIII and XIX, although representing separate philosophical concepts, their areas of effectiveness in many instances overlaps and one may readily interchange one with the other. The question of semantics, sometimes affords refuge from a convert act which will ultimately become overt.

Under the guise of advancing the quality of "care and standards", a set of rules and regulations have been created on the part of the State Department of Health, through the utilization of Section 364, chapter 256, of the Laws of 1966, amending Article V of the Social Welfare Law, Title XI, New York State, and titled "Medical Assistance for Needy Persons". (Exhibits 2, 3 and 4.) The substantive part of this section states:

"to asure that the Medical care and services rendered pursuant to this Title are of the highest *quality* and are available to all who are in need, the responsibility for establishing and maintaining *standards* for care and eligibility shall be as follows;" (our emphasis)

The background for the development of these requirements under the Medicaid Program is evident in a communication from the University of the State of New York, to members of the Dental Profession in New York State, dated May 15, 1967. (Exhibit #5) Although the purpose of discussion proposed in exhibit #5 may be lauditory—in some instances—it's concern and policy is that of the State Department of Education and it's Board of Dental Examiners. The overextension of the State of New York Department of Health's powers appears to be arbitrary and out of it's jurisdiction and simply echoes a principle that has first to be mandated into law, and not to be used as a wedge (by the Department of Health) in the administration of the Medicaid Program. (Exhibit #5)

This discussion is not intended to embroil the Department of Health, Education and Welfare in a policy-concept that is being stimulated within the State of New York. It is very reasonable to understand that eight million people, approximately one-half the population of the State of New York, involved in the Medicaid Program, would because of the nature of its broad scope, require the administrative agencies of the State of New York to express concern and attempt to dictate concepts to all participants, although this intent may, or may not be valid and within the confines of the Law.

Rule 85.10 of the State Board of Social Welfare, adopted July 19, 1966 states:

"Medical care and Health Services furnished pursuant to Title XI, of the Social Welfare Law, shall be provided in accordance with regulations of the Department and provisions of contracts entered into between the Department and the Department of Health, pursuant to Section 364(a) of the Social Welfare Law, which regulations and contracts shall include the right of each individual entitled thereto to obtain such medical and health srevices from any institution, agency, or person *qualified to participate* under medical assistance if such institution, agency or person undertakes to provide him of such medical care and health services." [Our emphasis.]

The underlined words "qualified to participate" under Medical Assistance, etc., is almost a direct extraction from Title XVIII, Section 1802:

"Free choice by patient guaranteed—qualified to participate under this title, if such institution or agency—:"

Further definition of a physician, part (c) Section 1861, paragraph (r).

"The term physician—*legally authorized to practice medicine and surgery by the state*—." [Our emphasis]

Title XI of the Social Security Act, Section 1101 (a), (7):

"The terms 'physician', and 'Medical Care' and 'hospitalization' include osteopathic practitioners or the services of osteopathic practitioners and hospitals within the scope of their practice as defined by State Law."

By statute and intent, free choice is guaranteed under Federal Title XVIII, Federal Medicare Program. One assumes that qualified and standards of care shall be the best in all instances, whether one is under the Medicare program, private paying fee for service patient, or Medicaid patient, since the foregoing three categories all must receive the best care, and furthermore, it may be the same physician or purveyor of services that renders care to all.

We don't believe that one who renders services to a medicare patient who may subsequently become medicaid eligible, that the purveyor can change his hat so quickly or either be unable to do so as to be unable to render medical care, and to have to transfer that patient to one who the State of New York deems more able to render such service.

In the wisdom of the Department of Health, Education, and Welfare, in its preparation of HR 5710, as well as the honorable Mr. Mills, who introduced the bill, and which was referred to the Committee on Ways and Means, they have deemed fit to introduce an amendment under Title XIX, Section 226 A, 1902 (a), 23:

"provide that any individual eligible to medical assistance may obtain such assistance from any institution, agency, or person, *qualified* to perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis) who undertakes to provide him such services." [Our emphasis.]

The terminology is strikingly similar in all instances to Title XVIII and rule 85.10 of the New York State Board of Social Welfare.

I do not believe that the intent of Congress in the promulgation of Title XIX legislation, intended it to be as restrictive to the purveyor as noted in the exhibits 1 through 5.

Within the Public Law 89-97, Title XIX, Section 1905, paragraph (a) (6):

"Medical care, or any type of remedial care, *recognized under State Law*, furnished by *licensed practitioner*, within the scope of their practice, as defined by State Law," [Our emphasis.]

stresses the fact that one only has to be licensed within the scope of his practice, in order to practice within that state, and it must be the intent of the Congress that no further extension of the definition was necessary, since within the Title XVIII, the concept of free choice was guaranteed, and the definition of the purveyor described, as well as in Title XI, Section 1101 (a) (7).

The continual problems arising from New York State's implementation of the Program, aside from its broad scope has been and will be further heightened by the arbitrary out of context utilization of the word "*qualified*" which has bearing on licensure, and not referable to a newly applied concept, or a degree of competence, or membership or certification by a private professional organization, or society. Section 364 of the State Law, paragraph 1, subparagraph f.

"promulgating and maintaining the *qualifications* for physicians employed by the Public Welfare Districts as Medical Directors, certified to it by the Public Health Counsel," (our emphasis),

as well as Section 364, paragraph 4, the word *qualifications* has been used specifically and correctly. In no other instance is it so applied or stated in the Law.

Section 364 (a), paragraph (2), subparagraph (a):

"services of a *qualified* physician, etc." (our emphasis) is utilized and I believe it should be consistent with the terminology in Title XVIII and XIX and not any other arbitrary definition.

It must be readily apparent from your sources as well as our own, too numerous to detail, that the unilateral and arbitrary action of one and several Governmental Agencies of the State of New York, has not only impeded the progress of this Program, but we believe has acted contrary to Title XIX.

We respectfully request the Department of Health, Education, and Welfare to review this Memorandum, and in the light of the preceeding, exercise the authority so vested in Section 1904 of the Social Security Law, 89–97, Title XIX.

Sincerely,

E. J. FELDERMAN, M.D.,
President.

RULE 85.10 OF THE STATE BOARD OF SOCIAL WELFARE

On April 30th, 1966, Governor Rockefeller signed two bills which became Chapters 256 and 257 of the Laws of 1966. Together these measures constitute what is now known as New York State's Medicaid program. There had been one dissenting vote in the Senate and twenty-six in the Assembly on final passage of the two measures.

There had been no criticism of this program by outside, interested groups while it was before the Legislature for consideration and it was not until after final passage and executive approval that the public became aware of the breadth and scope of the measure.

Then a statewide storm of protest swept across New York, led by newspaper disclosures of the details and cost estimates of the program that may well pay the medical expenses of seventy-five percent of the people of the state at an annual initial cost of $1.4 billion.

After the Legislature recovered from the first shock waves of public indignation, they brought forth a series of proposals aimed at reducing the program's original scope.

Concern was also expressed that the program would restrict a patient's free choice of a physician when medical need arose.

While some of the changes in the law were proposed in the form of legislation the social welfare department agreed to insure free choice of physician by an amendment to the official rules of the State Board of Social Welfare. This assurance was accepted by the legislative leaders and no bills were introduced which would amend the basic Medicaid law insuring the patient's free choice.

Accordingly, the State Board of Social Welfare promulgated the following as a new rule 85.10:

"Medical care and health serivces furnished pursuant to title II of the Social Welware Law shall be provided in accordance with regulations of the Department and provisions of contracts entered into between the Department and the Department of Health pursuant to Section 364–a of the Social Welfare Law, which regulations and contracts shall include the right of each individual entitled thereto to obtain such medical care and health services from any institution, agency, or person qualified to participate under medical assistance, if such institution, agency or person undertakes to provide him such medical care and health services."

Attempting to insure what many believe to be fundamental rights of a citizen to the free choice of a physician or other health practitioner by administrative rule, and the above rule in particular, has certain inherent weaknesses.

In the first place, the rule can be repealed or rendered meaningless by amendment by the same board which promulgated it. In this respect, it in no way compares as a safeguard to the patient's rights as does a statute enacted by the Legislature and approved by the Governor.

Whether intentional or otherwise, other existing regulations of the departments administering the program have already rendered 85.10 meaningless.

The fact that the patient must obtain prior authorization from his local welfare office destroys his freedom of election.

And the imposition of a free schedule automatically acts as a limitation on the individuals right of choice if he wants bills paid under the program.

In considering another of this rule's weaknesses, it is assumed that no little care was given to the precise wording employed. When the rule finally speaks of the patients right of choice it immediately limits this choice to such "*institution,* *agency or person qualified to participate under medical assistance.*" [Emphasis supplied.]

The portion of the rule emphasized above immediately creates the potential destruction of the right which the rule purports to protect.

The Social Welfare department and the department of health will still have the inherent power to determine which "institution, agency or person" is qualified to participate under this medicaid program.

While the program is in its initial stages it will be reasonable to expect that the departments will allow each patient some latitude in his selection of a clinic, hospital or physician (after prior authorization is obtained and a fee schedule agreed to). But the past history of the exercise of administrative powers suggests that after the program becomes well entrenched many restrictive provisions will be invoked, considerably circumscribing the list of institutions, agencies and persons qualified to render service under Medicaid.

In any case, the power to limit the choice is there present in an administrative body and its mere presence is a violation of the patient's rights.

Not until the right is clearly spelled out in the law itself can the patient and those whom he elects to have treat him, know for certain that their rights are adequately assured and protected.

SEPTEMBER 19, 1966.

EXHIBIT I

STATE OF NEW YORK DEPARTMENT OF HEALTH,
Albany, N.Y., June 1, 1967.

DEAR DOCTOR: Under the regular program of Medical Assistance for the Needy (Medicaid), eligible recipients have free choice of any qualified physician and certified hospital. Such physician and hospital may provide the necessary medical and hospital services without prior authorization.

The purpose of this communication is twofold:

A. To alert all physicians and hospitals in regard to the existing standards concerning qualifications under Medical Assistance.

B. To point up that the Physically Handicapped Children's Program is maintained in its entirety in regard to the standards and qualifications for physicians and hospitals, even though the major funding will be through Medical Assistance.

The following is a brief summary statement on these two matters. The attached exhibits are intended for those physicians and hospitals wishing more detailed information.

A. MEDICAL ASSISTANCE (MEDICAID) PROGRAM

Under the Medicaid standards, which have statewide application, most general practitioners and specialists are immediately eligible to participate in the program *without any enrollment or application*. The standards are contained in Exhibit A attached.

1. General practitioners

For general practitioners, please note that all those who are members of the active or attending staffs of hospitals holding a valid operating certificate from the Health Department are immediately eligible without further requirement. Likewise, physicians who are members of the New York State Academy of General Practice and are continuing to meet the educational requirements for that membership, are also immediately eligible. Other general practitioners may likewise participate in the program immediately but must have completed the educational requirements, as listed in Exhibit A, by *March 1, 1968.* Any physician who has questions concerning whether he is qualified or how to qualify should make inquiry of his city, county or district health officer. It is suggested that physicians make the necessary plans to complete this requirement by March 1, 1968, unless otherwise qualified.

2. Specialists

Physicians meeting the specialist requirements listed in Exhibit A may serve as specialists or consultants in the Medicaid Program. Physicians may inquire concerning their qualifications under the established standards from their city, county or district health offices.

The specialty status of many physicians has already been officially recognized by virtue of their inclusion in the Department's File of Clinical Consultants which was established for the Medical Rehabilitation (Physically Handicapped Children) and Vocational Rehabilitation Programs. Enrollment in this File is automatic recognition of specialist qualification in the Medicaid Program. Physicians who believe themselves qualified may apply for enrollment in the File of Clinical Consultants by submitting the usual applications form, MR 3, through the county medical society (Exhibit B).

The New York State Department of Health and the local health departments which have medical responsibility for the Medicaid Program will give every assistance to those physicians who must satisfy educational requirements to meet Medicaid standards by aiding in the development of courses that are desired or may provide such courses. The objective is to include all physicians rather than to exclude any, and to do so in the most convenient and effective manner for all concerned.

While physicians not meeting the qualifications in any form after March 1, 1968 cannot be reimbursed for their services under Medicaid, this eventuality is entirely avoidable, and it is expected the number of physicians so affected will be minimal.

B. THE PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM

Although care provided under the Physically Handicapped Children's Program will be paid from Medicaid funds to a large extent, it must be emphasized that the goals, standards of care and procedures in that program remain unchanged. For over 40 years, this program has been a source of great pride to all persons concerned with provision of high quality care to physically handicapped children. It is directed at the treatment and rehabilitative care of children with complex diseases and disabilities which require the services of highly trained specialists and frequently subspecialists. Likewise, many of the diagnostic and therapeutic procedures provided under the program require special staffs and equipment beyond what would be available in most hospitals.

The nature of the program, the services covered, the standards and the procedures are presented in Exhibit C. Actually these services cover a very small part of the total medical care services in this State. Only about 25,000 children receive specialized services under this program yearly, and all remain under the care of their personal physicians for noncovered services. However, to avoid misunderstanding, it is important that all physicians and hospitals participating in the Medicaid Program become familiar with the clinical conditions included in the program and the type of services covered, as *only specially qualified physicians and hospitals can be reimbursed* for them. Moreover, in the Physically Handicapped Children's Program, *prior authorization is a requirement* for services both by physicians and hospitals. This is true whether Medicaid funds or special medical rehabilitation funds are used in payment. Other physicians and hospitals cannot be reimbursed for any of these special services and should refer the patient promptly to a qualified resource.

We recognize that there have been many problems in the inauguration of the Medicaid Program but assure you of our efforts to resolve them at the earliest possible time with all fairness to providers and recipients of service.

Sincerely yours,

HOLLIS S. INGRAHAM, M.D.,
Commissioner of Health.

NOTE.—This letter is being sent to all physicians and hospitals outside New York City. New York City physicians and hospitals will receive a similar communication from Dr. Edward O'Rourke, Commissioner of the New York City Department of Health.

EXHIBIT 2

Exhibit A.—Qualifications of Practitioners Participating in the Medical Assistance Program

A. LEGAL BASIS

Chapter 256 of the Laws of 1966, amending Article 5 of the Social Welfare Law by adding a new title, Title 11, entitled "Medical Assistance for Needy Persons" makes the following statements pertaining to qualifications for non-institutional medical care services.

§ 364 Responsibility for standards.

To assure that the medical care and services rendered pursuant to this title are of the highest quality and are available to all who are in need, the responsibility for establishing and maintaining standards for medical care and eligibility shall be as follows:

1. The department of health shall be responsible for establishing, maintaining and certifying to the department of social welfare standards for all non-institutional medical care and services rendered pursuant to this title:
2. The department of social welfare shall be responsible for promulgating and maintaining standards for non-institutional medical care and services rendered pursuant to this title, as certified to it by the state department of health pursuant to this section;

B. PRINCIPLES CONCERNING STANDARDS FOR QUALIFICATIONS OF PRACTITIONERS

Any agency, whether public or private, to which is assigned a public responsibility has the obligation of carrying out that responsibility with consideration of reasonable standards relating to quality of service. Such standards should be established by consideration of the accepted practices in the state which have been established by the practitioners themselves and the professional associations with which they are associated, beyond what might be the minimal requirements of the pertinent licensing law. In the field of medicine, standards for care have been established in the specialties by several different agencies but most pertinently by the several American specialty boards and by the hospitals.

In the field of general practice, standards have been set by the American Academy of General Practice as well as by community hospitals. To allow participation in a publicly supported program by physicians not meeting qualifications established by their professional colleagues or professional organizations would be inconsistent with the carrying out of the public trust.

The following statement by the American Medical Association is pertinent in this regard:

"Patient care in these programs 'should meet as high standards of quality and adequacy as can reasonably be made available to others in the community.' "

C. PRECEDENTS

1. Standards for practicing physicians have been established by voluntary hospitals and, indeed, is a requirement for accreditation.
2. Standards have been established for the specialized service of physically handicapped children by the State Department of Health. This program would not be eligible for federal reimbursement without such standards. These standards have been developed in cooperation with nongovernmental consultants and have been generally well accepted.
3. The medical program of the Division of Vocational Rehabilitation follows standards similar to the physically handicapped children's program for similar procedures.
4. Standards are an inherent part of the Workmen's Compensation Program.
5. Standards have been established for certification of psychiatrists.
6. Standards have been established for qualifications of laboratory directors.

EXHIBIT 3

QUALIFICATIONS OF PHYSICIANS FOR PARTICIPATION IN THE MEDICAL ASSISTANCE PROGRAM

1. GENERAL

Physicians shall be licensed and currently registered by the New York State Education Department, or, if in practice in another state, by the appropriate agency of that state and shall meet the qualifications of a general practitioner or of a specialist to participate in the program of Medical Assistance for Needy Persons.

2. QUALIFICATIONS OF GENERAL PRACTITIONERS

A general practitioner is a physician who:

(a) is a member of the active or attending staff at a hospital holding a valid operating certificate from the New York State Department of Health; or

(b) is a member in good standing of the American Academy of General Practice or of the American College of General Practitioners in Osteopathic Medicine and Surgery; or

(c) has given satisfactory evidence of completion of a total of 150 hours of continuation education over a three year period based on standards approved by the State Commissioner of Health in accordance with the following:

(1) Not less than 50 hours of the 150 hours required shall be attendance at planned instruction which shall include one or more of the following:

(i) courses conducted by a medical school or school of osteopathy;

(ii) planned continuation education preceptorships or similar practical-training approved on an individual basis by the Medical Society of the State of New York or the New York State Osteopathic Society, jointly with the Office of Professional Education of the State Department of Health;

(iii) for not more than 20 hours credit in any given year, preparation and/or presentation of acceptable scientific exhibits or papers evaluated by the Medical Society of the State of New York or the New York State Osteopathic Society, jointly with the Office of Professional Education of the State Department of Health;

(iv) continuation education approved for this purpose by the Medical Society of the State of New York or the New York State Osteopathic Society, jointly with the Office of Professional Education of the State Department of Health.

(2) the remaining 100 hours of continuation education shall be satisfied by allowing credit on an hour for hour basis for attendance at specific scientific meetings, such as the following:

(i) attendance at meetings of medical groups, such as local, state or national, including but not limited to county medical societies, county osteopathic societies, academies of medicine, academies of general practice, district and state medical societies, district and state osteopathic societies, specialty medical meetings and meetings of the American Medical Association and of the American Osteopathic Association;

(ii) attendance at scientific programs, hospital staff meetings or similar medical meetings;

(iii) teaching responsibilities in a teaching hospital or in a medical school; a nursing school or other accredited school which teaches some branch of the health sciences;

(iv) as a preceptor for medical students;

(v) other continuation education activities accepted by the Office of Professional Education of the State Department of Health, jointly with the Medical Society of the State of New York or the New York State Osteopathic Society as meeting these requirements.

(3) physicians not possessing the above qualifications shall be given one year from the effective date of this Part or the date of licensure to meet the qualifications;

(4) if qualification is to be achieved by approved continuation education as provided for in paragraph "(c)" above, the physician shall complete at least 50 hours of such continuation education within one year of the date, specified as "(3)" above. In addition he shall complete the remainder of the required 150 hours of continuation education within two subsequent years.

(5) in extenuating circumstances involving personal or family illness or disability, health emergencies or epidemics in the community endangering the public health, or unavailability of adequate medical coverage through other sources, the above requirements may be waived for any individual physician at the discretion of the State Commissioner of Health.

EXHIBIT 4

DEFINITION OF A SPECIALIST

A specialist is a licensed physician who limits his practice to his specialty and who, on the basis of standards approved by the State Commissioner of Health:

1. is a diplomate of the appropriate American Board, or Osteopathic Board; or

2. is a fellow of the appropriate American Specialty College, or member of an Osteopathic Specialty College; or

3. has been notified of admissibility to examination by the appropriate American Board, or Osteopathic Boards, or presents evidence of completion of an appropriate qualifying residency approved by the American Medical Association, or American Osteopathic Association; or

4. holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or

5. holds a specialty rating under the Workmen's Compensation Board, provided that such rating was recommended by a county medical society or the New York State Osteopathic Society (see reverse side).

6. In psychiatry, a physician may be recognized as a specialist if he satisfies the following additional alternatives:

a. Has been Chief or Assistant Chief Psychiatrist in an approved psychiatric clinic and who is recommended for approval by the Director of Psychiatry of the Community Mental Health Board; or

b. Who graduated from Medical school prior to July 1, 1946, and who during the last five years has restricted his practice essentially to psychiatry, and is certified by the Commissioner of Mental Hygiene after approval by a Committee of the New York State Council of District Branches of the American Psychiatric Association appointed for this purpose by the President of the Council.

Workmen's compensation rating	Specialty	Residency, fellowship, or full-time graduate study, in years	Equivalent for 1-year residency
SJM-12	Allergy	Same as for SJ plus 1 year	Staff appointment plus 2 years' limited practice.
SM-6	Anesthesia	2 years	
SJM-4	Cardiovascular diseases.	Same as for SJ plus 1 year	
SH	Dermatology	3 years	
SJM-3	Gastroenterology	Same as for SJ plus 1 year	Staff appointment plus 2 years' limited practice.
SJ	Internal medicine	3 years	Staff appointment plus 3 years' limited practice.
SM-9	Neurosurgery	1 general surgery plus 4 years	
SI-1	Neurology	3 years	
SL	Obstetrics and gynecology.	....do	
SE	Ophthalmology	....do	
SB	Orthopedic surgery	1 general surgery plus 2 years	
SF	Otolaryngology	1 general surgery plus 3 years	
SK	Pathology	4 years	
SM-1	Rehabilitation and physical medicine.	3 years	Staff appointment plus 2 years' limited practice.
SM-7	Plastic surgery	2 general surgery plus 2 years	
SM-10	Occupational medicine and public health.	1 year	2 years' limited practice.
SM-8	Proctology	2 years	
SI-2	Psychiatry	3 years	
SJM-2	Pulmonary diseases	Same as for SJ plus 1 year	
SO	Radiology	3 years	
SA	Surgery	4 years	
SG	Genitourinary diseases	1 general surgery plus 3 years	
SJM-11	Metabolic diseases	Same as SJ plus special training, experience, and proficiency.	Affiliation with accredited hospital for 3 years as specialist in this field.
SM-13	Bronchoscopy	Same as SF plus special training, experience, and proficiency.	
SJM-14	Endrocrinology	Same as SJ plus special training, experience, and proficiency.	
SM-15	Oral surgery	Same as SA plus special training, experience, and proficiency.	
SM-16	Vascular and venotherapy.	Same as SA or SJ plus special training, experience, and proficiency.	
SM-17	Thoracic surgery	Same as SA plus 2 years	

Note: The above requirements were developed as guidelines by the Medical Society of the State of New York in 1960.

EXHIBIT 5

THE UNIVERSITY OF THE STATE OF NEW YORK,
THE STATE EDUCATION DEPARTMENT,
Albany, N.Y., May 15, 1967.

To: The Members of the Dental Profession in the State of New York.
From: The New York State Board of Dental Examiners.

The office of the State Board of Dental Examiners has received many telephone calls and letters asking for clarification of the legal positions and responsibilities of dentists and their auxiliary personnel in providing dental care to meet the present demands. This communication is intended to be a guide this immediate period.

We all face the fact that confusion exists, largely due to the legislation, both Federal and State, which was enacted in 1966 and called for rapid implementation of decidedly momentous programs.

Those responsible for that implementation in the state have been called upon to draw guidelines to control the complicated administration of the program and to insure that the principles of high quality dental care would be maintained from the very beginning. You have received information from the New York State Department of Health concerning these matters.

This message will discuss two very important areas of the professional life of the practicing dentist which have been receiving emphasis in study over the past several years prior to 1966. These are *continuing education* for the practicing dentist and the maximum utilization of the services of *dental auxiliary personnel.* The program mentioned in the paragraph above have brought that emphasis to an immediate prominence in all of the health professions. Let us consider each of those items separately.

Continuing education

Section 1 of the Principles of Ethics of the American Dental Association is entitled: "Education Beyond the Usual Level." It reads as follows:

"The right of a dentist to professional status rests in the knowledge, skill and experience with which he serves his patients and society. Every dentist has the obligation of keeping his knowledge and skill freshened by continuing education through all of his professional life."

This principle is incorporated in the Code of Ethics of the Dental Society of the State of New York.

In spite of this declared maxim, held out by the dental organizations representing the vast majority of the profession, it is an established fact that far too small a minority participate in continuing education. Although this has been noted in various writings, and greater participation urged by responsible representatives of the profession, the response has been minimal. The State Board of Dental Examiners has adopted a resolution, as has the Dental Society of the State of New York, to recommend to the State Education Department that a study be made of the desirability and feasibility of requiring some form of continuing education for advancing the competency of the practice of dentistry in New York State.

A definite stimulus in the direction of such a requirement has been the recent position taken by the State Department of Health that the individual practicing dentist must engage in a given minimum of continuing education in order to be eligible for participation in the Medicaid Program. If this is necessary to assure adequate care for those eligible for medical assistance, then it stands to reason it is necessary for all the people in whose name the license to practice dentistry is granted.

To resolve the present controversy over what appear to be dual standards, serious and concerted studies must be made by all concerned to establish a sound policy regarding continuing education for the licensed professions, and its relation to the welfare of the public.

Preliminary steps are being taken toward ways and means of providing adequate opportunity for continuing education to all dentists in the state. An Inter-agency conference on April 20, 1967 brought together representatives of such organizations as the Dental Society of the State of New York, the eleven District Dental Societies, the three dental schools of the state, the State University of New York, the State Department of Health, and the State Education Department to study existing facilities and future needs.

Auxiliary personnel

The published results and analyses of dental manpower studies over the past several years have shown that the number of dentists available in the state could not possibly care for the dental defects that exist among the people. In fact the number of dentists has not been truly adequate to meet the demands of the public which has sought dental care, and those demands have been estimated at less than fifty percent of the existing need for dental care.

With the development of insurance programs, dental service corporations, and medical assistance programs such as Medicare and Medicaid, the public is seeking dental care in unprecedented quantity and the demand is increasing rapidly. There is a consensus that the number of dentists available must have more adequate auxiliary assistance to meet the growing demands.

There is strong and growing support in responsible circles for increasing the abilities of auxiliary personnel and for delegating more of the procedures in the dental office to those auxiliaries. The questions presented to the office of the Board of Dental Examiners from practicing dentists indicate an awareness of the position of the A.D.A. House of Delegates and of the programs of experimentation in expanded duties of auxiliary personnel being conducted by such agencies as the U.S. Public Health Service.

The questions also indicate a general uncertainty as to the proper delegation of duties by the dentist in his office under present circumstances. There seems to be a mistaken impression that the private office is encouraged to experiment in expanded utilization of auxiliary personnel without regard to existing legal and regulatory provisions.

The Board of Dental Examiners strongly recommends that every dentist familiarize himself with the provisions of *Section 6601, Subdivision 3* of the *New York State Education Law* wherein the *practice of dentistry* is defined. While those provisions exist in their present form, the person who engages in the activities described in the definition without possession of a license to practice dentistry in the state is in violation of Section 6612 of the Education Law and liable for penalties if convicted. At the same time there are provisions in Section 6613 of the Education Law which jeopardize the license of the dentist who employs or induces, aids or abets an unlicensed person to practice dentistry.

Certain procedures are defined as proper for the licensed dental hygienist in Section 6614, Subdivision 3 of the Education Law.

Not the least of the concerns in this matter is the potential liability of the dentist, as well as his auxiliary, if anything, no matter how trivial, should go wrong while an unauthorized procedure was being undertaken by an auxiliary.

In conjunction with this present note of caution, the Board of Dental Examiners is fully aware of numerous continuing studies for determining the effectiveness of expanded or additional functions of qualified auxiliary personnel. The Board will work closely with the Dental Society of the State of New York in evaluating results of studies as they are received and in making any indicated further studies with the Dental Society. Should a new position be justified, appropriate and cooperative steps may be taken to seek amendments to the Education Law or pertinent rules and regulations.

DONALD F. WALLACE, D.D.S.,
Secretary.

Senator METCALF. The next witness is Mr. Myron L. Mayer, chairman, Public Welfare Committee of the Council of Jewish Federation & Welfare Funds, and Federation of Jewish Philanthropies of New York. Mr. Mayer, we are very pleased to have you before the committee.

STATEMENT OF MYRON L. MAYER, CHAIRMAN, PUBLIC WELFARE COMMITTEE OF THE COUNCIL OF JEWISH FEDERATIONS AND WELFARE FUNDS, AND FEDERATION OF JEWISH PHILANTHROPIES OF NEW YORK; ACCOMPANIED BY MAURICE BERNSTEIN, EXECUTIVE SECRETARY, COUNCIL OF JEWISH FEDERATIONS AND WELFARE FUNDS; AND MILTON D. LEVINE, DIRECTOR, SOCIAL LEGISLATION COMMITTEE, FEDERATION OF JEWISH PHILANTHROPIES

Mr. MAYER. Senator Metcalf, I would like to present Mr. Bernstein, the executive secretary of the Council of Jewish Federation of Welfare Funds, the Public Welfare Committee secretary, and Mr. Levine, who is the secretary of the Social Legislation Committee of the Federation of Jewish Philanthropies.

I have been asked to try to make this brief so if I skip a little and don't hit it exactly it is all to our mutual benefit.

I am Myron L. Mayer, and I serve as chairman of the Public Welfare Committee of the Council of Jewish Federations and Welfare Funds. I am also a member of the Federation of Jewish Philanthropies of New York City, serving on its Committee on Social Legislation and its Functional Committee on the Aging.

I am here today to testify as a representative of the Council of Jewish Federations and Welfare Funds, and also of the Federation of Jewish Philanthropies.

I won't go into the details of the Federation Council, they are composed of and represent a great many people throughout the whole country, and it is indeed a fact that many other businessmen who like myself volunteer their time and efforts for their organization such as the council in the New York Federation, in addition to providing support for taxes and contributions, also have an interest in the need for social work. By participating actively we try to do our part in seeing that the programs we support are carried out efficiently and for the true benefit of those in need, that is after all the end we are all looking for.

On the basis of our experience, we urge the committee to return to H.R. 5710 which embodies the proposals submitted by the Federal administration for amending the Social Security Act. We believe that H.R. 5710 contains provisions which are superior to H.R. 12080 in many ways. We feel however that H.R. 5710 can be improved, and we urge that several changes be made.

H.R. 5710 provides, as you know, for a greater increase in social security benefits—an overall average of 20 percent, and at least a 59-percent increase for those who receive minimum benefits, which, of course, are very, very low. We feel that the increases should be even greater, but would regard this new level as an essential step forward.

It seems almost a truism to say that social security benefits should be sufficient to raise recipients above the despair of poverty. But, unfortunately, it seems that this point must be made. And it must be made even though Congress has committed itself on the record—in the Economic Opportunity Act of 1964—by declaring: "It is the policy of the United States to eliminate * * * poverty * * *." It is estimated that the standards of H.R. 5710 would lift 2 million people out of poverty.

In line with the recommendations of the Advisory Council on Public Welfare, of the Department of Health, Education, and Welfare, the Council of Jewish Federations has urged the adoption of minimum Federal standards for all persons in actual need, regardless of age, family situation or residence. At the same time, the council went on record at its annual national assembly last year with these goals:

> Elimination of arbitrary distinctions related to residence or categories of aid.
> Simplification of eligibility procedures for obtaining assistance.
> Comprehensive State plans with universal availability of services to eligible persons.
> Better organization and coordination of services.
> More and fuller interpretation of the role and programs of public welfare.

H.R. 5710 moved in the direction of these principles in requiring States to meet the full need of individuals eligible for public assistance according to the State's standards for the financial aid required, and as reviewed and revised annually.

The principle of meeting full need is very sound.

We urge that the Federal Government require States to meet adequate minimum standards set nationally—but taking the differing costs of living in each State into account.

We could not agree more with the conclusion of the advisory Council on Public Welfare:

> Public assistance payments are so low and so uneven that the Government is, by its own standards and definitions, a major source of the poverty on which it has declared unconditional war.

All too often there is an assumption that most people who require public assistance should, and can, be removed from its rolls, and the corollary, that being in need of such aid is itself a sign of individual failure. The fact is that the vast majority of those who are in need are too young, too sick, or too old to work. And these conditions require aid—aid administered with dignity and a full understanding of the condition of the individual.

Such people require skilled social services to achieve their maximum potentialities for useful lives—as do those others—a small minority—who are employable but who need aid in qualifying for finding, and holding jobs, and these people, I think you are taking care of.

We welcome the increased Federal matching of 75 percent with the States' 25 percent for services to children on the aid to families with dependent children program. We feel that such Federal assistance should be available for comprehensive child welfare programs, so that services may be available for all children who need them including those not on AFDC.

But, we are very concerned because H.R. 12080 requires that all adults on the rolls, including mothers and youths over 16 who are out of school, work or engage in a work training program—unless specifically exempted—as a condition of receiving assistance. We believe that skilled counseling services— as currently provided in the act, and now expanded by increased Federal financial assistance—are required to enable those parents to work who can do so—and whose best interests, and those of their families would be served by working—if they can find jobs.

Many mothers will provide greater benefits, both social and financial, to their children by acting as full-time mothers rather than being pushed into involuntary employment.

We applaud the increased funds made available for day-care services and for foster home placement. Certainly more of such services should be available for those who need them, but not on an arbitrary basis.

We regret the new restrictions in H.R. 12080 that would be placed on Federal assistance to families on the AFDC program with unemployed fathers. We fear that exclusion of such families could only lead to greater hardship and possibly the creation of more broken homes. In our judgment, such restrictions should be removed. Fathers without the required recent employment are likely to be in the greatest need of the aid and, if this is not forthcoming, their children could be caused unnecessary suffering.

We urge the provision of work incentives whereby adults in the AFDC program may be permitted to retain part of their earnings, as a great step forward. We urge return to the H.R. 5710 version which makes it possible for such adults to retain $50 monthly, rather than $30, plus one-half of any additional earnings, with no reduction in assistance. The increased amount is more likely to achieve the objective sought.

We are fearful also that the specifications for the requirement that all States "establish programs to combat illegitimacy" may lead to undesirable coercion.

The Federal financing limitation of the number of those on AFDC—establishing a quota tied in with the ratio of such children to the total child population of each State as of January 1967—is definitely unsound. As a result, children and families may be deprived of assistance at the level needed for healthy development as good citizens in the future.

When the 89th Congress adopted title XIX, the medical assistance to the needy program—we welcomed it as a major achievement. The program is still in its beginning stages. Not all the States have yet acted on it. A number of the States which have taken action, in accordance with the present law, have established effective programs which should not be undermined. We, therefore, urge the maintenance of the program in its present terms—at least until greater experience makes possible accurate evalution.

We do not think it sound policy to tie in eligibility for medicaid with the amounts paid under the AFDC program.

The bill before this committee would permit the States, as a condition for approval of title XIX, to offer any seven of 14 services without any necessary regard to the Social Security Amendments Act of 1965 which required the provision of five basic services.

These five basic services are, I am sure you know, they are inpatient, outpatient services, other laboratory and X-ray services, skilled nursing home services, and physicians' services. They are truly basic and have greater value for those covered by title XIX than the other nine, even though we look forward to the day when all are provided. We urge that this committee continue the present title XIX requirement for the States to provide, as a minimum, the five basic services.

In these ways—it is possible to assure required health services for all people who are in need.

We support the provision in H.R. 5710 extending health insurance benefits—medicare—to the 1.5 million seriously disabled Americans who receive social security and railroad retirement benefits. As the President himself pointed out—

> The typical member of this group is over 50. He finds himself in much the same plight as the elderly. He is dependent on social security benefits to support himself and his family. He is plagued by high medical expenses and poor insurance protection.

We approve the provision for increased coverage in the number of hospital days in a spell of illness from 90 to 120 days.

Similarly, we welcome the provision for payment of full reasonable charges for radiological or pathological services furnished by physicians to hospital inpatients.

We also support enthusiastically, and very enthusiastically, title IV in section 401, in both H.R. 5710 and H.R. 12080, which authorizes grants to colleges and universities and to accredited schools of social work, for the purpose of meeting part of the cost of development, expansion or improvement in graduate or undergraduate programs in the field of social work.

We regard the authorization of $5 million as a minimum initial amount for this indispensable program. We urge that it be increased thereafter to help provide the professional personnel essential to worthwhile welfare programs.

In conclusion, we recommend a return to H.R. 5710 with the improvements we have suggested. We believe that our recommendations will achieve the purposes of bringing to self-support all who can achieve it, more effectively than would H.R. 12080; and would serve, more humanely and wisely, those who cannot support themselves based on tested experience and analysis of the facts.

On behalf of the Council of Jewish Federations and Welfare Funds, and the New York Federation of Jewish Philanthropies of Greater New York, I thank you for the opportunity of appearing and for your consideration of our views. Thank you very much.

Senator METCALF. Senator Bennett?

Senator BENNETT. No.

Senator METCALF. Mr. Mayer, the members of the committee thank you for raising questions and very authoritatively discussing some of them. They are being seriously considered and they are problems in the mind of this committee. We thank you for your appearance and those of your colleagues and your testimony before this committee.

Mr. MAYER. Thank you very much.

(The prepared statement of Mr. Mayer follows:)

PREPARED STATEMENT OF MYRON L. MAYER ON BEHALF OF THE COUNCIL OF JEWISH FEDERATIONS AND WELFARE FUNDS AND THE FEDERATION OF JEWISH PHILANTHROPIES OF NEW YORK CITY

Mr. Chairman and Members of the Committee: My name is Myron L. Mayer and I live in New York City. I serve as chairman of the Public Welfare Committee of the Council of Jewish Federations and Welfare Funds. I am also a member of the Federation of Jewish Philanthropies of New York City, serving on its Committee on Social Legislation and its Functional Committee on the Aging.

I am here today to testify as a representative of the Council of Jewish Federations and Welfare Funds, and also of the Federation of Jewish Philanthropies.

Through the Jewish community organizations which make up its membership, the Council is involved with the planning and financing of local health, welfare and educational services is almost 800 communities across the country.

The New York Federation is the largest affiliate of the Council of Jewish Federations. It is the communal representative of 110 health and welfare agencies in Greater New York, whose services are used annually by close to a million people of all races and religions.

But, I am also appearing in another role. That of a businessman who contributes, hopefully, to the well-being of my country in the many various taxes I pay. I feel that as such a contributor, I have an interest—and an obligation—to speak out about the social welfare policies and practices in my community . . . whether it be the town in which I live, or the country in which I live.

And, I am representing many other businessmen who, like me, volunteer their time and efforts for organizations such as the Council and the New York Jewish Federation . . . in addition to providing support through taxes and contributions. We also have an interest in the need for social work. By actively participating—such as my presence here—we try to do our part in seeing that the programs we support are carried out efficiently and for the true benefit of those in need.

On the basis of our experience, we urge this Committee to return to H.R. 5710 which embodies the proposals submitted by the Federal administration for amending the Social Security Act. We believe that H.R. 5710 contains provisions which are superior to H.R. 12080.

We also feel, however, that H.R. 5710 *can be improved*, and we urge that several changes be made.

H.R. 5710 provides, as you know, for a greater increase in Social Security benefits—an overall average of 20-percent, and at least a 50-percent increase for those who receive minimum benefits. We feel that the increases should be even greater, but would regard this new level as an essential step forward.

It seems almost a truism to say that social security benefits should be sufficient to raise recipients above the despair of poverty. But, unfortunately, it seems that this point must be made! And it must be made even though Congress has committed itself on the record—in the Economic Opportunity Act of 1964—by declaring: "It is the policy of the United States to eliminate . . . Poverty . . ." It is estimated that the standards of H.R. 5710 would lift two million people out of poverty.

In line with the recommendations of the Advisory Council on Public Welfare, of the Department of Health, Education, and Welfare, the Council of Jewish Federations has urged the adoption of minimum Federal standards for all persons in actual need, regardless of age, family situation or residence. At the same time, the Council went on record at its annual national Assembly last year with these goals:

> "Elimination of arbitrary distinctions related to residence or categories of aid.
>
> "Simplification of eligibility procedures for obtaining assistance.
>
> "Comprehensive State plans with universal availability of services to eligible persons.
>
> "Better organization and coordination of services.
>
> "More and fuller interpretation of the role and programs of public welfare."

H.R. 5710 moved in the direction of these principles in requiring States to meet the full need of individuals eligible for public assistance according to the State's standards for the financial aid required, and as reviewed and revised annually.

The principle of meeting full need is sound.

We urge that the Federal government require States to meet adequate minimum standards set nationally—but taking the differing costs of living in each State into account.

We could not agree more with the conclusion of the Advisory Council on Public Welfare: "Public assistance payments are so low and so uneven that the Government is, by its own standards and definitions, a major source of the poverty on which it has declared unconditional war."

All too often there is an assumption that most people who require public assistance should, and can, be removed from its rolls, and the corollary, that being in need of such aid is itself a sign of individual failure. The fact is that the vast majority of those who are in need of aid are too young, too sick or too old to work. And these conditions require aid—aid administered with dignity and a full understanding of the condition of the individual.

Such people require skilled social services to achieve their maximum potentialities for useful lives—as do those others—a small minority—who are employable but who need aid in qualifying for, finding, and holding jobs.

We welcome the increased Federal matching of 75-percent with the States' 25-percent for services to children on the Aid to Families with Dependent Children program. We feel that such Federal assistance should be available for comprehensive child welfare programs, so that services may be available for all children who need them, including those not on A F D C.

But, we are very concerned because H.R. 12080 requires that all adults on the rolls, including mothers and youths over 16 who are out of school, work or engage in a work training program (unless specifically exempted) as a condition of receiving assistance. We believe that skilled counseling services—as currently provided in the Act, and now expanded by increased Federal financial assistance—are required to enable those parents to work who can do so—and whose best interests, and those of their families would be served by working—if they can find jobs.

Many mothers will provide greater benefits to their children by acting as full-time mothers rather than being pushed into involuntary employment.

We welcome the increased funds made available for day care services and for foster home placement. Certainly more of such services should be available for those who need them, but not on an arbitrary basis.

We regret the new restrictions in H.R. 12080 that would be placed on Federal assistance to families on the AFDC program with unemployed fathers. We fear that exclusion of such families could only lead to greater hardship and possibly the creation of more broken homes. In our judgment, such restrictions should be removed. Fathers without the required recent employment are likely to be in the greatest need of the aid and, if this is not forthcoming, their children could be caused unnecessary suffering.

We welcome the provision of work incentives whereby adults in the AFDC program may be permitted to retain part of their earnings. We urge return to the H.R. 5710 version which makes it possible for such adults to retain $50 monthly, rather than $30, plus one-half of any additional earnings, with no reduction in assistance. The increased amount is more likely to achieve the objective sought.

We are fearful also that the specifications for the requirement that all States "establish programs to combat illegitimacy" may lead to undersirable coercion.

The Federal financing limitation of the number of those on AFDC—establishing a quota tied in with the ratio of such children to the total child population of each State as of January, 1967—is definitely unsound. As a result, children and families may be deprived of assistance at the level needed for healthy development.

When the 89th Congress adopted Title XIX—the Medical Assistance to the Needy program—we welcomed it as a major achievement. The program is still in its beginning stages. Not all the States have yet acted on it. A number of the States which have taken action, in accordance with the present law, have established effective programs which should not be undermined. We, therefore, urge the maintenance of the program in its present terms—at least until greater experience makes possible accurate evaluation.

We do not think it sound policy to tie in eligibility for Medicaid with the amounts paid under the AFDC program.

The bill before this Committee would permit the States, as a condition for approval of Title XIX, to offer any seven of fourteen services without any necessary regard to the Social Security Amendments Act of 1965 which required the provision of five basic services.

These five basic services are: inpatient, outpatient services, other laboratory and X-ray services, skilled nursing home services, and physicians' services. They are truly basic and have greater value for those covered by Title XIX than the other nine, even though we look forward to the day when all are provided. We urge that this Committe continue the present Title XIX requirement for the States to provide, as a minimum, the five basic services.

In these ways—it is possible to assure required health services for all people who are in need.

We support the provision in H.R. 5710 extending health insurance benefits (Medicare) to the 1.5-million seriously disabled Americans who receive Social Security and railroad retirement benefits. As the President pointed out, "The typical member of this group is over 50. He finds himself in much the same plight as the elderly. He is dependent on social security benefits to support himself and his family. He is plagued by high medical expenses and poor insurance protection."

We approve the provision for increased coverage in the number of hospital days in a spell of illness from 90 to 120 days.

Similarly, we welcome the provision for payment of full reasonable charges for radiological or pathological services furnished by physicians to hospital inpatients.

We commend, particularly, Title IV, Section 401, in both H.R. 5710 and H.R. 12080, which authorizes grants to colleges and universities and to accredited schools of social work, for the purpose of meeting part of the cost of development, expansion or improvement in graduate or under-graduate programs in the field of social work.

We regard the authorization of $5-million as a *minimum initial* amount for this indispensable program. We urge that it be increased thereafter to help provide the professional personnel essential to worthwhile welfare programs.

In conclusion, we recommend a return to H.R. 5710 with the improvements we have suggested. We believe that our recommendations will achieve the purposes of bringing to self-support all who can achieve it, more effectively than would H.R. 12080; and would serve, more humanely and wisely, those who cannot support themselves based on tested experience and analysis of the facts.

On behalf of the Council of Jewish Federations and Welfare Funds, and the New York Federation of Jewish Philanthropies, I thank you for the opportunity of appearing before this Committee, and for your consideration of these views.

Senator METCALF. The next witness is Mr. James W. Fogarty, executive director, Community Council of Greater New York.

Mr. Fogarty, there isn't a greater name in health and welfare than Fogarty because I was formerly a colleague of the great Congressman from Rhode Island who made such a great contribution.

STATEMENT OF JAMES W. FOGARTY, EXECUTIVE DIRECTOR, COMMUNITY COUNCIL OF GREATER NEW YORK

Mr. FOGARTY. I don't happen to be a relative of his. I used to be related to the Portuguese Fogartys of Rhode Island.

Senator METCALF. We are delighted to have you before the committee.

Mr. FOGARTY. Of course the loss of Congressman Fogarty was a tremendous loss to those of you and certainly to us in this field.

I am James W. Fogarty, the executive director of the Community Council of Greater New York and a former member of the advisory council on public welfare which was appointed by the Secretary of Health, Education, and Welfare pursuant to congressional directive contained in the Public Welfare Amendments of 1962 to make recommendations for improvements in the public assistance and child welfare programs authorized under the Social Security Act. The community council is the central planning, educational, and research unit for the more than 1,200 public and voluntary social agencies which seek to serve effectively the health and welfare needs of the eight million people of Greater New York. We have been in this business for some 40-odd years.

The main thrust of my testimony today will be that the community council supports those proposals of H.R. 12080 that extend services and make adequate appropriations. I testified before the House Ways and Means Committee and I will not repeat that testimony here although it is attached to my general testimony today.

Senator METCALF. It will be accepted and received for the record.

Mr. FOGARTY. I testified on that bill. I believe that bill was better in many respects than even the one you have before you now, was insufficient to resolve the health and welfare problems of the people it intended to benefit. But the present bill—despite some definitely good and progressive features—is not only insufficient but, like the Mr. Hyde side of Dr. Jekyll, is vicious, cruel, and unacceptably paradoxical.

I am not going to follow the written text. I have a very high regard for Wilbur Mills and his committee. I think that over the course of the years he has done a tremendous job. I was terribly disappointed when I saw this bill and saw the language in the bill which returned to what we considered to be punitive and unjust suggestion, at least, with respect to certain parts of the population on public welfare.

The part I am referring to are sections, title II, the "Public Welfare Amendments" of H.R. 12080 that seek additional law enforcement efforts in cases of parental desertion or abandonment in AFDC cases and impose a freeze on Federal financial participation in that same category of cases. In our opinion these sections of the bill are unnecessary because they are already embedded in policy papers and directions from the Secretary of Health, Education, and Welfare, to the departments of welfare in the United States. For example, the section dealing with law enforcement is an absolutely unnecessary cost since such procedures were inherent in the original act of 1935 and have been a continuous concern of administration at the Federal, State, and local level of public welfare administration. For example, there have been clear administrative orders by the U.S. Secretary of Health, Education, and Welfare since 1961 requiring that State public assistance agencies have a central unit for registration and follow-up of nonsupporting parents in AFDC cases and this whole subject was the topic of a meeting held by HEW in May of 1963 on "Coordination in the Location of Absent Parents of Children Receiving Aid to Families With Dependent Children."

The then Commissioner of Welfare, Dr. Ellen Winston, who, as you know, served as Director of Public Welfare of the State of North Carolina for many years pointed out the large number of absent parent cases in AFDC and pointed out the reciprocal support acts existing between States for dealing with the problem and pointed out that in her own home State of North Carolina use of these procedures resulted in a threefold increase in support by absent parents. She pointed out that local welfare agencies should have legal counsel since without such counsel little progress was made in locating absent parents but noted that at that time Federal financial participation was available for the cost of such legal services.

The second aspect of this is the freeze on certain subgroups in the AFDC category, based on the total number of such children receiving assistance in January 1967. I have no intention of going into any great extent at this time in my testimony for reasons why we have a million or more minority families in New York City from the Negro and Puerto Rican group. I have no intention of going into the historical background of why there is such a high rate of illegitimacy among these particular groups. I am going to say this though that I believe that the section on the freeze in some way suggested that if you cut off families on public assistance, if you set an arbitrary level of numbers, and ordered the welfare departments not to go beyond that level that in some way this is going to resolve the problem of illegitimacy or it will force families not to have illegitimate children.

Senator Metcalf, I think we are both too sophisticated, and I think that the committees on Congress are too sophisticated in our experience with the Prohibition Act to think that legislation can do away with fornication and adultery. I think this problem has deep-seated historical and cultural roots with which the Members of Congress are familiar and I do not think that any useful purpose is honestly served by having language in this bill with respect to both the freeze and the matter of going after the husband, and so forth.

George Wyman testified this morning, but they already have an extensive apparatus for this very purpose of going after fathers. The reason they are not going after many of the fathers is because they are being pursued by the law enforcement elements which are associated with this problem on orders from so-called nonsupport courts. I can tell you, I served in both the family court and the children's court in New York City as a social worker for a number of years in the 1930's. I was on the staff of the juvenile court here in Washington, D.C. I am familiar with the juvenile courts and family courts all around the Southeastern part of the United States, including Mississippi, Louisiana, Florida, Virginia, in fact I have been there for a number of years, and this whole matter of nonsupport orders is an extremely difficult, and I would say administratively impossible to do. The courts just do not have the staffs to do it. They have never been adequately staffed to do this type of thing, and I have grave question that the committee itself, and I think the House Ways and Means Committee, feel that these provisions were going to have any substantial effect.

At a meeting I attended shortly before the bill was brought out, Mr. Mills said the committee is worried about the problem of illegitimacy, and I said to myself, "Wilbur, so am I. Very worried about the problem of illegitimacy, I don't think this bill will make a substantial contribution to that."

In addition to that in a sense it is going to force the State to do one of two things. Either they are going to cut aid to mothers, to illegitimate mothers, off relief which they have done in some States and for which the HEW lifted the approval of the State plan because of this, and you know of the circumstance about which I am speaking, or it is going to force those States, as the Congressman from California testified this morning, to make an across-the-board cutback in all public welfare expenditures in order to meet the provisions of this bill, and I think that is regressive.

Now, with respect to medical assistance, there has been considerable discussion about this and there was this morning before the committee. Our agency is the agency which does an annual cost-of-living survey in New York City.

Last year four people to live in modest and adequate comfort in New York City cost $6,400 a year. This year it has gone up to $6,600 a year.

Now, we can talk and talk and talk about why is it so expensive to live in New York City versus why a similar situation across the country, as was discussed this morning with George Wyman when he was testifying. The fact of the matter is that New York City is an expensive city to live in, and the setting down of arbitrary limits which prevent the State of New York from meeting the medical needs of the people is going to return this program, the medicaid program, to the level that it was at and it is going to turn title XIX into a public assistance program, and if you remember medical assistance for the aged program a number of States would not participate in that program and vast numbers did not apply because they did not want to be characterized as public assistance recipients. So I think that on the medicaid I am opposed to again this arbitrary limit that the committee has proposed to put upon it. I would much rather see a constructive approach to it through some suggestion being made in our State for a variety of statewide medical insurance under private auspices or otherwise.

As the Congressman from California testified this morning, it is this type of approach which will force us eventually to get national compulsory health insurance programs.

Now, with respect to the social insurance and public welfare, the council on which I serve had this to say about the social insurance "clearly the social insurance programs need to realize more adequately their primary function of underpinning income.". Now, we know that the social security and public assistance programs which are matching programs and which in the case of one where the insurance program would increase, private insurance would drop. This has not occurred as some of the statistics we have heard. For instance there are a million people who are getting public assistance and social security at the same time. There are large numbers, Senator, where the cost of living has so far exceeded the benefit rate so that more than one-half are also receiving old age and survivors benefits. I am sure this would not be the intention of Congress when they passed the social security bill. Their intention was to see people would live adequately on their retired benefits.

I am happy to see the child welfare provisions of this bill. I believe there were provisions in the other bill which were preferable to this bill, but I am happy to see they—those provisions authorizing increased health care for children receiving day care, for increased day care benefits and services generally, and for providing day care for those persons of low income groups who are most needy of its services.

I am also happy to see in here a provision for aid to social work education. It happens I served for 8 years as professor of social welfare and dean of Fordham University School of Social Work in New York City, and I am familiar with the problems of social work education, and I am happy to see this provision in this bill. And we support it, particularly with the idea that it will also increase the undergraduate education in this field and I would hope the ceiling of $5 million would be removed after the first of the year of the appropriation.

I think that that about concludes what I wanted to say. I do feel, as I said earlier, I have a high regard for Wilbur Mills and his committee, and I would hope what I consider to be language which is pretty much out of date would be taken out of this legislation by the Senate.

Thank you, Senator.

(Statements of James Fogarty follow:)

TESTIMONY BY JAMES W. FOGARTY, COMMUNITY COUNCIL OF GREATER NEW YORK

I am James W. Fogarty, the Executive Director of the Community Council of Greater New York and a former member of the Advisory Council on Public Welfare which was appointed by the Secretary of Health, Education and Welfare pursuant to Congressional directive contained in the Public Welfare Amendments of 1962 to make recommendations for improvements in the public assistance and child welfare programs authorized under the Social Security Act. The Community Council is the central planning, educational and research unit for the more than 1200 public and voluntary social agencies which seek to serve effectively the health and welfare needs of the eight million people of Greater New York.

The main thrust of my testimony today will be that the Community Council supports those proposals of H.R. 12080 that extend services and make adequate appropriations. This is the same point I made in testimony on H.R. 5710 before the House Ways and Means Committee on April 11, 1967 (a copy of which is attached as a supplement to today's testimony). At that time I concluded that even that Bill, which was better in many respects than the one before you now, was insufficient to resolve the health and welfare problems of the people it intended to benefit. But the present Bill—despite some definitely good and progressive features—is not only insufficient but, like the Mr. Hyde side of Dr. Jekyll, is vicious, cruel and unacceptably paradoxical. It apparently attacks the stereotype of public welfare recipients instead of dealing with the realities of poverty and human nature. Instead of addressing itself to the basic reforms in our public welfare system recommended by the Advisory Council on Public Welfare, the House Ways and Means Committee in H.R. 12080 reflects an astonishingly regressive philosophy that very few states have ever put forward. We support the good Dr. Jeykll elements of H.R. 12080, but urge the Senate Finance Committee to cut out the horrible Mr. Hyde provisions.

Your Committee and the Committee on Ways and Means of the House of Representatives has heard testimony that certain sections of the proposed 1967 amendments to the Social Security Act and especially those sections of H.R. 12080 dealing with public welfare are cruel, punitive, unjust and unworkable. While I agree with this characterization, I will not belabor you with it. Instead I intend to bring to your attention another argument, perhaps even more persuasive on a cost-result basis, for the deletion of certain sections of the Bill before you. That argument is that these sections are *unnecessary and futile* and additional Federal expenditure for their implementation is wasteful. In addition to being wasteful these sections given an unnecessarily harsh emphasis to certain routine aspects of public assistance administration and they do it at a time when there is increasing legal objection on Constitutional grounds and professional and general public argument for relaxation of these measures in the name of just and dignified treatment for all Americans including those who may be financially dependent.

PUBLIC ASSISTANCE

I am referring specifically to sections of Title II, the "Public Welfare Amendments" of H.R. 12080 that seek additional law enforcement efforts in cases of parental desertion or abandonment in AFDC cases and impose a freeze on Federal financial participation in that same category of cases. The section dealing with law enforcement is an absolutely unnecessary cost since such procedures were inherent in the original act of 1935 and have been a continuous concern of administration at the Federal, state and local level of public welfare administration. For example, there have been clear administrative orders by the U.S. Secretary of Health, Education, and Welfare since 1961 requiring that state public assistance agencies have a central unit for registration and follow-up of non-supporting parents in ADC cases and this whole subject was the topic of a meeting held by HEW in May of 1963 on "Coordination in the Location of Absent Parents of Children receiving Aid to Families with Dependent Children." The then Commissioner of Welfare, Dr. Ellen Winston called attention to the large number of absent parent cases in AFDC and pointed out the reciprocal support acts existing between states for dealing with the problem and pointed out that in her own home state of North Carolina use of these procedures resulted in a three-fold increase in support by absent parents. She pointed out that local welfare agencies should have legal counsel since without such counsel little progress was made in locating absent parents but noted that at that time Federal financial participation was available for the cost of such legal services. These services are available under the 1962 public welfare amendments for Federal financial participation and on the same basis of "strengthening family life" which H.R. 12080 uses as a rationale for increasing Federal financial participation to the 75% level.

The freeze on certain sub-groups in the AFDC category, based on the total number of such children receiving assistance in January 1967, is not only unjust, punitive and possibly unconstitutional (philosophically if not in fact) under the equal protection of the laws clause, but will probably not be feasible of administration. Although it is likely that the Congress cannot be challended in its authority to determine limits on Federal financial participation according to formulas of its own devising, it is probable that the states can be successfully challenged on Constitutional grounds in their attempts to administer this limitation by denying assistance to certain groups of children who otherwise meet all the eligibility requirements of public assistance except that they exceed the total number that can be assisted on Federal matching grants because of this caseload freeze. This would also mean that intake and acceptance of applications in public assistance by public agencies would be closed for the first time since the passage of the original Social Security Act.

Further, those states with progressive public welfare programs and a policy of providing assistance to all needy persons eligible under Federal and state policy will not deny assistance to eligible persons simply because they exceed a given number. Therefore the Federal limitation is a retrenchment from Federal policy existing under the Social Security act since 1935 in that it forces a transfer to state financial responsibility of assistance to persons otherwise completely eligible under Federal programs. It will even be a retrenchment with respect to administration of public assistance in those states which for a variety of reasons—including low fiscal capacity—periodically cut back on the amount of assistance that can be paid even when families meet the state's standards for assistance and Federal matching is available. It will deny assistance in those states to specific groups of people for the first time. To the present, in those states with limited fiscal capacity the tendency has been to cut back grants to all categories of clients or all persons within a given category but not to deny assistance to persons above a certain number assisted in a given year.

TITLE XIX [MEDICAL ASSISTANCE TO THE NEEDY]

With respect to the new limitations on Medicaid (Title XIX) in H.R. 12080 establishing the maximum standard for medical indigency at one and one-half times the standard for public assistance with respect to allowable income, the Welfare Commissioner of New York State has indicated that these changes would deny aid to 600,000 New Yorkers currently eligible under that state's progressive plan, which was approved by the Department of Health, Education and Welfare under Congressional policy established at the time of enactment of Title XIX. The immediate additional cost to New York State in maintaining those otherwise eligible persons under its state plan is estimated to come to over $35 million under the proposed House changes. These changes would essentially reduce Title_XIX to the public assistance level rather than covering the medically indigent as Congress originally intended. Therefore it will be no more useful than its predecessor Medical Assistance for the Aged program (MAA) which nearly half the states refused to adopt during the five years of its existence. If the House intent is to limit Title XIX to public assistance cases then Medicaid is unnecessary legislation since the medical provisions pre-existing in public assistance are sufficient. Further, the estimated 7 million persons eligible for public assistance nationally but not receiving it will probably be no more interested in medical, vendor or reimbursement payments under public assistance-related Medicaid than they were in a money assistance grant under that system despite their need for medical care assistance.

There was a better chance of independent, highly motivated groups of needy persons in our population to have accepted necessary medical care under a true medical indigency program, than under a public assistance level approach. This is even more true of those additional persons above the public assistance level but with less than $6000 annual income for a family of four.

Turning to the relationship of our social insurance and public welfare programs noted by the Advisory Council on Public Welfare in its June, 1966 *Report* and its conclusion that "clearly the social insurance programs need to realize more adequately their primary function of underpinning income," I would like to comment on the adequacy of Social Security benefit increases under H.R. 12080.

Because of the inadequacy of the Old Age Survivors and Disability Insurance program it is necessary to have publicly supported welfare services including money grants, medical assistance programs, child-welfare services and supporting services such as staff training and administration. At the time of adoption of the Social Security Act in 1935 it was hoped that eventually all persons would be covered under its provisions although it was geared to the working population and their dependents. Public welfare programs were seen as supplementary to the basic social insurance program and meant to assist those not eligible for OASDI benefits.

In recent years there has been a steady total of 7 million persons in the United States receiving Federally aided categorical assistance and an additional 600,000 who are assisted by State and local funds alone. An indicator of the inadequacy of the social security grant—which is obvious to every local welfare department which characteristically has an appreciable number of persons who receive OASDI benefits but still require public assistance because their social security benefit grant is inadequate to meet their essential living cost is the number of aged beneficiaries receiving assistance.

In 1966 a minimum of one million persons, or about 15% of the total persons receiving public assistance, were persons who did in fact qualify for and receive Social Security money benefits but still required public assistance to meet their basic living expenses at the public assistance level which in many places is below the commonly accepted poverty standard. Actually the one million persons receiving both public assistance and OASDI refers to the group 65 years of age and over who receive both Old Age Assistance and OASDI. This figure does not even account for those other persons receiving public assistance such as dependent children or disabled persons many of whom also receive some form of OASDI benefit which, as in the case of the older group, is inadequate to their basic living costs either in a family group or on a single person basis.

If only the Old Age Assistance category is considered, then almost 50% of recipients of OAA also receive OASDI benefits. The figure is 6% for families of children receiving AFDC according to a 1961 HEW study. However, examination of the Old Age Assistance category alone is pertinent since Congress has historically been especially concerned with the elderly person who has worked and earned his way to retirement. As conceived in 1935 the Socity Security program would have provided reasonable basic maintenance for such persons. However this has not occurred. The cost of living has far exceeded the benefit rate to the extent that almost one half of all persons over 65 years of age who receive Old Age Assistance are also receiving benefits under OASDI.

It is inconceivable that this was the original intent of Congress and is one reason I support at least the amount of benefit increase in OASDI benefits recommended by the Administration, that is, 15% rather than the 12.5% authorized in H.R. 12080. This gap in the income maintenance ability of the OASDI program at present benefit levels is even more dramatic if one considers the recommendations of the Advisory Council on Public Welfare which called for a minimum national standard of income, extension of coverage and liberalization of benefits under the social insurance programs, and even consideration of a guaranteed national income as a right. With these goals in mind it is a curious paradox that over 5% of the aged population of the United States receives both OASDI and Old Age Assistance and this figure is increasing gradually but steadily. This indicates that the OASDI system is losing ground with respect to a group about which Congress has always been concerned—the aged. It also reflects the inadequacy of the benefit level.

CHILD WELFARE

The child welfare sections of H.R. 12080 are desirable in that they increase authorization for Federal appropriations almost two-fold beginning in Fscal 1969, expand foster home care under the AFDC Programs, and authorize some liberalization of appropriations for child welfare research and demonstration.

However, the appropriations authorized fall far short of meeting child welfare services costs at present levels.

I believe that the purposes of H.R. 12080 would be better served by implementing those features of the Burke Bill (H.R. 1077) providing necessary, supportive child welfare services and authorizing approriations adequate to realize this goal. This would abet the intent of H.R. 12080 in reducing costs of public assistance but it would do so on the humanitarian basis of protection of children rather than a denial to children of needed basic maintenance through various methods of either attempting to find families with children ineligible for assistance or placing an absolute freeze on the number of children who can be served with Federal financial participation. I applaud the move of the child welfare services program from Title V to Title VI if the intent is to upgrade child welfare services to children receiving public assistance. However, I would have hoped that such a transfer might logically have led Congress to conclude that child welfare services appropriations should be open-ended as are public assistance appropriations.

I am pleased that the House Ways and Means Committee report on H.R. 12080 recognizes the gap between Federal funds allocated for participation in State child welfare programs and the actual expenditures, but H.R. 12080 fails to adequately support these necessary State exenditures. The report recognizes that states are required to match Federal funds on a basis ranging from ⅓ to ⅔ but that in the overall Federal share amounts to only about 10% of total expenditures of over $307 million annually for State child welfare programs.

I, of course, support those sections of H.R. 12080 which authorize increased appropriations for the purpose of enabling State welfare agencies to establish, expand and strengthen child welfare services through the adoption of state plans which are to be operative according to state standards throughout the state. I also support those provisions authorizing increased health care for children receiving day care, for increased day care benefits and services generally, and for providing day care for those persons of low income groups who are most needy of its services.

CONCLUSION

In conclusion, I urge that you approve and perhaps expand and upgrade those features of H.R. 12080 which reflect a progressive Federal social security and public welfare policy, and that you delete or amend these regressive features that this and so much other testimony has pointed out. It is time to stop blaming the public assistance programs for the deficiences of the Social Security system, which has never realized its original goal of providing adequate basic maintenance for its beneficiaries. Congress should consider these deficiencies realistically either through greatly improved OASDI benefits or through serious consideration of a guaranteed national income above the poverty level. The Advisory Council on Public Welfare report summed up my point as follows: "If social insurance benefits are made adequate to help meet ordinary living costs during periods of income cessation or interruption, then the public welfare program will be better able to fulfill its primary functions: meeting special and unusual needs of wage earners and their dependents, providing for the income maintenance needs of individuals and families who are not covered by social insurance, extending medical assistance, and providing a broad range of social services." And may I add that all these things should be done on a helpful, humanitarian basis and not on a punitive or coercive basis.

SOCIAL SECURITY AMENDMENTS OF 1967 (HR 5710)—TESTIMONY BY JAMES W. FOGARTY, COMMUNITY COUNCIL OF GREATER NEW YORK, BEFORE THE COMMITTEE ON WAYS AND MEANS OF THE HOUSE OF REPRESENTATIVES

I am James W. Forgarty, the Executive Director of the Community Council of Greater New York. The Community Council is the recognized organization and central facility through which the citizens of New York City and their more than 1,000 public and voluntary social agencies seek to serve ever more effectively the health and welfare needs of eight million people. Its membership includes executives and volunteer leaders of social welfare organizations, professional bodies, business and labor, and heads of City departments concerned with health and welfare. Its Corporate Members encompass more than 800 social service agencies.

Operationally, the Community Council is divided into Central Services with six departments and a Program Planning Division with five major functional committees. The following testimony is a composite of the findings and recommendations of our Citizen's Committee on the Aging which has given special attention to problems of income maintenance and financing medical care as well as services to conserve the physical and mental health of the aged, our Family and Child Welfare Committee which has focused on the prevention of family breakdowns and the integration of services for families and children, and our Public Health Committee which has a long history of attention to health legislation, neighborhood health services and care for the medically indigent. We have also drawn from the work of our Research Department which surveys the city's health and welfare problems and from our Information Bureau which puts the person who needs help in touch with the organization best equipped to give it. Therefore, my testimony will range through the Social Security, Medicare, Medicaid, Child Welfare, Public Assistance and Manpower sections of the Bill.

The main thrust of my testimony will be that while the Community Council supports these proposals in the bill which extend services, many are simply insufficient to resolve the health and welfare problems of the people they are intended to benefit. We believe that where the private and voluntary sectors are not meeting the health and welfare needs of the citizens, they become the full responsibility of the government—and because of the nature of its resources, the Federal Government must directly or indirectly carry an ever increasing share of the costs. We believe our nation has the resources to further expand its supportive, preventive and remedial services for its poorer citizens. Now to be specific:

1. SOCIAL SECURITY BENEFIT INCREASES

The increasing economic insecurity of older people is the most fundamental public policy issue in the field of aging. The economic well-being of the older population has declined since World War II, during a period of unprecedented economic growth, technological advance and wide enjoyment of affluence. With each advance in production and consumption, older people on fixed incomes have had comparatively lower purchasing power.

Although the aged total 10% of New York City's population (800,000 people) they account for 25% of the City's poverty population. Consequently, they increasingly live in substandard housing, suffer preventable health deterioration, and too often are needlessly placed in institutions.

Therefore:

(1) We reluctantly support the recommendation for a 15% increase in cash benefits, feeling that it is a step in the right direction, but very inadequate to achieve the original intent of Congress in the 1935 Social Security Act. At that time, the Congress visualized a social insurance system which would maintain for senior citizens a decent American standard of living.

We strongly recommend that this Committee adopt as a goal a level of benefits at least equal to a "modest but adequate" budget. The New York Council's Budget Standard Service estimated the monthly cost of such budget, based on October 1966 prices, as totaling $190.75 for an elderly retired man, and $184.17 for an elderly retired woman. These costs compared to average monthly Social Security payments to retired workers in New York City of $91.06 as of December 1965 and only $78.08 to widows or widowers.

(2) Because further substantial increases are needed to alleviate wide-spread poverty and prevent health deterioration, we advocate the use of general tax revenue to supplement appropriate Social Security taxes. To keep this program on an acturial basis, is to penalize the poorest and most needy sections of our country.

(3) We urge that the categories of beneficiaries furthest below the level of decent living receive the highest priority in benefit increases. We also support the extension of coverage to disabled widows under 62 years of age and to additional agricultural workers.

(4) We further advocate some type of built-in provision for automatic increases in benefits tied to the cost of living or increase national productivity.

(5) Finally, we support the recommendations that present ceilings on allowable earnings be liberalized.

2. TITLE XVIII (MEDICARE)

We strongly support the change in Part 3 Section 125 that would extend to disabled Social Security beneficiaries under age 65 the hospital insurance now enjoyed by their elders. This step, plus the option to buy into Part B of Title

XVIII, will go a long way toward relieving this high risk group of excessive medical and hospital costs, which they are less able to bear.

Despite its many achievements, additional changes are needed if Title XVIII is to fulfill its promise of becoming a program that would relieve the anxieties of the aged with regard to their health. The definition of hospital care in part A should be expanded to include ambulatory care, out-patient diagnostic workups and hospital based home care. The effect of such an amendment would be beneficial to both the patient and to the hospital. Patients who might otherwise occupy a hospital bed could then be treated by less costly ambulatory care and thereby reduce the utilization rate of hospitals. Perhaps even more important, patients would also be encouraged to seek preventive care which in the long run is the best way to reduce both costs and human misery. Therefore, we oppose the provision in Part 3 of Section 130 of the proposed amendments restricting out-patient diagnostic and therapeutic services to patients enrolled under Part B of Title XVIII.

Another barrier to early health care is to be found in the deductibles and co-insurance features of both parts A and B of Title XVIII. These exclusions had the laudable intent of preventing over-utilization by those not in need of hospital or medical care. However effective they have been in this regard, they also have prevented many social security beneficiaries from seeking preventive care, the best and cheapest kind of care available. Therefore, we urge the repeal of the deductibles and co-insurance features of both Sections of the law, but particularly those in Part A. If the definition of hospital care is to be expanded as recommended, then the protection of co-insurance and deductibles becomes completely unnecessary.

3. TITLE XIX

We regard Title XIX as being one of the most important and potentially far-reaching pieces of social legislation ever to be passed by Congress. However, because it is a new program and because it has been so recently implemented by so many states, too little experience has been accumulated to definitely state what changes are needed.

In the case of New York State, legislation implementing Title XIX has been in existence only since last May and actual programs in localities have been in effect for less time than that. Therefore, at present, we are unable to assert with any degree of confidence whether any changes should be made. Additionally, no sudies have been made by the Department of Helath, Education and Welfare on the country-wide effectiveness and economy of Title XIX programs, largely due to the severe limitation on research funds that may be applied to such studies. We would suggest that the Department of HEW be asked to research whether amenmdents to Title XIX are necessary, and if so, what type. Until their report is received, we urge that no amendments to Title XIX be included in this Bill.

4. PUBLIC ASSISTANCE

As you know, in 1962, Congress authorized the creation of an Advisory Council on Public Welfare to review the current provisions of the Federal Government for public assistance and child welfare services, and to submit recommendations for improving them. I was a member of that Council. Our report, released in June 1966, showed not only that public assistance payments were so low and uneven that most recipients were living on financial grants below the level of poverty, but that many other individuals in need were excluded from such grants, that methods for determining eligibility were demeaning and confusing for the applicants and time consuming for the workers, and that the extreme lack of adequate services for families, children and youth perpetuated crime, juvenile delinquency, illegitimacy, mental illness and multigenerational dependency.

The Advisory Council therefore, recommended the addition of a title to the Social Security Act to provide in cooperation with the States, a new nation-wide program of basic social guarantee. To make adequate financial aid and social services available to all a matter of right, the Federal Government was asked to set nationwide standards and assume the total cost of their implementation above a stipulated State share. To participate in the new program, each State would be required to establish a floor of individual or family income in terms of the cost of a modest but adequate family budget. All persons with income falling below such a level would be entitled to receive aid to the extent of that deficiency, with need the sole measure of entitlement. Initial eligibility for such aid would be established by personal statement, affidavit or simply inquiry of their situation. Further, under the comprehensive new program, protective and social services for children in their own homes; foster care placement; adoptive placement services; services to unmarried mothers; homemaker services; day care and other special programs for your people would be included.

I have gone into some detail about this report because the proposed Public Assistance Amendments in HR 5710 fall short of these recommendations. Many of the problems we uncovered are simply being allowed to continue; they are ignored. The Community Council supports the recommendations of the Advisory Council and, therefore, recommends that Title II be amended to provide for the inclusion of more of the specific recommendations made by the Advisory Council on Public Welfare.

5. CHILD WELFARE

The Child Welfare Service Amendments are disappointing and do not fulfill even our limited expectation based on the "President's Message on Children and Youth". It is simply not sufficient to authorize the Federal Government to pay States 75% of the cost of employing and training additional child welfare personnel. The overall needs of children require the comprehensive child welfare programs included in the Burke Bill—HR 1077 and the Gilbert Bill—HR 5429.

This type of legislation would remedy a long-standing inequity by bringing programs for children into parity with the Federal welfare programs for the aged, blind, financially dependent, sick and disabled. Child welfare service is the only one of the categories in which the Federal Government does not match appropriations and expenditures of the various governments. The suggested bills provide for Federal sharing of the cost of a State's child welfare services, based on the State's per capita income, and would authorize the sums of money necessary to carry out the purposes of the act. The Federal Government would pay three-quarters of all personnel costs and from 50 to 83% of all other costs, plus grants for special experimental projects.

This estimated doubling of funds available for the care of children would have a tremendous effect. It would mean availability of services for the first time for children in half the counties of the United States in which there are presently no child welfare services. For children in families where there are serious problems, it would mean more services to help the child and family stay together. It would also enable communities to establish needed protective services for abused children.

While the major responsibility for care of children has been left up to the States, prime responsibility for other dependent groups such as the aged, the blind, the widowed, etc. has been assumed by the Federal Government. The money spent for child welfare services is one of the smallest expenditures for any of the programs under the Social Security Act. We urge you to remedy this inequity by inclusion of the provisions of the Burke and Gilbert Bills in the Social Security Amendment for 1967.

6. SOCIAL WORK AND MANPOWER AND TRAINING

There has been a dramatic increase in the numbers of social programs as new needs and old problems receive ever more community attention, and it is the social worker who primarily services these programs. An HEW task force has estimated that, by 1970, for public social services alone, 100,000 new social workers will be needed. At best, 20% of that number will be trained by that time by the existing schools of social work. Despite the increase in the use of college graduates without a masters degree in social welfare programs, despite the increasing performance of essential functions in these programs by aides and other subprofessional workers, the social welfare manpower shortage has reached crisis proportions, and will become overwhelming.

We, therefore, welcome and endorse the proposal in Section 401 of Title IV which encourages expanded educational facilities for social work training. Without social work personnel, the potential inherent in the government's vast investment in health, mental health, welfare housing, aging, community planning poverty, etc. cannot be realized. The many new programs to be staffed by neighborhood workers and volunteers, such as the Foster Grandparents, and the Neighborhood Youth Corps, need a high quality of professional leadership from those who supervise the work, as do the also expanding older programs which also utilize volunteers. When competent leadership has not been available, chaos and inadequate services have been repeatedly seen in our community. Expanded training is also necessary to help end the increasingly expensive competition for the same social work personnel. We thus urge your support for the Bills' provisions which will allow the institutions educating social workers to receive the necessary assistance to start meeting this major need.

7. SUMMARY

In summary, we urge you to carefully review all of the statistics on the scope of the health and welfare problems as presented by President Johnson in his various messages. Then please measure the degree to which the provisons of this Bill resolve the needs described and the degree to which this Bill leaves known suffering unmet. The intent for our testimony has been to suggest that you close the gap.

Senator METCALF. Thank you, Mr. Fogarty. I just wanted to say as a former members of the Ways and Means Committe, I share your high regard for Wilbur Mills, a man who has made a significantly great contribution both to the welfare and public pension programs of the United States and who knows more about taxes than any man in America. I want to say before this hearing is over that whatever criticisms are made of the House bill certainly the members of the Ways and Means Committee and the Congressmen over in the House of Representatives were imbued by the same ideals that motivate the people who have appeared and testified here, and motivate us, we who sit on this committee, to do the best we can under the circumstances for the unfortunate of America.

I am glad to have you come in here and give approval to some features of the House bill and make some constructive suggestions. As a former lawyer who was engaged in hot pursuit of some of these vagrant husbands, as a formed judge who has participated in some of these cases, I want to say one welcome innovation in this House legislation is for provision of payment of court expenses and that is something that I think would be helpful in administering that phase. You suggested it costs so much.

Mr. FOGARTY. I think, unfortunately, the public welfare program is frequently named for the problems they try to resolve as you know.

Senator METCALF. I have been associated with it for so many years.

Mr. FOGARTY. And I hope Congress can make the proper corrections in the proper places and I think if we can really do something about the Social Security Act it would be very well.

Thank you.

Senator METCALF. Thank you, Mr. Fogarty.

Our next witness is Mr. Paul D. Hill, vice president and legislative chairman of the International Association of Health Underwriters.

Mr. Hill we are glad to have you before the committee and please identify your colleague.

STATEMENT OF PAUL D. HILL, VICE PRESIDENT AND LEGISLATIVE CHAIRMAN OF THE INTERNATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; ACCOMPANIED BY ROBERT J. FINNEGAN, EXECUTIVE VICE PRESIDENT

Mr. HILL. Thank you, Senator Metcalf. If I can paraphrase Greta Garbo I think we are practically alone. I am Paul D. Hill from Indianapolis and this is Robert Finnegan, our vice president, our permanent head of the organization.

You have our testimony in bound form. It also includes in the front of the testimony a two-page summary, so I hope you will pay attention to that and will take a look at it in total.

We would like to, if we may, because of the lateness of the hour, take about 3 minutes, Senator Metcalf, and just give you a summary of our testimony.

We would like to say this: That as we all know, H.R. 12080 has been passed by the House of Representatives. We believe this is a very reasonable bill for a number of reasons: First of all, it provides modest increases in cash benefits that average about 12½ percent. We believe these are needed now.

It increases the wage base, as you know, from $6,600 to $7,600, an amount which we believe is not totally out of line with today's average income.

It provides benefits for disabled widows and widowers over age 50 and we believe that this is good since this should result in a lessened demand for welfare benefits for these recipients.

It increases the amount that a beneficiary can earn from $1,500 to $1,680, and we believe that this is also good because it should result in greater self-reliance on the part of the individual.

The changes that have been made in the health insurance section of the present law appear to be modest ones made more to iron out administrative difficulties than anything else, and as such we support those.

In short, we believe that the bill has been passed as a reasonable bill and we sincerely hope that not only the Senate Finance Committee, but the Senate as a whole will concur in that conclusion.

In summary we would like to say this, that as members of the International Association of Health Underwriters, and this is an organization, incidentally, composed of some 5,000 people in every State of the Union, who every day are visiting with millions of people selling health insurance and life insurance, as such we would express to you this wish. That we could at this time allow the social security system to reach maturity. The social security system has gained an accepted place in the financial planning of millions of Americans when they consider death benefits for their families and retirement benefits for themselves. We believe that it should be maintained on that basis and that benefits should be increased only as the cost of living increases, and that these costs of living increases should be tied to a cost-of-living index, so that social security increases are not at the beck and call of any politician of either political party who is thinking of the next election instead of the next generation.

We believe this Congress should not extend medicare benefits to anyone under age 65 until experience has shown exactly what the actual cost of the program is going to be.

We believe that at the same time that Congress should put a ceiling on medicaid programs so that the whole social security system can be maintained on a sound financial basis.

We believe that any other course of action is going to result in a decreased desire on the part of young people to provide for their own families at their premature deaths and for their own retirement, and that it is ultimately going to siphon so much money out of the economy that a slowing down of business and consequently of tax revenues will inevitably occur, and could, if unwise liberalizations of the act continue on an indiscriminate basis, bring about the destruction of the whole system by an electorate that is no longer able to bear the overwhelming costs.

Senator Metcalf, on behalf of the organization we thank you for the privilege of being here.

Senator **Metcalf.** Thank you very much for your summary of statement. Your complete statement, as all statements, will be incorporated in full in the record. You have given us quite a statement of beliefs, and I want to assure you that as one who has worked in this field for many years, that members of this committee are as concerned as you are about many of the problems that you have raised, and we hope that we will be able to solve some of them in this legislation and lay the foundation for others in future legislation.

Mr. **Hill.** Thank you.

(Statement of Mr. Hill follows:)

Statement of the International Association of Health Underwriters

Mr. Chairman and members of the committee, my name is Paul D. Hill, CLU. I am Vice President and Legislative Chairman of the International Association of Health Underwriters, and am accompanied by Robert J. Finnegan, Executive Vice President. Our organization is made up of more than 5,000 members in nearly 100 state and local associations all over the country. It is our privilege to visit with millions of people annually about the health and life insurance needs of themselves and their families; to talk to them not only about the financial present, but also about the financial future.

Today, people are vitally concerned about the whole concept of Social Security; not only what it is, but also what it could become.

As we all know so well, the Presidential Study Commission in 1935, whose activities resulted in the original Social Security Act, conceived of Social Security as providing a floor of benefits for those age 65 and over after a lifetime of work. Social Security would provide the floor; those who wanted more than a minimum standard of living would provide the balance themselves through their own savings. On this basis, Social Security taxes were paid by workers starting in January, 1937.

In 1939, before any benefits had been paid under the Act, Congress changed it to add survivors' benefits and supplementary benefits for wives and eligible children of retired workers. The date to start benefits was moved from 1942 back to 1940.

In the years from 1940 to 1950, a number of liberalizing amendments were enacted, but the tax rate remained the same. In 1950, self-employed persons were brought under the act, and the tax rate, the wage base and benefits were all raised. Further liberalizing amendments were made in 1952, 1954, 1956, 1958, 1960, 1961 and 1965—seven changes in fourteen years—one every two years. And of these changes, five of the seven were made in election years.

From a long range standpoint, of all these liberalizations perhaps those made in 1965 were the most significant, since they changed the whole concept of Social Security. For the first time, benefits were paid other than cash benefits. These "service" benefits were for medical care for those over age 65, thus getting the federal government into medicine on a base far broader than had been even imagined a few years earlier. "Medicare" was put into law in spite of the fact that a majority of surveys taken by members of the House of Representatives in two consecutive sessions had shown that by far the greater number of Americans were opposed to the whole concept.

For this reason, and because of the large number of changes that have been made in election years, an ever-increasing segment of the American public has come to think of Social Security as a political football—a method of influencing a large portion of the electorate by promising them greater and greater benefits, in return for which they would vote for those who granted the benefits. And it is undoubtedly true that many older persons have received a windfall—instances are not at all rare in which a retired person received 100 times or more what he had paid in Social Security taxes. And those receiving 10 times or more what they had paid in taxes numbered in the many millions!

But for the young American just entering the labor market, the situation is far different. Today, Social Security taxes, including .5% for medicare, are 9.68 times the original tax, and will go to 12.43 times the original tax just under the law as it is presently constituted. Many young Americans, burdened with the costs of purchasing and furnishing a home, raising children, etc., are paying more in Social Security taxes than they are paying in Federal income taxes!

Their employers are paying a like amount for them, or so it is often said. Actually, as we all know, this is far from the truth. Social Security taxes are a cost of doing business for the employer, just like materials, labor and the other costs of overhead. If the money were not paid in Social Security taxes, it would be available to give the worker the raise that in many cases is desperately needed to keep up with today's rapidly depreciating dollar and accompanying ever-increasing cost of living.

Officials of the Department of Health, Education and Welfare have already conceded to Congress that the Social Security tax rate has just about reached the breaking point—that it shouldn't go much higher. Yet, the administration is asking for a substantial increase in benefits and consequently in taxes! Under the bill often proposed, the wage base would be raised to $10,800 in 1975—nearly 2½ times the $4,800 of 1965. Social Security taxes, currently 4.4% for employer and employee each, would go to 5% in 1969 and 5.55 percent in 1973. Under this bill, many employees would be paying $12 per week just in Social Security taxes.

It has always been a well-settled principle of Social Security taxation that taxes should not be exacted on income above the average income of the American worker. Raising the wage base to $10,800 would violate this principle.

Since many experts believe that neither the tax rate nor the wage base should be raised, the suggestion has been made that Social Security benefits should be financed in part out of general tax revenues. This should be avoided completely. Once a cost becomes a part of the general budget, it becomes all but hidden from the public view. Should this happen, it will destroy the integrity of the Social Security system.

H.R. 12080 has been passed by the House of Representatives. We believe that this is a reasonable bill. Among other things, it provides for: (1) Modest increases in cash benefits, averaging some 12½ percent; (2) An increase of $1,000 in the wage base from $6,600 to $7,600, an amount that is not totally out of line with today's average income; (3) Benefits to the disabled widow or widower age 50 and over, which should result in a lessened demand for welfare benefits for these recipients; and (4) An increase from $1,500 to $1,680 in the amount a Social Security beneficiary can earn before losing benefits, which should help result in greater self-reliance on the part of the individual.

It appears that the proposed changes in the health insurance section of the present law are modest ones, made more to iron out present difficulties than to increase coverage on an indiscriminate basis, and as such we support these changes.

In short, we believe that H.R. 12080 is a reasonable bill. We sincerely hope that the Senate Finance Committee and the Senate as a whole will concur, and will pass the 1967 amendments to the Social Security law substantially in their present form.

In summary we, the members of the International Association of Health Underwriters, believe that it is time we allow the Social Security system to reach maturity. It has gained an accepted place in the financial planning of millions of Americans when they consider death benefits for their families and retirement benefits for themselves. It should be maintained on that basis; benefits should be increased only as the cost of living increases; these increases in benefits should be tied to a cost of living index, so that they are not at the beck and call of any politician of either party who is seeking short-term political gain at the expense of millions of younger working Americans.

Congress should not extend "medicare" benefits to those under age 65 until experience has shown what the actual cost of the program is likely to be; it should, at the same time, put a ceiling on the amount that states can spend on "medicaid" programs, so that the whole Social Security system can be on a sound financial basis. Any other course of action will, we believe, result in a decreased desire on the part of young people to provide for their own families at their premature death, and for their own retirement; will ultimately siphon so much money out of the economy that a slowing-down of business and consequently of tax revenues will inevitably occur; and could, if unwise liberalizations of the Act continue on an indiscriminate basis, bring about the destruction of the whole system by an electorate no longer able to bear the overwhelming cost.

Senator METCALF. Our last witness this morning is Mrs. Dorothy Ferebee, who is on the national board of the YWCA. Dr. Ferebee was scheduled to testify yesterday, was prevented from doing so, and we are delighted to have you here today, and you may go right ahead and close out this hearing for today.

STATEMENT OF DR. DOROTHY FEREBEE, MEMBER, NATIONAL BOARD, YWCA

Dr. FEREBEE. Thank you, Mr. Chairman.

My name is Dorothy Ferebee and I am a member of the national board of the Young Women's Christian Association of the U.S.A., which currently includes 2 million members and participants in over 400 communities. I am here to express the position of our organization in regard to H.R. 12080, the Social Security Amendments of 1967, as passed by the House and before the Senate for consideration. Because the YWCA as a Christian women's movement is deeply committed to work for the welfare, dignity and the full development of all women and girls, and because among our members and those we serve of all races, creeds, and degrees of economic and social status there are many whose lives would be affected by this legislation, we feel impelled to make this presentation this morning.

First, I should skip here and there, Mr. Chairman, because, to save time, on the social insurance proposal, if it is the intent of this legislation to further the reduction of poverty and dependency in the United States, and to assist individuals and families to become self-sustaining and participating members of society, then we submit that one of the best ways to accomplish this goal is through increases in social insurance benefits. Therefore, we would urge first the committee to return, if possible to the proposals that have been set forth in 5710, to insure maximum social security benefits of $70, recognizing that even this increase is far below that needed to maintain adequate standards of health and dignity for our aged citizens.

2. The YWCA would urge a further return to the proposals in H.R. 5710, with respect to the eligibility of widows and widowers for disability benefits below age 62. Our experience indicates that this is a problem which especially affects women in the United States.

3. With respect to medicare benefits, we strongly urge the restoration of the recommendation in H.R. 5710 that these benefits be extended to all persons receiving disability benefits. This would be yet another way of reaching those on welfare rolls, and providing a basic minimum income.

4. The YWCA favors no changes in the present title XIX of the medicare law. We feel that these very much needed provisions need a longer period of testing before being revised. We are particularly opposed to the income limitations which H.R. 12080 would impose, and to the cutback which would no longer require that the five fundamental health services be provided. To lump these most needed serv-

ices with optional ones, and make them all optional is an invitation to mediocrity, and to a lessening of the quality of services medical recipients have a right to expect.

The welfare proposals, and especially title II. Seldom in its history has the YWCA been placed in a more ambiguous and difficult position in relation to a piece of social legislation. The distinguished members of this committee do not need to be told that the YWCA has strongly supported for years many of the services proposed in this bill. We have worked long and hard for more child care services, more and better training and employment opportunities for women and for youth. We believe that adequate provisions for securing family planning advice and aids should be made available; and, of course, we endorse fully the need for increased funds for social work education—to mention some of the things in those proposals. But we find it intolerable, Mr. Chairman, to be placed in the position where we are asked to endorse greatly needed social services in a package which includes coercive provisions, and indeed a whole set of assumptions which subvert the very purposes which we believe should undergird such benefits.

We must say to the members of this committee that the YWCA does not agree with the basic premises which appear to underlie the amendments to title IV in this bill.

The original premise of AFDC, and one which the YWCA still supports, regards this assistance as part of a basic right of protection for needy women and children, who have been deprived of the supports enjoyed by other families, including the option open to the mother to choose to work or to remain in the family, so that she can maintain the family structure. This is especially important if she is alone and thus carrying a double burden. Now we are being asked to use social benefits and services as a means of social control. The whole burden of proof is being shifted from the responsibility of society to care for the helpless, to putting the burden of proof of "worthiness" on AFDC mothers.

No longer are we to affirm equality of access to these benefits on a nondiscriminatory basis. Rather we would be shifting our policy to one of coercive requirements against a special group of the poor, AFDC mothers, as a means of getting them off the relief rolls and regulating their behavior.

The YWCA believes it is wrong to use services intended to help make peoples lives better as an instrument for controlling their behavior. We believe it is wrong to use a different standard for poor women. In fact, some legal experts are questioning the constitutionality of some of these provisions.

Many women are eager to work, and would benefit from training programs, especially if they lead to meaningful and productive work with a future. But to make this a condition of assistance is to deny them the privilege which other women have of deciding whether to remain in the home. It is putting a higher value on work outside the home than within it. It is putting economic considerations before all other values. To add to the already oppressive situation of many of these women, beset with poor health, deserting husbands, little or no education, loneliness, and anxiety, the further threat of loss of assistance, and even worse the loss of their children to foster care is indeed intolerable. The vague language of the bill provides no real guidelines as to what would be acceptable as "good cause" for refusing the work-training.

Moreover, we cannot but view this proposed requirement with an even greater disquiet when we reflect on our poor performance to date in helping low-income women obtain wages which lead to real economic independence. A recent Labor Bureau study—Women in Poverty—Women's Bureau, 1964—reveals that of 21 million women with full-time jobs, 56 percent received less than $3,000 a year, 36 percent received less than $2,000 and 20 percent less than $1,500 a year. Nothing in the proposed legislation guarantees that this slave-wage condition of many women would not continue.

Rather the YWCA favors measures to provide a greatly expanded program of work opportunities—for example such as the proposed public employment for lower income groups set forth in several amendments being considered to the 1967 OEO legislation. Another possibility is through the greater pooling of public and private resources such as that imaginatively set forth in the recent conference of the urban coalition. It is our conviction that work opportunities should provide real wages for real work, without being tied to assistance eligibility requirements and budgets, or used as work in payment for relief assistance.

The YWCA believes that all women should have the right to work and earn their living, and have full access to opportunities through education and training to pursue meaningful work—whether volunteer or employed. But we also believe that women, and especially mothers, have the right to be at home, and to be dependent during certain critical child rearing years if they so decide. The health and welfare of our children, and the future of family life and the social order require us to see that all children are sheltered and protected, preferably in the family. Even the most deprived mother will fight to keep her family together, even if it means great privation as we have learned from recent history.

Child care services are needed not only to allow the mother to work but to enhance the child's environment, as we have seen so clearly in Headstart. Child welfare services are intended for the protection of children and should be available to all who need them regardless of their economic status.

The YWCA cannot support title II in H.R. 12080. Instead we urge a return to H.R. 5710 with these further provisions:

1. That the optional provision for children of unemployed parents in the present AFDC law be made mandatory in the States.

2. That States not only be required to meet the full need of all recipients according to their own standards, but the Federal Government also set minimum standards of assistance. Not only are many States not meeting their own standards, but many of these standards are far below the level of health and decency.

3. We would favor measures prohibiting States receiving federally aided assistance from imposing residence requirements.

4. The YWCA favors an increase in the funds available for child welfare services, including day care services sufficient to permit the Federal Government to meet 75 percent of the cost.

The YWCA shares with the Members of Congress a deep concern over our failure to find more quickly an adequate response to poverty in the most affluent nation the world has known.

As a people we are often tempted to find scapegoats for our dilemmas, or to seek oversimplified solutions to complex problems. Above all, we are reluctant to face the costs in money and effort required. It is easier for us to appropriate $70 billion for defense, and other billions for space exploration than to pay the real costs of a "war on poverty."

It is the hope of the YWCA that, in dealing with this particular legislation, Mr. Chairman, and in all other similar proposals, that the Congress will replace punitive and coercive measures with those which more nearly reflect the enlightened and compassionate resources we are fully able to bring to bear as a nation. We need your leadership to move us ahead.

Thank you very much.

Senator METCALF. Thank you, Dr. Ferebee. Incidentally, we had lots of doctors here; what kind of a doctor are you?

Dr. FEREBEE. I am doctor of medicine.

Senator METCALF. You are a medical doctor?

Dr. FEREBEE. Yes; for many years medical director of the student advisory of Howard University, and I shall now be medical director of comprehensive health service for everybody at Howard University.

Senator METCALF. Well, I am pleased to have asked that question to learn of those qualifications.

You are a resident of Washington, D.C.?

Dr. FEREBEE. I am; yes.

Senator METCALF. Even though the statement is for the National Board at New York?

Dr. FEREBEE. Yes; the National Board has membership——

Senator METCALF. I know you dropped by for a second opportunity to be heard.

Dr. FEREBEE. Yes. I was here all day yesterday.

Senator METCALF. We are very grateful for your waiting and we are grateful that you did stop by, and you have made a very helpful and informative statement and both the weight of your testimony and your prestige and your influence will be considered by the committee. Thank you very much, Dr. Ferebee.

Dr. FEREBEE. Thank you for allowing me to appear.

Senator METCALF. That is the last witness for today and the committee will now be in recess until tomorrow at 10 o'clock.

(Whereupon, at 1:55 p.m., the hearing was recessed, to reconvene Thursday, September 21, 1967, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1967

THURSDAY, SEPTEMBER 21, 1967

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

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

Present: Senators Long, Anderson, Talmadge, Harris, Williams, and Curtis.

The CHAIRMAN. The hearing will come to order.

Before we hear from our first witness, it may be well to announce that Secretary Gardner will be back before the committee on Tuesday, the Secretary of Health, Education, and Welfare for a final wrap-up to express the views of the Department particularly with regard to testimony that has been presented to the committee. Some of the testimony has brought to our attention constructive suggestions for changes that could be made in the bill before us.

Mr. Walter Reuther was to be our leadoff witness today but he is unable to be here. I regret that because he is a very stimulating and informative witness. However, we do have the good fortune of having Mr. Melvin Glasser, who is director of the Social Security Department of the United Automobile Workers here to represent Mr. Reuther and his union. Mr. Glasser, we are very happy to have you.

STATEMENT OF MELVIN GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTOMOBILE WORKERS; ACCOMPANIED BY LEONARD LESSER, GENERAL COUNSEL, INDUSTRIAL UNION DEPARTMENT, UAW; AND DAVID MILLER, PRESIDENT, DETROIT AREA, RETIRED WORKERS COUNCIL, UAW

Mr. GLASSER. Thank you, sir.

Associated with me are Mr. Leonard Lesser, who is general counsel of the Industrial Union Department of UAW——

The CHAIRMAN. He is well known to us. He does a good job for the automobile workers on the Hill.

Mr. GLASSER. Thank you.

And Mr. David Miller, who is president of the Detroit Area Retired Workers Council, who would like a minute, sir, to introduce his petitions.

Mr. MILLER. My name is Dave Miller. I live at 9915 Chenlot Street, Detroit, Mich. I represent 57,000 retired workers affiliated with the Detroit Area UAW Retired Workers Council. I also represent the efforts of 300 UAW retired worker chapters across the country whose

175,000 members are deeply concerned with the social security and medicare programs.

I come here today to present petitions to this august body with more than 150,000 signatures. We believe that it is important for citizens to utilize the right of petition inherent in a democratic society. We, in the UAW, are deeply disturbed as we look at the plight of many of our older citizens of our country.

We are deeply disturbed because they have neither sufficient income nor adequate health programs to meet the problems of daily living with dignity.

When approximately one-half of retired worker beneficiaries are receiving less than $75 a month, it is clear our social security program is totally inadequate. In a country as affluent as is the United States, this is both morally and financially indefensible.

In our petition, therefore, we call upon you to strengthen the social security program immediately by a 50-percent increase in all benefits; by establishing the minimum monthly benefits of $100 for older workers retiring at 65 and for all disabled workers with $150 for couples over 65; by building in the future benefits automatic cost-of-living increases and by allowing the Federal Government to share the cost of social security benefits equally with employers and workers by contributing from the general revenue.

To be sure, the medicare program is a good beginning; however, we ask you to strengthen this health program for the members of our society over 65 by removing the economic barriers. We ask that the whole bill for inpatient and outpatient and long-term services be paid instead of continuing the so-called "deductibles." We believe that we need 365 days of care instead of the present 90 days in the hospital. We ask that the law be strengthened so that doctors who participate in the program shall receive their payments directly from the Federal Government. We also request that all necessary prescription drugs be paid for in or out of the hospital.

I deem it a privilege to have the opportunity to present to the Senate Finance Committee, not only the petitions, but a brief summary of the program for which we petition. I hope that your committee will truly come forth with a program which befits the greatness of America. It is important that the world's most powerful democracy provide its older members—the people who built America—with opportunity, dignity, and security.

Thank you, gentlemen, for listening to me.

The CHAIRMAN. Thank you very much for your statement, sir. And I appreciate that petition you presented.

May I say that I can't speak for the committee, but I personally intended either to offer or vote as the case may be for a proposal to raise that minimum to $100. I think that the people who have worked and reached 65 ought to receive at least enough income so they don't have to ask for public assistance under the welfare program. I think that you are very correct about that.

Mr. MILLER. Thank you.

The CHAIRMAN. While I have high regard for the House ways and Means Committee, this committee has consistently been more favorable to the retired workers than the House has been, and I think that will be the case in the future.

Mr. GLASSER. Mr. Chairman, you start our hearing in a salubrious fashion.

I apologize again, sir, for Mr. Reuther who, because of a special executive board meeting of the UAW which was called this morning, had to absent himself. He was sorry but he is not as sorry as I am.

My teenage daughter, sir, informed me last night that my substituting for Mr. Reuther was like a young man kissing his girl on the telephone. She got the message but the impact was reduced. [Laughter.]

We, sir, are submitting a full statement for the record, and I, of course, do not plan to read the 96 pages, but to take a few minutes to hit some of the highlights that the UAW feels are particularly important to this hearing.

Gentlemen, we find the H.R. 12080 a very disappointing bill. We felt that the administration proposals in 5710 were exceedingly modest. The bill before this committee we find less satisfactory and in many ways retrogressive. You have already had before this committee many witnesses of standing and direct experience who have spelled out in detail the gross inadequacies and the injustices in the bill before you. We associate ourselves with these criticisms and shall not attempt to repeat many of them.

Our basic objection, Senator Long and Senator Williams, is to the present bill as written because we believe it is essentially a bill which will punish the poor. Under each of the titles of the measure as now written, the bill strikes out against those whom we believe are less able to defend themselves, and because in the area of new cash benefits offered it provides so little it is bound to be a source of cruel disappointment to those whom it professes to attempt to assist.

I shall just take a few minutes on each of the four titles.

First as to the income maintenance programs: Basically the income maintenance programs must be seen, as you know, sir, as part of the war against poverty, and they must be seen this way because one out of every five Americans, who are poor is also 65 or over, and real improvements in the social security system would, in fact, reduce public welfare and make inroads in reducing poverty.

The proposed $50 minimum benefit is not a meaningful step in this direction. It is essentially a 12½-percent increase for the millions of aged Americans who live in degrading poverty, and who will continue to do so, sir, with the token increases offered in the $50 minimum.

You have already heard that one-half of retired workers receive less than $75 a month. Accordingly, we recommend, first, a minimum monthly benefit of $100 a month for a worker retiring at age 65, $100 for a disabled worker, and $150 for an elderly couple, both aged 65 and over.

Secondly, we recommend an increase of 50 percent in the current and prospective benefit payments applicable throughout the range of covered earnings. Present average benefits of $1,000 for a retired worker, and $1,680 for an elderly couple, place the benefits of the social security program firmly below the poverty level defined by even the most conservative standards.

H.R. 12080 has proposed a 12½-percent increase, which represents only a 4-percent increase in benefit levels since 1954. It does very little for the elderly poor.

We have made a number of other proposals, and they are incorporated in our testimony.

The UAW is realistic about this. We know these income benefits, if they are to be augmented, require additional revenue, and we wish to put before you two proposals that will deal with this responsibly.

First, to increase by several broad annual stages the covered earnings base so that it reaches $15,000, and an exemption for the first $600 of earnings.

As you know, sir, when social security started 95 percent of the earnings of all people in covered employment were covered by a $3,000 base. The base in the present bill of $6,700 would cover about two-thirds of the earnings. In essence this base means lower revenue for the system, and it also means a disproportionately higher tax on those with lower incomes.

This, we feel, is unfair and unconscionable, and we propose that the committee give serious consideration to raising the earnings base to $15,000 in several broad increases.

The second revenue measure, sir, that we propose is that social security contributions from general revenues now be incorporated in the measure.

As you well know, every nation that has social security other than the underdeveloped nations and those which are under Communist control have general revenue contributions. We stand alone with Argentina and France against the tide. It is generally recognized by all the experts that deal with this that this day will have to come.

As you may know, interestingly enough, the President's Cabinet Committee on Economic Security, when they drafted the social security proposals in 1935, suggested that general revenues would be needed probably around 1965. Since then, every committee that has reviewed this has come up with this.

We believe that it is fair and equitable if this is to be a social insurance system, to deal yith the social costs through general revenues.

We realize, sir, that there are heavy Government commitments. We recognize that this committee more than any other is aware of the financial problems involved in our Government's trying to pay its bills.

We believe, however, that the problem of meeting the needs of the poor can be met by raising the floor immmediately, by making an immediate commitment with a very modest initial general revenue contribution, and a commitment for additional general revenues further down the road. We think this is realistic, and there have been a variety of formula by which this can be done.

But we urge, sir, that the general revenue matter not be delayed to further Congresses. It will have to be faced, and we believe on the basis of equity it should be faced today.

Now, sir, a few words about medicare.

Medicare in its present form falls considerably short of providing adequate comprehensive health programs for the elderly. Our deep regret is that many of the provisions of the House bill do not deal with the deficiencies in the program but rather appear to provide new protections for the providers of service.

This is particularly true for the new payment program for physicians. We believe the poor continue to be penalized by no protection against the escalation of costs of medical care. I believe this committee is conversant with the fact that in the first 6 months of 1967, the costs of the medical care in the United States increased four times more rapidly than the increase in the cost of living, and, therefore, if this program is not to see its benefits in effect by any other way, and the costs continue to rise, these facts must be taken into account, we believe, in the legislation.

We have essentially five recommendations to put before you:

First, the extension of the 90-day time limit on in-hospital stay to 120 days is a step in the right direction. We urge, however, that the $20 coinsurance for the last 30 days and the $10 coinsurance for the 60 to 90 days be eliminated. It is at this point that the elderly can least afford to pay for this, and it seems to us to be a very unfortunate step when a person is in the hospital, and when he is covered by insurance that covers roughly 40 percent of his medical care costs, to impose these cash penalties on him.

Secondly, Mr. Chairman, we know of your own interest in providing a drug program under medicare. We ardently support that and urge, sir, that a prescription drug program be included in the medicare program now. You well know that the elderly have more than twice the number of prescriptions of all other groups in the population. But even more than this, 50 percent of the drug costs are incurred by 10 percent of the elderly, 50 and 10. This means that this smaller group, faced with a very low income in the first place, cannot, in fact retain their health if they can't pay for drugs.

The CHAIRMAN. Would you mind giving me that again?

Mr. GLASSER. Yes, sir.

Fifty percent of the drug costs are incurred by 10 percent of the elderly.

The CHAIRMAN. So there are only 10 percent of the aged people who account for 50 percent of the costs of drugs?

Mr. GLASSER. Yes, sir. And we feel this is a compelling argument to consider at this point.

Senator ANDERSON. Would you cite the authority for that?

Mr. GLASSER. Yes, sir. It is in the testimony. I will give that to you at the end of the hearing.

Senator ANDERSON. I thought the testimony was——

The CHAIRMAN. He is abbreviating a 90-page statement, Senator Anderson.

Senator ANDERSON. I don't mind that when I get interested.

Mr. GLASSER. I will get it for you.

The CHAIRMAN. We will get it for you.

Let's just put that in the record. It is a very interesting figure. We hadn't heard that before.

Mr. GLASSER. I was trying to cut down 90 pages in a few minutes.

The CHAIRMAN. It is not that we don't believe you, we would like to see the documentation.

(The material referred to follows:)

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE
& AGRICULTURAL IMPLEMENT WORKERS OF AMERICA-UAW,
Detroit, Mich., September 22, 1967.

Senator CLINTON P. ANDERSON,
Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR ANDERSON: During the hearings of the Senate Finance Committee on H.R. 12080 yesterday, I promised to send you the citation of source of the statement I made in my testimony to the effect that as much as 50% of the drug costs of the aged are incurred by only 10% of the aged population.

This evidence comes from the brief to the Legislative Committee of Ontario, Canada, to the Select Committee on Aging, submitted by Prescription Services, Inc., September 27, 1965.

As you know, there has been considerably more experience with prepayment for prescription drugs in Canada, and Prescription Services, Inc., is one of the leading underwriting agencies for these services.

I appreciate your interest in this matter and hope it will be possible for the Senate Finance Committee to include coverage of prescription drugs in the Medicare legislation now before this Committee.

Sincerely,

MELVIN A. GLASSER,
Director, Social Security Department.

Mr. GLASSER. Further in our recommendations we would recommend that medicare payments for physician's services be limited to those physicians who accept assignment. We believe that the provision in H.R. 12080 which adds the proviso for payment on the basis of an itemized bill, while it might give some relief to the elderly, will provide a built-in escalation clause again in that it will not require physicans to hold to reasonable and customary charges. It provides a way of their getting assurance of reasonable and customary payments plus.

We have had, sir, 25 retiree centers around the country in which we advised on the problems on medicare to our own members and others, and in this, this problem of payment has been a constant problem. We are concerned that the House formula will, in fact, not deal with the problem but will make it worse.

Our fourth recommendation is that coverage be provided for disabled workers as proposed by the administration, and we are disappointed that the House in reporting this out of committee indicated they were not covering the disabled workers because the costs were higher for the disabled workers.

Well, we believe that is precisely the point. Because the costs are higher they can't mount these bills, and we believe this is a compelling argument for this committee to consider.

Finally, with relation to medicare, we wish, again, to urge that utilization review programs be set up not only for part A, the hospital part of the program, but for part B, the physician and other services part of the program. We again call to your attention that which this committee has heard before, the costs are exceedingly high, and they are getting higher, and we believe there is a responsibility to intelligently set controls on costs.

This brings me to part 3, sir, and that is the public welfare amendments.

The UAW believes that while the bill professes the desirable objectives of seeking to rehabilitate the poor and reduce the costs of public welfare, it would attempt to accomplish these goals by means that are repugnant and reflect a harsh and a punitive attitude toward the poor.

We do not believe Congress wishes to do this, and we urge that corrective measures be taken in this regard.

The provision that no State may have a higher percentage of children on welfare than it had at the beginning of the year defies rational analysis. We wonder if it is the intent of Congress to enforce some new moral standard by means of the public welfare mechanism. Certainly this cannot be the answer in a nation which tried on a far more modest basis to impose a moral standard in the 18th amendment.

If this is not the answer, what is involved here, then, is a shifting of the financial burden of the care for destitute children to the States and to the localities. These communities, those communities, with higher welfare standards would have to pick up the burden, although as you well know their ability to raise increasing revenues is sharply limited. Those States with lower welfare standards would simply lower the standards further so that the inadequate payments now being made would be even thinner.

This arbitrary limitation on AFDC, the UAW believes, is an emotional response to what is undeniably a distressing condition in our country. Its primary effect would be to punish the children for the alleged errors of the ways of their parents.

We don't believe that you should support that.

Secondly, with regard to assistance for the children of unemployed parents, we thought a proper step was taken in 1962 when these programs were set up, and we urge that in fact these programs be made permanent.

But from our own experience in the labor movement, we can assure you, gentlemen, that the men in most difficulty are those who have had no recent attachment to the work force. These families, who most need the help, are the ones who are eliminated by the House proposals.

The requirement of 30 days of unemployment before assistance can begin, and the prohibition of assistance when unemployment compensation regardles of how miniscule its amount must, we believe, be interpreted as nothing more than punishment requiring an appropriate amount of suffering before aid can begin.

This version of punishment in the public stocks for those who are unfortunate enough to be poor we don't believe is appropriate for 20th century Americans. And we recommend, therefore, the continuation of AFDC by requiring its implementation in all of the States, and with the elimination of the new restrictions proposed in H.R. 12080.

The third item is assistance at full need standard.

The failure to include the administration-backed section 202 of 5710 is only further evidence that the major emphasis of the public welfare amendments of the House passed bill is on reduced size in the cost of AFDC rather than as a necessary aid to the States in meeting the overwhelming social problems that are destroying our cities.

This ought to be our primary concern. It seems inconceivable in 1967 to us that anyone could seriously entertain the idea of starving people off of assistance and into self-sufficiency.

Regrettably, we have had enough experience with that approach to know that it only increases the misery of those whose best efforts leave them economically dependent.

We know that the members of this committee are aware of the fact that in 33 of the States assistance payments that are at a level below the standards which the States themselves, the States themselves, have determined as necessary to meet basic human needs, and that eight of these States pay to the welfare recipients less than half of what those States have determined to be the minimal rate of assistance.

Accordingly, we urge that to avoid coercion and improve the present unsatisfactory performance of AFDC there be restoration of the proposed section, section 202, of H.R. 5710 which would require the States to meet their own current definitions of need.

A word, sir, about community work and training.

We in the labor movement are fully sympathetic to the basic objective of this legislation to prepare welfare recipients to become employable, and to assist them in finding jobs at fair wages and under decent working conditions.

President Reuther, as you know, was part of the group of Americans who convened the urban coalition in August 1967, and defined as a first goal at least 1 million of the presently unemployed be placed in productive work. There is no question we believe all Americans should work if possible.

But we also know something about what motivates people to work and not to work, as in the present strike which the UAW is conducting, and we are appalled at this proposal which assumes that the threat to cut off assistance will force all adults and children over 16 and not in school into work and training programs. If the motivation to work is not present, gentlemen, these people can be trained from now until eternity and their training will be useless.

Even if the motivation to work is present, unless job opportunities and decent working conditions are available, reasonably shortly after the training periods are concluded not only is the training money wasted but those trained are psychologically worse off than they were before.

We urge, therefore, that there be opportunities for work and training. We urge that the provision that it be mandatory be dropped.

Now, a few words, sir, about medicaid.

The new ceilings proposed on Federal grants for medicaid would work to the disadvantage of the poor who can least afford to pay for medical care. We believe in the UAW it would substitute fiscal values for human values.

We have two recommendations only we would like to urge you to consider.

First, that you delete from the current legislation the provision that would limit Federal participation in State medicaid programs on the basis of arbitrary income ceilings. It is a departure from the precedent of Federal legislation to set these kinds of maximums. They are unrealistic. You have heard ample testimony, which we do not propose to repeat, to the effect that in numerous States it would cut the aid available, the medical aid available. We believe that if one is opposed to poverty, one ought not only to provide the kind of medical care that would help the poor to become self-sufficient, but would help the near poor, if you please, to become—to be—to be prevented from becoming so ill that they cannot work.

You have heard testimony that there is six times as much chronic illness in those who are earning $7,000 or more a—I beg your pardon, I reversed that—six times more chronic illness among those who have incomes of less than $2,000 than those who have incomes of more than $7,000.

I shall not repeat this.

Our second recommendation with regard to medicaid is that you delete from the legislation the provision that would permit the States to cut back on the comprehensiveness of a medicaid program by substituting less essential health services for the five basic services now required.

Gentlemen, the five services, as you know, are inpatient hospital care, outpatient hospital care, lab and X-ray services, nursing home services, and physician's services.

It is quite possible to substitute cheaper services for these. It is not possible to provide decent medical care without these services.

We urge, sir, that these provisions be kept in the legislation and that the present provision in 12080 be dropped.

Now, one final word, sir, because these hearings have had a great deal of testimony about the costs of the social security program, the costs of welfare; there has been concern about this.

As far as my reading of the record shows, it does not show these facts. In terms of the rising welfare costs in this country that we have heard about, it has not been brought to the attention of this committee that Federal, State, and local social welfare expenditures when one does not include the social insurances, which are paid for by employers and employees, have not, in fact, increased in relation to gross national product, which we believe is a fair measure.

In 1939 and 1940 these expenditures for social welfare were 7.9 percent of GNP. In 1965 and 1966 they were 7.8 percent of GNP, and if one wished to define this further and take out the education factor, they, in fact, declined from 5.2 percent in 1939–40, to 3.3 percent in 1965–66.

We believe there is something this committee should be aware of. There has not been an increase in relation to GNP for social welfare expenditures in this country despite much of the propaganda you gentlemen have heard to the contrary.

I would be glad——

The Chairman. I would suggest you put that table in the record.

Mr. Glasser. I would be glad to.

The Chairman. Thank you.

(The table referred to follows:)

FEDERAL, STATE, AND LOCAL SOCIAL WELFARE EXPENDITURES

[Dollar amounts in billions for selected fiscal years 1940-66]

Fiscal year	GNP	Social welfare expenditures[1]					
		Total		Less social insurance		Less social insurance education[2]	
		Amount	Percent of GNP	Amount	Percent of GNP	Amount	Percent of GNP
1939-40	$95.1	$8.8	9.2	$7.5	7.9	$4.9	5.2
1949-50	263.4	23.0	8.7	18.1	6.9	11.4	4.3
1959-60	495.6	52.2	10.5	32.9	6.6	14.9	3.0
1961-62	541.7	62.2	11.5	38.0	7.0	17.1	3.2
1964-65	654.0	77.5	11.9	49.4	7.5	20.8	3.2
1965-66	715.3	87.6	12.3	55.7	7.8	23.4	3.3

[1] Includes public and welfare services, health, medical and veterans' programs, public housing, social insurance and education.

[2] Expenditures for education through Veterans' Administration included. Exclusion of such expenditures in 1950 would have decreased percentage of GNP figure from 4.3 to 3.3 percent. In other years listed, such exclusions have virtually no impact on percentage.

Note: The chief reasons for the increase in the proportion of GNP allocated to welfare between the fiscal years 1950 and 1966 are the sharp increases in social insurance payments and expenditures for education. The social insurance expenditures include OASDI primarily, but also railroad retirement, unemployment compensation, and other insurance items.

Source: Social Security Administration, U.S. Department of Health, Education and Welfare, Social Security Bulletin, Annual Statistical Supplement, 1965, table 1, p. 2; table 3 ,p. 3. Economic Almanac, 1967-68, NICB. Economic Indicators, August 1967, Council of Economic Advisers.

Mr. GLASSER. Because we think this is important evidence that would help the committee make a decision. We know the committee is concerned about the costs of Government, we know the committee is equally concerned about a stable, secure America.

We believe that the proposals which the UAW is submitting meet both the objectives of the committee, and we urge your favorable consideration.

Thank you for your kindness, sir.

The CHAIRMAN. Well, thank you very much for your statement.

I, for one, have never objected to the Government paying the cost of drugs. I just don't want us to pay any four to 10 times what it is worth.

Awhile back a friend of mine, somewhat elderly, suffered an accident. The doctor told him that he would have an arthritic condition for the rest of his life and every time he takes a glass of water he ought to take a couple of aspirin tablets. I pointed out to him there is no real difference in aspirin tablets, they are all about the same thing, and if anybody is making an aspirin tablet which is not what it is supposed to be I will see what we can do to make him improve it or close the shop down.

You can go into a big drugstore, Walgreen's or Rexall drugstore and you can buy tablets seven for a penny or even 10 for a penny.

When a Senator goes to get an aspirin tablet he goes to the Senate doctor. He just hands you some aspirin tablets—there is no particular name on them—and those are bought for about 10 for a penny.

We are going to hear the drug people today, and they are going to advocate that we pay 10 times as much or put a premium on the name.

I assume that the people who manufacture those tablets are part of organized labor, and in one respect or another organized labor speaks for them.

Do you see any point in paying 10 times for what the thing costs to manufacture or what the man can sell it for if he sells it competitively?

Mr. GLASSER. Mr. Long, if Mr. Reuther were here today he would tell you that at this moment we are negotiating with the major automobile and agricultural implement manufacturers for a prepaid drug program as part of our collective bargaining package.

The UAW has studied this question. And we are convinced, sir, that wherever it is possible generic drugs should in fact be used for brand names.

We believe there is substantial evidence to support your view, and we would wholeheartedly concur in the view you have expressed.

The UAW does not believe, sir, that if these matters are prepaid through collective bargaining we should encourage the increase of costs for the whole community. Quite the contrary. We believe we ought to attempt to reduce costs. We believe there is sound evidence to indicate that generic drugs should be used wherever possible.

We know the costs of the prepaid drug program would be very radically reduced.

The CHAIRMAN. Well, as a practical matter, all we really want to know is that this drug is what it is supposed to be, and if you check that it is, there is no particular point in paying 10 or 20 times what it should be selling for in order to provide it to some aged person.

If that aged person can be fooled into paying 10 or 20 times what the drug is worth, I suppose that is his misfortune. But if the Government is going to pay for it, we should pay no more than what it is worth. If the public is going to be overcharged 10 times the price, I think that labor in the drug industry ought to get their share of it.

There is no particular point in just letting everybody suffer that kind of a skinning in order to provide some drugs for some good people who deserve it.

I have many times offered amendments to increase welfare payments, so much so that sometimes Louisiana has been dubbed the welfare State. We have had an elaborate welfare program, and I have helped to put that into effect.

But it seems to me that people who are able to work ought to do something constructive if they can, and I really can't see the logic in paying somebody not to work. In other words, it seems to me that in the last analysis those female broodmares who were here yesterday, picketing our committee, are really entitled to no more dignity than people who work in those United Automobile Workers plants. I don't see why we ought to pay them when there is work, honorable good decent work available to them, but they won't take it.

Sometimes when I go for a walk in front of my home I find beer cans and soft drink cans and bottles that people threw out of automobiles. I pick them up. I would be willing to pay somebody to pick the trash up, just as I do when I just go out for a walk because I like to have the place clean.

If I am willing to pay a little something for someone to do that, wouldn't it be a better answer to simply supplement that welfare payment and tell that person if they don't feel like doing anything, not even kill a fly, we are not going to pay them until they move?

Mr. GLASSER. I think there are three matters that I would comment on in response, Senator Long. One is there is no question but that we would like to see people who are able to work be given decent job opportunities at decent wages so they could work. There is no question but what that is the sound answer.

The second, however, sir, is that a very minuscule percentage, as you well know, because you have had much testimony on this, of those who are on the relief rolls are able-bodied males who are able to work.

There is an exceedingly small percentage.

As a matter of fact, other testimony has indicated, for example, other studies have shown, that roughly 25 percent of the families that have a male head who worked 12 months in the last year are still in the poverty group.

So that if people will continue to work on this basis obviously there is a wish to work on the part of the overwhelming number of people who can.

The third question, sir, is one that we may have some difference, and that is the very real question as to whether one wishes to separate a mother from her children. Now, this is a very tricky kind of question. Whether one can say to a mother or should say to a mother, "We will deprive your children of basic maintenance unless you leave them and unless you go and take training for work."

Now, I am not sure, sir—my wife doesn't have to face that issue, I don't know what my wife's answer is, I suspect that it would be, she would not want to leave her children, and I am sure that is true of many of us.

It deals with a kind of authoritarian philosophy that we in the UAW find repugnant, sir. We would like to see opportunities for work and training made available. We would like to see decent day care available for such mothers and, as you well know, there is a colossal shortage at this time of such facilities.

We would like to see incentives in money for mothers to be encouraged to go to work if they feel they can arrange it. Our objection is to compulsion because we think it treats these women in a different category and, frankly, we are horrified at the prospect of a generation of children brought up already largely without fathers, and now to propose to bring them up without mothers.

We think that the social costs are much too high.

The CHAIRMAN. Well, now, look, it is perfectly all right with me when a woman has seven or eight children in that home, particularly some young ones, for us to pay the entire cost of that woman staying there with those children. I see no particular advantage in trying to urge that woman to do any work other than look after those children.

But where a woman has a child, 6, 5, 7, 8, 9, 10 years old, and we are in a position to provide that child with schooling, with recreation, with organized play, in position to have someone who is a much better qualified person than that mother try and teach that child something, why shouldn't that mother do what the lady who works in my home in the morning does, go to work and do a few hours work in the morning, help clean, straighten the place up, help do something constructive? It would seem to me a far better answer to just supplement that welfare check by whatever amount somebody is willing to pay to put that person to work doing something constructive.

The people you represent in organized labor, United Automobile Workers, if they lost their jobs, after a couple of weeks, they are entitled to draw an unemployment insurance check, but, if you have a job over here and the man doesn't want to take it, that check is terminated.

Would you mind telling me why these welfare clients are any better people or deserving any more than your workers who pay you dues?

Mr. GLASSER. I think the essential difference, Senator Long, is that in our instance we are talking about men who are the heads of families. In the situation with relation to welfare, we are talking primarily about AFDC mothers, and let me say to you, sir, that in visiting the inner city of Detroit which I know reasonably well as I know Harlem in New York City, we have made yeoman efforts, I think we have tried as any major city in the country to do a job in the inner city of Detroit in the school system. It isn't good enough, but we have tried. We have good schools. We try to have recreation programs. We try to improve the facilities for after-school hours, and, sir, in my judgment one of the real problems we face is that we are defeated by the fact that these children go into homes where there isn't a set of parents to give them care and nurture and affection and protection, that we feel every child should have.

We believe that 12080 is a step in the opposite direction. If one deprives a mother, and the bill does not have any age limitations, she may have children of 3 or 9 years of age, and the mother is taken away from those children against her will, we believe we will further increase the social problem which is very trying in this country today, and in all sincerity we say let's make work and training available to these mothers.

Many will be able to take advantage of it. But let's give them a choice, those who don't should protect their children.

The CHAIRMAN. Well, now, how about the House bill which refers to appropriate person and appropriate cases? It says we shouldn't pay welfare money to people who decline to work in appropriate situations.

Now, what would your answer be about that woman who just sits around the house and drinks Hi-Fi or Gypsy Gold wine all day while the children are out or in school, and declines to take a job—won't do anything except produce more children for the public to pay for at taxpayers' expense?

If a job is available and somebody is willing to hire that person, would you still insist while that child is in school that that mother shouldn't do anything more than drink that Hi-Fi wine?

Mr. GLASSER. I would answer you, sir, in two ways:

In the first place, in relation to your comment about appropriate work, this opportunity or this proviso is now available on a permissible basis and in fact has already been used in the States and misused in the States. This appropriate work thing can be interpreted in any way in the world by States and is already being interpreted in that way.

Now, for example, what we find is that there is constant criticism made about the woman who sits, as you say, sir, and drinks wine.

Well, I am certain there are such women, I have no question about it. There are even women who drink harder things than wine, but that doesn't mean one condemns the whole program. That doesn't mean that one says that these 4 million children should be deprived of mother's care when one recognizes there are many more children than that, below the poverty line whose mothers in fact are not on AFDC, and that there is a constant movement off the rolls as well as on the rolls.

It is, we believe, very clear that most mothers attempt to protect their children.

I live in a much better class neighborhood than the inner city of Detroit. The children in my neighborhood are well cared for. We have among them a group that I would not be very proud of, but I would not condemn all my neighbors because some children stay up until 3 in the morning and drink beer, although they are only 16 years old.

What I am saying, sir, is let's not tar the whole group for the faults of the few, and let's not pay the social price we are going to have to pay if we make children be separated from their mothers.

The **Chairman**. Well, the people who pay the dues to support your union don't draw that unemployment insurance money if there is a job available——

Mr. **Glasser**. That is correct.

The **Chairman** (continuing). And they are not willing to work.

Now, my guess is if I were talking to the average automobile worker he would say if those people have a job available—let's talk about the time while a child is in school—if they have got a job available and they won't work, I will bet you that the average automobile worker would refuse to give them 5 cents.

Mr. **Glasser**. Senator Long, the average automobile worker is a fiercely loyal family man, and I would suggest to you, that if you said to the average automobile worker that we have here almost 4 million children, most of whom are in fatherless families, what would you think about requiring that their mothers be separated from them during the day, I do not believe your conclusion is sound.

The **Chairman**. Well, now, you advocate that mother take that child out of school, do you advocate that?

Mr. **Glasser**. No, sir.

The **Chairman**. What is she going to do while the child is in school?

Mr. **Glasser**. She should participate, sir, we want her to participate in the life of that child.

One of the real problems in the schools of the inner city, as many of the educators have testified, is the fact there is no involvement of the child's family. A child is part of a family, sir, and we can't send the kid off to school and say, "Go get educated and come home a better child."

The schools that are a success in America are schools where the parents are involved, where their mothers are in the classrooms, where they are part of the PTA, where they are following up in assisting their children, where they are finding what is going on, where they are home during lunch periods, and incidentally, most of the schools in the inner city don't even have lunchrooms so they have to come home for lunch.

With these kinds of things, we want parents to participate in the life of the child and we think this bill is depriving the child of that.

The **Chairman**. How is this mother going to participate in the life of the child when it is school being taught, may I say, by a schoolteacher whose child is also in school?

Mr. GLASSER. They will participate in a number of ways, Senator Long. They will be room mothers and part of the PTA, and there will be other children at home as well in many other situations. It isn't only one child in the school or two. We believe the mother ought to be providing a home life for the child.

The CHAIRMAN. May I say a woman who refuses to work and insists on living on welfare while the child is in school can do very little to help that schoolteacher who is out there working while her child is going to school.

Mr. GLASSER. I would suggest, sir, that we are not getting very far in a difference of opinion. Neither you nor I are qualified as mothers, I would suggest——[Laughter.]

The CHAIRMAN. Well, now, let us get to point No. 2.

Mr. GLASSER. I would suggest you ask any group of mothers middle-, low-, or upper-income group.

The CHAIRMAN. Do you have any suggestions as to what we might do with regard to runaway daddies who leave their children? Can you offer us any suggestion as to what we can do to help us make those people fulfill their duty to society?

Mr. GLASSER. I believe this is a real problem. I believe these fathers have a responsibility, and in any way that we can hold them to that responsibility they should be held. I don't have any magic way of doing it. I can only tell you that for at least 40 years on a voluntary as well as an official basis, I have known of efforts to do a job of holding them responsible.

However, sir, the thing that we would like to stress to this committee, let us not make the children pay the penalty for the errors of their fathers.

The CHAIRMAN. That is something we are just not going to do may I say, sir. You don't need to worry about that with this committee.

Mr. GLASSER. Thank you.

The CHAIRMAN. But can you offer us some advice as to how we could better provide for those children?

For example, so far as I am concerned, I think the committee might agree with this. I would be perfectly content if that father will put up $50 to help support that family, let that mother have the $50 for the children in addition to that welfare check. But somebody is going to have to find him. I am against unnecessary Federal interference in somebody's affairs, but as far as that runaway daddy is concerned, and as far as this Senator is concerned, I would be willing to put the long arm of the Federal Government to work finding him and garnisheeing his paycheck and sending some money back to support those children. Do you object to that?

Mr. GLASSER. I don't object to that, no, providing, I assume which is one of your provisos, the proper legal protections are incorporated in it. I am a little reluctant to testify to this effect because my memory is vague on it. It goes back a bit, Senator Long, but it seems to me that in New York City they did some work some 15 years or so ago in an attempt, they had a follow-father clause regulation, and they found in fact it was costing them just about as much money to find and hold the responsible fathers as the amounts they collected.

However, I want to make clear, I believe the responsible fathers, should be held responsible, I will support that.

The CHAIRMAN. So far as I am concerned, if it cost more money I would still be in favor of making the daddy pay something. He has a responsibility, and at least he ought to learn that he won't gain anything by running across the State boundary to avoid his responsibility to his family.

Mr. GLASSER. I support that as long as we will not treat people on welfare as second-class citizens, and as long as we won't punish the children for the errors of their parents.

The CHAIRMAN. It would seem to me that we would be making superclass citizens out of them if we are going to tell those people that they can draw Government money and decline to work while the people that you represent, work by the sweat of their brow to make an honest living, and pay tops to support that kind of riffraff.

Do you know what a Hobson's choice crew is? Captain Hobson stayed in the barroom while the other captains chose their crews, and he got what was left. When I was in the Navy I was given a Hobson's choice crew.

Mr. GLASSER. You are lucky, sir, you are still here.

The CHAIRMAN. Some of those fellows, may I say, were very good men, but they were misunderstood. They did a job. But, generally speaking, someone has to push them a little bit. There as just a lot of people who could make a greater contribution to society if we took a little more interest in them, tried to find some job they could hold, and subsidize them, if necessary, to do something that presently is going undone.

Now, I know there is nobody on that House committee who intends to be cruel or mean or vicious. Those are good people, and I think they are seeking to achieve an objective that you would approve if you had discussed it with them. They want to see to it where people are capable of doing something worthwhile that they do it.

I could not cite a better example than that crowd who came in here to call a sit-in strike on this committee. They had time to come from New York down to Washington, D.C.—some even came across the continent to impede the work of Congress, protest, just raise the devil around this place for 3 days running, and throw the schedule out of line. But they have not got time to pick a beer can off of the street in New York City in front of their own house or catch a rat. People of that sort, I would think, if they do not earn but $1 of their keep, could at least do something better than just get in the way of somebody who is trying to do something.

Mr. GLASSER. Mr. Senator, this colloquy makes me say this: We are all very frustrated by the operations of the public welfare system in this country. I do not think there is any question that the system has not achieved its objectives. It has very real defects.

We would like to get the people off the welfare rolls if we can. I think the real problem is that we are trying to deal with a very complex situation, a frustrating situation, in a single-minded way; namely, by changing welfare we will change people.

Regrettably, I wish it were that simple—regrettably it cannot be done that simply. We have to do the best we can with the welfare mechanism for the time being. But we need a system where, in fact, there are jobs available for all Americans, not only for those on welfare but for the many who are struggling at the same low levels, and have not applied for welfare.

We need these jobs available at decent wages so that people will be able to work a full year and end a year even, at least at a decent standard.

We need decent social insurances. We need decent housing, we need to eliminate the effects of segregation and discrimination. All these things are part of the picture.

We cannot solve it solely by the welfare mechanism. So what we are saying is let us face it realistically and not attempt to believe that using the welfare mechanism we will solve all of America's problems.

Let us do a decent job in welfare and let us try to do as we are trying to do, a decent job in all these other areas that affect the poverty scheme.

The CHAIRMAN. Here is one point where we differ, and I just cannot understand why you differ with me on this.

If a female worker in the Chevrolet plant loses her job, starts collecting unemployment insurance, and you say, "Look, we have got you a job over in the Ford plant doing exactly the same thing you were doing in the Chevrolet plant. Report to work there and they will pay you the same thing you are making working for General Motors." Well, if that woman does not want to take that job she does not get her unemployment insurance check in the future because she has work available she is fully capable of doing. She just does not get the unemployment insurance check. It would be a burden on the program to pay folks just not to work, and so the check is terminated.

Now, if we can agree that is correct, why should it be any different if she happens to be on public welfare and there is a job she is fully capable of performing? Why should she be treated any differently?

Mr. GLASSER. It should be different for two reasons: In the first place, she has free choice as to whether to work or not.

The CHAIRMAN. She does not have any choice of whether that check is going to be cut off when you say there is a job available.

Mr. GLASSER. She has free choice as to whether she should work or not. I think all Americans are entitled to that.

Secondly, these are essentially not the women we are talking about. These are not the younger women, Senator Long. These are basically unmarried women or women with older children. There are some exceptions, but most of the women who work in the auto plants are the women who came into those plants in the defense period during World War II.

The amount of new employment of younger women is quite small, and continues that way. So that I do not think the analogy works, sir, because these are not the women who are the same kind of women in terms of age and family composition as those on relief.

The CHAIRMAN. I know a great number of good women who work, schoolteachers, professional women. They work and their husbands work, too; they work to supplement that family income. They think it is a good idea for the family to live better, have a better home, and enjoy more of the better things in life, and they work——

Mr. GLASSER. And they have a choice.

The CHAIRMAN (continuing). To get their family ahead.

Mr. GLASSER. Senator Long, but they have a choice.

Senator LONG. I am not complaining about that. Why should we pay them if they elect not to work when there is a job they are fully capable of performing?

For example, why not work while the child is in school? If you want to say they should stay home while the child is there, how about when the child is in school, why not work then and do something constructive besides picket a Senate committee?

Mr. GLASSER. Assume that is right. What happens to the child in the interim? What happens when the child is ill? What happens about the lunch period? What happens when the child has to participate in school activities where a parent is necessary?

The CHAIRMAN. I think we have exhausted this.

Mr. GLASSER. We have exhausted this.

Senator ANDERSON. I did not get the first part of your testimony. Did you recommend changing deductibles in medicare?

Mr. GLASSER. Yes, sir.

Senator ANDERSON. What is it?

Mr. GLASSER. We urge that, first, with regard to the 90 to 120 days that the $20 deductible and the $10 be eliminated because we believe that this is the period when the retired person most needs the money, and it is when he can least afford to pay for it when he is ill.

I said, Senator Anderson, that our estimates are that medicare at this point pays somewhere in the neighborhood of 40 to 45 percent of the expenses of medical care of the elderly, so obviously he is already filling a large gap out of his pocket, and he could ill afford to do it, both on this as well as on the coinsurance deductibles.

Senator ANDERSON. Well, the original act was $40, was it not?

Mr. GLASSER. The original Social Security Act.

Senator ANDERSON. The Medicare Act.

Mr. GLASSER. Yes.

Senator ANDERSON. Have you any idea how much of a battle that was?

Mr. GLASSER. I have some idea, and I know the yeoman fight you put up, sir.

Senator ANDERSON. It was tough enough to get $40 when many people said that $60 was right. Don't you think we ought to try it at $40 to find how it works?

Mr. GLASSER. We feel we have tried it, Sentor Anderson. We have had now some 20 years of experience in the UAW with prepaid medical care programs. There are no coinsurance and no deductibles in our basic medical care program for a reason, sir. We want to encourge early diagnosis and early treatment because that is good medical care, and we believe over the 20 years we have saved money, not lost, by not having coinsurance and deductibles.

Senator ANDERSON. Do you regard the Medicare Act as insurance?

Mr. GLASSER. As it is now written there is no question but that it is social insurance.

Senator ANDERSON. In 1956 the Congress passed a bill, with the help of Senator Walter George, which provided for disability at 50. I participated in every discussion with Sentor Kerr when we talked with Senator Walter George, and we had to have him on our side if there was any possibility of passing it.

He laid down certain requirements. He wanted to be sure it was a separate fund and it did not touch general taxes at all.

What about this discussion now, you say about general proposals to make use of Federal revenues for deficits in medicare?

Mr. GLASSER. This goes, sir, I believe, to the——

Senator ANDERSON. I quote your phrase that you used earlier, that general provisions are to be paid by the taxpayer and not by the insurance programs. Is that your contention?

Mr. GLASSER. Our contention is, sir, precisely that. We believe that a sound system with general revenue contributions is essential to the continuing growth of this.

I stated, sir, that we stand with Argentina and France as the only nations which do not have general revenue contributions, other than the underdeveloped countries in Africa.

We believe that it is more equitable. We believe that employers would in this way be paid and individuals in relation to ability to pay.

We believe that it is in accord with the social goals of the country and the disability you cite, sir, the disability situation, is the best proof.

The House committee, reporting on why they did not accept the administration's recommendation to cover those who are disabled, indicated they did not cover them because the cost of coverage would be higher per capita than the cost of coverage for the elderly per capita.

Well, we feel this is just the point. There is a real social problem for these people who are sicker, if you please, or more disabled than the general population, and it is proper for the Federal Government to consider a subsidy, if you please, to make this system continue to serve its social purposes.

Senator ANDERSON. I think I am the last surviving member of the group that promised Walter George. How do you think I should vote when we told him we would be in the black at all times?

Mr. GLASSER. May I ask Mr. Lesser to comment on this?

Mr. LESSER. Senator, if I may, Senator Anderson, since I think I was part of some of those discussions. As you know, we do in the medicare program now use general revenues to pay for the costs of covering those persons who were over age 65.

We think that there are certain costs, as Mr. Glaser said—our system is a social insurance system—and we think that it is perfectly proper to pay for some of the social costs of our system out of general revenues.

We think the best example of this is the minimum benefit. This is a benefit which, in a sense, is unrelated to the wage the person earns. We do need the minimum benefit.

As the chairman said, it was his opinion that a $100 minimum was a proper figure, and it is for this figure that we have testified.

We think general revenues are the proper and equitable source for the paying of this minimum benefit.

Senator ANDERSON. I am merely trying to cover the fact that the bill would never have been passed, at that session at least, if we had not made the concession to Walter George. He was one of the great Senators, and he had to have some proof that we would not bankrupt the Social Security Act by the Disability Act.

Mr. LESSER. I remember that well, sir.

Senator ANDERSON. I am glad you support my testimony at least.

Mr. LESSER. And we did put in the age should be at that point.

Senator ANDERSON. We did.

Mr. LESSER. And then, if you will recall, some of us said this was not necessary, and experience showed that age 50 was not necessary, and 2 years later the age 50 was eliminated.

Senator ANDERSON. I only say, Mr. Lesser—I do not agree with you when you say the 50 was not satisfactory or necessary. We did have to change it. But instead of moving it down on an insurance basis where an insurance company would operate, to 40 and perhaps 35, and then 30, we would go all the way down and we would have gotten in the red.

Mr. LESSER. Well, you mentioned an insurance company. We, in the UAW and in many other private pension plans where we do provide a disability benefit, permanent and total disability benefit, we, too, started with age 50. Actually we started with age 50 in 1950 for permanent and total disability, and we removed the restriction of age 50 and eliminated any age requirement before——

Senator ANDERSON. But not before 1956.

Mr. LESSER. Before, we actually eliminated it before Congress eliminated it. Before Congress eliminated it we eliminated the age 50 in our private programs.

It was in the 1955 negotiations, I believe, that we eliminated the age 50 requirement for disability benefits, permanent and total disability benefits.

Senator ANDERSON. I still insist the bill would not have been passed if we did not make certain promises, and those promises have been very quickly changed. Some cost estimates have been brought up to show that it would be too expensive. I tried to point out the other day the fact that the cost estimate was originally $225 million. A new estimate hardly 6 months later showed $695 million, and it would be over a billion dollars after a while.

We would not have passed the bill on that, I do not believe.

Don't you agree with these cost estimates? Are they badly off?

Mr. LESSER. I think the cost estimates have been greater than those which were originally estimated.

Senator ANDERSON. We found out about it.

Mr. GLASSER. May I comment about it?

Senator ANDERSON. Surely. I am only trying to say here is a hearing in which a request is made for Members of the Senate to continue to support many of these things. I, for one, already have had one experience where we passed this bill and said we would never dip into the Federal Treasury, and now we are trying to dip in as fast as we can.

You testified a while ago—I made some sort of a notation—that you didn't believe in using general revenues.

Mr. GLASSER. May I say, sir, we are not proposing that general revenues be used simply to pay increasing costs. Regrettably social mechanisms are imperfect mechanisms at best because they deal with imperfect subjects; namely, human beings and, therefore, in a new measure such as medicare, it is going to have to be tinkered with from time to time to improve it.

We believe that one of the strong measures that needs to be taken is a hard-nosed look at why the costs are in fact, going up, and the institution of a far more effective cost control than now exist.

You have testimony here from California as to what is happening to physicians' fees, for example. You have had testimony on what is happening to hospital day care fees.

Now, part of the problem we believe is it is unpleasant, if you please, to institute cost controls in certain of these sectors except that I do not know any other kind of situation in the Government where a government says to a contractor who is going to offer services to the Government, "We will pay you what you determine to be your reasonable and customary fee. But then if you can get some more money out of somebody else on top of that for the same service that is all right with us."

Now, that is what is written in 12080, sir, and we believe these are factors which, factors like these which are, contributing to the increase in costs.

Senator ANDERSON. You commented earlier on the general provisions for taxation and commented that in the original act that was discussed.

Mr. GLASSER. It was discussed and recommended by the President's—President Roosevelt's, Franklin Roosevelt's Cabinet Committee on Security. He had a Cabinet Committee, and in their report they said they thought this would work on the basis of employer-employee contributions, but somewhere down the road, probably around 1965, general revenues would be required.

Senator ANDERSON. Could you cite that someplace where I can read it?

Mr. GLASSER. Yes, sir. That one I think I can put my hands on in a great hurry.

Mr. LESSER. It is the original report of the Committee on Economic Security.

Mr. GLASSER. It is the report to the President of the Committee on Economic Security, 1935, page 3.

Senator ANDERSON. Well, I appreciate that. I came in here at that time and had some discussions with some officials in my State later on. I never heard that satement before, that there was such a report.

We were talking about raising the floor. How far would you raise it?

Mr. GLASSER. We would recommend, and we have recommended and, as I say, my day was made and I was ready to leave as soon as Senator Long introduced this by saying he supported a floor of $100 for retired persons. He did not say, but I presume he meant, and I do not mean to put words in your mouth, a comparable floor for disabled persons now on social security, and $150 for a couple is our recommendation.

Senator ANDERSON. Were you referring at all to the $6,600?

Mr. GLASSER. Pardon me?

Senator ANDERSON. Were you referring at all to the——

Mr. GLASSER. The wage base?

Senator ANDERSON (continuing). Wage base.

Mr. GLASSER. With relation to the wage base we urged, and we urge, that the wage base be moved over several years to a $15,000 wage base, and we recommend that there be an exemption of payments for the first $600 on earnings.

I need hardly tell you, sir, that the tax as it is now constructed is a highly retrogressive tax. It does not, in fact, enable people who are better able to pay, to pay, and we see no sense in keeping to the $7,600, for example, ceiling which is in the House bill.

Senator ANDERSON. I believe I made the motion to adopt the $6,600 from the smaller amount, and I have no objection to it because I have a figure that shows about $14,500 would be about the same as $3,000 in the 1935 act.

Mr. GLASSER. Yes, sir. I will not bargain with you for $500. My figure is $15,000. I will take yours.

Senator ANDERSON. I only want to say that is not a great change from what we originally adopted, $3,000. Everybody was satisfied at that time.

The CHAIRMAN. Thank you very much, sir.

Mr. GLASSER. Thank you very much for your kindness.

The CHAIRMAN. Incidentally, on that $3,000, if a person does not own his own home and really has no other income, so he would be having to pay rent as well as medical expenses and other things, he is drawing, let us say, $70 in social security, and that is all the income he has, my impression is that State governments have found means to modify their programs so that they will give him the welfare check of $30.

Out of that the Federal Government is paying 84 percent. We are paying $5 out of every $6. So if we could simply say that the social security would be $100 and take him off the welfare rolls, he would get all in one check instead of two, and the costs for that person would be very modest, and we would only lose $1 out of $6, and the State would probably use that saving anyhow—most States are hard pressed for revenue—and we would be justified, I think, in using general revenues and taking that person off welfare by raising the social security payments so he would not be a welfare client.

Mr. GLASSER. May I augment your statement in two ways, sir? One, you would not require this elderly individual to go through a demeaning means test if you did this; and, second, you will accomplish additional savings because you would not have the administrative costs of investigating eligibility and everything else that is required in welfare. So the additional $24 would be less than that because of the savings.

The CHAIRMAN. When you really get down to it, the reason a fellow is getting a minimum is not that he did not work hard—a lot of folks who worked for low pay are working a lot harder than I am working now—but he just did not have the good fortune to make much money for it. He did not have much training and never had a good job, but he worked very hard.

Mr. GLASSER. Yes, sir.

The CHAIRMAN. So for people of that sort they would live in a much more dignified fashion if they were on social security entirely, rather than being on public welfare plus what the social security gave them.

Mr. GLASSER. Yes.

Senator ANDERSON. Can I just say I have now read the quotation from 1935. I appreciate your drawing it to my attention. I frankly never heard it, but it is exactly what you said.

Mr. GLASSER. You have seen it?

Senator ANDERSON. Yes. You are fully confirmed.

Mr. GLASSER. Thank you very much, sir.

Mr. LESSER. I might say later advisory councils made the same recomendation. I think the 1938 advisory council and subsequent ones, too, Senator.

Senator ANDERSON. All I wanted to check was the early part of it. There were a great many people here who were trying to establish social security, and the group that I had been working with were all Germans. They had the only experience in social security.

Mr. LESSER. Thank you.

The CHAIRMAN. Thank you very much, Mr. Glasser and Mr. Lesser, and your associate.

(The prepared statement referred to previously follows:)

STATEMENT OF WALTER P. REUTHER, PRESIDENT OF THE INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA

My name is Walter P. Reuther, I am appearing on behalf of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW), of which I am President. I am pleased to have the opportunity to appear before your committee to present our views on the prospective Social Security legislation, H.R. 12080. My organization is concerned with both the social insurance programs and the asistance programs under the Social Security Act. Accordingly, I have divided my remarks into four parts to reflect the areas of our greatest concern. The first part deals with the need for substantial revisions and improvements to the present cash insurance benefit provisions of the Social Security Act. The second part states our views respecting changes and improvements we feel would be desirable in Title XVIII (Medicare). The comments on proposed amendments to Title XIX (Medicaid). The final section expresses our position respecting the public welfare program.

I. INCOME MAINTENANCE PROGRAMS

Monthly cash insurance benefits paid under Title II of the Social Security Act are the major source of income for most of the more than 23 million Americans now on the benefit rolls. But from the inception of the program to the present time, benefits have been chronically inadequate. We have made considerable progress towards achieving nearly universal coverage for the working population and broadening the scope of the program, but we have failed in spite of repeated liberalizations, to provide sufficient retirement income to permit security and dignity to which American workers are entitled after a lifetime of work. The result is that millions of older persons are living in poverty.

Members of the UAW and their leaders believe that a free and abundant economy can provide more than existence at the bare margins of subsistence for workers ceasing active employment because of old age or disability and for their families and survivors. The goal of our Social Security system should be to assure wage earners upon retirement of income from the public program equivalent to at least two-thirds of average covered earnings in the years before leaving the work force, with regular adjustments in benefits to reflect changing economic conditions. Such a program supplemented by private group pension plans, would assure a standard of comfort, decency and dignity which workers in America have a right to expect.

Important new measures are required now to achieve practical improvements in Social Security programs. The amendments included in the House-passed H.R. 12080 fail to deal adequately with these problems and go to extraordinary lengths to protect the interests of those in the most fortunate economic circumstances to the detriment of the poorest and the most disadvantaged. Accordingly the UAW, in behalf of more than one and a half million members and their families recommends the enactment of the following program by this Congress:

1. Guaranteed minimum monthly benefits as follows:
   a. $100 for a worker retiring at age 65.
   b. $100 for a disabled worker.
   c. $150 for an elderly couple, both age 65 or over.
2. An immediate increase of not less than 50% in current and prospective benefit payments applicable throughout the range of covered earnings.
3. An increase, by means of several broad annual steps, in the contributions—covered earnings base to $15,000.
4. An exemption from the payroll tax for the first $600 of covered earnings.
5. Provision for automatic adjustments in benefit payments to reflect not only upward changes in consumer prices but also to enable beneficiaries to share in the growth of the American economy as evidenced by advances in real wages and improved living standards.

6. An immediate Federal Government contribution to the Social Security Trust Funds from general tax revenues and subsequent contributions from general revenues on a gradually increasing basis, ultimately sufficient to provide an approximately equal sharing of costs among workers, employers and government.

7. Increased benefits for an elderly widow payable on the basis of 100% of her deceased husband's entitlement.

8. Measures to protect benefit levels of early retirees and workers who are displaced by technological change or who have suffered prolonged periods of involuntary unemployment and to provide benefits for all workers reasonably related to pre-retirement earnings by providing for the computation of income benefits on the basis of the ten years of highest earnings.

9. The specific recommendations of President Johnson embodied in H.R. 5710 to increase the special benefits payable to persons over age 72, to provide benefits for disabled widows under age 62, to cover 500,000 more farm workers now excluded and to apply federal service towards Social Security credits for government workers ineligible for Civil Service benefits.

II. PROPOSALS FOR MEDICARE IMPROVEMENTS

The adoption and subsequent implementation of Title XVIII of the Social Security Act (Medicare) are proud achievements of recent U.S. history.

Medicare has enhanced the economic security and human dignity of millions of older Americans by establishing as public policy their right of access without the humiliating means test, to modern health services under a publicly sponsored health insurance program.

For all its great value, Medicare in its present form, however, falls short of providing a truly adequate, comprehensive program. H.R. 12080, unfortunately, does practically nothing to meet this need and offers solutions to problems growing out of the original legislation that are far more responsive to the special interests of providers of health services than to the intended beneficiaries of the Medicare program. To correct existing deficiencies, and to improve the program, the UAW proposes the following revisions in Medicare.

1. Extension of 90 day time limit on inpatient hospital stay to at least 120 days of fully paid hospital care and removal of time and dollar limits on care for mental illness.

2. Additional coverage for the costs of prescription drugs used outside the hospital.

3. Limiting Medicare payments for physicians' services only to those cases in which the physician accepts assignment.

4. Provision of immediate coverage for disabled workers as proposed by President Johnson.

5. Reimbursement under Part A of both the technical and professional costs of services rendered by hospital based physicians.

6. Provision now incorporated in H.R. 12080 to permit the Secretary of HEW to enter into agreements with providers of service to establish alternative payment methods to reasonable cost reimbursement as a basis for arriving at an appropriate payment procedure for group practice, prepaid health care plans.

7. Establishment of utilization review programs, similar to those in operation under Part A, under Part B at state and local levels.

8. Elimination of present coinsurance and deductible requirements from both Part A and Part B. This would provide full inpatient hospital services, full hospital outpatient diagnostic services, no patient payment in extended care facilities under Part A and the entire reasonable cost of services under Part B, including out-of-hospital psychiatric services.

9. Establishment of National Advisory Health Council to represent professional and consumer interest in the development of administrative policies under Titles XVII and XIX and under other legislative programs in the health field.

III. PROPOSALS CONCERNING TITLE XIX (MEDICAID)

Poverty and poor health go hand-in-hand. The adoption by the 89th Congress of Title XIX (Medicaid) of the Social Security Act was a recognition of the inferior quality of the health services that have been available to the poor. Title XIX explicitly acknowledges public responsibility to assure adequate health care for needy Americans, whether or not they have reached age 65.

A good medical care program must be an integral part of any comprehensive effort to aid the poor to achieve independence and self-sufficiency. It would be tragic, therefore, to cut back now on the Title XIX program in the manner contemplated by H.R. 12080. In the belief that the poor require more, rather than less, health services, the UAW proposes that there be no major changes now in Medicaid and calls upon the Senate to delete from H.R. 12080 the following:

1. Provision that would limit federal participation in state Medicaid programs on the basis of arbitrary income ceilings.
2. Provision that would permit the states to cut back on the comprehensiveness of their Medicaid programs by substituting less essential health services for the 5 basic services now required.
3. Provision that would dilute the requirement of the present law for maintenance of state effort.
4. Provision that would allow the states to reduce the services made available to needy persons under age 65 by amending the present requirement of comparability of services for all ages.

IV. PUBLIC WELFARE AMENDMENTS

The UAW shares the feeling of concerned citizens that the public welfare system in the United States is not performing in satisfactory fashion. It is degrading to those who are dependent on it, often fails to meet minimum subsistence needs and has not achieved its objective of helping the poor to become independent and self-supporting.

While H.R. 12080 professes the desirable objectives of seeking to rehabilitate the poor and reducing the cost of public welfare, it would attempt to accomplish them by means that are repugnant and reflect a harsh and punitive attitude toward the poor.

We in the UAW give our full support to the constructive provisions of H.R. 12080, but we believe the bill would be much improved if the Senate would:

1. Eliminate the requirement that no state may have a higher percentage of children on welfare (AFDC) than it had at the beginning of this year.
2. Require all states to provide assistance programs for families with dependent children when the parents are unemployed without the additional restrictions included in H.R. 12080.
3. Restore the Administration proposal to require the states to meet their own current definitions of need.
4. Protect the right of a mother to choose, or refuse without penalty, to participate in the work and training programs.
5. Remove the incentives that H.R. 12080 would provide the states to remove a child from the care of a parent and place the child in a foster home.
6. Remove the use of the threat of the device of protective and vendor payments to force participation in the work and training program.
7. Retain the provision of H.R. 12080 for aid to the social work education program, but without the $5 million ceiling after the first year.

V. IMPROVEMENT IN CHILD HEALTH (TITLE III)

The UAW supports the action of the House in including in H.R. 12080 increased appropriations for maternal and child health and crippled children's services and the consolidation of the two programs into one.

I. INCOME MAINTENANCE BENEFITS

We are living in a time of grave domestic unrest. For the first time since the Civil War there are those who question openly whether one nation, indivisible is attainable or even desirable. The firmness of our determination to stamp out poverty in America is being tested. Bitterness, alienation and violence attack the foundations of our national community. Some question whether we have the will, both public and private, to provide the jobs, the houses and the education that are needed to assure every American of an opportunity for full participation in our society.

It is no exaggeration to suggest that our immediate response to these current challenges will shape American life for decades to come.

As the members of this Committee know the UAW is currently engaged in major collective bargaining negotiations with the employers in the automobile industry and we are currently on strike at the Ford Motor Company because of the unwillingness of that Company to make concessions substantial enough to meet the demands of the workers. High on the priority list of our members is the security of an annual income, wage increases to meet sky rocketing costs of living and decent pensions. These demands, and others which are related, are so important to our members that they are willing to give up their regular incomes and accept the personal and family deprivations of a strike to achieve their goals.

The elderly people in America by and large do not have a strong union, nor can they strike. Their needs and problems are, however, in many ways similar to those of striking Ford workers. The problems of deprivation which retired workers face may be greater, but the proposed remedies offered in H.R. 12080 also constitute essentially token acknowledgement of need, rather than substantial solutions to problems.

To me, as it must have been to the more than 23 million Americans receiving monthly Social Security cash benefit payments as retired or disabled workers and as dependents or survivors, H.R. 12080, as passed by the House of Representatives, was a profound disappointment. Because 1 of every 5 Americans who ar poor is also age 65 or older, real improvements in our social security system would make inroads towards reducing poverty. Instead, the House chose to turn its back on the problems of the aged, the sick and the needy by passing a bill with, as it was aptly characterized by *The New York Times* a "soak the poor" bias.

Because I believe the current poverty in America is inextricably linked to the inadequacies and deficiencies of our social security system. I also believe that the Senate still has an opportunity to correct the deficiencies in the House bill and make of it a comprehensive and constructive contribution to our national well-being.

When it comes to social security legislation the United States remains an underdeveloped country.

For more than 30 years we have strayed from the original objectives of the 1935 Social Security Act and have perpetuated a myth which has it that the Old Age, Survivors and Disability Insurance (OASDI) programs, popularly referred to as Social Security, need provide no more than a bare floor of protection for the lowest paid worker and accepts most grudgingly the need for supplementing the floor with a modest wage-related benefit for workers who earned more than the amount required to qualify for the minimum. For more than 30 years, opponents of adequate Social Security have maintained a successful rear guard action against meaningful improvement. For years we have refused to acknowledge that the floor of protection concept was hardly more than rationalization for a social insurance system that does little more than subsidize poverty. We have the means, and can surely find the will to aspire to a more acceptable level of performance for the 1960's and 1970's.

More than 30 years ago, a Cabinet committee reporting to President Roosevelt suggested that a program of economic security- "must have as its primary aim the assurance of an adequate income to each human being in childhood, youth, middle age or old age—in sickness or in health. It must provide safeguards against all of the hazards leading to destitution or dependency."[1] The original Social Security Act in 1935 expressed a similar purpose.

In 1967, our economy has achieved unparalleled abundance with a Gross National Product approaching $750 billion, yet we have failed to achieve the goal we set for ourselves as national policy a generation ago, when Gross National Product was less than $73 billion. The unpleasant truth is that OASDI cash benefits are not adequate today, nor have they been adequate at any time in the entire history of the program.

It was with profound disappointment, therefore, that I followed the progress of H.R. 12080 through the House of Representatives. I welcome such changes as the liberalized test of insured-status for young workers who become disabled, more favorable treatment for the dependent children of women workers, granting additional wage credits for military service and the less stringent formula for reducing disability benefits for workers who are also entitled to workmen's compensation. But I am frankly appalled that the House can consider a 12½% benefit increase and raising to $7,000 the contributions-earnings base, as appropriate and adequate to our current needs and responsibilities. Even worse was

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[1] "Report to the President of the Committee on Economic Security," 1935, p. 3.

the decision to raise the minimum benefit by applying the same 12½% to the present $44 and adjusting that up to the next whole dollar to yield a pitiful $50.

No one can be unmindful of the strains on the economy imposed by our commitments in Vietnam and other parts of the world and by our efforts at home to cope with problems whose magnitude is only now becoming known to us. But too many Americans—about 1 out of every 8—depend too heavily on their Social Security incomes to allow us to choose a time when we can "more comfortably afford" an adequate benefit increase.

Our economy can support it and our society owes to every American worker assurance that he may look forward after a lifetime of work to retirement in comfort and dignity. The goal of our Social Security system should be to achieve and maintain a public retirement income program replacing approximately two-thirds of the worker's average covered earnings prior to retirement, appropriately adjusted to post-retirement changes in wages, prices and living standards. This is a realistic goal, and the proposals advanced in this statement are constructive steps in that direction.

In my lifetime the average life expectancy at birth has increased by 20 years—from 50 to 70 years. If the advances in longevity made possible by medical science are not to become travesties, social improvements of equal magnitude, such as those we are proposing in Social Securty are imperative. It has often been said and is worth restating that we must not only extend life, as we are doing, but also make that life worth living.

By any reasonable measure current OASDI benefit levels are shockingly inadequate and fail to afford minimum standards of decency and self-respect to the millions of Americans for whom the monthly insurance benefits are either the sole, or major, source of income. The deficiencies bear most heavily on the aged past 65 and those who retire between 62 and 65 and receive permanently reduced benefits for early retirement. Together these groups constitute more than 75% of the number on monthly income beneficiary rolls.

Although the aged make up less than 10% of the total U.S. population, it appears that about 20% to 25% of those we count as poor are 65 and over. The Bureau of the Census reported that in 1965, 43% of families headed by a person 65 and over—compared to 16.5% of all families in the population—had incomes of less than $3,000. Of the families with an aged head having incomes below $3,000, more than half had less than $2,000. Among single persons 65 and over, nearly one in three had 1965 incomes of less than $1,000; another two-fifths of unrelated individuals 65 and over had incomes between $1,000 and $2,000.[2]

Similarly, in reporting on poverty and low incomes of Americans not living in institutions in 1965, the Social Security Administration estimated that of persons age 65 and over, very nearly 66% of unrelated individuals and a third of all such persons living in family units are "poor and near poor". (For this purpose, poor is defined as annual income of less than $1,500 for a single person and less than $1,900 for a couple; near poor or low-income status means less than $1,800 for a single person and less than $2,600 for a couple.) Another 13% of those in family groups were deemed to be "hidden poor"—individuals with sub-poverty incomes living in families with incomes over the poverty line.[3]

Without launching a technical review of these Social Security Administration yardsticks, I believe that the effort to distinguish between "poor" and "near poor" is scarcely productive and that an excellent case can be made to set the poverty threshold at income levels higher than SSA's "near poor." Using these yardsticks, however, we find only 16 percent of aged OASDI beneficiaries with sufficient other income to keep them above the near poor level without their benefits, and only 25 percent who would be above the poverty line without benefits. Even with benefits, 30% are below poverty and another 10% below the low income level. With respect to beneficiaries below age 65, the estimate is that 32% are poor, but no estimate is made for the near poor.[4]

About 80 percent of the current population 65 and over are now receiving regular monthly OASDI benefits. The non-beneficiary aged population consists mainly of retired public employees and dependents receiving benefits under other publicly sponsored retirement systems, persons who did not have sufficient

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[2] "Current Population Reports: Consumer Income." U.S. Department of Commerce, Bureau of the Census, Series P-60, No. 49, August 1966.

[3] "The Poor in 1965 and Trends, 1959–65," Social Security Administration, Office of Research and Statistics, Research and Statistics Note No. 5, 1967.

[4] "Social Security Benefits and Poverty." Social Security Administraiton, Office of Research and Statistics, Research and Statistics Note No. 6, 1967.

covered employment to qualify for OASDI benefits and persons between 65 and 72 whose earnings prevent them from receiving OASDI benefits.

No one can doubt the link between poverty and inadequate OASDI benefits. The 1965 "Annual Statistical Supplement" of the *Social Security Bulletin* provides data to give some indication of just how inadequate the benefits are. The following statements are derived from data available for 1965 and include adjustments made by the 1965 amendments to the Social Security Act:[5]

1. At the end of 1965, about one-fifth (19.8%) of retired workers beneficiaries received monthly benefits of less than $50; more than two-fifths (42.3%) received less than $75; and more than three-fifths (60.6%) received less than $100.
2. For retired workers and wives age 62 and over, 20.1% had combined monthly benefits of less than $100 and nearly half (48.6%) less than $150.
3. Almost a fifth (19.2%) of aged widows had monthly benefits below $50; practically another one-fourth (24.3%) were receiving between $50 and $70; and all but 14.4% were below $100.

Inasmuch as most of our aged citizens have neither significant incomes nor assets that can be converted into incomes to supplement their benefits, it should be unmistakably clear that current benefit levels are hopelessly inadequate. The great majority of older Americans now living below the statistically defined poverty level have put in a lifetime of working and contributing to society. Their drop to a dreary subsistence stems primarily from having largely ceased active employment. Others have existed on substandard incomes and experienced want for all, or for long periods, of their lives.

H.R. 12080 cannot solve the problem with a simple benefit increase that goes about 3 or 4% beyond restoring the purchasing power of Social Security benefits to the level realized on the occasion of the last previous general increase in benefits. I refuse to believe that maintaining more or less constant purchasing power for a benefit structure that has never approached the goal contemplated in the original legislation represents an acceptable performance. But I believe the questions of adequate, decent Social Security, and the means of achieving it, should be faced forthrightly now. If the 90th Congress avoids the issues with another "cost-of-living" increase, they will fall to the 91st, but the day cannot be put off forever.

We need an unflinching appraisal of the economic condition of the aged and a thorough overhaul of the Social Security system to relate its benefits realistically to the worklife earnings and retirement security needs of American workers and to cure permanently its chronic inadequacy. A system that requires constant tinkering and patching and continues to yield benefits below the barest levels of subsistence for the majority of beneficiaries is patently defective. We must undertake a fundamental rethinking of the role of social insurance in a free society, so that we can arrive at a system that is consistent not only with our tradition of esteeming work and self-help, but that is consistent also with our esteem for the worth and dignity of each human being and is responsive to the needs of people of all ages.

We can neither neglect the present elderly nor impose on the young adults of America, just beginning to raise their families and struggling to achieve economic security, unnecessary and burdensome taxes on their pay, when the means for financing benefit increases more equitably are readily at hand.

But we are faced with immediate problems that require more than token action now.

We need something better than the "soak the poor" bias of H.R. 12080, which does least for those in most need. The proposals outlined below are offered both as something better and as initial steps towards longer range goals of fundamental reform in Social Security.

1. *Guaranteed minimum benefit*

H.R. 12080 turns its back on the problems of the poorest persons receiving cash insurance benefits; those receiving the minimum benefit including a disproportionate share of Negroes, farm workers, workers who were unable to compete in the job market, and persons whose benefits and other resources are so insignificant that they must be supplemented by public assistance.

Social Security Administration studies indicate that approximately 17% of beneficiaries entitled on the basis of their earnings receive the current $44 mini-

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[5] "Annual Statistical Supplement, 1965," *Social Security Bulletin*, tables 73, 87, and 88.

mum benefit or, if retired before age 65, less. The raise in the minimum to $50 voted by the House in approving H.R. 12080 reflects no credit on the House. I suspect the $50 figure was arrived at for no reason other than that it represents the smallest whole dollar amount consistent with a 12½% increase from $44. As a matter of fact, while the Ways and Means Committee in reporting H.R. 12080 to the House issued a 200 page document explaining and justifying the provisions of the bill, the comment concerning the minimum benefit covers less than 4 lines in the main section of the report. The report, with remarkable lack of conviction, says:

"Unfortunately, your committee could discover no definitive guide for determining what the level of the minimum benefits should be. At this time, a $50 minimum appears appropriate to the continuation of a wage-related system."[6]

If there is a national consensus on any issue concerning Social Security, it is that the system should provide at least a basic floor of protection. The protection now afforded by the minimum benefit is so meager that proposals for a substantial increase in the minimum should command a top priority in any allocation of funds available for Social Security reform. The present $44 minimium monthly bnefit for a worker retiring at age 65 is nowhere near an acceptable floor. It is so far below that level that an increase to $50 should have been unthinkable. Even increasing it by approximately 60 percent, as the President has suggested, would still leave the minimum far short of a desirable figure.

We need to keep in mind that the minimum affects the neediest persons receiving benefits. Workers who have been unable to build up the credits towards substantial OASDI benefits can rarely be expected to have any significant savings or incomes from other sources. Although private group pension plans now cover an estimated 25 million American workers, benefits from this source amounted to less than 1% of total income for the aged with the lowest incomes in 1962.[7] How little savings the low income aged have is illustrated by the 1963 Survey of the Aged by the Social Security Administration. That study reported 32% of married couples with at least one member over 65, 54% of unmarried men past 65 and 55% of unmarried women over 65, as having no life insurance. Another 9% of the couples, 15% of the men and 25% of the women, had less than $1,000 of life insurance.[8]

The conditions in which persons receiving the minimum Social Security benefit exist are truly depressing.

A recent "Social Security Bulletin" article reviewing the status of these persons said:

"Briefly summarized, the data show that among this group—

—there were twice as many women as men

—in their peak earning year from 1951 to 1963, the majority earned less than the amount permitted under the present earnings test in the law.

—fewer than half worked in the year before entitlement, and two-fifths had not worked since 1955.

—mong the men, one-sixth had worked 9 or more years in covered employment in 1951–63.

—half the men earned insured status at least in part from farm employment.

—close to one-fourth were getting help from public assistance.

—almost one-sixth of the couple but less than 1 in 25 of the nonmarried workers had other retirement benefits."[9]

The Administration has recommended a minimum guaranteed benefit ranging from $70 up to $100 to those who have made 25 years or more of contributions to Social Security. For practical purposes the full protection of the $100 amount would apply almost exclusively to retired workers with a history of long, regular and continued attachment to the workforce; those who have made uninterrupted contributions to the system almost from its inception to the present. For all but a small fraction of such workers, their own earnings entitle them to the $100 amount.

It is my belief, however, that we ought to apply a $100 minimum to a much broader group than the President contemplated. It should include every worker

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[6] "Social Security Amendments of 1967," Report of the Committee on Ways and Means on H.R. 12080, House Report No. 544, 90th Congress, first session, pp. 23–24.

[7] Erdman Palmore, "Differences in Sources and Size of Income. Findings of the 1963 Survey of the Aged." *Social Security Bulletin*, May, 1965.

[8] Division of Research and Statistics, "Assets of the Aged in 1962: Findings of the 1963 Survey of the Aged." *Social Security Bulletin*, November, 1964.

[9] Lenore A. Epstein, "Workers Entitled to Minimum Retirement Benefits Under OASDHI." *Social Security Bulletin*, March 1967.

in the covered workforce including those whose particular employment became covered by the system only in relatively recent years and workers who have been unemployed for prolonged periods through no fault of their own. They should not be made to suffer for the inadequacies of our economic system.

We recommend amendments to the OASDI system that would provide a guaranteed minimum monthly benefit, with no change in current coverage requirements, of at least $100 for all disabled workers and workers who retire, or have retired, at age 65. For a husband and wife, each of whose benefits commence at age 65, this would provide a minimum of $150. Payments for other beneficiary groups would also be proportionately adjusted.

2. *General benefit increase*

A general benefit increase substantially in excess of the 12½% voted by the House in H.R. 12080 is essential to preserve the historic character of the system as a contributory, wage-related retirement program for virtually all of the working population.

To preserve that character, the Social Security system must have more than a floor benefit. It must also have a meaningful benefit structure well above the floor, for we are here discussing not simply insurance, but *social* insurance.

Given current benefit levels, I do not understand how in good conscience we can consider benefit increases of no more than 12½%. The fact is that a 12½% increase will do little more than match total benefit increases since 1954 to the increases in consumer prices from that date. The 7% benefit increase provided for in 1965 legislation did not fully compensate for the rise in consumer prices after 1958 when the last previous benefit adjustment—also in an amount of about 7%—had been made, presumably to catch up to price changes since 1954. (Taking the 1957–59 average as the base, from 1954 to the present, the Bureau of Labor Statistics Consumer Price Index has risen by almost 24%—1954 average of 93.6 to 116.0 as of June 1967—while benefits were increased in 2 steps of about 7% each). A current benefit raise of 12½%, therefore, in real terms, amounts to an improvement from 1954 levels of perhaps 4%. In other words, Social Security beneficiaries as a group, are effectively barred from enjoying real participation in sharing the fruits of the growth of the American economy since 1954. It is a hoax on American workers to make periodic revisions in Social Security benefit amounts for past increases in living costs, without acknowledging that the base for determining the amount of adjustment is so hopelessly, appallingly and chronically insufficient.

At the present time, the average annual Old-Age Benefit for a retired worker is a little more than $1,000; for an elderly couple about $1,680. Adding $125 or $130 a year to the benefit payments of a retired worker, or $200 or $225 a year for a couple is not going to spell the difference between want and a standard of minimum comfort. Indeed, for the neediest among the elderly, increases of several times these amounts would not suffice.

We should have a general increase throughout the range of covered earnings of sufficient magnitude to maintain benefits in some significant relationship to pre-retirement earnings, to provide a fair return to beneficiaries for their contributions, and to avoid requiring the majority of retired persons to forego even the modest levels of comfort and sefl-sufficiency they attained while working.

An adequate public program of the kind we are proposing will permit the development of a supplemental system of private group pension plans. The private system will continue to have a significant function to perform in our economy. An effective private system will make it practically possible to realize and maintain standards of retirement living comparable to those enjoyed prior to retirement.

We must not forget, however, that the private pension system does not make available retirement incomes adequate to provide meaningful supplementation for most Social Security beneficiaries. Only 15% of the current aged have any income from private pension plans. It has been estimated that about 45% of the employed in our country are covered by any kind of private pension plan. But private plan coverage does not reach much of the workforce, and many persons who are covered at one time or another never manage to qualify for benefits at retirement. We should continue to look to the public program to meet universal and basic needs in retirement, while the private system would act in complementary fashion to meet special needs of individuals and specific groups in our economy.

If these objectives are sound, and I believe they are, then we must recognize unhesitatingly as a practical matter that we have to rely on OASDI as the only effective means for reaching them in the lifetimes of the present aged, and at least the older half of the present workforce.

Most people who work have little margin from their earnings to provide for retirement. It is to be expected that the only truly significant source of retirement income for them, other than OASDI benefits, would be from nongovernmental pension arrangements.

The report of the Advisory Council on Social Security to the OASDI Board of Trustees in 1965, however, indicates that we can expect only modest supplementation from such sources. The Council stated:

"About half of the aged social security beneficiaries have practically nothing (less than $12.50 a month per person) in continuing retirement income other than their social security benefits; and for all but about one-fifth of the aged beneficiaries, benefits were the major source of continuing retirement income. (Only 15% of the aged, for example, have any income from private pension plans and even for this 15% the amount from social security is generally larger than the private pension.)"[10]

We can anticipate only slight improvement in the capacity of the private plans to supplement OASDI. Over the next 25 years, Commissioner of Social Security, Robert M. Ball, predicts the percentage of retired workers receiving private plan benefits will rise to about 25%.[11]

Regardless of likely future developments in private benefit plans, it seems clear that the Social Security system must remain the basic economic underpinning of the retirement security of American workers.

We recommend, therefore, in addition to raising minimum benefits, that a general increase of at least 50% be provided in current and prospective benefit payments based on the full range of covered earnings for both worker and dependent or survivor beneficiaries.

Broadening the contributions—earnings base

The increase in the maximum covered earnings amount to $7,600 provided in H.R. 12080 is unacceptable and inhibits the proper growth and development of the social security system.

No systematic, rational modification of the present structure of OASDI benefit payments is possible without establishing an appropriate level for the contribution and benefit base— the maximum amount of annual earnings that is taxed and counted for benefit purposes. In fact, the equities of an effective, wage-related, contributory social insurance system requires a substantially higher base than we now have. It was particularly regrettable therefore that the House voted to cut back even on the relatively limited improvement suggested in the Administration proposal which would have raised the base to $7,800 now and to $10,800 by 1974. Many of the most serious shortcomings of the benefit structure in the past have been directly attributable to the chronic and continuing inadequacy of the base.

(a) Almost from the outset, it has not been practically possible to relate, on some reasonable basis, all benefits over the minimum to employment earnings, because the base has persistently failed to keep pace with the rising wage levels which have characterized our economy over the last quarter century. One indication of how far we have slipped is that while the base has risen from the initial $3,000 to $6,600, average earnings in manufacturing employment from 1940 to 1965 more than quadrupled from $24.96 per week in 1940 to $107.27 in 1965.[12]

(b) Once a worker with earnings in excess of the current base retires, he has no opportunity to match the benefits of a worker with comparable pay who retires later with the advantage of a higher base. Earnings over the base are lost forever for benefit purposes. Those who retire with benefits at or near the maximum, can, if they survive long enough afterward, live to see their benefits become a fraction of the prevailing levels of new benefit awards. The following comparison shows benefits payable at time of retirement and currently to male workers who retired at age 65 with maximum

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[10] Report of the Advisory Council on Social Security—1965, "The Status of the Social Security Program and Recommendations for Its Improvement," p. 32.

[11] Robert M. Ball, "Policy Issues in Social Security," *Social Security Bulletin*, June 1966, p. 8.

[12] U.S. Department of Commerce, "Statistical Abstract of the United States," 1966, p. 239.

wage credits following the various amendments to the Social Security since 1950.

Year of retirement	Monthly benefit amount	
	At retirement	Current
1951	$63.50	$101.70
1953	85.00	112.40
1955	98.50	112.40
1957	108.50	124.20
1959	116.00	124.20
1960	119.00	127.40
1963	122.00	130.60
1965	132.00	132.00

For those with uncovered earnings in excess of the base, the penalty, therefore, is double; lower benefits at retirement than appropriate to maintain a reasonable relationship to pre-retirement earnings and lower benefits than those of workers who, retiring later, are able to count all, or at least a greater proportion of, earnings.

(c) Inadequacy of the base distributes the burden of contributions inequitably among wage earners. The worker with earnings just equal to the current $6,600 base pays at twice the effective rate of one earning $13,200. A husband and wife each earning $6,600 pay twice the amount paid by a worker earning $13,200 with a non-working wife, but the working couple receives only a third more in benefits. I agree with the principle in the present computation formula which weights benefits in relation to contributions in favor of the lowest paid workers. But the worker earning $6,600 and contributing precisely the same amount as one earning twice or perhaps several times that, and the working couple, bear a disproportionate share of the burden of the subsidy involved in the formula.

In approving H.R. 12080, the House chose to impose a higher tax than the Administration had requested on those earning less than $7,600 and a lesser burden on those earning more. This action is further evidence of the inequitable treatment accorded to the "have nots" by H.R. 12080 for the benefit of the "haves."

The original Social Security Act in 1935 wisely set the base at a point ($3,000) where 95% of earnings in covered employment were subject to the tax and counted for benefit purposes. In fact, the full earnings of 98% of all workers were covered. From 1935 to 1950 there was a constant erosion of the base. Partial restoration was made in 1950 and on several occasions since then, but at no time was the 1935 relationship restored. In fact, by 1968, the present $6,600 base would cover the full earnings of only a little more than half of regularly employed males, and the $7,600 as proposed, the full earnings of no more than two-thirds of the regularly employed males. To restore the 1935 relationship now, a base of about $15,000 would be necessary.[11]

We recommend, therefore, raising the base to $15,000 in fairly broad steps over the next several years. We also propose to begin to lighten the burden of the regressive payroll tax on the lowest paid workers by exempting the first $600 of covered earnings from the tax.

4. Present beneficiaries and automatic adjustments

The House Ways and Means Committee Report on H.R. 12080 indicated that the benefit structure of the bill was designed to provide benefits for an elderly couple at least equal to half of the man's preretirement covered earnings. That is not a particularly useful standard in the light of the historic lag of the earnings-benefits base to actual earnings and the progressive changes characteristic of a dynamic economic system.

It does not matter that except at the very top of the benefit table, the level of average wage replacement for a couple even exceeds half of average Social Security earnings. Groceries are not sold and houses not rented on the basis of average prices, nor indeed should people be expected to live on the average of the various customary standards prevailing throughout their lifetimes. In terms of earnings levels current at the time of retirement, benefits for a couple under H.R. 12080 represent considerably less than half of wages initially, and a declining percentage from that over the period of retirement. The fact is that under H.R. 12080, a worker (with wife age 65 and no earnings record of her own) who retired this year at age 65 after have made contributions on maximum

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[11] Robert M. Ball, "Policy Issues in Social Security," *Social Security Bulletin*, June 1966, p. 8.

taxable earnings from 1951–1966 would receive, for himself and his wife, a monthly benefit of $229.40, or at best 41.7% of what he was earning prior to retirement.

From 1950 to 1965 average weekly earnings of workers in manufacturing employment increased from $58.32 to $107.27. Price changes account for part of the difference (the 1950 average was equivalent to $76.44 at 1965 prices) but the fact remains that average real wages rose a full 40 percent in this period with no commensurate change in the benefits of those who retired from the work-force. In effect, there has been a marked improvement in the general standard of living, but retirees have not shared in it.

The significance of changing economic conditions on the welfare of beneficiaries is expressed rather concretely in a recent SSA Research and Statistics Note as follows:

"The worker who retired in 1954 received an average monthly benefit of $66.60 and increases, in 1959 and 1965, which raised the amount to $76.00. Neither of these increases, however, completely restored the purchasing power of the original award. By the end of 1966, a year in which prices increased by 3.3 percent, the 1954 retiree would have required a monthly benefit of nearly $82, 8 percent greater than he was receiving, to purchase the same goods and services. Similarly, the 1950 retiree, who had his benefit increased from $89.00 to $95.30 by the 1965 legislation, needed nearly $100 in December 1966 to maintain his original purchasing power."

and

"The tabulation below shows the *amounts paid in 1966* (emphasis added) to workers who retired in specified years and the amounts that would have been required to maintain parity with the wage level.

Year of award	Benefit amount payable	Benefit amount needed to maintain parity with wages	Percentage difference
1940	$59.00	$85.00	−44
1950	69.60	89.85	−29
1954	76.00	103.95	−37
1959	95.30	112.95	−19

As shown above, the benefits of the 1954 and 1959 retirees lagged behind wages by 37 and 19 percent, respectively."[14]

Thus there is a persistent gap between what we have come to regard as a suitable American standard and what retirees can realistically expect. It is perfectly obvious that a 12½% benefit increase will not close it, let alone keep it closed. In fact, judging from the historical development of the OASDI benefit structure and keeping in mind that spendable wages have increased by an average of about 4% a year over the last 10 years, the gap is almost certain to resume widening again.

The best that can be said is that Congress has not quite managed to match benefit increases to increases in consumer prices over that period. I believe it is fair to suggest, however, that we are, in fact, fostering a progressive deterioration of the economic wellbeing of retirees at the more advanced ages.

What we must do, therefore, is create the machinery to protect the benefits of workers once they retire to reflect trends in wages after retirement, to protect against benefit erosion caused by rising consumer prices and to permit retired workers to share in the bounty of a growing American economy.

As a basic new feature of the system we propose the addition of a built-in mechanism in the benefit structure for the automatic adjustment of benefits to reflect changes in both the cost of living and the average wage levels of workers still in employment.

5. *Financing Social Security*

In its financing provisions, as well as in the benefit side, H.R. 12080 does least for those who need most and turns away from the basic issues of sound social security financing. It hides from the fact that general revenue contributions are essential to an adequate system, as the experience of other free world, industrial nations has demonstrated time and again.

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[14] "OASDHI Retirement Benefits, Prices and Wages: 1966 Experience," Social Security Administration, Office of Research and Statistics, Research and Statistics Note No. 8, 1967.

Ever since 1935, Presidents, Congress and public have properly insisted on a soundly financed and self-sustaining Social Security system. Each act of amendments has been accompanied by adequate provision for increased contributions to meet anticipated benefit claims. Accordingly, the original 1937 contribution rates of 1% of the first $3,000 of earnings for both employers and employees have increased over the years to the 1967 OASDI contribution rates of 4.4% each on the first $6,600 of earnings. The current schedule calls for reaching 5.65% each on the $6,600 by 1987. H.R. 12080 would amend the present schedule to provide for a contribution rate of 5.9% on each up to $7,600. Every responsible person, therefore, proposing improvements in OASDI is obligated to make known his proposals for paying for the improvements.

Beyond question, an overhaul of the magnitude I believe is necessary, will require the infusion of unprecedented amounts of money to the system. A small part of the required additional financing is available from a currently existing favorable actuarial balance of the OASDI Trust Funds, as reported by Mr. Robert J. Meyers, Chief Actuary of the Social Security Administration. In fact, it has been estimated that an increase of about 7½% can be covered by the current favorable balance.[14] In addition, raising the taxable base to $15,000, without changing the contribution rates could finance a further 7% benefit increase.[11]

Clearly, however, both the current favorable balance and any conceivable increase in the base would fall far short of supplying the funds to finance the improvements of the kind proposed here. The bulk of the necessary additional funds then would have to be derived either from increases in contribution rates or from regular contributions to the Social Security Trust Funds from the general revenue of the Federal Government.

We believe it is both possible and desirable now to start with a modest general revenue contribution and to provide for progressively increasing amounts in coming years.

Except for the underdeveloped countries and those under Communist domination, the United States, along with a few others such as Argentina and France, is almost alone in depending so heavily on employee-employer financing of social insurance. Among the nations of the world, government participation in sharing social insurance costs is the general rule. Governments regularly contributing from general revenues to social security programs include those of Australia, Austria, Belgium, Brazil, Canada, Chile, Costa Rica, Denmark, Federal German Republic, Iceland, Ireland, Israel, Italy, Japan, Mexico, Netherlands, New Zealand, Norway, Philippines, South Africa, Spain, Sweden, Switzerland, and United Kingdom.

For a variety of reasons, the contributions from general revenues are also our only logical and equitable choice. This conclusion flows from the following:

(a) Higher payroll tax rates would intensify the regressive character of the present contribution structure and place an unjustifiable burden on low paid workers, middle-income families with 2 wage earners, young workers just entering the labor force and small businessmen.

(b) The responsibility for past neglect and the deplorable level of present benefits is one we all share. If we seek to remedy that neglect and do justice now, for the millions on the rolls living in poverty and on whose behalf contributions to the system have been minimal, we cannot fairly expect Social Security taxpayers alone to assume the cost, particularly when those with the highest earnings make contributions on less than the full amounts of their earnings. By every criterion of equity and justice it must be shared by all taxpayers.

(c) Although what may constitute the practical ceiling for payroll taxes has been a subject for some debate, the history of Social Security legislation clearly indicates that while we continue to rely exclusively on payroll taxes, we will never achieve a decent minimum benefit.

(d) More adequate Social Security benefits made possible by general revenue financing will reduce sharply the numbers on public assistance rolls, particularly among those receiving Old Age Assistance and Aid to Families with Dependent Children. By providing an alternative to public assistance under a means test, many will become self-supporting. These savings would reduce the net cost of the new funds required from general revenue contributions.

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[11] Robert M. Ball, "Policy Issues in Social Security," *Social Security Bulletin*, June 1966, p. 8.

[14] "Social Security Keeps Building Momentum," *Business Week*, October 22, 1966, p. 44.

> (e) The concept of general revenue contributions for adequate financing of social insurance is neither strange nor new. Congress has already adopted the principle for financing the special Social Security benefits for persons over age 72 and for Part B of Medicare. It has been recommended on previous occasions by competent and responsible public advisory groups. I refer to the fact that President Roosevelt's Cabinet Committee on Economic Security, in drawing up the blueprint for the original Social Security Act clearly envisioned—interestingly enough, beginning sometime about 1965—the need for contributions from general revenues. Last year, the "Report of the Advisory Council on Public Welfare" also called for a substantial general revenue contribution. In between, a number of the Social Security advisory councils recommended general revenue support, and during the 1940's Congress actually authorized general revenue appropriations, although none were made and the authorization was repealed in 1950.

The demands of our commitments abroad do not preclude adequate support for Social Security now. On the contrary, I am convinced that our fiscal capacity permits, and our national goals demand, far-reaching reform and improvements of the system.

Support of the Vietnam war should not require neglect of our elderly. Nor should the young adults of America, just beginning to raise their families and struggling to achieve economic security, be saddled with unnecessary and burdensome taxes upon their pay, when general revenue can readily be used to finance increases in the Social Security benefits.

We must recognize that ultimately there is no practical and conceivable level of payroll taxes that will fully and equitably pay for a Social Security system that deals generously with those whose earnings have been lowest and that provides decent, adequate benefits for those who have more than minimum earnings. This is an issue that will not fade away. It will be with us next year and the year after and the year after, unless the Senate now assumes the leadership and faces it squarely.

Our recommendations for financing Social Security are twofold: We believe first that the substantive improvements we propose require the allocation to Social Security of considerable sums of money. The logical and preferable source of this money is a regular contribution to the Social Security Trust Funds from the general revenues of the Federal Government. We believe it is both feasible and desirable to begin now to provide for these improvements through modest initial general revenue contributions with commitments for more substantial general revenue payments in later years. We believe further that the contribution from general revenues of government should be large enough so that workers, employers and government each bear about one third of total costs.

While the minimum, the overall benefit structure and the financing determine the basic shape of the OASDI system, I cannot leave the subject of the income benefits without advancing several additional proposals and commenting briefly on various aspects of H.R. 12080.

6. Widow's benefits

It is doubtful whether there is any class of beneficiaries for whom benefits are less adequate than for aged widows. In mid-1965, their average benefit was a little over $68. In logic, or on any basis other than as a device for holding down costs, there is no magic in pegging their benefits at 82½% of the amount that was or would have been payable to their husbands on retirement. Without minimizing the obvious public interest in maintaining a proper relationship between income and outgo of the Trust Funds and in continuing an appropriate balance among the various beneficiary classes, I believe the circumstances of aged widows justify giving them a great equity in the Social Security system. *Accordingly we recommend paying aged widows 100 percent of the primary amount that would have been paid at age 65 to their husbands.*

7. Early retirement benefit reductions

We are concerned with the low benefit amounts payable to the large, and increasing, numbers of workers and their spouses who elect the permanently reduced, early retirement benefits available starting at age 62.

Unfortunately, our public retirement system, unlike private pension plans, is unable to distinguish between those who choose voluntarily to retire and those who are displaced and forced prematurely to retire.

Under present law, the "drop out" provisions affecting computation of average earnings, in combination with the actuarial reduction for retirement before age

65, may exact an unjustifiable extra toll from the benefits of workers least able to afford it. Those most affected include workers who are forced into early retirement by technological change, plant closings or because of inability to sustain the exacting pace of many kinds of industrial employment. If these workers happen also to have had gaps or reductions in earning in prior years caused by layoffs, short weeks or shifts to lower paid jobs, they lose much of the benefit of the "drop out".

These are the persons who reach retirement with low average earnings and qualify for low benefits—much lower than would be caused by the actuarial reduction alone. They are required to use their allowable "drop out" years to exclude periods of unemployment and have to retain for benefit computation purposes years with a low taxable wage base. In addition, if they are male, they gain little from the "dropout" because they must count the years between retirement and age 65.

In all parts of the country, I have met workers in their fifties and early sixties whose skills have become obsolete, who have lost their jobs when a plant was moved, or was closed in a corporate merger or whose job is performed by an automated machine.

I believe we owe it to these people to assist them to upgrade and update their skills so that if they are able to do so, they continue to be productively employed.

To anyone who cannot find suitable employment, equity demands steps to protect the benefit rights he earned while his skills and labor could command a wage in the job market.

To protect victims of technological change and other displaced workers and to establish benefits for all workers reasonably related to pre-retirement income, we propose a new formula to compute benefits on the basis of a worker's highest ten years of earnings.

8. *Other proposed income benefit changes*

Finally with respect to the income maintenance benefits, let me, on behalf of the UAW urge your committee and the Senate as a whole to take favorable action on President Johnson's specific recommendations to—

(a) increase to $50 ($75 for a couple) the special benefits payable to persons over age 72

(b) provide benefits for disabled widows under age 62 without age restrictions and without actuarial reductions

(c) cover an additional 500,000 farm workers whose earnings are so low that they are currently excluded from coverage, and

(d) apply federal service to Social Security credits for government workers ineligible for Civil Service benefits.

In addition, I hope you will also support the principle expressed in the President's proposal to revise the income tax rules applicable to the aged, though I believe the exemptions should be higher.

I share the concern of others interested in our social security system who have voiced distress at the tone and temper of some of the provisions of H.R. 12080 which are punitive, newly restrictive and would, in effect, widen the gap between the "haves" and the "have nots". Provisions of this nature in H.R. 12080 that we urgently recommend be dropped include those which would:

(a) Establish 50 as the minimum qualifying age for benefits for disabled widows and widowers and limit benefits at age 50 to 50 percent of the primary insurance amount at age 62.

(b) Limit the special benefit increase to $5 for a single person and $7.50 for a couple.

(c) Fix a ceiling on a wife's or husband's insurance benefits,

(d) Redefine disability on the basis of inability to engage in any kind of substantial gainful work which exists in the national economy, and

(e) Apply a more stringent definition of disability to disabled widows and widowers.

Our proposals concerning the cash income benefits are more than temperate when compared to needs and not beyond the minimum improvement justified by today's economic circumstances. They are in no way radical, and are novel only in the sense that they represent a break with the practice of periodically doling out minute benefit increases and tinkering with this or that inequity without ever admitting how pitifully small the benefits are in comparison to the function assigned to them.

Far reaching as these recommendations may seem, they still do not provide the measure of security and dignity to which an American worker is entitled after a lifetime of work. We will not have achieved an effective and adequate social insurance system until the OASDI program can assure that workers can look forward to Social Security retirement incomes of at least two-thirds of average annual wages before retirement, with subsequent adjustments to follow wage, price and living standard changes.

There are other nations of the Free World that have tackled some of these problems successfully.

Starting this year, our Canadian neighbors, for example, are paying to each eligible resident age 68 or older, without any means or income test, an old age pension of $75 a month. In addition, those persons 68 or older who have no other income, will receive a further supplemental monthly payment of $30. An elderly couple will thus be guaranteed a minimum monthly income of $210. By 1970, these pensions will become payable at age 65.

It is significant that the Canadian old-age pensions are not supported by payroll taxes, but out of general revenues from earmarked taxes on sales (excluding food), personal income and corporate profits. Canada also has a new near-universal, public retirement system (Canada Pension Plan) that is financed by an employer-employee payroll tax and that will provide a wage-related benefit in addition to the flat old-age pension.

Although the Canada Pension Plan is new and not yet fully operative, it appears that the Canadians have had the good sense to avoid some of the errors in the design of the United States system. The Canada Pension Plan, for example, will make adjustments to reflect changes in wage levels. It also provides for automatic increases in benefits to reflect increases in the Canadian Consumer Price Index. In addition, it exempts the first $600 of annual earnings from the flat payroll tax, but includes this income for purposes of the benefit computation.

Sweden is another free nation that provides a universal, guaranteed flat rate pension (with supplements for eligible dependents) largely financed from general revenues. Sweden also provides a wage-related supplemental pension for earnings over a base figure. Interestingly enough, both the universal and supplemental pensions are adjusted for changes in the price level, and the supplementary benefit is adjusted to reflect wage movements. France is another country that makes automatic adjustments to reflect changes in national-average wages. There are many more.

There is no cheap or easy way to meet our responsibilities, and no way in good conscience to avoid them.

H.R. 12080 falls woefully short, but the opportunity still exists in the Senate to move forward to meet the social needs of our times. It should not require domestic strife, dissension, further riots and burning to dramatize for us the inadequacies of our social programs. The Senate has the power to make of H.R. 12080 a constructive contribution toward solving pressing social problems. I urge you to seize that opportunity.

II. PROPOSALS FOR MEDICARE IMPROVEMENTS, 1967

The adoption and subsequent implementation of Title XVIII of the Social Security Act (Medicare) rank high on the list of noteworthy legislative and administrative achievements of recent U.S. social history.

Medicare gives tangible expression to this nation's determination to safeguard economic security and to assure access to the means of protecting and maintaining health for our older citizens, under a publicly sponsored health insurance program that implicitly respects the concern for human dignity that is the hallmark of a free society.

Because of Medicare, millions of our older Americans now share in a fuller measure of that economic security and human dignity. We in the UAW are proud to have been counted among the original supporters of the principle that adequate health care through Social Security is a right to be enjoyed by all our older citizens.

There is a growing awareness among the American people that health care is fundamental to the achievement of well-being and security for the family and the community. We have reached broad acceptance of the idea that access to modern health service is a right for all people, a right intimately related to the right to life itself. Medicare, in principle, recognizes this right for an important and growing segment of the population, and establishes public responsibility for a partial program of basic personal health care services.

In its first year of operation, Medicare is estimated to have provided some 2.4 billion in benefits for 4 million hospital patients. Medicare also paid $640 million for physicians' services under the voluntary insurance coverage of Part B.[15] As time goes on, Medicare will touch the lives of more people and pay out greater sums of money for health services.

Because of the pride Americans can feel over the success of the Medicare program, we should exert every effort to make it more effective, more equitable and more aptly structured to meet current health needs. I am convinced that the H.R. 12080 Medicare amendments fail to meet this challenge and would permit continuation of deficiencies that not only work to the disadvantage of elderly persons but contribute significantly to the escalating costs.

I am convinced that Medicare in its present form falls considerably short of providing the type of financially adequate, comprehensive program which the aged require, and which must be provided, if they are to gain full health security. Certain major limitations of Medicare dilute the basic protection the program sets out to provide. In fact, it has been estimated by government officials that Medicare will cover no more than 40 percent of an individual's hospital and medical care costs. We must do better.

Medicare has brought with it some severely troublesome problems, particularly with respect to payments for care under the control of hospital-based specialists and the billing and payment procedures for the services of physicians under Part B. I am convinced that the transfer of hospital outpatient benefits from Part A to Part B, as provided in H.R. 12080 will not untangle the confusion surrounding methods of payment for these specialists or provide equitable treatment for the public. I also believe that the decision in H.R. 12080 to permit payments to physicians on the basis of itemized, unpaid bills represents an abject surrender to the more backward elements of the medical profession.

The refusal to drop the unenforceable, so-called "non-communist affidavit" requirement of the present legislation is a futile gesture of defiance and vindictiveness that ill becomes Congress.

In addition, while I question the desirability of the administration proposal to make payments from the health insurance trust funds for Medicare services in federally owned facilities, I also believe that a number of specific suggestions advanced up to now deserve favorable action. Those that appear to have particular merit include the proposals to limit reimbursement for depreciation allowances under Titles XVIII and XIX to providers of service who participate in health facilities planning through official state planning agencies; to transfer from Part B to Part A coverage for the services of physicians whose licenses restrict their practices to hospitals; to provide for purchase, in addition to rental, of durable medical equipment under Part B; to reduce the quarters of coverage required to qualify for entitlement to hospital insurance benefits for persons attaining age 65 in 1968 and extend the period of time during which persons who do not have fully insured status may qualify; to establish eligibility for Medicare benefits for persons who die in the month they would attain age 65 but prior to their actual birthdays; and to make several other technical and clarifying amendments.

I hope both your Committee and the Congress will give sympathetic attention to other important revisions in the health insurance program. I particularly urge your consideration of the following:

1. Time and dollar limitations

H.R. 12080, in a limited way, recognizes the inappropriateness of time and dollar limitations in a soundly conceived program of health benefits. This recognition consists of an extension of the maximum duration of covered days of hospital stay from 90 to 120 and the elimination of the reduction in hospital care entitlement now imposed on persons confined in a tuberculosis or mental hospital immediately prior to becoming eligible for Medicare. I recognize these changes as progress, although the pace is less than breathtaking. Even these small improvements are marred by the decision to require a patient payment of $20 per day from the 91st through the 120th days.

A health program for the aged must be based on a full recognition of the known needs of some patients for extensive care and should provide coverage appropriate to those needs. Artificial and arbitrary time limits, such as the 90 day maximum per spell of illness for inpatient hospital care, have no place in a public program.

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[15] H. J. Maidenberg, "Health Insurers Discover a New Friend—Medicare," *New York Times*, July 2, 1967.

Maximum benefit durations far in excess of 90 days, without any requirements for patient payments, are commonplace in private group health insurance plans. Most UAW members (including our retired members over 65 for whom our collective bargaining agreements provide supplemental coverage), for example, are entitled to receive a continuous period of as much as 365 days of hospital care, if that is required, for a hospital admission.

The rational criterion on limits of care for individual patients must be medical necessity, not ability to pay. Extension of the present 90 day maximum to 365 days would not go beyond a reasonable limit.

Similarly, the discrimination implicit in the special time limitations and dollar restrictions applied to beneficiaries in need of psychiatric treatment is also unsound. In my judgment, the perpetuation of the distinction made between physical and mental illness is both unscientific and unworthy of a nation that is attempting in so many important ways to recognize the rights and meet the needs of the mentally ill.

I believe it would be particularly desirable, therefore, to provide fully paid coverage for general hospital care for at least 120 days for any spell of illness. In addition, the unique limitations of the program related to mental illness should be discarded.

2. *Prescription drugs*

There has been repeated and extensive documentation of the fact that older persons need to have more than twice the number of prescriptions and spend more than twice as much for them as the population as a whole. Moreover, there is evidence from comprehensive prepaid drug plans indicating that as much as 50% of the drug costs of the aged are incurred by only 10 percent of the aged population. Among the aged there is high incidence of chronic conditions for which, either after discharge from hospital or without requiring hospitalization, continuing use of costly drugs and medicine is necessary.

While Medicare does pay for drugs received by hospital patients, I am constantly reminded by UAW retirees who meet me or write me that there is no coverage for drugs consumed outside the hospital. Our UAW Medicare Advisory centers throughout the country report frequent complaints about the lack of drug coverage among Medicare beneficiaries. It is interesting to note that our experience parallels that reported in a recent interview of the Commissioner of Social Security published in "Hospitals"; Journal of the American Hospital Association, Mr. Ball, who also cited the lack of coverage for prescription drugs as one of the specific causes of complaint from the public about Medicare.

There is no doubt that the addition of coverage for drugs and medicine under Medicare would bring with it new technical and administrative problems to be faced. At the request of Congress in 1965 the Social Security Administration undertook an intensive study of methods of providing prescription drugs under the program, and this highly relevant information should be readily available. In addition, our own UAW experience with negotiated drug benefits for our members in Canada has demonstrated that such coverage is feasible, practical and of great value. I do not believe that further study is required, nor do I have hope, as the House appears to, that the problems will vanish if we ignore them.

I urge you, therefore, to take favorable action now to include coverage for the costs of prescription drugs used outside the hospital.

3. *Payments for professional services*

Of all of the vexing problems attending the birth of Medicare none has been more troublesome, more divisive, more productive of red tape, and created more hardship than the matter of disbursements to physicians. H.R. 12080 tries to deal with this problem by permitting payment on the basis of unpaid bills sent in either by the patient or the doctor.

From presently available information, it appears that as many as half of physicians are not accepting assignment. There are many areas of the country where considerably more than half of the doctors are refusing assignment. According to a report in "Senior Citizens News," a publication of the National Council of Senior Citizens, for July 1967, the percentage exceeds 60 in the Medicare payment areas that include Ohio (except Cleveland area)—60.0%, Cleveland area—61.6%, Louisiana—62.8%, and Chicago area 60.7%. All indications are that the proportion of physicians refusing assignment will, if anything, grow.

Our experience in the UAW Medicare Advisory Centers (we operated 25 in 19 communities across the country this past Winter & Spring), indicated that permitting physicians to obtain payment via the so-called direct pay route has caused unnecessary hardship to patients and considerable escalation in costs. We have received complaints from all over the country from elderly persons with limited incomes who in advance of receiving medical and surgical procedures are required by physicians to produce cash, which hopefully they will receive back in whole or in part from the Federal Government. Through the use of this device physicians are also inclined to charge "what the market will bear" rather than the reasonable and usual cost in the community.

The approach taken by H.R. 12080, while it doubtless eases the pressure on patients by assuring quick payment by Medicare of 80% of the reasonable and customary charge, for that very reason can only further undermine the assignment method of payment which best serves the public interest. The net effect is to put on an equal footing with doctors who have conscientiously tried to serve their patients and have fully cooperated with Medicare all those physicians who have refused to cooperate—this despite the fact that Medicare assures them of their reasonable and customary fees. I wonder if the Congress would for a moment tolerate an arrangement with any private for-profit contractor who would insist that the government not only guarantee his usual price but anything above what he can get.

I would like to believe that only a handful of doctors are still burdened with the idea they alone can properly determine the cost of their services, and that the consumer has nothing to do with the process, but my better judgment tells me otherwise. Unfortunately there have been too many firebrand speeches at medical society conventions, public statements by physicians and communications to patients to believe otherwise.

To illustrate, the following remarks are taken from statements given by physicians to patients:

From Peoria, Illinois:

"I am not a government doctor. I do not practice socialized medicine. All transactions with Medicare shall be between you and this federal system of socialized medicine. When you have settled your account in full with me, I will provide you with a receipt which you may use to collect whatever amount the federal dictatorship considers is due you."

"Service charge of ½% per month will be added to all OVERDUE accounts."

From a physician in Lima, Ohio:

"I will continue to care for you as a private patient as I have always done.

"I will expect you to pay for my medical services as you have always done.

"Medicare is socialized medicine. It is bad for both you and me because it will prevent me from doing for you what you and I decide is best for you.

"I will not participate in Medicare or any government program of medical services because I am ethically and morally bound to render to you superior medical treatment and to protect you from inferior care. Government medicine is—and always has been—inferior medicine in every instance.

"I will not complete or sign federal forms involving such services and I will not accept federal fees.

"If you need to be admitted to the hospital and wish to be admitted under the Medicare plan, it will be necessary for you to secure the services of a physician who practices under Medicare for your hospital stay.

"In this respect, if you wish to be admitted under my care, I urge you to keep (or secure, if you do not already have) private hospital insurance, that will, in the case of injury or illness, enable me to hospitalize you independent of the Federal program."

From a physician in Columbus, Ohio:

"The Medicare law will not alter the policies of this office, all patients being rendered services as in the past. Also, as in the past, fees for services will be billed directly to the patient.

"You may send or take my receipted (paid), itemized bill and your claim form from the post office to the insurance carriers in our area (Nationwide Insurance Company, Columbus, Ohio) who has been selected to represent the government in the handling of funds for this Medicare program. You will be reimbursed by the carrier for that portion of your medical expense covered by the law."

From the President of the American Academy of General Practice:

"But overall, my prediction is that 90 percent of the doctors in practice will do direct billing and will continue to do direct billing under Medicare."

These quotations are illustrative of physician attitude. I am deeply concerned about the impact of this upon the patients. From the thousands of cases that have come to our attention at UAW headquarters and in our Medicare Advisory Centers, the following are illustrative of what happens to patients:

A 72 year old Detroit UAW retiree whose monthly income is $190.90 had a cataract removed in September 1966. Although the same doctor had accepted $210 as full payment for this patient from Michigan Blue Shield for removal of a cataract on the other eye in March 1966, his charge in September for the operation and 5 follow-up office visits was $500. The doctor refused initially to assign the bill to Medicare but was eventually persuaded to do so by a UAW Medicare Counselor. Medicare and the complementary carrier paid the physician an amount based on the reasonable charge which was determined to be $350. Citing an agreement between the physician and the patient that the latter was to make payment for any amount not covered by Medicare, the physician reduced his overcharge by $50 and billed the patient for an additional $100. When the Medicare Counselor advised the physician's bookkeeper that Medicare regulations prohibit billing for additional amounts if the doctor accepts assignment, the bookkeeper nonetheless suggested that the patient pay what he could afford.

A UAW member in Detroit received a $500 physician's bill for surgery. In order to meet the physician's demand that he be paid in advance, our member had to secure a bank loan requiring him to get an additional mortgage on his modest house as security. After four months he received $280 reimbursement from Medicare.

A 73 year old retired UAW member in Cleveland reported that his family physician who had been his doctor for 16 years refused to treat him or to treat any Medicare patients. According to this retiree he was "in a coma" when his family doctor was summonel and refused to visit him. The doctor referred him to another physician who did see him.

A retired General Motors worker in Flint, Michigan, received a $202.50 bill from a physician for bladder surgery on the retiree's wife. The bill read as follows:

> "Surgery—(patient's name). Blue Cross and Medicare. Patient to do her own billing."

A follow-up visit by the retiree to ask the physician to assign the bill to Medicare resulterd in the physician's refusal. The physician refused even to give the retiree an itemized statement of his services.

A UAW member in Toledo, Ohio, received treatment for a complicated heart and kidney ailment requiring the services of some six physicians with a total physician bill of $1400. All six physicians refused assignment. The Local Union arranged for a loan.

A Michigan UAW retiree who underwent surgery for a stroke was presented with a surgeon's bill for $1,050. The attending anesthetist billed another $110. Both physicians refused to assign the bills to Medicare and suggested that the patient pay and request reimbursement from Medicare. The patient had additional bills for several office visits.

A 71 year old California retiree (non-UAW) received bills from four physicians and surgeons following a heart operation. Since all four doctors refused assignment, the patient and his family had to raise the $479 required. They came to the UAW Medicare Advisory Center to learn how they could secure early reimbursement from Medicare for all or part of the bills.

A 74 year old Waterbury, Connecticut (non-UAW) retiree with a monthly income of $150, whose only medical care insurance is provided by Medicare, was forced to borrow money and pay interest on a loan to pay a doctor's bill of $1,950. Reimbursement from Medicare for the government's liability was delayed approximately two months because the intermediary had to obtain additional information from the claimant.

The wife of a St. Louis, Missouri, UAW retiree was informed by her doctor during a routine office visit for treatment of a chest condition that he would no longer accept her as a patient. Henceforth he intended only to accept under 65 patients, because Medicare requires too much "book work" and "red tape."

It is strange indeed that half of the current generation of American physicians should find themselves conscientiously unable to accept assignment and perform the necessary paper work. The procedures are no more onerous than those required by their own Blue Shield organization and commercial insurance companies with which they have worked for years . . . , and which have relieved them of the much more troublesome and costly tasks of collecting bills and following up on delinquent accounts.

The basic difficulty, in my opinion, stems from regrettable attitudes and prejudices of some members of the medical profession. There are those in American medicine who are unable or unwilling to adapt their attitudes to the social aspects of medicine, even in the face of overwhelming public and congressional support of new public means to pay fairly and fully for their services. Others are incapable of recognizing that under public programs the profession can no longer be given the power to establish "administered prices" for their services, without regard to the reasonable and fairly determined charges established by the program for their services.

Even more reprehensible is the continued efforts by substantial groups of physicians to intimidate the aged by demanding payment at the time of service in a poorly concealed attempt to sabotage and discredit Medicare.

To confuse the issue by claiming, as some do, that the government's payment mechanism constitutes unwarranted interference with the "doctor-patient" relationship is blatant misrepresentation.

We believe conditions created by the existing statutory requirements which permit either the assignment or direct pay procedure cry out for correction. We *urge the Senate to reject payment on the basis of unpaid bills and to provide instead that Medicare payments be limited only to those cases in which the physician accepts assignment.*

4. Medicare coverage for disabled workers

By appointing an Advisory Council to report in 1969 on the problems of covering disabled workers under Medicare, H.R. 12080 would guarantee a moratorium on legislative action for at least 2 years. This is one more instance of turning away from the problems of the poor and the disadvantaged. We don't really need an advisory council which, I am convinced, would be merely a cover-up for an unwillingness to act.

On several occasions President Johnson has stated the case for extending Medicare coverage to disabled workers under age 65, disabled adults receiving Social Security benefits on the basis of childhood disabilities and disabled widows under age 65. We in the UAW fully share in the President's opinion. We also believe there is an equally good case for including under Medicare all other persons receiving monthly cash benefits under the system. whether as retired workers, dependents or survivors, and the under-age-65 spouses of retired or disabled workers.

I know, for example, that while the UAW has had some success in negotiating coverage for survivors at their own expense, most employers, including the Ford Motor Company to this moment, refuse to pay any part of the cost. It is common practice, moreover, in many employee group health insurance plans to discontinue coverage for all survivors upon the death of the worker.

Other persons, including disabled workers, may also lose their private coverage upon retirement, so that even if the retiree is eligible for Medicare, he may have dependents who are not. The entire family of a worker retiring at 62 may be excluded from all coverage both private and Medicare. Many in these groups would be considered bad insurance risks in that they have high medical expenses. Most of them have in common the precarious existence accorded by the current meager levels of Social Security cash benefits and simply lack the resources to obtain private coverage.

As a practical matter, however, I know that consideration for providing Medicare protection to under age 65 OASDI beneficiaries has been largely limited to disabled persons and that covering the non-disabled beneficiaries would immediately put in excess of 3 million additional persons on the Medicare rolls. Accordingly there is some reasonable basis for a study and review of the cost implications and other problems involved in bringing the entire group under Medicare.

There is not the same justification for delaying coverage for disabled beneficiaries. To postpone action for a minimum of 2 years, as the House would do, would be both unnecessary and inexcusable. We *therefore propose that the Senate insist on the President's recommendation that Medicare be extended now to disabled beneficiaries now on the rolls of the Social Security and Railroad Retirement systems.*

5. Hospital-based professional services

H.R. 12080 attempts to remedy the serious blunder of the original Medicare legislation growing out of the formula for payment for the services of hospital-based physician specialists. I do not believe, however, that we can regard the transfer of coverage for hospital outpatient services to Part B, and providing inpatient radiology and pathology services under Part A, as an equitable or economical solution to the problem.

The original Medicare legislation restricted the right of hospitals to bill for the professional component of in-hospital services in pathology, anesthesiology, physiatry, and other hospital-based specialist services. This restriction has seriously disrupted traditional relationships between hospitals and these specialists, and caused immense confusion to the public. From it stem administrative problems that many of the fiscal intermediaries now consider insoluble. In addition, it has opened the door to inflation of costs, and, most regrettable of all, it has impaired the quality and efficiency of hospital care by removing effective control by the hospital over the services performed in departments of the hospital by the hospital-based specialists for the medical staff.

The route H.R. 12080 proposes to travel does nothing to correct the basic flaw of the present arrangement with its built-in bias toward cost inflation and the unjustifiable enrichment of a select group of physicians.

These unlooked for and unwanted consequences grow out of the following:

> . . . a lack of any established guidelines for constructing fees for only the professional component of diagnostic services;
>
> . . . loss of the "built-in" cost controls inherent in the fact that the remuneration of hospital-based physicians has historically been controlled by the cost-charge patterns of the hospitals with which these physicians have had contracts of service;
>
> . . . introduction of a piecework method of payment directly related to the volume of service generated by the departments of the hospital involved; and
>
> . . . the continuing responsibility of the hospital to remunerate these physicians in their capacities as directors of certain hospital departments involved in the provision of diagnostic services.

In addition, the inclusion of hospital outpatient benefits under Part B would deprive persons who have elected not to enroll in Part B, of coverage of the hospital outpatient diagnostic services now provided under Part A. Furthermore, the application, to services now subject to a $20 deductible, of a $50 deductible under both proposals, is clearly a retrogressive step. The transfer of outpatient benefits to Part B cannot repair the damage already done, and can only result in further confusion to the public.

I must inform you that based upon my experience with 200,000 retired members of our Union there is massive confusion and misunderstanding about benefits, coverage and administrative interpretations of the program. From the thousands of inquiries we received from our own members and the general community at our temporary Medicare Advisory Centers, it is readily apparent that many, many retirees are bewildered by the program. Rather than consider the alternatives advanced so far, I urge upon the Congress adoption of the recommendations we are making which would help simplify the program, make it more rational, more equitable. It is unreasonable and unfair to expect a retiree facing a health crisis to bring the skills and knowledge of a "Philadelphia Lawyer" to his application for government paid health benefits.

I hope you will reject the proposal to transfer outpatient benefits to Part B. I urge you to amend existing legislation to provide for reimbursement under Part A to hospitals for both the technical and professional costs of services rendered by hospital-based specialists.

6. *Encouragement of group practice medical care plans*

As an officer of the Community Health Association (CHA), a direct service group practice health care plan in Detroit, I am pleased that H.R. 12080 includes provision in Section 402 to permit the Secretary of Health, Education, and Welfare to develop, and experiment with, methods of reimbursement under Medicare, as well as under Titles V and XIX, for services provided by prepaid group practice plans. These experiments would be aimed specifically at providing incentives for participating organizations to furnish health care economically and efficiently while maintaining high quality standards.

Direct service group practice plans have clearly demonstrated that they can provide comprehensive high-quality care at lower unit costs than other forms of health insurance. Group practice also makes highly efficient use of limited resources. The UAW has had extensive and satisfying experience with prepaid group practice programs.

The present administrative interpretations implementing the legislation do not sufficiently recognize that the encouragement of this kind of organization of medical care is in the interest both of the recipients of the care and of the government, which should be assisting plans with the kind of built-in preventive medicine and demonstrable cost controls that characterize these organizations.

Group practice plans should not be treated more favorably than other providers of service, but equity requires a method of reimbursement that does not penalize them for the economies in the cost of providing services. *As a basis for establishing approprate methods for reimbursing prepaid group practice plans, I urge you to concur in the action of the House and grant authority to the Secretary to enter into agreements with providers of service to establish payment alternatives to reasonable cost reimbursement.*

7. *Cost and quality controls*

Another disturbing feature of the present legislation is the apparent lack of effective means to establish cost controls under the voluntary program and the failure to make full use of those that exist under Part A.

Recent trends in the cost of health care are nothing less than alarming. The Bureau of Labor Statistics Consumer Price Index shows the cost of all health services in the United States in the first 6 months of 1967 rose almost four times as rapidly as the general cost of consumer goods and services. Physcians' fees rose three times as rapidly and hospital service charges by more than eight times. While all consumer prices in the first 6 months of 1967 were increasing by 1.1 percent, the prices of health services as a whole increased by 4.1 percent, physicians' fees by 3.3 percent and hospital service charges by 9.3 percent.

These figures should be cause for serious concern. They demonstrate that prices for health services continue to rise more rapidly than consumer prices generally. Competent observers, such as Professor Herman Somers, are anticipating that hospital costs will double their 1966 level by the early 1970's. Ray E. Brown, Director of Duke University's Graduate Program in Hospital Administration, has predicted a 15% rise in hospital costs this year and a return in 1968 and continuing indefinitely into the future, to an annual rate of increase of 7%, which has come to be regarded as "normal." Walter J. McNerney, Blue Cross Association president, foresees average hospital costs per patient-day of more than $69 by 1970.

In the light of these figures and informed predictions, it is no exaggeration to suggest that the entire Medicare program is threatened by apparently uncontrolled escalation of costs. Whether Medicare is its author or is simply swept along in the general trend, the escalation affects all consumers, not simply those over age 65. These increases are now being reflected in the collective bargaining costs of health benefits in contracts we have negotiated in recent months. Furthermore, because practically all Blue Shield plans do not cover physicians' home and office visits, we have had a barrage of complaints from our members about increased charges made by their doctors.

There is no sound evidence to suggest that the Administration is ready to undertake the necessary efforts to control costs. Another commission to study costs will not help. We must take positive action and do it now.

The provisions of the Medicare legislation for establishing hospital utilization review plans and for creating a National Medical Review Committee offered a commendable and promising mechanism for assuring the public of a well run system on the institutional side of the program. There was a chance both for controlling costs and assuring the public of a high quality of service. That promise has not been realized.

I believe it is highly regrettable that there has been confusion between the wish not to interfere with medical practice and the need to assure medical care of good quality. It will be seriously detrimental to the health of our people if the Medicare program continues to ignore the need for quality controls.

May I quote to you from the findings of "A Study of the Quality of Hospital Care Secured by a Sample of Teamster Family Members in New York City" made by the respected Columbia University School of Public Health:

"In the opinion of the reviewing surveyors, only 57 percent of the care given in the total of all admissions reviewed represented 'optimal' medical care; 43 percent of the care was believed to have been performed in a 'less than optimal' fashion when viewed in the light of the standards of present day medical practice.

"The principal reason that medical care was considered 'less than optimal' was the failure to adequately determine the cause of the patients' presenting symptoms so that rational, as opposed to symptomatic, therapy could be given."

This is one of the many studies which would support the thesis that prepayment which neglects quality controls undermines the objectives of the program.

I am also impressed by the fact that comprehensive group practice health care plans such as CHA-Detroit, HIP in New York and Kaiser on the West Coast, while maintaining high quality standards of care, make far more economical use of funds than other forms of medical practice. Numerous studies have demonstrated such plans have significantly lower rates of hospital admissions and lower surgical frequency rates when compared with comparable insurance groups under fee-for-service medicine. The following data, based on a continuing review of the experience of more than 6 million persons covered under the Federal Employees Health Benefits Program (both options), clearly reflect the impact on costs of the controls used by participating group practice groups as compared to nonprofit Blue Cross-Blue Shield or commercial insurance plans.

HOSPITAL-SURGICAL UTILIZATION STATISTICS [16]

A. COMPARATIVE HOSPITAL UTILIZATION RATES

	Annual days of hospital care (excluding newborns) per 1,000 members		
	1963	1964	1965
1. Plan statistics:			
(a) CHA-Detroit	728	719	696
(b) Michigan Blue Cross	1,465	1,489	1,444

	November 1962 to October 1963	November 1963 to October 1964	November 1964 to December 1965
2. Federal employees health benefits programs (both options):			
(a) Blue Shield-Blue Cross USA	919	881 (10.2)	924 (10.1)
(b) Indemnity benefit plans	820	880 (8.4)	945 (8.5)
(c) Group practice plans	444	451 (5.4)	416 (5.1)

Note: Figures in parentheses indicate number of subscribers receiving benefits for each 1,000 subscribers enrolled.

B. COMPARATIVE IN-HOSPITAL SURGICAL PROCEDURE RATES

	Rate per 1,000 members November 1961 to October 1962	
	Blue Shield, U.S.A.	Group practice
1. Federal employees health benefits programs (both options):		
(a) All procedures	70.0	39.0
(1) Tonsillectomy and/or adenoidectomy	10.6	4.0
(2) Female surgery	8.2	5.4
(3) Appendectomy	2.6	1.4

The answer to the problem of increasing costs is not to increase the share of the costs required of the elderly nor to deprive them of sorely needed increases in cash benefits. The answer lies in having the courage to deal with the problem at its source.

We believe that intensive efforts are needed now to strengthen the cost and quality controls under Part A and that similar utilization review programs should be established at the state and local levels for non-hospitalized services.

We also believe the escalation of physicians' fees and the possible over-servicing and rendering of unnecessary care, can be obviated, to the extent that the program seeks and obtains the highest level of cooperation and participation by

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[16] A.1. CHA Research and Statistics Division, Michigan Hospital Service Annual Reports.
A.2. Special Supplements to Group Health & Welfare News, March 1964, February–March 1965, May 1967 and 1965 Report of Bureau of Retirement and Insurance, U.S. Civil Service Commission.
B.1. Federal Employees Health Benefits Program—Utilisation of Hospital Services, by George S. Perrott. Abstract of paper presented at APHA Medical Care Section meeting, October 7, 1964, New York City.

the medical profession in implementing high standards of care and, where necessary, controlling abuses, under self-governing arrangements.

8. Deductibles and Coinsurance in Part A and Part B

In a program providing services to the public from tax revenues, taxpayers have a paramount right to continuing assurances that the services are not abused, and that costs are maintained within reasonable limits. These are the justifications most commonly offered in defense of the deductible and coinsurance features in Parts A and B of Medicare. While we can all endorse the objectives, I challenge the notion they can, or should be realized by introducing obstacles, in the form of coinsurance and deductibles to receipt of the services.

Looking back now at the years-long battle leading up to Medicare legislation, there can be no doubt that the critical issue, once it became clear government participation was essential in meeting the costs of care for the aged, was whether to have a system of social insurance providing non-discriminatory benefits for all aged persons on the basis of right or a welfare program that would limit eligibility to those aged individuals able to demonstrate need. Happily, we chose to rely on right. Having won that principle, it was rather ironic to find it seriously undermined by the decision to require beneficiaries to share in the cost at the inopportune moment of receiving the services. Such cost sharing bears more heavily on, and discriminates against persons with low incomes and/or in poor health. For those who cannot scrape up the first $40 of the cost of a hospital bed stay, the $10 per day for hospital care from the 61st through the 90th day, the first $50 and 20 percent of the remainder of physicians' charges, the first $20 and 20 percent of the balance for outpatient hospital diagnostic services, at least half of the cost of out-of-hospital psychiatric care, and the $5 daily charge in an extended care facility after the 20th day, the escape from the means test is illusory. For most others, whose incomes, I remind you, consist largely of inadequate Social Security retirement benefits and precious little else, these cost sharing arrangements can only be regarded as unduly burdensome.

The imposition of these "dollar barriers" represents a distinct hardship for those aged who have extensive and prolonged requirements for ambulatory care and are particularly prohibitive for aged persons who suffer periods of institutional care. What is worse, such charges tend to discourage early and continuous care and management of illness. They also require costly and complicated administrative arrangements and controls which only confuse and complicate doctor-patient relationships.

Economic deterrents to the use of services, moreover, represent a "scatter-gun" approach to the problems they are alleged to control. There is, for example, no evidence under either public or private insurance that a hospital inpatient deductible either deters unnecessary hospitalization or reduces length of stay.

In the place of deductibles and coinsurance, to prevent abuses and control utilization, it would be far more appropriate to rely on hospital and medical review and control of the use of covered services. *Accordingly, I believe the Medicare program should be amended to eliminate the present deductible and coinsurance requirements so as to provide for full inpatient coverage, full hospital outpatient diagnostic services, no patient payments in extended care facilities under Part A and the entire reasonable cost of services made available under Part B, including services for out-of-hospital psychiatric care.*

9. National Advisory Health Council

In the structure of the Medicare program, provision has been made to consult on an organized basis with providers of care, particularly hospitals, physicians and commercial insurance, and Blue Cross and Blue Shield fiscal intermediaries. As a part of this structure, a National Medical Review Committee was to be established to study the utilization of hospital and other medical care and services under Medicare. H.R. 12080 would bolish this Committee, which I understand has not been brought into operation, and transfer its functions to an expanded Health Insurance Benefits Advisory Council of 19 members, the majority of whom would continue to represent the providers of health services. In addition, H.R. 12080 would establish a consumer advisory council under title XIX, with a majority of consumer representatives.

We seriously question this particular approach to insuring that the millions of consumers of care can make known their needs, interests, concerns and experiences with the current range of publicly financed personal health service programs now under Federal or State-Federal auspices, including titles XVIII and XIX.

Our basic concerns, however, public review and advisory functions under Title XVIII being dominated by representatives of the providers of service, rather than the general public, and creation of a separate body under Title XIX, remain.

With the impressive expansion of public programs in the field of personal health services there is now an urgent need to provide an important, high level forum for purveyors of service and consumers to hear, discuss and make recommendations on all developments in the health care field that are under the aegis of HEW. Opportunities must be provided to bring to the attention of the Administration needs, problems, gaps in service and/or policies which are interfering with sound development of the programs. There is a similar need to provide a channel for reviewing administrative regulations and interpretations which may adversely affect consumers of health care and privately negotiated programs, as well as for a nonpolitical public forum to consider and recommend legislation to strengthen existing programs and to correct inequities that develop.

We therefore recommend the establishment of a single National Advisory Health Council to serve the programs under both Titles XVIII and XIX and other specialized programs under HEW concerned with the planning and development and health resources and services, and the provision of special disease oriented or special group oriented programs. This new body would replace the proposed Consumer Advisory Council under Title XIX as well as the Health Insurance Benefits Advisory Council. The new National Council should consist of representatives of hospitals, physicians and other providers of service, but a majority of members should be broadly representative of the consuming public including the major segments of the population.

The members of the UAW support fully the objectives of Medicare. We applaud the vision of the Congress and Administration for the constructive steps thus far taken, and particularly commend the Administration for the constructive steps thus far taken, and particularly commend the Administration for the conscientiousness, vigor and dedication with which efforts were made to carry out the spirit as well as the letter of this complex legislation.

At the same time we recognize, as I am confident do the members of this Committee, that this long overdue pioneering effort in social legislation inevitably will have inadequacies and initial inconsistencies.

The right to good health is now established in the value system of the American people. We know the Congress is genuinely concerned with making it possible for all our people to achieve good health. To enable our older citizens fully to benefit from the opportunities for improved health which the miracles of modern science have made possible in recent years will now require the substantial improvements we are recommending in the program. The health and wellbeing of our senior citizens will not be protected nor can it wait the promise of more adequate measures at some point in the future.

III. MEDICAID (TITLE XIX)

While Medicare is universally accepted as an expression of national policy for establishing the right of access to health care for the aged through the application of social insurance principles, the adoption of Title XIX (Medicaid) amounted to an equally unambiguous recognition of the inadequacies, indignities and generally poor quality of "welfare medicine" as practiced in the United States in 1965. Medicaid represents a sincere, good faith commitment by the federal government to provide the financial backing for developing a single, consolidated, improved and liberalized program of medical assistance for the medically needed aged, public assistance recipients and needy children and adults. It explicitly acknowledges public responsibility to assist in meeting the health needs of people, whether or not they have reached age 65.

It is undeniable that the Medicaid program has been controversial and has generated pressures on Congress to make a number of changes.

It would be tragic now, however, to announce, to the poor and the near-poor, as well as to the world at large, a reversal of this policy as soon as we are presented with the check.

Decent medical care, readily available, accessible and acceptable, is an integral part of programs to aid the poor to become self-maintaining. Almost five times as many persons in families whose income is under $2000 a year are confined to their homes because of chronic disease as among families earning $7000 or more. Persons in families earning less than $2000 are almost five times as likely to have a disabling heart condition as those in the $7000 plus families, over six times more likely to be handicapped by arthritis and rheumatism, more than six times more likely to be handicapped by a nervous or mental condition and very nearly nine times more likely to have a visual impairment than those in the $7000 plus group.

The poor, therefore, are faced with a vicious cycle in which their children are born under more adverse conditions, they become sicker more often and for longer periods of time, they suffer more mental and physical handicaps and are therefore less able to secure training and go into the marketplace to secure work. Because they cannot secure work they are forced on to the public welfare roles where they become sicker and more disabled and less able to achieve independence.

The heartening aspect of the Title XIX programs was that they attempted to deal realistically with this major aspect of a situation which helps to keep the poor from becoming self-sustaining.

The cutbacks in the Title XIX program proposed in H.R. 12080 are self-defeating. In essence by their very limitations they will deprive tens of thousands who need medical care from receiving it and will add to the very relief roles that Congress is trying to reduce.

Among the most damaging aspects of H.R. 12080 are the following:

1. Limitation on federal participation

I believe the 89th Congress acted wisely in not setting for the states any upper income limits on Title XIX eligibility. It would be unfortunate to undo that now before many of the state programs are even fully operative.

Both the Administration proposal in H.R. 5710 and the House-passed H.R. 12080 attempt to set maximum income limits on federal participation. The difficulty with these limits, however, is that they ignore an essential characteristic of health care costs—their wide and unpredictable variation among individuals. Otherwise self-sufficient families, with the most modest incomes above the limits, are especially vulnerable if they experience costly illness. And it is precisely such families who would receive less of the care they need and bear the brunt of the cutbacks.

The present standards for cash assistance in many of the states are so low, that even the Administration proposed 150% ceiling, based on each state's highest standard for cash assistance, would effectively exclude persons in those states who could qualify on any reasonable test as medically needy. With the ceiling of 133⅓% of the AFDC assistance payment level ultimately to be established by H.R. 12080, the "medically needy" all but disappear.

In my own State of Michigan, for example, the 133⅓% formula would set a limit of $1500 for a single person, $2100 for two persons, $2600 for three, and $3000 for four. Title XIX intended that the level of medical indigency be above that of the states' public assistance definition of minimum need. But because the present provision of H.R. 12080 relates to the amount which the state actually pays for public assistance, Mississippi, for example, which only pays 22.8% of its own definition of minimum need to its ADC children, would have a ceiling for medical assistance that will be approximately 30% of its own definition of minimum need.

Of the 20 states, in addition to Michigan, which operate programs that include the "medically needy", 13 others—California, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island and Wisconsin, would eventually be required to make cutbacks.

It is not realistic to expect, as suggested by the House Ways and Means Committee report, that the states would provide the additional funds without federal matching grants. Such a suggestion ignores the realities of state finances.

I urge that the Senate not limit, by setting income ceilings, the existing right of each state to establish its own criteria for determining medical need.

2. Required services

The provision of H.R. 12080 which would modify the present requirement that state medical assistance programs provide at least inpatient hospital services, outpatient hospital services, other x-ray and laboratory services, skilled nursing home services and physicians' services, must also be considered as an attempt to reduce the value of total services provided under Medicaid to the detriment of persons who need health services and are unable to pay for them. It also amounts to an abdication of the leadership role assumed by the federal government looking toward the development under Title XIX of soundly planned, improved and liberalized state medical assistance plans.

By giving the states the option of providing any 7 of the first 14 types of health services listed in Section 1905 of the Social Security Act, it becomes possible for the states to substitute less essential and less costly services for those now required. This approach removes the basis for constructing a rational program of comprehensive health services and gives undue encouragement to programs developed solely on the basis of fiscal considerations and the desires of pressure groups not necessarily identified with the public interest.

While it may represent the worst possible kind of public planning, it would be conceivable, nevertheless, under H.R. 12080 for a state to exclude all of the 5 basic services and select 7 that represent a relatively small fraction of a family's total health needs. The fact is that in 1965 almost 59% of private consumer expenditures for health services went to hospital and physicians' services.[17] A program that excluded them might well have relatively low dollar costs, but, in addition to being virtually worthless, could have extremely high social costs.

It seems particularly important to me, therefore, that the present provisions concerning required services be retained intact.

3. Maintenance of state effort and comparability provisions

I would also like briefly to express my concern over the amendments that both H.R. 5710 and H.R. 12080 would make to the provisions on maintenance of state effort and to the requirement that states make available to persons under age 65 the services provided under Part B of Medicare to persons over 65 under the so-called "buy-in" arrangements.

While the changes may ameliorate the problems that prompted them, it is not at all clear that the proposed solutions are either the most satisfactory available or will not damage the program in important ways. What is clear is that ultimately these changes create disincentives to the development of adequate medical assistance programs and can only result in a reduction in services.

If it is not possible to devise alternatives that would not have these consequences, I can only suggest that you retain the present provisions without change.

I believe cutting back now on Medicaid would be short-sighted and unwise. Members of this Committee may have seen the statement of a Bureau of Labor Statistics official quoted recently by Dr. Howard Rusk in the *New York Times*—"health ranked only below lack of education as a causative factor in unemployment".[18]

Medicaid is an essential ingredient in any carefully planned system of public welfare. It should place maximum emphasis on rehabilitation, restoration of self-sufficiency and overcoming or correcting handicaps. To perform its function effectively, it needs to be strengthened, rather than weakened, to provide more, not fewer, services.

IV. PUBLIC WELFARE AMENDMENTS (TITLE II)

On numerous occasions in behalf of the millions of individuals in UAW families and other concerned citizens, I have spoken out against the way in which the public welfare system in this country is operating. It is in many ways overly bureaucratic and complex. It is frequently degrading to the individuals who must be dependent upon it. More often than not it does no provide minimum subsistence and by and large it has failed of its original objective to help the poor become independent and self-supporting.

Accordingly, we in the UAW share the concern expressed by the House of Representatives in H.R. 12080 to assist the recipients of public welfare to find new and more satisfying ways of life, to secure adequate training, to find work, to achieve independence. We concur in the views expressed that if these objectives were achieved the poor would be better off and the escalation of costs of the program would be reduced. It is a source, however, of the deepest concern that the route proposed by H.R. 12080 to achieve these objectives is based upon discredited approaches to the problems and a harsh, punitive attitude to the poor, more characteristic of Elizabethan England than of the United States in the twentieth century.

Underlying many of the public welfare proposals in Title II is the implicit assumption that people want to live in poverty and that its causes lie primarily in the individual and very little in the society. If the error of these views is not

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[17] Ruth S. Hanft, "National Health Expenditures, 1950–65," *Social Security Bulletin*, February 1967.

[18] Dr. Howard A. Rusk, "Poverty and Health," *New York Times*, August 13, 1967.

already clearly apparent, a very short visit to Watts in Los Angeles, downtown Newark, Harlem in New York, or Twelfth Street in Detroit would provide object lessons on the role of the society in perpetuating poverty cycles.

The proposals in H.R. 12080 by their very restrictive and punitive methods would largely vitiate the achievement of the very objectives they seek.

1. AFDC freeze

The provision of H.R. 12080 which would limit federal participation in aid to families with dependent children, on the basis of a parent absent from home, to the proportion of children in each state on the roles in January 1967, defies rational analysis.

Is it the intent of Congress to enforce some new moral standard by means of the public welfare mechanism? Certainly this cannot be the answer in a nation which once tried on a far more modest basis to impose a moral standard in the 18th Amendment.

If this is not the answer, what is involved here then is a shifting of the financial burden of the care for the destitute children to the states and localities.

Those communities with higher welfare standards would have to pick up the burden, though as we well know, their ability to raise increasing revenues from state and local taxes is sharply curtailed.

Those states with lower welfare standards would simply lower the standards still further so that the inadequate payments now being made would be spread even thinner.

Certainly it cannot be the intent of this measure to require that AFDC mothers who have the misfortune to bear children after the passage of this legislation be required to withhold sustenance from these children and restrict it only to those fortunate enough to be born before the 90th Congress acted.

This arbitrary limitation on AFDC is an emotional response to what undeniably is a distressing condition in our country. Its primary effect is to punish the children for the alleged errors in the ways of their parents. It will encourage states either to seek new ways to disqualify needy families, to reduce the level of support already provided, or by other means to punish the children and their mothers.

This is unsound legislation and I urge its rejection.

2. Assistance to children of unemployed parents

The 1962 Amendments to the Social Security Act which set up the AFDC–UP program were sound in that they were designed to remedy an unfortunate situation which developed in the federal programs, namely the encouragement of economically insecure fathers to desert their families so that those families would be eligible for AFDC.

We in the UAW strongly support, therefore, the proposal in H.R. 12080 to make this program permanent, although we would have wished to see a requirement making it mandatory for all states.

It is with deep regret, however, that we again see in this provision of H.R. 12080 expression of the "punish the poor" theme through the introduction of additional devices which would require withholding assistance from needy families by:

a). excluding families in need because of the unemployment of the mother;

b). requiring 30 days of unemployment before assistance can begin;

c). prohibiting assistance when unemployment compensation, no matter how little, is paid; and

d). eliminating families in which the father has had no recent attachment to the labor force with no apparent regard for the cause of his lack of attachment.

From my own experience in the labor movement I can assure you gentlemen that the men in most difficulty are those who have had no recent attachment to the work force. These families who most need the help are among those who would be eliminated by this proposal. The requirement of 30 days of unemployment before assistance can begin and the prohibition of assistance when Unemployment Compensation, regardles of how miniscule, is paid must be interpreted as nothing other than public punishment requiring an appropriate amount of suffering before aid can begin.

This version of punishment in the public stocks for those who are unfortunate enough to be poor is hardly appropriate for twentieth century America.

We recommend, in accordance with the proposals of the Advisory Council on Public Welfare, the continuation of AFDC-UP by requiring its implementation in all of the states and with the elimination of the new restrictions proposed in H.R. 12080.

3. Assistance at full need standard

The failure to include in H.R. 12080 the Administration-backed Section 202 of H.R. 5710 is only further evidence that the major emphasis of the public welfare amendments of the House-passed bill is on reducing the size and cost of AFDC, rather than as one necessary aid to the states in meeting the overwhelming social problems that are destroying our cities.

It seems inconceivable that anyone seriously could entertain the idea of "starving" people off of assistance and into self-sufficiency. Regrettably, we have had enough experience with that inhuman approach to know it only increases the misery of those whose best efforts leave them economically dependent.

I believe that the members of this Committee well know that in 33 of the states, assistance payments are at a level below the standards which the states themselves have determined as necessary to meet basic human needs and that 8 of those states pay to the unfortunate welfare recipients less than half of what those states have determined essential for minimum subsistence.

I heard recently of an AFDC mother who required surgery and was informed that the Welfare Department's appropriation for medical care had run out and the only basis on which she could obtain the surgery was if she paid half the cost. The welfare workers could not answer her dilemma when she pointed out that if she had the funds to pay for half the cost of surgery she would not be eligible for AFDC in the first place. This poor lady's novel proposal finally shocked the local Welfare Department into action. She suggested that they authorize the doctors to take out only half of her tumor—that half for which the Department was prepared to pay.

The states presently paying below subsistence levels are not only the poorer ones. They include those who have among the highest per capita incomes in the nation. In 1965 Indiana was paying 49.1% of its own standard of need, Nevada 40.2%, Michigan 71.7% and Delaware 69.6%.

Furthermore, among those states paying 100% of need, none defined the need level as high as the officially recognized poverty level. I wonder whether any member of this Committee genuinely believes maximum encouragement will be given to the restoration of families to self-reliance and employment when at the same time no provision is made for decent subsistence of those who are to be rehabilitated. Is the implied device here to starve the poor to become independent?

To avoid coercion and improve the present unsatisfactory performance of AFDC we recommend the restoration of proposed Section 202 of H.R. 5710 which would require the states to meet their own current definitions of need.

4. Community work and training

We in the labor movement are fully sympathetic to the basic objective of this legislation to prepare welfare recipients to become employable and to assist them in finding jobs at fair wages and under decent working conditions.

As you know, I was one of the group of concerned Americans who convened an emergency convocation of the Urban Coalition on August 24, 1967. In that Washington meeting we defined as the first goal "at least one million of the presently unemployed be placed in productive work at the earliest possible moment."

I also know something about what motivates people to work and not to work, and I am appalled at this proposal which assumes that the threat to cut off assistance will force all adults and children over sixteen and not in school into work and training programs. If the motivation to work is not present, these people can be trained from now until eternity and the training will be useless. Even if the motivation to work is present, unless job opportunities and decent working conditions are available reasonably shortly after the training is concluded, not only is the training money wasted, but those trained are psychologically worse off than if they had not gone to the effort of taking the training and having their hopes built up needlessly. If welfare recipients are assigned to training in work for which they are unfitted because appropriate programs for them are not available, they will be worse off than before. If welfare recipients are assigned to programs at 75¢ an hour learners' wages, they will not earn enough on which to live and will undermine the standards of other workers who are performing similar jobs at more appropriate wages.

I find it hard to believe that the Committee would be willing to go along with a program which requires that all AFDC mothers who are available to work take training or work as a prerequisite to continuation of AFDC. Are we now moving to the totalitarian philosophy of some countries which believe that a growing child does not need the supervision and care of a mother and that impersonal day care centers can provide the appropriate nuture and love which a child requires to grow to sound adulthood?

Certainly some AFDC mothers can and should profit from training and work opportunities. In the tradition of a free democratic society I urge that such facilities be set up and such mothers be given a choice as indeed all Americans should be given. But let us not make mandatory such an unsound provision.

I am told that if all other considerations were set aside, this proposal is unrealistic and impractical. It is just not possible at this point in history to make available adequate day care centers for the children who need these services. I am informed that there are now some 350,000 places in day care centers available to children and that there are long waiting lists in all these facilities. We would need to increase this number almost immediately to one million places. Has any consideration been given as to who would build the physical facilities, where we would find the trained personnel, who would supervise these programs? It just cannot be done in the terms suggested by this proposal.

I recommend that the Senate protect the rights of mothers to choose to participate in work and training programs or not to participate, without penalty, so that if they determine their places are at home with their children, that determination be respected.

5. Foster Home Care

In the name presumably of encouraging participation in the work and training programs, discouraging illegitimacy and having children brought up in more wholesome surroundings, H.R. 12080 provides the states with incentives to remove a child from the care of a parent and place the child in a foster home.

It is apparent from the Ways and Means Committee Report on H.R. 12080, that it is intended to increase very substantially the number of children in foster care. But good foster homes are scarce now and there is not the slightest reason to believe there would be an increase in facilities sufficient to handle a much larger number of children.

I believe these provisions of H.R. 12080 are of a piece with others I have enumerated in that they are punitive, coercive and unwise. In addition, they will be both costly and unpractical. Even if they are not, there is no moral justification in a free society for confronting a mother, for example, with a choice between being separated from her child and being forced into work and training that may be inappropriate or worse.

Accordingly, I you ask to strike these provisions from H.R. 12080.

6. Protective and vendor payments

For reasons similar—and no less firmly held—to those already mentioned in connection with other objectionable features of the public welfare amendments included in H.R. 12080, I also protest the use of the threat of the device of protective and vendor payments to compel participation in the work and training programs.

I urge you also to eliminate these amendments.

7. Social work manpower

It was recognized by the House Ways and Means Committee in its report to the Congress that to achieve the goals of independence and self-maintenance for those on welfare requires the skills of far larger numbers of well trained social workers than are now available in this country. I note with satisfaction that the Secretary of H.E.W., in an internal reorganization in the Department, has set up a new Social and Rehabilitation Service for the purposes of providing more effective social rehabilitation services in the welfare programs.

I am sure the Secretary of H.E.W., as well as the members of this Committee, recognize that structure alone will not achieve the purposes and that we require far more trained people than we now have. Accordingly, it is a progressive step that H.R. 12080 includes a provision for general aid to the social work education program. The $5 million ceiling imposed on this aid, however, appears to be unrealistic and unsound. It may well be that in the tooling up stages in the first year no more than $5 million could be soundly spent. There are substantial indications, however, that in subsequent years larger sums than this will be required and would be effectively employed.

I therefore recommend support of the aid to social work education program and elimination of the $5 million ceiling after the first year.

Improvement of child health (title III)

Our experience in this country with public programs which provide medical care services has repeatedly demonstrated that we have dual problems in assuring continuing high quality care through such public programs and avoiding fragmentation of services.

The vigorous fight made by the Children's Bureau from the very beginnings for high quality health care for children is favorably reflected in what are generally considered fine child health and crippled children services throughout the country. These deserve support in increased appropriations.

Furthermore, I believe it is a progressive step to reduce fragmentation and assure maintenance of quality medical care to bring together the maternal and child health and crippled children's services, as is proposed in Title III of H.R. 12080.

We recommend support for increased appropriations for maternal and child health and crippled children's services and for consolidation of these two programs into one.

I recognize that the Congress has been under pressure to "do something" about the growing costs of public welfare. I believe that the most affluent nation in the world has the means to eliminate poverty and alienation of millions of its citizens. The basic error in the Title II proposals of H.R. 12080 is that they assume that by punitive means all these problems can be solved by a public welfare system.

Reforms are essential in that system. They will not, however, provide many of the answers. Rather, solutions are more likely to be found in a series of interrelated economic and social measures that have been endorsed by growing numbers of thoughtful and responsible citizens. Among the measures which must be included in a meaningful and effective reform program are the following:

1. In a society that is work-oriented, there must be opportunities for employment at decent wages and reasonable conditions of employment for every American who can, and whose family responsibilities permit work. While we would want the private sector of the economy to be encouraged and stimulated to provide the bulk of these jobs, public employment should be available to take up any slack.
2. For those who leave the workforce because of old age, sickness, disability or unemployment, we need improved and expanded social insurance to maintain the incomes of these workers and their dependents at decent levels, consistent with prevailing community standards. The fact that so many Americans now receiving social insurance benefits live below the poverty level or require public welfare supplementation, emphasizes the urgency of substantial improvements.
3. For those Americans either unable to be self-supporting through work or whose history of attachment to the work force is so limited as to prevent them from qualifying for adequate social insurance benefits, there should be an assured minimum income provided, without a means test, perhaps in the form of family allowances, or through a categorical guaranteed income plan, or a negative income tax.
4. In a context of adequate income guarantees a reformed and reorganized public welfare system assuring basic living needs and needed social services, along the lines recommended by the Advisory Council on Public Welfare becomes feasible and manageable. The need for soundly conceived and decently administered public welfare programs will continue for many years to come.

The CHAIRMAN. Now we will call Mr. C. Joseph Stetler, president, Pharmaceutical Manufacturers Association.

Mr. Stetler, we are pleased to welcome you, notwithstanding a minor difference of opinion between some members of your organization and myself.

We think you are doing a fine job in producing drugs for the people of this country, and I believe we share your objective even though some of us differ with your idea about how some of us ought to go about buying some of these products.

STATEMENT OF C. JOSEPH STETLER, PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION; ACCOMPANIED BY THEODORE G. KLUMPP, M.D., MEMBER, BOARD OF DIRECTORS; AND LLOYD N. CUTLER, SPECIAL COUNSEL

Mr. STETLER. Thank you, Mr. Chairman, and members of this committee.

I am, as you have indicated, president of the Pharmaceutical Manufacturers Association, and I am delighted to be here today, Senator, to discuss our views on the drug bills that are before your committee.

I am accompanied today by Mr. Lloyd Cutler, who is legal counsel to the PMA, and Dr. Klumpp, who is a member of our board of directors, and president of one of our member firms.

We have two statements for introduction into the record, but we are prepared to give a brief summary if that is agreeable.

The CHAIRMAN. We will print the entire statement, Mr. Stetler.

Mr. STETLER. Thank you.

In presenting the association's position before the committee today, I am going to concentrate on two bills relating to drugs which have been proposed as amendments to the House-passed social security amendments. They are S. 17 and S. 2299.

At the outset, I would like to say that the PMA fully recognizes the very proper interest of the Government and this committee in attempting to control the amount of Federal expenditures for drugs and, of course, other benefits under the various social security programs.

We feel strongly, however, that the bills in question would establish an impractical and unjust method of controlling Federal expenditures, and that they would impair competition in the manufacture and distribution of drug products, and would adversely affect the quality of health care provided to beneficiaries under the Social Security Act.

In light of the complexities and subtleties of the problems in the areas covered by the bill which are so vital to the national welfare, we strongly urge this committee to delay action on the subject matter of these bills until completion of studies currently being conducted, as you know, at the President's request, by the Department of Health, Education, and Welfare.

S. 17 and S. 2299 have of course, many provisions which are quite similar. S. 17, however, would provide in addition for the expansion of benefits under title XVIII, part B of the Social Security Act, by authorizing partial reimbursement of prescription drug costs incurred by nonhospitalized beneficiaries.

The PMA does not oppose reimbursement for drugs to title XVIII nonhospitalized beneficiaries, but urges, because of the current HEW study on the subject and in light of other proposed changes in the Social Security Act, affecting both benefits and tax rates, that the expansion of medicare benefits, as proposed by S. 17, not be adopted at this time.

Now turning to S. 2299, our comments fall into several areas. We think its administraition would present serious practical difficulties. These have already been pointed out in detail by Secretary Gardner in his September 1 statement to the Senate Finance Committee and by Dr. Goddard in his testimony last week. We felt that the bill would jeopardize the future development of new medicines; that it would interfere with the physician's free choice of those drug products that his individual experience and training have indicated are best for his patient, or would unfairly penalize the patient whose physician prescribes a drug product that is familiar to him and in which he has faith, but is not included in the proposed formulary.

In our opinion, the Formulary Committee that is proposed by the bill would be presented with an impossible task in carrying out its assignments, and in attempting to determine such things as whether drug products listed in the "U.S. Pharmacopeia," the "National Formulary," the "U.S. Homeopathic Pharmacopeia" or "Accepted Dental Remedies," and currently in general use pursuant to existing law, should nonetheless be excluded from the formulary because they are of "unacceptable quality" or "unnecessary therapeutically duplicative for purposes of diagnosis, cure, mitigation, treatment, or prevention of disease in man."

We think the committee would have trouble in determining whether combinations and other drug products not currently listed in USP or the other cited compendia, should be inserted in the new formulary, because they are "proper or necessary" for treatment of disease.

In this connection it should be noted that about 100 of these combination products which are thus "disadvantaged" by the language of the bill are among the 200 drug products which were most frequently prescribed by doctors in 1966.

We think they would have trouble in determining—this is the Formulary Committee—which products are to be included in the formulary by their trade name designation based on the criteria established in the bill; that is, lower price, or that they are the only such products of quality acceptable to the formulary committee; or that they have distinct demonstrated therapeutic characteristics not otherwise available.

And, lastly, the committee would have trouble in promulgating regulations establishing requirements for drugs prescribing conditions and quantities they use to assure, as the bill indicates, proper usage of drugs.

Now, we already have under the existing Federal Food, Drug, and Cosmetic Act, comprehensive mechanisms for assuring that only safe and effective drug products are on the market. To superimpose upon this existing system a separate set of standards and decisions under the aegis of the proposed Formulary Committee would lead to great confusion, additional expense, delay, and uncertainty.

As noted, the bill provides that the Formulary Committee may include drugs or combinaiton drug products by trademark designation—but only if these products are sole source items, or if they have distinct demonstrated therapeutic characteristics not otherwise available, or if such products are available at a lower price than other products sold by the same generic name.

In other words, the trademark product is not entitled to a listing in the formulary by its trademark name if it is just as good or costs no more than a product sold only by its generic name. Rather, in order to be listed by trademark name, the trademark product must be better—not just as good, but better; or the trademark product must be cheaper—not cost the same, but be cheaper.

One can only wonder why the institution of trademarks, which is fundamental in the American economic system as a means of identifying the producing source, should thus be selected for special prejudicial attention, insofar as drug products are concerned.

In addition to the above, the bill, if enacted, would seriously limit the physician's freedom of choice in prescribing those drug products which his training and experience indicate as best for the particular patient concerned.

We agree with the proposition endorsed by the medical profession itself that physicians should price in selecting drug products as well as any other medically indicated procedure or treatment. But all would agree, we believe, that the physician's primary consideration should remain the selection of the particular drug product, diagnostic procedure or treatment best suited for the individual patient's medical problem. As far as pharmaceuticals are concerned, our position has always been that the physician should be free to exercise his professional judgment in selecting the drug product which he considers most beneficial for his patient.

How free would the physician really be in drug prescribing with the Formulary Committee determining whether the products of his choice are of "acceptable quality" or whether they are "unnecessary or therapeutically duplicative," or—in the case of combinations and other drug products not included in existing compendia—whether they are "necessary or proper" in the treatment of disease?

Even more serious, we think, because of its more general application, would be the inhibitory effect of S. 2299 on the physician's choice among various products included in the Formulary. Doctors would be deterred from prescribing a particular, preferred version of a drug product—whether sold on a brand name or generic basis—where it is sold at a price higher than the price for the drug specified by the Secretary of HEW. Again, the physician could be forced to chose between selecting a product which he feels may be inferior, or prescribing a higher priced product of his choice and financially penalizing his patient.

Such a limitation of reimbursement to a specific ceiling price of the so-called generic version of the drug product is based on the false assumption that all products containing an ingredient with the same generic name are chemically identical, and equal in their therapeutic effect.

One thing is certain, however, and that is that it is not possible for any Formulary Committee, governmental or otherwise, to make scientifically supportable value judgments applicable to every patient, regarding the relative therapeutic value of one drug product over another, as would be required by this bill.

We have no objection to generic prescribing in those cases where the doctor wishes to delegate to a pharmacist the selection of the drug product. Nor do we think it inappropriate for physicians to prescribe by using the generic name of the drug and designating the product of a particular manufacturer. A brand name prescription, after all, is but a convenient shorthand method for doing precisely this.

On the subject of therapeutic equivalency, Dr. Klumpp is prepared to give a brief statement after I have completed my remarks, which I shall do very shortly.

On the subject of cost range guide, and that is an important part of this bill, S. 2299 would authorize the Secretary of HEW to establish and publish a guide showing the "reasonable cost range" of each qualified drug. The reasonable cost would be the amount at which the product is generally available by its established name, "or if lower, by trademark designation." The "reasonable charge," or the amount which the Government would authorize for reimbursement, would consist of the acquisition cost to the dispenser, within the reasonable cost range, plus a "reasonable professional fee."

Thus, under the so-called reasonable cost range provision of the bill, not only would the manufacturers and wholesaler be faced with fixed ceiling prices but also a price regulation system which would drastically limit prompt and flexible adjustment in prices in future periods to take care of possible higher material or labor costs or any other development.

As if the sweeping economic and price control regulation or drug products, as set forth in this bill, were not enough, producers and suppliers—by the terms of the bill—would be required to accept the administrative decisions as to prices made by the Secretary or his representative without any right to administrative review or any right to a hearing.

We had major price control legislation during World War II and during the Korean conflict. Under that legislation—which did not incidentally select only one category of products to control—there was provision for administrative review hearings; and for an appeal to the courts by those individuals or firms who felt that a given decision made by some Government official was wrong.

The price of a product must be such that it equates demand and available supply. Prices provide a measure of relative value of different factors employed in the production process. If the returns to such factors are arbitrarily cut off or lowered, then they will seek other uses. This reallocation of resources out of the pharmaceutical industry certainly, in our opinion, will not be to the benefit of the sick.

Now, on drug prices, there is one further aspect of the proposal to limit Government reimbursement for drug products to "generic" price levels that deserves comment. This is the assumption that there is no valid reason for a drug product, manufactured by one pharmaceutical company, to be priced higher than a product made by another company. This observation overlooks the vital differences among firms with respect to services performed in behalf of the health industry. Some firms are quality conscious, research oriented, innovative, and furnish substantial and valuable services to physicians and pharmacists, while others, very frankly, are concerned little, or not at all, with such matters.

The costs of maintaining expensive laboratory facilities and large staffs of highly trained scientific and medical personnel, conducting animal and clinical testing, and striving to insure the production of consistently top quality products, are enormous. Many companies bear none or only a fraction of these costs. Others spend large sums on these activities and on informing physicians about their products and in maintaining medical reference services for physicians. They maintain expensive and reliable national distribution systems. They market their products in less popular but important dosage forms, and they develop and make available so-called "public service drugs" used for treatment of rare diseases. None of these costs is borne by the typical product-copying company.

Recent statements with respect to drug prices may create the impression that drug product price levels are rising as much or more than other products. Let me assure you that exactly the opposite is true. Not only have manufacturers' selling price levels for prescription drug products declined, but so have drug products at retail, while prices of most other products in our economy have risen.

In fact, the U.S. Department of Labor reported at the end of last month that the consumer price index for prescription products dropped 1½ percent in the first 6 months of this year. Since the 1957–59 base period, prices of all consumer items have increased 16 percent, while the price index of prescription drugs products declined 11 percent.

A similar price trend is displayed by the Wholesale Price Index for ethical pharmaceuticals, also pubished by the U.S. Department of Labor. The most recent Government report shows that the level of manufacturers' prices of ethical pharmaceuticals has declined 8 percent since January 1961.

The final provision of this bill deals with expanded FDA authority.

Under this provision, the bill would entitle FDA, for all practical purposes, to cause a particular product to be taken off the market—or the closing of a plant, without an opportunity for the manufacturer to be heard. This most extraordinary authority is included in what might appear to be a simple system, requiring manufacturers to place their registration number on their products.

While we believe that the registration number and the name of the manufacturer or distributor should be placed on the label of each package or container of a drug product, S. 2299 would go on, to provide that if the Secretary of HEW, or some other person in that Department, makes an inspection and concludes that a product is adulterated or misbranded, within the meaning of other provisions of the Food and Drug Act, that the manufacturer would be prohibited from placing his assigned registration number upon any of the drug product packages involved. This administrative action could be taken by an official of HEW without according any hearing to the manufacturer. The manufacturer would, under the language of this bill, be entitled to a hearing only after the action was taken.

The net effect of this procedure would be to ban a manufacturer's product from the market by administrative action, without a hearing. It is immaterial whether by precise legal interpretation this provision is applicable across the board to the sale of drug products generally or only to the sale of drug products to a beneficiary under one of the social security programs, since the manufacturer's product would be effectively foreclosed from whatever private market may remain.

In summary, we are opposed to the bill because we believe that it will reduce the quality of medical care for social security beneficiaries; that it sets up an involved and expensive scheme that would be difficult, if not impossible, to administer fairly and successfully; that it would interfere unduly with physicians providing the best possible medication for patients under social security programs; and that it would jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively.

In closing, I would like to say that we strongly support Secretary Gardner and Commissioner Goddard in asking this committee not to approve the provisions of S. 2299. We also believe that the Congress will be in a better position to appraise all possible approaches to the questions which have been raised relating to the reimbursement for drug products under federally financed programs after the Department of Health, Education, and Welfare has completed its comprehensive study of this subject and has made its report available to the Congress and the public.

Thank you, Mr. Chairman.

(The statements of Mr. Stetler and Dr. Klumpp follow:)

STATEMENT OF C. JOSEPH STETLER, PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION

I am C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, on whose behalf I welcome the opportunity to appear before this Committee today. Accompanying me are Lloyd N. Cutler, special counsel to the PMA, and Dr. Theodore G. Klumpp, a member of the Board of Directors of our Association and President of Winthrop Laboratories.

PMA is a voluntary, non-profit trade association composed of some 140 companies engaged in the development and production of prescription drug products. These firms account for 95% of the prescription drug products made and sold in the United States today.

Among our members are those companies, significantly engaged in pharmaceutical research, which are primarily responsible for making available the great number of life-saving and life-sustaining medicines that have come into use during the past 30 years. Most of the prescription products which are widely used today were unknown or unavailable ten years ago.

Our member companies have facilities in 44 states and employ more than 121,000 workers, including a high percentage of scientists and research specialists. These companies have an annual payroll of more than $897,000,000 and pay taxes of approximately $506,000,000 annually to federal, state and local governments. In addition, PMA companies have substantial sales in foreign countries and operate at least 230 manufacturing facilities abroad.

Our member companies vary greatly in size. Several do an annual pharmaceutical business of less than $200,000, while others have drug sales of $100,000,000 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.

This is simply another way of pointing out that the drug industry is not a corporate monolith representing the concentrated power of a handful of large firms. Rather, this industry, one of the most intensely competitive in our entire economy, is comprised of a great many companies, large and small. It is highly significant, I believe, that no one firm accounts for more than 7 per cent of the total prescription drugs sales which last year exceeded $3 billion in the United States.

In presenting the Association's position to the Committee today, I shall concentrate on two bills relating to drugs which have been proposed as amendments to H.R. 12080. They are S. 17, otherwise identified as Amendment number 265, and S. 2299, offered as Amendment number 266.

At the outset, I wish to assure you that the PMA fully recognizes the very proper interest of the government in controlling the amount of federal expenditures for drugs and other benefits under various Social Security programs.

We feel strongly, however, that the bills in question would establish an impractical and unjust method of controlling federal expenditures, would impair competition in the manufacture and distribution of drug products, and would adversely affect the quality of health care provided to beneficiaries under the Social Security Act.

Further, we fail to see how the legislation can be regarded as other than discriminatory toward the elderly and financially unfortunate. Under its terms, these beneficiaries of federally financed health programs would become a secondary class of patient. The number and variety of drug products now available to them at government expense would be curtailed while the whole range of the nation's drug products would remain available to other Americans.

In light of the complexities and subtleties of the problems in this area which are so vital to the national welfare, we strongly urge this Committee to delay action on the subject matter of these bills until completion of studies currently being conducted, at the President's request, by the Department of Health, Education and Welfare.

S. 17 and S. 2299 have many provisions which are quite similar. S. 17, however, would provide in addition for the expansion of benefits under Title XVIII, Part B of the Social Security Act, by authorizing partial reimbursement of prescription drug costs incurred by non-hospitalized beneficiaries.

The PMA does not oppose reimbursement for drugs to Title XVIII non-hospitalized beneficiaries, but urges, because of the current HEW study on the subject and in light of other proposed changes in the Social Security Act, affecting both benefits and tax rates, that the expansion of Medicare benefits as proposed by S. 17 not be adopted at this time.

Turning to S. 2299, our comments fall into several areas. We think its administration would present serious practical difficulties. These have already been pointed out in detail by Secretary Gardner in his September 1st statement to the Senate Finance Committee and by Doctor Goddard in his testimony last week. We feel that the bill would jeopardize the future development of new medicines for the yet unconquered diseases; that it would interfere with the physician's free choice of those drug products that his individual experience and training have indicated are best for his patient, or would unfairly penalize the patient whose physician prescribes a drug product that is familiar to him and in which he has faith, but is not included in the proposed Formulary.

The bill would: (1) establish in the Department of Health, Education and Welfare a Formulary Committee with the power to determine which drugs and drug products would be qualified for reimbursement for beneficiaries of the various Social Security programs; (2) require the Secretary of HEW to establish and publish a "cost range" guide for all qualified drugs and establish maximum permissible professional fees for pharmacists; and (3) modify the present compulsory registration system for prescription drug manufacturers and through this and other provisions place substantial additional authority in the Food and Drug Administration.

Formulary Committee and the Publication of a U.S. Formulary

The Formulary Committee would be comprised of the Surgeon General of the Public Health Service, the Commissioner of Food and Drugs, the Director of the National Institutes of Health, the Commissioner of Narcotics, and five non-government members from the fields of medicine and pharmacy. The chairman of the Formulary Committee would be named from among the non-government members.

The Formulary Committee would be required to prepare, publish, and periodically revise, a listing of drugs, biologicals and drug products by their established or generic names. To be included in this Formulary would be those drugs and biologicals which are included or approved for inclusion in the United States Pharmacopeia, the National Formulary, the United States Homeopathic Pharmacopeia, and Accepted Dental Remedies, except as the Formulary Committee decides to exclude specific drugs or biologicals.

However, the bill expressly provides that the Formulary Committee shall *not* include in the Formulary—

> those drugs or biologicals which the Committee determines to be unnecessary or therapeutically duplicative for purposes of diagnosis, cure, mitigation, treatment, or prevention of disease in man.
>
> any drug product which the Committee determines to be of unacceptable quality.

The bill would provide that the Committee *may* also include in the Formulary combination drug products and biologicals, if the Committee determines these combinations to be "necessary or proper."

In addition, the Committee would be authorized to include in the Formulary a drug or combination drug product by trademark designation—but only if the product has distinct therapeutica characteristics not otherwise available, if the product is available at a lower price than a generic name product with no trademark, or if the product, which is sold under a trademark designation, is the only such product of a quality acceptable to the Formulary Committee.

Finally, the Formulary Committee could issue regulations, in identifying a drug qualified for reimbursement, relating to prescribing conditions and quantities in order to "assure the orderly, efficient, and proper use of drugs and biologicals."

In our opinion, the Formulary Committee would be presented with an impossible task, in carrying out these assignments and in attempting to determine:

(1) Whether drug products listed in the USP, the National Formulary, the U.S. Homeopathic Pharmacopeia or Accepted Dental Remedies, and currently

in general use pursuant to existing law, should nonetheless be excluded from the Formulary because they are of "unacceptable quality" or "unnecessary therapeutically duplicative for purposes of diagnosis, cure, mitigation, treatment, or prevention of disease in man."

(2) Whether combinations and other drug products, not currently listed in the USP or other existing compendia, should be included in the new Formulary because they are "necessary or proper" for treatment of disease. In this connection it should be noted that about 100 of these combination products that are thus "disadvantaged" by the language of the bill were among the 200 drug products most frequently prescribed by physicians in 1966.

(3) Which products are to be included in the Formulary by their trade name designations based on the criteria established in the bill, i.e., lower price; that they are the only "such products of quality acceptable to the Formulary Committee"; or that they have "distinct demonstrated therapeutic characteristics not otherwise available."

(4) Requirements for drug prescribing conditions and quantities to assure "proper usage of drugs."

We already have, under the Federal Food, Drug and Cosmetic Act, comprehensive mechanisms for assuring that only safe and effective drug products are on the market. To superimpose upon this existing system a separate set of standards and decisions under the aegis of the proposed Formulary Committee would lead to great confusion, additional expense, delay, and uncertainty.

With specific reference to the first point mentioned, suppose the Committee finds that similar drugs are being marketed throughout the United States which—under the language in this bill—are "therapeutically duplicative."

Which of the drugs would the Committee exclude from the Formulary and in effect condemn to extinction? Which one of the drugs would be permitted a viable commercial life, virtually free of competition?

Surely a government committee should not be empowered to decide the life or death of a particular drug which is lawfully on the market; nor should a government committee be empowered to decide the life or death of an entire company.

As noted, the bill provides that the Formulary Committee *may* include drugs or combination drug products by trademark designation—but only if these products are sole source items, or if they have distinct demonstrated therapeutic characteristics not otherwise available, or if such products are available at a lower price than other products sold by the same generic name.

In other words, the trademark product is not entitled to a listing in the Formulary by its trademark name if it is just as good or costs no more than a product sold only by its generic name. Rather, in order to be listed by trademark name, the trademark product must be better—not just as good but better; or the trademark product must be cheaper—not cost the same, but be cheaper.

One can only wonder why the institution of trademarks, which is fundamental in the American economic system as a means of identifying the producing source, should thus be selected for special prejudicial attention, insofar as drug products are concerned.

Effect of formulary on medical practice

In addition to the above, the bill, if enacted, would seriously limit the physician's freedom of choice in prescribing those drug products which his training and experience indicate as best for the particular patient concerned.

We agree with the proposition endorsed by the medical profession itself that physicians should consider price in selecting drug products as well as any other medically indicated procedure or treatment. But all would agree, we believe, that the physician's primary consideration should remain the selection of the particular drug product, diagnostic procedure or treatment best suited for the individual patient's medical problem. As far as pharmaceuticals are concerned, our position has always been that the physician should be free to exercise his professional judgment in selecting the drug product which he considers most beneficial for his patient.

Much has been made of the fact that S. 2299 does not specifically compel generic prescribing, and does not purport to limit the prescribing practices of physicians. But how free would doctors actually be to prescribe, for patients under Social Security programs, drug products that are not included in the Formulary—for which no reimbursement may be obtained—or those drug products listed in the Formulary but sold (whether on a brand name or generic basis) at a price higher than the price ceiling determined by the Secretary of HEW—for which only partial reimbursement may be obtained?

How free would the physician really be in drug prescribing with the Formulary Committee determining whether the products of his choice are of "acceptable quality" or whether they are "unnecessary or therapeutically duplicative," or—in the case of combinations and other drug products not included in existing formularies—whether they are "necessary or proper" in the treatment of disease?

We strongly question whether it is good policy to interfere with the physician's responsibility to prescribe any drug product with which the physician has had satisfactory experience in treating his patients. The physician desiring to prescribe such a product, where the Formulary Committee has decided it is "therapeutically duplicative" is placed on the horns of a dilemma: Either he must forego prescribing the therapeutic agent he considers best, or he must financially penalize the patient by prescribing something for which no reimbursement may be obtained.

Even more serious, because of its more general application, would be the inhibitory effect of S. 2299 on the physician's choice among various products included in the Formulary. Doctors would be deterred from prescribing a particular, preferred version of a drug product (whether sold on a brand name or generic basis) where it is sold at a price higher than the price for the drug specified by the Secretary of HEW. Again, the physician could be forced to choose between selecting a product which he feels may be inferior, or prescribing a higher-priced product of his choice and financially penalizing his patient.

Generic and Therapeutic Equivalence

Such a limitation of reimbursement to a specific ceiling price of the so-called "generic" version of the drug product is based on the false assumption that all products containing an ingredient with the same generic name are chemically identical, and equal in their therapeutic effect.

The generic or established name of a drug describes or refers only to the pharmacologically active ingredient of the drug product—not to the finished product itself. The finished drug product usually includes inactive ingredients affecting such crucial factors as dissolution and release of medication. Therefore, although a drug product may contain the prescribed amount of active ingredient and may meet USP or NF standards, there is no guarantee it will produce the same result in a patient as another product containing an active ingredient with the same generic name.

One thing is certain, however, and that is that it is not possible for any Formulary Committee, governmental or otherwise, to make scientifically supportable value judgments *applicable to every patient,* regarding the relative therapeutic value of one drug product over another, as would be required by this bill.

We invite your attention to the statement of Dr. Milford Rouse, President of the American Medical Association, who testified before this Committee and said, "Drug therapy is one area in which the art of medicine is practiced to its fullest extent. In order to cope with the subtle differences that are to be expected among various patients in response to drug therapy, the physician must be allowed the greatest freedom in prescribing and his drug armamentarium should be as flexible as possible."

Moreover, it is important to bear in mind that drug manufacturing is a complex and sophisticated process, in which total quality control procedures are crucial in assuring safe and effective drug products.

As physicians are aware, not all drug manufacturers devote the same careful attention to quality control, the elimination of potential defects and sources of error in manufacturing and packaging procedures. And it is for this very reason that reliability and consistency of quality are such important factors to the physician when he chooses a product for his patient. But the vast disparity in the quality control capability and programs of various manufacturers, and in their resultant "reliability," is something that the generic equivalency contention completely overlooks.

We have no objection to generic prescribing in those cases where the doctor wishes to delegate to a pharmacist the selection of the drug product. Nor do we think it inappropriate for physicians to prescribe by using the generic name of the drug and designating the product of a particular manufacturer. A brand name prescription, after all, is but a convenient shorthand method for doing precisely this.

Doctor Klumpp is prepared to present additional comment on this important point.

Cost Range Guide

The bill would also authorize the Secretary of HEW to establish and publish a guide showing the "reasonable cost range" of each qualified drug. The reasonable cost would be the amount at which the product is generally available by its established name, "or if lower, by trademark designation." The "reasonable charge," or the amount which the government would authorize for reimbursement, would consist of the acquisition cost to the dispenser (within the reasonable cost range) plus a "reasonable professional fee."

The Secretary, or his designee, would presumably carry out this sweeping price control authority, by looking at the market—as narrowed by the Formulary—to determine the prevailing prices of a given drug product. He would then publish a guide book or some kind of list showing the price range for each approved drug. In an individual transaction the pharmacy, hospital or other dispenser of the drug product would be reimbursed for the actual acquisition cost (at or below the ceiling established) plus, in the case of a community pharmacy, a negotiated "reasonable professional fee."

Thus, under the so-called "reasonable cost range" provision of the bill, not only would the manufacturer and wholesaler be faced with fixed ceiling prices but also a price regulation system which would drastically limit prompt and flexible adjustment in prices in future periods to take care of possible higher material or labor costs or any other development.

As if the sweeping economic and price control regulation of drug products, as set forth in this bill, were not enough, producers and suppliers—by the terms of the bill—would be required to accept the administrative decisions as to price made by the Secretary or his representative without any right to administrative review or any right to a hearing.

We had major price control legislation during World War II and during the Korean conflict. Under that legislation—which did not incidentally select only one category of products to control—there was provision for administrative review hearings; and for an appeal to the courts by those individuals or firms who felt that a given decision made by some government official was wrong.

This provision of the bill can be seen then as an anti-competitive price-fixing measure that would discourage competition at the manufacturer and retail levels. It would give unjustified status to a few drug products in each therapeutic class where many now compete.

Even in the short run the ceiling price, determined by the Secretary on the basis of generic name items currently available on the market, may not enable the full-service producer to break even.

The price of a product must be such that it equates demand and available supply. Prices provide a measure of relative value of different factors employed in the production process. If the returns to such factors are arbitrarily cut off or lowered, then they will seek other uses. This reallocation of resources out of the pharmaceutical industry will not be to the benefit of the sick.

Drug Prices

There is one further aspect of the proposed to limit government reimbursement for durg products to "generic" price levels that deserves comment. This is the assumption that there is no valid reason for a drug product manufactured by one pharmaceutical company to be priced higher than a product made by another company. This observation overlooks the vital differences among firms with respect to services performed in behalf of the health industry. Some firms are quality-conscious, research-oriented, innovative, and furnish substantial and valuable services to physicians and pharmacists, while others are concerned little, or not at all, with such matters.

The costs of maintaining expensive laboratory facilities and large staffs of highly trained scientific and medical personnel, conducting animal and clinical testing, and striving to insure the production of consistently top quality products, are enormous. Many companies bear none or only a fraction of these costs. Others spend large sums on these activities and on informing physicians about their products and in maintaining medical reference services for physicians. They maintain expensive and reliable national distribution systems. They market their products in less popular but important dosage forms, and they develop and make available so-called "public service drugs" used for treatment of rare diseases. None of these costs is borne by the typical product-copying company.

At this juncture, I would like to correct the immpression that the Federal Government's "drug research expenditures" exceed industry research spending.

On the contrary, the pharmaceutical industry's drug research and development expenditures are about three-and-a-half times as great as the Federal Government's drug-related research. Our studies show clearly that the industry is the recipient of less than 4 per cent of its research funds from governmental sources. Annual expenditures on research directed by prescription drug producers now exceed $400 million a year.

Research-oriented, innovating drug manufacturers, in sum, perform a vital role in protecting the nation's health. The "product" provided by these companies to physicians, pharmacists and to society—in terms of new and effective drug products, information, research and service—is, in the last analysis, a very different one from that provided by the imitator. Any action by Congress which would reduce the incentive to companies offering high "total product" values to continue to operate their businesses in the way they do, and the incentives to others to invest capital and resources in such companies, should be approached with great caution. The health of all of us and of future generations are dependent on the continued growth and vitality of a progressive and successful pharmaceutical industry.

Recent statement with respect to drug prices may create the impression that drug product price levels are rising as much or more than other products. Let me assure you that exactly the opposite is true. Not only have manufacturers' selling price levels for prescription drug products declined, but so have drug products at retail, while prices of most other products in our economy have risen.

In fact, the U.S. Department of Labor reported at the end of last month that the Consumer Price Index for prescription products dropped one-and-a-half per cent in the first six months of this year. Since the 1957–59 base period, prices of all consumer items have increased 16 per cent, while the price index of prescription drug products declined 11 per cent.

A similar price trend is displayed by the Wholesale Price Index for ethical pharmaceuticals, also published by the U.S. Department of Labor. The most recent government report shows that the level of manufacturers' prices of ethical pharmaceuticals has declined 8 per cent since January 1961.

Expanded Authority in FDA

Finally, the bill would entitle the Food and Drug Administration, for all practical purposes, to cause a particular product to be taken off the market—or the closing of a plant, without an opportunity for the manufacturer to be heard. This most extraordinary authority is included in what might appear to be a simple system of requiring manufacturers to place their registration number on their products.

While we believe that the registration number and the name of the manufacturer or distributor should be placed on the label of each package or container of a drug product, S. 2299 would go on, to provide that if the Secretary of HEW, or some other person in that Department, makes an inspection and concludes that a product is adulterated or misbranded, within the meaning of other provisions of the Food and Drug Act, that the manufacturer would be prohibited from placing his assigned registration number upon any of the drug product packages involved. This administrative action could be taken by an official of HEW *without according any hearing to the manufacturer*. The manufacturer would, under the language of this bill, be entitled to a hearing only after the action was taken.

The net effect of this procedure would be to ban a manufacturer's product from the market by administrative action, without a hearing. It is immaterial whether by precise legal interpretation this provision is applicable across the board to the sale of drug products generally or only to the sale of drug products to a beneficiary under one of the Social Security programs, since the manufacturer's product would be effectively foreclosed from whatever private market may remain. A prudent wholesaler or retailer could not tolerate being placed in the position of selling a product which has been labeled "illegal" by a government official.

Under existing law, a drug product believed by the FDA to be adulterated or misbranded is subject to seizure, but only pursuant to a Court order.

We simply cannot understand why there should now be proposed this extraordinary procedure for taking a drug product off the market, without the right of an administrative hearing or even without a Court order based upon a determination of "imminent hazard to the public health."

Summary and Conclusions

Section 1801 of Title XVIII of the Social Security Act which was enacted in 1965 provides:

"Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or authorization of any such institution, agency, or person."

If S. 2299 is enacted into law, it will, in our opinion, constitute an abrogation of this provision.

In summary, we are opposed to the bill because we believe that it will reduce the quality of medical care for Social Security beneficiaries; that it sets up an involved and expensive scheme that would be difficult, if not impossible, to administer fairly and successfully; that it would interfere unduly with physicians providing the best possible medication for patients under Social Security programs; and that it would jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively.

We strongly support Secretary Gardner and Commissioner Goddard in asking this Committee not to approve the provisions of S. 2299. We also believe that the Congress will be in a better position to appraise all possible approaches to the questions which have been raised relating to the reimbursement for drug products under federally financed programs after the Department of Health, Education, and Welfare has completed its comprehensive study of this subject and has made its report available to the Congress and the public.

SUPPLEMENTARY STATEMENT OF THEODORE G. KLUMPP, M.D.

Mr. Chairman, I am pleased to have the opportunity to supplement Mr. Stetler's statement on the question of drug equivalency. During my career I have had many opportunities to deal with this matter—first as an Instructor and Assistant Professor of Medicine at Yale, and at George Washington University as Adjunct Clinical Professor of Medicine, and between 1936 and 1941, when I was the Chief Medical Officer and later Chief of the Drug Division of the Food and Drug Administration.

I am also acquainted with the important and largely unheralded services of the United States Pharmacopeia. Since 1950 I have served as Vice President of the U.S.P.

By virtue of these assignments and my activities in the pharmaceutical industry, I know something about the factors that affect drug quality and I am also aware of the limitations facing the diligent but over-extended people of the FDA in attempting to monitor this very large drug industry, composed of hundreds of firms of widely varied technical capabilities. It is simply wrong, given the present state of the art of pharmaceutical manufacture and the capabilities of enforcement agencies, to pretend that all drug products of like generic name are equal.

Former FDA Commissioner George Larrick once testified that in the decade 1950–1960 FDA took legal action 484 times on drug composition violations against the firms that produced only 13 per cent of the nation's drug products; he said FDA had to take similar action only four times against the firms that produced 87 per cent. More recently Commissioner Goddard has made it plain that while he would like to be able to say all drugs in the marketplace are reliable, this is just not true at the present time.

I submit we are not likely to have that assurance soon despite the best efforts of all involved. Recent figures on FDA inspection, for example, do little to encourage optimism in this regard. The Agency made 3,651 inspections of drug plants in 1966; impressive as that may seem, it is 150 inspections lower than the 1965 figure, and 341 lower than it was for 1964. I do not recite these figures to criticize the FDA, Mr. Chairman. Their inspections of necessity are becoming more complex and time consuming, and FDA personnel shortages are persistent.

I have before me a listing of pharmaceutical firms in New York State furnished to me by the State Department of Commerce. There are 238 firms either making, selling or distributing pharmaceuticals under their own names. Of the 238 firms in my own state, I have no knowledge and have never heard of some 200, and I have been concerned with drug manufacturers for almost 40 years. Based on my experience with the Food and Drug Administration, I would suspect that there are also many concerning which the FDA has no record of inspection. While New York is a highly industrialized state, and therefore not typical of the country as a whole, nevertheless these figures reflect the enormity of the problem of trying to assure the identity, strength, quality and purity of each batch of every pharmaceutical product. It seems to me that it would be imprudent to rely heavily on this mechanism as "the method" of assuring drug quality.

Even if we make the unassumable assumption that all manufacturers are capable of passing an FDA inspection, we are still in no sense out of the dilemma of generic equivalence.

There is the matter of conforming to U.S.P. or other standards. The question is not whether drug products should conform, but whether each batch of every drug product conforms. The fact that standards exist—and that companies put "U.S.P." on drug labels—does not establish that in fact the companies actually have adequate control procedures, or that they follow them. In short, the question is, do drug products conform to the standards they claim to meet? FDA drug recall figures provide a partial answer: In the 12-month period ending in June, 1967, FDA reported hundreds of drug recalls. Little known or obscure firms were involved more than 80 per cent of the time. That is, the firms that make about five per cent of the drugs had 80 per cent of the recalls. I would suspect that the figures would be still more lopsided were it possible for FDA to intensify its monitoring program to give increased attention to marginal operators.

In all candor, as one who has long participated in the work of the U.S.P., I must also note that the standards of the U.S.P. do not pretend to include all the standards and tests that a highly skilled manufacturer requires of his product before he will put his name on it.

The fact is that the detailed specifications needed to produce a quality drug product under good control procedures are of an utterly impractical length for inclusion in a book of this sort. Quality control tickets used in leading drug firms, for even the simplest drug product, are many yards long—and they simply list steps that are to be taken. On one product alone, manufactured by my company, for example, over 200 tests are performed. These begin with the raw materials and end with the finished perparation. Details of the procedures required on the control ticket would constitute a book in itself.

What I am saying is that conformance to compendial standards like those of the U.S.P., while of unquestioned importance, represents only part of the story. Total quality control involves much more. A quality control department is of no consequence if it fails to test for, and ignores variations in, raw materials used for compounding pharmaceutical preparations. The best production technique is useless if the shelf life of the drug is not tested and if the drug deteriorates under normal as well as unusual conditions of transport and storage. It is of small comfort to the angina patient whose pain is not relieved to tell him the product met U.S.P. specifications when first manufactured and tested.

Indeed, the experiences of the most sophisticated mass purchasers of drug products, agencies such as the Defense Department and the larger hospitals, show that drug companies possess varying technical capabilities. Defense, in a four-year period, found it necessary to reject bids from 44% of the companies who tried to sell it drugs, on the basis of plant inspections. And in the same period, 54% of the samples of drug products submitted to that agency by low bidders failed laboratory tests. We have seen many examples of a similar nature among community hospitals, where experience has taught that to avoid misadventure the institution must insist on the products of firms it trusts.

But even if one ignores all of this experience and assumes that all drug products of a given name are produced with equal competence, the doctrine of therapeutic equivalency still remains a dangerous myth. The fact is that when two organizations set out to produce the same product, they commonly proceed in different ways, and while the agents they produce may meet legal or other standards, they often vary in many other respects.

The importance of particle form and size in antibiotics, like chloramphenicol and sulfadiazine and the anti-fungal agents come to mind. Variability in response to different formulations of the anti-coagulant dicumarol are so significant that the choice of brand is as important as the choice of the agent itself. With particles of one size larger, doses are required to prevent the formation of blood clots. With another brand in which the articles are in a finer state of subdivision, the effect of the same dose is excessive, and dangerous bleeding occurs. There are many examples of this sort.

A few examples of the steps over and above standard procedures or official standards taken by a quality manufacturer to improve his product and distinguish it from competing products are the following:

(a) To lessen pain on injection. As you, no doubt, all know, the injection of some drugs is painful. We are constantly striving to lessen such pain and some of us have learned that by the addition of certain ingredients we can produce a product that produces less pain on injection. For example, investigators told us that our influenza vaccine was the least painful on the market. This didn't happen by accident.

(b) To produce medications, particularly injections, which lessen the liability of allergic reactions, which are sometimes not just troublesome but, on occasion, fatal. Much can be done to exclude as far as possible ingredients suspected of causing such reactions. Again, such procedures are sometimes costly, but the manufacturer who values his identity and reputation will constantly strive to attain higher levels of purity. The manufacturer who competes on price alone avoids raising costs to introduce ultimate refinement in his product.

(c) To produce more prompt solution in the stomach and absorption in the blood where this is desired. Variations in manufacturing procedures, differences in the state of the active ingredient and its purity, differences in the combination of excipients, all affect gastric solution and distinguish one product from another. Such differences may have a crucial effect on the therapeutic efficacy of the product.

(d) To retard solution in the stomach where the active ingredient is better absorbed in the intestinal tract, or performs its function better if it is gradually released. All this is and can be influenced by different methods of compounding the preparation, or by different tablet coating, or by the addition of other nonactive ingredients.

(e) To mask bad flavor of an active ingredient which not infrequently causes adults as well as children to resist and even refuse to take the medicine. The problem of getting a child to take a prescribed and oftentimes extremely necessary medicine is something that every mother is familiar with. Pediatricians and general practitioners choose their medicines carefully and by specification with this in mind.

Recently, we undertook a careful search of the literature on the effects of drug formulation on therapeutic activity of drug products. We rapidly collected a total of 211 references. About half of them are reports on variations in therapeutic activity observed in human volunteers and patients; the second half cover both *in vivo* and *in vitro* laboratory experiences. These articles, I should point out, are solely related to the subject of generic and therapeutic equivalence.

In fact, much additional literature on pharmaceutical sciences, published in thousands of articles annually, bears on this question; much of it relates to corollary subjects like stability variations, behavior of inactive constituents of finished drug products, particle size and form, and other significant factors ultimately affecting quality. Gentlemen, there is a whole profession, international in scope, with thousands of practitioners who are dedicated to the study of these subjects. The scientific literature output of these scientists has been estimated to be nearly 10,000 articles each year.

The legislative proposal we are considering calls for an unworkable oversimplification of an exceedingly complex problem.

As I understand it, one of the objectives of S. 2299 would be to eliminate or to curtail therapeutic duplication of drug products. In my opinion, such a step would serve as a devastating setback to medical progress and deprive patients of essential medication. In illness, patients vary in their response to medicaments. Patients vary in their physical idiosyncrasies, sensitivities, allergies and tolerances of drugs.

It is, for example, a well known fact that no one or two drugs are suitable for the treatment of all cases of epilepsy. The wide spectrum of drugs available for epilepsy exists solely because a half century of experience has shown that there is a great variability in how individual epileptics respond to available drugs, and what we need is more and not fewer strings to our bow.

The same is true of almost every disease and disability. The broader the therapeutic armamentarium, the better our physicians can care for the sick and suffering. The harm of eliminating one necessary drug far outweighs the alleged burden of too many drugs.

Mr. Chairman, the evidence of variability in drug product performance is too obvious to be ignored. The inability of FDA to assure even the *competence* of all drug firms, let alone the clinical equality of their products, is too longstanding to brush aside, and the possibility of that situation changing is extremely remote. Reasonable approaches to the problem of controlling drug costs will, I earnestly hope, be worked out in the days ahead. Of one thing I am certain: tying the doctor's hands, binding him in a kind of pharmaceutical straightjacket, will not answer the problem. It will compound it. It will be more constructive to work toward a Federal drug program that will take cognizance of all the realities of medicine and pharmacy today. And in that task we are most anxious to join you.

The CHAIRMAN. Well now, let me just ask you a question or two about this matter. I am sure you are familiar with the story I have told about my father's experience when he used to sell two patent medicines. One of them was named high poplalorum and the other was named low poplahirum.

Both of them were extracted from poplar bark. The only difference was that one was made from poplar bark skinned down the tree and the other was made from poplar bark skinned up the tree. One cost 50 cents and one cost $1. Most people bought the dollar bottle but they were of the same size and no different in quality whatsoever.

Now, knowing this if a man was voting to buy that stuff why shouldn't you buy the one that cost half as much? It is all the same thing.

Mr. STETLER. Mr. Chairman, I am not familiar with high poplalorum or low poplahirum drugs, but I would like to comment on the point you have made regarding price.

The CHAIRMAN. It is all the same thing now—all the same—not a bit of difference in it. Really, the fellow manufacturing the stuff did not know whether the bark had been skinned up or down the tree. He just put out one that he sold at 50 cents and the other that he sold at $1.

Mr. STETLER. I have a distinct feeling that either the manufacturer of high poplalorum or low poplahirum would be out of business today given the FDA regulations.

The CHAIRMAN. You would be surprised. Have you ever heard of Hadacol? The product got so well known that my Uncle George had a product called Vitalong, and he had somebody in the back stirring it. It had a little wine in it, a little sherry wine, and he mixed some brown stuff in it and Vitamin B, and you would feel better after you drank it.

Mr. STETLER. On the point about the varying prices you asked, when the last witness was here if anybody would suggest that it is proper or that the Government particularly should pay 10 times as much for the same product? Well, I think no one could suggest to you or anyone else, and certainly I would not apply it to myself in my purchasing practices that anybody should pay 10 times for the same thing. I think the points on which we may disagree, or where there is certainly a point for discussion, is whether there is a 10 times difference in price or whether we really are talking about the same products.

We think we can show you that it is not the same thing and it is in this area of chemical and therapeutic equivalency on which most of this legislation has been, we think, falsely based.

I wonder if I could ask Dr. Klumpp to make his presentation which really does deal with the subject of therapeutic equivalency, sir?

The CHAIRMAN. Before you get off on that let me ask you this. Here are some products which I am sure you are famiilar with. Achromycin, Panmycin, Polycycline, Steclin, Tetracyn. What is that?

Mr. STETLER. Various products of Tetracycline.

The CHAIRMAN. It is Tetracyclene, right. Lederle makes Achromycin; Panmycin, by Upjohn; Bristol Myers manufactures Polycycline and Tetracyn is manufactured by Pfizer. Which is better?

Mr. STETLER. I am not prepared to say which is better, but I can say that a physician who has had an acquaintanceship with all of these products and knows about the particular condition of his patient is able to make value judgments as to which of these products works best for the condition of his particular patient.

The CHAIRMAN. Do you know how I went about getting those products? I did not pay anything for them. I got them free because my cousin was head of the doctors association in Louisiana. Any time I had some bacteria in my body he would just reach down in the desk drawer and pick up a handful of free samples your salesmen left with him. It did not make any difference whether it came from Lederle or Squibb or Bristol Myers, he would just hand out a bunch of free samples. He did not see any point in my going to the drugstore for what little difference there might be in Squibb or Bristol Myers. He would just hand me a free sample, all of the same thing.

You say you cannot tell me which one is better. Can the doctor tell me which one is better?

Dr. KLUMPP. I might be able to, Senator Long, if I were treating you as a patient and in the long experience of treating patients I would find no doubt that there are differences among those preparations.

The CHAIRMAN. How would you know?

Dr. KLUMPP. By the results,

The CHAIRMAN. Would you give the same—would you give all four products to the same patient?

Dr. KLUMPP. No, but that is evened out by a long experience in treating many patients.

The CHAIRMAN. If you take 16 of those capsules it is going to kill every bacteria in your body, I am told, including those which are good for you, someone said. Is that correct?

Dr. KLUMPP. I have found patients that are sensitive to one product, not so much because of the active ingredient but because of other features of that product that they simply cannot tolerate. Another product may work perfectly and still have the same active ingredient.

The CHAIRMAN. Here is Squibb producing one kind to sell under the trade name and the other kind to sell by the official name of Tetracycline off the same production line with the same labor and the same material. Which is better?

Dr. KLUMPP. Mr. Chairman, I do not know where you got that information, but I am taking my own experience with my own company.

The CHAIRMAN. Which company is that?

Dr. KLUMPP. Winthrop Laboratories.

The CHAIRMAN. Do you produce a great number of brands?

Dr. KLUMPP. Yes, sir.

The CHAIRMAN. Do you produce Tetracycline?

Dr. KLUMPP. No, sir?

The CHAIRMAN. What are some of the things you sell most?

Dr. KLUMPP. We are the chief supplier of antimalarial drugs for the Armed Forces.

The CHAIRMAN. You bid for that business, by the way?

Dr. KLUMPP. Pardon me?

The CHAIRMAN. You bid for it or do you have a patent on it? Do you bid for it or is it patented?

Dr. KLUMPP. We bid for it.

The CHAIRMAN. Let me ask you whether your product is any more inferior because you have to bid for some of that business, Doctor? Does that downgrade the quality of your product when you have to bid with the Department of Defense?

Dr. KLUMPP. That is the way the Department of Defense sets it up. But the fact is that we have been fortunate enough to receive all the bids for the antimalarials used in Vietnam, in World War II, and in Korea.

The CHAIRMAN. How much competition is there? Does anybody else manufacture it?

Dr. KLUMPP. Nobody else manufacturers this particular one used now.

The CHAIRMAN. What do you manufacture that you have to compete to get business for?

Dr. KLUMPP. Well, let me say this——

The CHAIRMAN. What do you produce that somebody else produces?

Dr. KLUMPP. We have competition here in that there are other antimalarials of a different composition and structure. We compete with them.

The CHAIRMAN. But that is not the same product. What do you manufacture that somebody else manufactures, the same thing? You say you do not manufacture Tetracycline. I could run through this list of things. Just name something you manufacture that somebody else manufactures. You do not manufacture aspirin tablets, I take it.

Dr. KLUMPP. Yes, we do. We are the largest manufacturer of aspirin tablets.

The CHAIRMAN. You are?

Senator ANDERSON. What is their name?

The CHAIRMAN. What brand name do you sell it under?

Dr. KLUMPP. Bayer aspirin.

The CHAIRMAN. Yours is Bayer? [Laughter.] Let me ask you this. Does anybody manufacture any better aspirin than you?

Dr. KLUMPP. No, sir.

The CHAIRMAN. Can you state for certainty that somebody manufactures any worse?

Dr. KLUMPP. Testimony before congressional committees given by members of our organization showed differences between the aspirins that are on the market.

The CHAIRMAN. Well, they will not let you put in your advertising that yours is better than the other fellow's. Why not? You say there is none better and that is correct, there is none better, but you cannot say that yours is better than the other fellow's and he cannot say his is better than yours. Why not?

Dr. KLUMPP. We can say it is the best aspirin.

The CHAIRMAN. You have not and you are not going to say that.

Dr. KLUMPP. We do.

The CHAIRMAN. You do not say it on television.

Dr. KLUMPP. I think we do.

The CHAIRMAN. I have seen your ad many times, "None better," which leaves a lot to be desired because the other fellow is privileged to say exactly the same thing.

Dr. KLUMPP. Well, the crux of the situation, Mr. Senator——

The CHAIRMAN. You say you produce Bayer aspirin.

Dr. KLUMPP. That is right.

The CHAIRMAN. Does somebody else sell that same aspirin?

Dr. KLUMPP. No, sir; absolutely not.

The CHAIRMAN. You only sell it by the trade name "Bayer."

Dr. KLUMP. Yes; and we do not sell that aspirin to anybody else to market it under any other labels.

The CHAIRMAN. How about your——

Dr. KLUMPP. This is the only formulation of aspirin that we make and sell and we sell all of it.

The CHAIRMAN. Is your competitor going to agree with you that Bayer aspirin is the best? I heard him advertise there is none better either. None better. It is all the same thing, just like sugar. It is all the same thing whether you buy Louisiana cane or Florida cane or make it out of beets.

Dr. KLUMPP. Mr. Chairman, on Bayer aspirin we conduct 150 control tests to be sure that the product meets in every tablet the high standards that we have set for it, and I seriously question whether our competitors go to the same pain, the same trouble and expense to produce an equally good aspirin.

The CHAIRMAN. Well, when I get aspirin, I do not know who makes it. I do not know whether you made it or somebody else made it. I just go to the doctor and say, "Doctor, I have a headache," and he hands me some aspirin tablets and he does not tell me who manufactures it. That is how the President gets his aspirin tablets.

Dr. KLUMPP. For your information——

The CHAIRMAN. So far as I know the drugs that are supplied by the Department of Defense have been tested to a greater degree than those that you just sell over the counter.

Dr. KLUMPP. Mr. Long, until last year we supplied the aspirin that was used in the two governmental hospitals at Bethesda and Walter Reed.

The CHAIRMAN. Did you bid for it?

Dr. KLUMPP. Yes, sir.

The CHAIRMAN. How much did you sell them for when you were bidding for that business?

Dr. KLUMPP. I do not know. That is not my part of the business.

The CHAIRMAN. Would you mind finding out and providing it for the record?

Dr. KLUMPP. Yes, sir; I can.

The CHAIRMAN. My impression is that you were selling it to the Government at about 10 tablets for a cent. If I buy them across the counter and buy them by the name "Bayer" I am going to pay almost a penny apiece for them. Why should I pay 10 times as much as when we buy in quantity for the Government? You do not even advocate that, do you? You are bidding right now to sell to the Government, are you not?

Dr. KLUMPP. I do not know whether we are bidding for the aspirin business now.

The CHAIRMAN. You do not know. Why do you want to come to testify before a Senate committee if you do not know how you do business?

Dr. KLUMPP. As I mentioned, this is a proprietary over-the-counter product, and you have gotten into a part of the business that does not concern me. I am testifying about prescription products.

The CHAIRMAN. I want to know why we ought to pay 10 times as much for aspirin tablets as you can sell them for if you have to bid for the business. When you say you do not know what you are selling them for, my reaction is, why not provide it to us? I just urge you to provide for the record what your people sell those aspirin tablets for when you have to bid for the business.

Dr. KLUMPP. I would be glad to do that.

The CHAIRMAN. Thank you.

(The material referred to follows:)

Following my appearance before this Committee on September 21 I consulted with those who have direct and immediate responsibility for the manufacture and sale of Bayer Aspirin. As I told the Committee, I, personally, am directly responsible for the operations of Winthrop Laboratories, which deals solely in ethical pharmaceuticals, and not with Bayer Aspirin, which is a proprietary medicine. I have been advised that my understanding of Bayer Aspirin sales to the Government which I communicated to the Committee was not correct. In fact, a review of our records shows that Bayer Aspirin has never been sold to the Government on the basis of a bid. I have been further advised, however, that in September, 1966, the Department of Defense told us that it needed immense quantities of aspirin tablets in a very short period of time and requested us, the largest manufacturer of aspirin in the United States, if we could, to supply 100,008,000 tablets of 5 grain aspirin within two months. We were further advised that no bidding would be involved because the Defense Department was of the opinion that its then critical need for aspirin brought it within the statutory provision allowing the negotiation of a purchase contract without bidding or formal advertising when "the public exigency will not permit the delay incident to advertising." (10 U.S.C. 2304(a)(2)). In view of the expressed national need in this situation, we agreed to help the Defense Department solve its problem and were awarded a contract for eight truckloads of aspirin tablets (100,008,000 tablets) at a total price of $140,011.20. We are pleased to state that we were able to satisfy the Defense Department's needs and made timely delivery.

The CHAIRMAN. Now, among these products here, Achromycin, Panmycin, Polycycline, and Tetracyn, can you tell me which one is better than the other?

Dr. KLUMPP. I could if I were using those products in the treatment of patients; yes, sir.

The CHAIRMAN. You think you could.

Dr. KLUMPP. Yes, sir.

The CHAIRMAN. But can you tell me someone who can say for certain one is better than the other?

Dr. KLUMPP. I think you would have to go to practicing physicians who have had experience in using those products in the actual treatment of patients.

The CHAIRMAN. What does it cost to produce them?

Dr. KLUMPP. We do not make those products. I do not know.

The CHAIRMAN. Who knows that, speaking for the Pharmaceutical Manufacturers Association. Who knows what it costs to produce a capsule of that? Can you tell me, sir?

Mr. STETLER. Can I go back just a moment to your basic point and that is: Is one any better than the other? We do not state that only brand name products are good products, and that products that are marketed generically are bad products. All we say is that whether it is the Government that is purchaser or a physician, or an individual, that they should know something about the source of the product. Now, many of those products that you mentioned are manufactured by very fine firms, and I am sure that there are many of them that are very fine products, but we are trying to make one point—that in the application of some of these very fine products in a particular patient for a particular disease there are differences in effect, and no one really but the physician who has the patient and knows about him and has had the experience with various drugs should make the decision—not me, and I think not a Member of Congress—as to which should be available to him. That is really the point we are trying to make.

As to what they cost to make, I am sure it varies a great deal, and as to the cost of the entire manufacturing process for these various firms, as I have tried to state, that varies a great deal, too.

The CHAIRMAN. Let me ask you this: Are you familiar with the speech I made about the fact that Upjohn, Lederle, Bristol, Pfizer, and Squibb were for some time in an international conspiracy to price Tetracycline at 50 cents a capsule although it only cost about a cent and a half a capsule to manufacture?

Mr. STETLER. I am familiar with your speech. I am familiar with the charge. As a matter of fact, that case has not been decided. It is in the courts right now; the charge is there, but the decision has not been made.

The CHAIRMAN. I have talked to a man who would like to compete with those fellows. He is manufacturing Tetracycline, and he says it is ridiculous to charge 50 cents a capsule for that product. Would you think the product is any better if you pay 50 cents rather than a nickel?

Mr. STETLER. I would have to know who the manufacturer is. The manufacture of Tetracycline is not something everybody should be doing. If he knows how and he is doing it properly and he can do all this is a fine way and sell it for 5 cents, that is quite a phenomenal performance.

The CHAIRMAN. Do you know what happened to Tetracycline prices after I made that speech?

Mr. STETLER. No, sir.

The CHAIRMAN. Well, it is your business, or you represent them. The price came down, at least it came down some.

Mr. STETLER. I do not know that it was the result of your speech.

The CHAIRMAN. Why should we pay 50 cents for something that only costs a cent and a half to manufacture?

Mr. STETLER. When a manufacturer sets a price, whether he is a drug manufacturer or in any other business, there are a lot of elements involved and I mentioned a few, not just what the basic ingredient for that particular product might cost, but what it has taken to develop it, to research it, to get it through the Food and Drug Administration, to promote it, to distribute it nationally to make that product known, all of those are proper elements. Also a manufacturer like Dr. Klumpp's firm that manufactures 97 products does not survive or exist on its price for one product. I think they manufacture a great number of biologicals and if you were to look at the price structure on those products you might wonder how they could sell them as cheaply as they do. They do not do business on the basis of one price for one product based on the basic ingredients of that product or they would not be in business very long.

The CHAIRMAN. You are familiar with George Squibb's statement the other day that appeared in the press. I know it caused your industry some consternation. He said there is no other industry on earth that attempts to do business the way you people do. I take it he has partly in mind that you manufacture the same product on the same production line and sell one for 10 times the price you sell the other for. Why should somebody pay 10 times as much if he knows what he is buying?

Mr. STETLER. Can I comment on that Squibb statement?

The CHAIRMAN. Sure.

Mr. STETLER. The statement by George Squibb was just made available to me yesterday for the first time, and I had not seen it before that, but I have read it.

Senator CURTIS. May I ask, is that the telegram sent to various members of the committee?

Mr. STETLER. This is a 30-page statement, but I believe you did get a telegram in relationship to this particular statement and the way it has been discussed in a story in the Washington Post and with respect to its relationship to the legislation before this committee.

Senator CURTIS. May we have the telegram put in the record?

The CHAIRMAN. At the conclusion of his statement I will put it in the record.

(Mr. Squibb's statement and a telegram received from him appear at pp. 1424 and 1425.)

Mr. STETLER. This statement I understand was put in in its entirety by Senator Nelson yesterday in the Congressional Record. But as I read this statement, and it is a long one, and I have not studied it——

The CHAIRMAN. I do not care for you to read the whole thing. Why not summarize it?

Mr. STETLER. I would say it is a summary of a great number of problems that have been discussed vitally affecting the drug industry. I think it has not been accurately described in the story in last week's Washington Post that was inserted in the record on Tuesday of this week and I think really as long as the matter has been brought up it would be well to put the complete statement into the record because Mr. Squibb says a lot of things. I do not think it could be categorized as a denunciation of the drug industry. He makes a lot of statements, some favorable, some unfavorable. But the main point is——

The CHAIRMAN. He is in the drug business, as you know. His company manufactures these porducts. They sell them both by generic name and also sell by trade names.

Mr. STETLER. George Squibb is a former employee of Squibb & Co.

The CHAIRMAN. When did he cease to be an employee? When he expressed his honest opinion about the matter or prior to that?

Mr. STETLER. He terminated his relationship with Squibb last March, many months ago, without any relationship to this document. Now what I want to say is that he has spoken as an individual, as he has every right to do, and I am not trying to discredit him or dispute his right to have his ideas. He did not speak for the drug industry, he did not speak for the PMA, he did not even speak for one company, but that is all right. He has a perfect right to express himself.

The CHAIRMAN. He ought to know something about it. He has been in the drug business all his life and his father before him.

Mr. STETLER. He knows something about it, and he has formed certain conclusions, some of which I would agree with heartily, some I might disagree with, but he is an individual. But I think in fairness since the document has come up it should be placed in the record in toto.

The CHAIRMAN. We will put it in the record.

Mr. STETLER. Because to give the matter balance you have to look at the whole thing.

The CHAIRMAN. The whole thing appears in the Congressional Record at page 13315.

Mr. STETLER. I said it appeared yesterday.

The CHAIRMAN. If you want to put it in the record, we will put it in. Go ahead.

(The material referred to appears at p. 1425.)

Mr. STETLER. That is all I have on his statement.

The CHAIRMAN. Here are the names of some products. Let us see. What is Serpivite? What is that?

Mr. STETLER. Serpasil?

The CHAIRMAN. No; Serpivite?

Mr. STETLER. I will let the doctor speak on that.

Dr. KLUMPP. I am not specifically familiar with that. There are over 7,000 different drug products on the market, but I assume it is a combination of Serpasil and a vitamin, just judging by the name.

The CHAIRMAN. Let me see, this product here, Kitine, K-i-t-i-n-e, what is that?

Dr. KLUMPP. I am sorry, I have never heard of it.

The CHAIRMAN. You would not know whether it would be good for me or bad for me if I took it right now.

Dr. KLUMPP. No, sir. [Laughter.]

The CHAIRMAN. How about this stuff over here, R-a-u-w-o-l-e-a-f?

Dr. KLUMPP. That is a preparation of Rauwolfia, which is the plant from which Serpasil is extracted.

The CHAIRMAN. All right.

Now, here is Serpasil, Serpasil. What is that?

Dr. KLUMPP. That is an extract of Rauwolfia.

The CHAIRMAN. All right.

Now Banasil, what is that?

Dr. KLUMPP. Banasil?

The CHAIRMAN. Banasil.

Dr. KLUMPP. I am sorry, I do not know it.

The CHAIRMAN. You would not know whether it was good for me or bad. I might be taking my life in my hands to try it.

Dr. KLUMPP. I would want to know a great deal more before I said it was good for you or bad for you.

The CHAIRMAN. All right, sir. Here is this thing over here, S-e-r-f-i-n. What is that?

Dr. KLUMPP. I am sorry, sir, I do not know where you got that list.

The CHAIRMAN. I am just reading this from a document by the American Pharmaceutical Association for whom you are testifying.

Dr. KLUMPP. No, sir.

The CHAIRMAN. I am sorry, these are the folks that sell the drugs, the American Pharmaceutical Association. This is your official publication?

Dr. KLUMPP. No, sir.

The CHAIRMAN. It says American Pharmaceutical Association. These are folks that sell your products, these are people you sell it to. They list here Anquil, Banasil, Elserpine, Eskaserp, Key-Serpine, Kitine, Lemiserp, Raurine, Rausingle, Rauwoleaf, Resercen, Reserpoid, Resine, Sandril, Serfin, Serpanray, Serpasil, Serpate, Serpen, Serpicon, Serpivite, Serpoid, Sertina.

All that is Reserpine, it is all that it is. This is Reserpine as far as a fellow who is selling this stuff is concerned.

Senator ANDERSON. Does he admit that?

The CHAIRMAN. I was asking about that. Can you tell me the difference between these products?

Dr. KLUMPP. Mr. Chairman, my understanding is that the list of names that you read refers to brands of Reserpine, and that there was testimony before Senator Nelson's committee that 22 percent of those that you referred to did not meet USP standards.

The CHAIRMAN. What percent?

Dr. KLUMPP. Twenty-two.

The CHAIRMAN. Do you not think we ought to test to see whether it does or does not meet standards, no matter who manufactures it?

Dr. KLUMPP. I think that each manufacturer, if he is a reputable manufacturer, should be doing enough tests and all the tests that are necessary to demonstrate that it not only meets the standards but that it meets the highest standards that we can achieve in this business. That is our objective.

The CHAIRMAN. All right. Here is Serpasil, manufactured by CIBA. Is that better or worse than the other products?

Dr. KLUMPP. I have not made such tests, Mr. Chairman.

The CHAIRMAN. What do I pay if I buy Serpasil?

Dr. KLUMPP. I think you have that information in testimony. I do not know.

The CHAIRMAN. No, we do not have that. I want to know if I buy some Serpasil what it would cost.

Dr. KLUMPP. I beg your pardon, the testimony was given before another committee investigating the same matter, the Nelson committee, but it is available in the record.

The CHAIRMAN. You are here to testify on this matter, but you do not know what I would pay.

Well, I made a speech about that matter some time back, and I think what I said was something to this effect, that—let me ask you, does Mr. Stetler know what do I pay if I buy Serpasil? I made speeches about it myself.

Mr. STETLER. I am not sure what you would pay at a retail drugstore where you would buy Serpasil, but it is true the manufacturer's price for Serpasil is higher than most other brands or generic products of reserpine. This was a matter that was discussed, as you know, in some detail before Senator Nelson's committee.

The CHAIRMAN. How much higher?

Mr. STETLER. At retail probably relatively little. I can tell you generally what the differences in prices are at retail.

The CHAIRMAN. Tell me the wholesale price. What is the difference at wholesale between that and other products?

Mr. STETLER. I think they run the whole gamut because there are about I think what, 50, 60 manufacturers of these products and I just cannot relate to you all the different prices at wholesale of all of these manufacturers.

The CHAIRMAN. Can you tell me whether Serpasil is superior to these other products?

Mr. STETLER. Serpasil is a fine brand and a good one and it is better than many of those from other manufacturers, there is no question about that.

The CHAIRMAN. Can you produce scientific proof that it is better than the others?

Mr. STETLER. Some of the others, yes.

The CHAIRMAN. Than most of them?

Mr. STETLER. Yes, sir.

The CHAIRMAN. Would you please provide that for the record with the proof?

Mr. STETLER. I will put it this way, and I think I can: In the testimony before the Nelson committee about 2 weeks ago, Mr. Silloway, who is the head of Ciba, did testify, and he referred to some testing by independent laboratories that was done on his product, which is Serpasil, and other brands of reserpine. I think I can get that information for you, and based on that one contingency, that he will make it available to me, I will be glad to put it into the record.

(The information referred to was received by the committee and made a part of the official files.)

The CHAIRMAN. As you know, Senator Nelson said that was a phony and fraudulent study.

Mr. STETLER. I know Senator Nelson said that, but I do not happen to agree. I know something about the study, and I think it was a valid study.

The CHAIRMAN. Assuming that same company sells that same product from the same production line and has to bid for the business, do they sell it for the same price?

Mr. STETLER. Do they sell what at the same price?

The CHAIRMAN. If they have to bid for the business. Suppose they want to sell to the U.S. Government and have to bid for it, do they sell at the same price?

Mr. STETLER. No, they do not.

The CHAIRMAN. What is the difference in price if they have to bid for the business?

Mr. STETLER. Well, it varies, of course, a lot, but I would agree that they sell it cheaper to the Government.

The CHAIRMAN. My impression is if they have to bid for the business they might sell it for 20 percent of what they would charge if they sold without bids.

Mr. STETLER. There is no question traditionally when you are talking about drugs, or automobiles, or most anything else, they sell more cheaply to the Government. Whether it is a wise or wrong decision, I do not know, but it is done.

The CHAIRMAN. Let me ask you this: Do they lose money when they sell to the Government?

Mr. STETLER. Some have and some do not.

The CHAIRMAN. Why do they sell it?

Mr. STETLER. Traditionally——

The CHAIRMAN. Why do they sell it if they are going to lose money?

Mr. STETLER. I am not saying they will lose money.

The CHAIRMAN. You are not saying they lose money?

Mr. STETLER. Not always, but once in a while.

The CHAIRMAN. Do you know any of your people who just deliberately bid for business to lose money?

Mr. STETLER. No. Some have bid for the Government and have lost money. Dr. Klumpp's firm is one.

The CHAIRMAN. Intentionally? Can even Dr. Klumpp say you have actually bid for Government business when you knew you were going to lose money?

Dr. KLUMPP. Yes, sir.

The CHAIRMAN. Intentionally?

Dr. KLUMPP. Yes, sir.

The CHAIRMAN. Why?

Dr. KLUMP. Why?

The CHAIRMAN. Why?

Dr. KLUMPP. Mr. Chairman——

The CHAIRMAN. Why did you bid for business knowing you are going to lose money if your bid was accepted?

Dr. KLUMPP. Because we are eager to have our brand name known to the physicians in the Government, in the Armed Forces, and for that reason we are willing at times, and sometimes more frequently than not, to bid actually and lose money. Now let me just illustrate.

The CHAIRMAN. Let me just make this clear. I do not want you people to lose money on anything you sell. So far as this Senator is concerned, I want you to make money every time you make an article, but this thing of making the public pay 20 or 50 times what the thing is worth does not make any sense, and I do not see how you can justify that.

Dr. KLUMPP. Mr. Chairman, the figures show that on the average the products that you are referring to, the trademarked products, costs not twice or three times, but 23 percent more than the generic price.

The CHAIRMAN. I will bet you that the Bayer aspirin out of that dispensary over here which we get for about 10 for a penny will not be sold across the counter to me for that price.

Dr. KLUMPP. No, sir.

The CHAIRMAN. But you would sell it to the Government.

Dr. KLUMPP. But we want you to use Bayer aspirin and we are willing to lose money so that Senator Long will use Bayer aspirin and not a competitive brand.

The CHAIRMAN. Let me tell you, when I go to a drugstore I do not buy Bayer because it is too expensive. I buy stuff that is just as good that sells for 10 percent of the price Bayer sells aspirin for. I am willing to use yours if you sell it at the same price as the other.

Dr. KLUMPP. You look in very good health to me.

Senator ANDERSON. I thought this witness testified a while ago he did not have any idea of costs. Did you not answer some questions a while ago that you did not have knowledge of costs and passed on that basis? Yet now you have a knowledge of cost. You do not know that you bid and lost money?

Dr. KLUMPP. I am assuming, Mr. Anderson, that Mr. Long's statement that it was being sold at a tenth of a cent a tablet, I am assuming that at that figure we are not making any money. But let us keep one thing in context here. I am head of a division of our company, and that is the pharmaceutical division. The Bayer aspirin is sold by an entirely different division, and I am not in detail familiar with their bids, their prices, or anything of that kind.

Senator ANDERSON. I was just curious, because I have been taking insulin for 30 some years at the same price, $1.50 at one drugstore and $0.99 at another, but we get the same price all the way through.

The CHAIRMAN. Let me ask you how many of your manufacturers produce generic products?

Mr. STETLER. A lot of them. I cannot tell you the exact number. We have 140 companies in our association and many of them manufacture and you know all drugs have a generic name, but they market them under a generic name, a lot of them.

The CHAIRMAN. Can you tell me what companies are the principal manufacturers of drugs sold by generic name?

Mr. STETLER. One I know has been referred to and by yourself and one of the better ones is Eli Lilly Co. It is one of our bigger members and they manufacture and market under a generic name, and they are good products.

The CHAIRMAN. I am told Lilly and Squibb are probably the two largest.

Mr. STETLER. They are. Squibb is another. They sell generic products.

The CHAIRMAN. Provide for the record if you will, what percentage of your firms sell by generic name?

Mr. STETLER. I will get that figure and provide it for you. I am not sure what the figure is.

(The information referred to follows:)

Approximately 90 percent of Pharmaceutical Manufacturers Association members manufacture and sell drugs by generic names.

The CHAIRMAN. What total generic drug production comes from members of your association?

Mr. STETLER. Well, since we produce 95 percent of all prescription drugs, I am sure we produce something comparable to that in terms of brands and generic.

The CHAIRMAN. Now, I have been told that when a drug is seized or called in by FDA, the hearing comes after the FDA acts. Is that substantially true? In other words, when the FDA seizes a drug or recalls it, the hearing happens after the FDA has acted.

Mr. STETLER. If it is a limited seizure, if they seize like one package of one product that would be true, yes.

The CHAIRMAN. Now, summary seizure is provided for in the drug abuse law. Was that supported by your association?

Mr. STETLER. Yes, it was.

The CHAIRMAN. The Canadian Government in its recent report on drugs said quality control was important but it constituted only a small part of drug cost. I understand the research cost of prescription drugs would probably not exceed 7 percent. Why then the tremendous difference in prices for products?

Mr. STETLER. The research expense of our industry in the United States is in excess of 10 percent, but it is true that quality control is one element. I would not say it is an unimportant or a small element, but it is one element. The elements, as I mentioned in my statement, that go into the pricing structure, are research, development, quality control, all of the things I mentioned, that is just one, as is research.

The CHAIRMAN. Can you tell me the total research expenditures of the industry?

Mr. STETLER. In 1966 it was in excess of $400 million. That is an increase of a great percentage. I think in 1959 it was something like $50 million.

The CHAIRMAN. How much of that is applied research as compared to basic research?

Mr. STETLER. There are some of both in that. I would have to give you a breakdown, but the total figure is $400 million, but a good part of it is applied.

The CHAIRMAN. Provide it for the record. How much of it is for over-the-counter as compared to prescription drugs?

Mr. STETLER. That is not included in that because we do represent only the prescription. I say ethical and I should say that is prescription products and drugs that are promoted only to doctors.

The CHAIRMAN. If you can get it, I would appreciate your providing that information.

(The information referred to follows:)

In 1967 the research expenditures of PMA members will exceed $476 million. On the basis of our information, wes estimate that 17.3 per cent of drug research and development financed by the pharmaceutical manufacturers in the United States is basic research, defined as "original investigations for the advancement of scientific knowledge . . . which do not have specific commercial objectives, although they may be in fields of present or potential interests to the reporting company." The National Science Foundation studies using this definition show the "drug industry" to be the leader among industries engaging in basic research with its own funds.

We do not have data on research expenditures for nonprescription drugs as such. Our estimate is that less than 5 per cent of total drug research expenditures is for nonprescription products.

Mr. STETLER. $400 million is for the prescription product.

The CHAIRMAN. I would appreciate your giving me the breakdown as to how much is for over-the-counter drugs. Now what proportion is research costs to worldwide drug sales of American companies?

Mr. STETLER. Well, we represent 140 firms. I would say about 50 of our firms have worldwide sales. Our association's membership sales in 1966 were $3 billion domestically. They were $4.7 billion worldwide. That $400 million applies. I guess, to your question, as I understand it, to the $4.7 billion figure.

The CHAIRMAN. You have been critical of the formulary committee which will choose drugs for which the Government will pay. Does not the medicare program choose the drugs we will presently pay for?

Mr. STETLER. The medicare program talks about drugs that are included in the USP, the NF, the Homeopathic Pharmacopeia, New Drugs, and Accepted Dental Remedies, and it makes provision for other drugs that are included in other formularies. It is not a strict prohibition or a limitation of drugs that are cited in those compendia. As a matter of fact, if you look at the experience under the title XVIII-A program you will find that they reimburse for drugs across the board. There are no limitations that apply really to just those drugs in those compendia.

The CHAIRMAN. Do not a number of States and cities also use formularies?

Mr. STETLER. Yes, they do. There may be another point on that if I might: Many State programs, title 19 programs, and some city programs, have the problem that we all have, and that is limited budgets, and although they have included drugs under their programs, they have had to limit in various ways what they can cover.

Now, to live within their budget, they have set up formularies which restrict in various ways the payments for drugs. Some places it is so restrictive that it is a distortion to really say they have a drug program. In other words, they have *x* number of dollars and they very arbitrarily say only such and such drugs will be accounted for.

The CHAIRMAN. Do not the majority of accredited hospitals use formularies?

Mr. STETLER. Many of them do. I am not sure of the number but there is a distinction between a hospital formulary and a State formulary and a Federal formulary.

At the State level the formulary is an open-end proposition where the doctors that serve on the hospital staff have a very definite voice in what is in the formulary and if they want to prescribe outside of the formulary they can. It is a method of controlling inventory within a hospital, but it is a much different formulary than would be involved in a State, in a Federal bill.

Dr. KLUMPP. May I add to that, Mr. Chairman, that the use of drugs by the Department of Defense, 30 percent of the drugs they use are also purchased outside of the formulary—I mean outside of the table of supply of the Department of Defense.

The CHAIRMAN. As I understand it, your association has been opposing the use of formularies by the States under title 19. But is it not true that the States have been adopting State formularies anyway notwithstanding your opposition?

Mr. STETLER. That is not so. We have not opposed State formularies under title 19 programs.

The CHAIRMAN. The States have been adopting them, have they not?

Mr. STETLER. I think 10 have, but we now have some ideas about how they should be set up.

The CHAIRMAN. As you know, sir, I have discussed this matter with you in my office on occasion and from time to time we find some area of agreement, even though we find maybe we disagree on some issues involved. But I want to make it clear that I never intended that this drug amendment should interfere with good medical practice or with the discretion of doctors. I have complete respect for doctors and the fine job they do and also for the doctor-patient relationship. I am satisfied that the doctors should have the right to prescribe whatever drug he thinks is particularly desirable for his patient.

Now, I would be willing to go an extra mile with regard to this matter and modify the amendment that I have introduced in bill form at the time that I offer it. The change would authorize Federal matching toward the full acquisition cost of any drug product, regardless of whether it was included in the formulary, when it is prescribed under its generic name plus the name of the manufacturer.

In other words, if the doctor wants Reserpine manufactured by Parke, Davis, all right, he just writes down Parke, Davis, or if he wants it manufactured by someone else do so by some other name. This procedure is recommended by medical educators, pharmacologists, and other physicians. It is also endorsed, I understand, in your prepared statement. This means that if a doctor wants a drug produced by a specific manufacturer, he can get what he wants providing he is willing to indicate on his prescription the official name of the product and its producer.

The provisions of this bill now provide for a July 1, 1969, effective date. Commissioner Goddard says he needs more time to get ready so I am willing to modify the amendment to provide 3 years and make the effective date July 1, 1970, to give them all the time they need to tool up, and do all the testing they want to do before they put it into effect.

My purpose in this matter is to simply see that when we pay for the drugs that we, insofar as possible and practical without unduly interfering with medical practice, get them at the best price that we can. That would meet some of your objections, but I knew it would not meet all of them.

Mr. STETLER. Senator, as you say, we have had discussions regarding some of this in the past. I am not quite sure of the effect of this change since I have just now heard of it. I do not know how it would affect the various provisions of your bill so far as the cost range is concerned. If the change were made, I am not sure what would be left in the bill in terms of the cost range, the reimbursable amount, or the criterion that was set for establishing the formulary which we find most objectionable.

But as we said in the statement and we mean it sincerely, we would like to work with HEW because we think there is a very proper concern by this committee about how to control Federal expenditures. We think we have a responsibility as manufacturers to be a part of that study and that decision, and we are trying to work with them.

We just think that there are other ways in which it could be approached which would not have the bad effects that we see in the bill.

The CHAIRMAN. Well, you see I am not being so cruel as to suggest that you bid for the business. I am still willing to allow you higher price than you would get if you had to bid for it. All I want to do is be sure that when we buy this stuff we get it within a reasonable price range.

Mr. STETLER. As you know, under various of these social security titles and certainly under 18(b) as they extend to drugs we are going to deal with a great number of retail outlets, 50,000 drugstores and 7,000 hospitals. We are not in a situation where we are going to have a central procurement and you should not. But when you look at the differences in retail price last year, you find it is not anything like what you referred to as 10 times. The actual percentage difference between prescriptions that are written by brand and written generically is 23 percent; that is not 10 times. And that is the actual percentage for 1966 on all prescriptions written, brands and generic. There is a 23-percent difference which we think is fully justified by the different factors that I have mentioned that go into the production of a quality drug product.

The **CHAIRMAN.** Senator Curtis.

Senator **CURTIS.** The U.S. News & World Report, I believe for September 18, 1967, had a paragraph on medical costs. I do not have it before me, but as I recall it, it stated that hospital costs in 10 years had gone up 68 percent and that prescription drugs during that same 10 years had gone down between 1 and 2 percent. Would that be about right as far as the drugs are concerned?

Mr. **STETLER.** That is right. All drugs, over the counter and prescriptions, have just about held the line, but prescription drugs have gone down. Other elements in medical costs have gone up a great deal, and the chart that was in Medical World News and Time about 2 months ago showed that very specifically.

Senator **CURTIS.** Well, hospitals led the parade, 60 percent.

Mr. **STETLER.** They have gone up a great deal, that is correct.

Senator **CURTIS.** And I think physicians' costs some 10 years ago went up between 20 and 25 percent.

Mr. **STETLER.** At least that amount.

Senator **CURTIS.** Is there any other line of products other than drugs and prescriptions where you have a similar problem of classification by name or is this something that is peculiar to the drug business?

Mr. **STETLER.** Right off I cannot think of anything that is comparable. I think it is relatively peculiar to the drug business. Where you have an established or generic name and all drugs have it and some are marketed just by that name and then in addition others have superimposed on them brand names, and they are sold by those brand names. Now brand names, of course, are common, but the generic counterpart is what is not common in other products.

Senator **CURTIS.** But it becomes much more sensitive because of the potency of drugs and the dependence of health on drugs, and as well as what can happen with the misuse of drugs.

Mr. **STETLER.** No question, high quality, high standards, potency, purity are imperative in a drug product.

Senator **CURTIS.** Yes.

I imagine if the Government undertook to have a uniform price of a pound loaf of bread, the source of the bread might be of great concern to the consumers of the country.

Mr. **STETLER.** They would be concerned just as we are concerned.

Senator **CURTIS.** Yes. But on the other hand, it would not be as important because even poor bread would not hurt a person very much, but a poor drug might be very disastrous.

Mr. **STETLER.** When you talk about bread and you talk about variations in price, this is a place where there might be a great variation. It ranges all over the lot; you can buy bread at a dollar a loaf and 20 cents a loaf. You have five times difference in retail in this and other food products. You do not find that in drugs at retail.

As I said, last year the difference is 23 percent between brand and generic. You find these variations, there is no question, in all types of products.

Senator **CURTIS.** Tell me this, does the generic name include every ingredient in a drug?

Mr. **STETLER.** The generic name is the name applied to the basic ingredient. Combination products that have a variety of products do not have a generic name to describe the inactive ingredients.

Senator CURTIS. The generic name does not describe everything in the drug.

Mr. STETLER. No, sir.

Senator CURTIS. In other words, there are perhaps filler—not necessarily filler—but something that holds the capsule together.

Mr. STETLER. Inert ingredients.

Senator CURTIS. Other ingredients.

That is all.

The CHAIRMAN. May I say that certain members of your association certainly have some influence in this Government. Here is Abbott Laboratories sending a letter to Members of Congress. In this they enclose copies of a memorandum about this bill, S. 1303, introduced by me, that my committee has been trying to get for a long time as critical to finding and correcting objections to the bill. Strangely enough here is something dated May 3, 1967, that I have not been able to get to this date but I have it now through Abbott Laboratories. They got it out of the Government. I cannot. I am chairman of the Finance Committee, and I am privileged to know the top defense secrets of this Nation even though I am not on the Armed Services Committee. But I am not privileged to know what the responsible officials over at the Department of Health, Education, and Welfare think about providing drugs and buying them at a competitive price.

I must congratulate Mr. George Cain, chairman of the board of Abbott Laboratories, for his fantastic influence in this Government. It is exceeded only by certain members of your association who succeeded in stealing research secrets out of Government laboratories and applying for private patents on them. So I can understand why maybe you would like to work with those people at HEW. They have been very cooperative with you, but not with the Senate, not with those of us trying to pass laws.

Mr. STETLER. Senator, I do not know the source of that document, and I do not know that it contains anything that was not in their statement that was submitted on September 1 to this committee from HEW.

So far as the comment on the research and the patents, I think that is another subject. I question the word "steal," however.

The CHAIRMAN. Well, any time—any time people go over there and apply for a private patent desiring to make it their own private possession and hope to charge the public far more than they can sell it for on a competitive basis on drugs developed with Government money and in Government laboratories by Government employees, it would seem to me that that is about the kind of word that you can think of to use for it.

Mr. STETLER. Senator, as you know, we have talked before about Government patent policy. This happens to be one area where I think our industry and your views are not too diverse. I do not think you have ever had the opportunity to sit down and discuss with us the statements that we made to the McClellan committee. We do not happen to think that a research effort, whether it is in the drug industry or any other industry that is heavily subsidized by Government, that the patent rights should come to this industry. We think there are certain equities that should be explored.

I think this is one of the areas where we do have some common ground, and I would like to discuss it with you.

The CHAIRMAN. I do not think that you contend for a moment that when the Government discovers some drug with Government money in a Government laboratory by Government employees, anybody is entitled to a private patent on that. That is something that the public has paid for already. They should not be charged twice for it, and you do not contend that.

Mr. STETLER. No, I am not familiar with those specific instances. But the illustration as you give it, of course, is a pretty extreme case and I am not familiar with that.

The CHAIRMAN. Well, that is worse—when that type of thing happens. It is worse than a case of improper influence. That is just downright thievery as I see it when someone steals something out of a Government laboratory and turns it over to somebody to apply for a private patent on it. That sort of thing has happened on occasion, and I have denounced it when it did.

But I am not accusing your association of that. Your association did not do it. Maybe it was a member which did that, but your association did not do it. Nor did your association, so far as I know, succeed in getting this information that Abbott Laboratories got. That was strictly their own idea. I would think that that is subject to severe criticism when a Government employee declines to make available to a Senate committee that has the responsibility for this legislation, and for their department, information which they make available to private firms.

Mr. STETLER. Obviously I do not know the history about the relationships of your request to HEW so I cannot comment on it.

The CHAIRMAN. Well, thanks very much.

I have some additional questions that I am going to submit to you. You can provide the answers in good time after you think about it. I am not going to ask all of those at this time. I think we have kept you on the stand long enough. Thank you very much.

Mr. STETLER. Thank you, Senator.

(Responses to questions submitted to the Pharmaceutical Manufacturers Association regarding S. 2299, by the Chairman of the Senate Finance Committee follow:)

Question #1:

You say my bill would "impair competition" among drug manufacturers. In fact, however, wouldn't it increase competition by providing a market for the small fellow who produces a quality generic and who doesn't have all the money that the big companies spend in propagandizing doctors? His products would be paid for if the drugs involved were included in the Formulary.

Haven't the small manufacturers of quality drug products successfully bid for Defense Department business and that of many leading hospitals where the biding was on a generic and not a brand name basis?

Response:

We do not believe S. 2299 would "increase competition by providing a market for the small fellow;" rather we think the effect of the restrictive formulary envisioned by this bill would unquestionably result in fewer competitive products being on the market, probably more to the detriment of the smaller manufacturer than the larger. The real possibility of elimination of competition from the market—rather than an increase in competition was recognized in the report of Secretary Gardner, dated September 1, to the Senate Committee on Finance. S. 2299 *requires* the proposed formulary committee to exclude from the formulary any drug or biological which is found to be "unnecessary or therapeutically duplicative". The above question assumes that the small company is more likely than the large company to have its products included in a formulary. The reverse is more likely because it will be the larger research-oriented companies which will more likely have "sole source" drugs; it will be the smaller firms which do not engage in research and development of new drug products but are largely in the business of manufacturing "me too" drugs and marketing them under generic names which, logically, would have their products characterized as "unnecessary or therapeutically duplicative." Leaving aside essential medical and pharmacological factors and considering solely the economic factors, we do not understand why it should be any less desirable to have several competing drug products than to have, for example, several competing brands of gasoline. Perhaps if this nation had only one brand of gasoline to use in our automobiles and only one manufacturer and one huge chain of service stations, matters would be "simpler" for the American motoring public. For example, we would have only one gasoline credit card to keep track of, assuming we could persuade the sole supplier to issue one. We wouldn't have to make bothersome judgments between one brand of gasoline or another or one company or another. Along with all of these advantages of a "simpler life" it is self-evident that with one or a few brands of gasoline available to the American public, competetition would certainly be drastically reduced or eliminated.

How can it be any different with any other product, including prescription drug products?

It is perfectly true that some "small manufacturers" have successfully bid for Defense Department business. First, the Defense Department does not restrict bidding on drug products to those which have only a generic name. Every brand name drug product also has a generic name. According to our information the majority of drug products purchased by the Department of Defense in recent years have been purchased from research-oriented firms. A detailed analysis of Defense Department records on purchase of drug products will show that the companies which market only by generic name and which do not engage in new drug research and development are certainly not the principal suppliers to the Department of Defense.

Question # 2:

You say my bill would adversely affect "the quality of health care". What adverse effect would result if we used Upjohn's prednisone which is available at one-eighth of the price of Schering's?

What adversity would occur if we used Squibb's reserpine instead of Ciba's high-priced product?

Response:

We would not assume that for each and every patient there would be any adverse effect with one company's less expensive prednisone rather than another company's more expensive product. Neither, would we claim, and we don't think the medical profession would claim, that for every patient one company's prednisone would be just as good as another company's prednisone. The same observation equally applies to one company's reserpine as compared with another company's reserpine.

We do not suggest at all that the most expensive drug product is the one that every doctor should always prescribe for his patient. Nor do we think that the cheapest drug product available is one which the prescribing physician should never use. Rather, we feel strongly that the professional judgment as between one drug product and another, should be made by the attending physician in the light of his knowledge and experience with the specific patient involved. The precise decision for prescribing a drug for an individual should not be based on the mythical "average patient" assumption anymore than the appendectomy on an individual should be handled on the assumption he must be an "average patient". The attending physician should not be restricted in exercising his best professional judgment and he should be held responsible for his professional medical judgment. Further, we emphasize that the practicing physicians in America, through their own prpofessional association—the American Medical Association—have fully recognized the responsibility of physicians to take into account drug product prices as well as the quality of the product which they prescribe. We think this is as it should be. In stating in my testimony that S. 2299 would adversely affect the quality of drug care, I had in mind the overall long range effect which would seem to be almost certain, S. 2299 would restrict competition by having a restrictive formulary and restrictive cost guide, and thereby keeping drug products, otherwise determined to be safe and effective under present FDA statute, off the market.

With this type of government control and restriction in effect, there is bound to be a debilitating impact on the capacity of manufacturers to spend the money and take the risk in new product research. Thus, S. 2299 not only poses the threat of denying Social Security program beneficiaries the best available drugs—because of the restrictive formulary and the cost range restriction—but also poses the real threat of inhibiting future new drug product development and marketing.

Question # 3:

Do you agree that my bill does not involve price fixing? Doesn't it simply mean that the Government, based upon the prices prevailing in the wholesale drug market, will determine how high it is willing to go towards the costs of *any* properly made product of a given drug in the Formulary. We don't decide the price—the manufacturers and the wholesale market develop that. You are still perfectly free to go on overcharging anyone for drugs except for those prescriptions which are paid for by the Federal Government.

Response:

We very definitely believe the effect of S. 2299 would be to impose price fixing or price regulation. Under Section 2004 of the proposed new Title XX, the Secretary of HEW is required to publish a "guide" showing the cost range of qualified drugs and the cost range cannot exceed the price at which a drug is "generally primarily available for sale in a given strength of dosage form by its established name or, if lower, by trademark designation." This bill further provides that reimbursement for drug products under the Social Security programs shall not exceed the amounts listed in the Secretary's published guide.

First, assuming the Secretary of HEW publishes an initial "guide" based on actual market prices at that time, S. 2299 *requires* the Secretary not to exceed the amount at which the drug is generally primarily available for sale by its generic name only. This indicates the Secretary is required to base his guide on the middle range of prices at which a drug product is apt to be available. The impact of this procedure is quite obviously an immediate "price fixing" as to those drug products which may then be selling at prices higher than the published guide, inasmuch as these drug products would be denied full reimbursement under the Social Security programs. The fact that this would not be a direct law prohibiting sale of drug products above a stated price would be of small comfort if the net economic effect is the same. S. 2299 would in fact control the prices of drug products made available to beneficiaries under Social Security programs and it must be recognized that these programs are now of sufficient size and impact in the total economy—and will become even greater in the years ahead—as to control substantially the remaining "private market".

Another effective price fixing impact under S. 2299 would come into play after a period of time, affecting even the lower price products which formed the basis for the initial publication of the required cost guide. How would these prices be adjusted in future years to take care of increased costs of doing business? Once published, reimbursement would not be available beyond the published guide amounts, meaning there would likely be no principal or primary prices for those drug products above the published guide limits. How then, is an actual market price experience at higher levels to be established as a basis for later revision of the "guide"?

Question # 4:

Isn't it true that my bill would still permit drug companies to charge what the traffic will bear for patented drugs included in the Formulary? Aren't the majority of the most frequently prescribed drugs patented?

Response:

According to our information, a majority of the 200 most frequently prescribed drugs are patented. This does not mean that all of those drug products still under patent are still "single-source products." While we do not have the exact data, it is generally known that some drug products still under patent are licensed for production and sale by other manufacturers. Obviously, if a particular drug product is a single-source item it is not in the same competitive situation as would exist if there were competing products possessing the same pharmacologically active ingredients. It is incorrect to suggest, however, that a manufacturer can sell even a strictly single-source product at just any price he may choose. In the final analysis, cost and price to the ultimate purchaser must always be taken into account in determining the marketing of a product. Also, in talking about the 200 most frequently prescribed drugs, it should be kept in mind that there is significant fluctuation in this list of 200 from year to year. For example, of the 200 leading products in 1965, 80 increased in rank in 1966 and 100 dropped in rank, 4 remained unchanged, and 16 of the products on the list in 1965 were off the litst in 1966 and replaced by 16 other drugs. Also, it should be noted that the majority of the 16 products which fell out of the ranking 200 in 1966 are under patent, three-fourths of these having been introduced on the market in the last ten years. This is simply to illustrate and to emphasize that, contrary to what may be popular assumption on the part of some, drug companies cannot simply charge what the "traffic will bear", and the fact that a drug product is under patent is by no means a guarantee of its being a commercial success.

Question #5:

On page 14 you say: "Prices provide a measure of the relative value of different factors employed in the production process."

Parke-Davis testified that it produced prednisone for about 50¢ per 100. Does that justify charging the local pharmacy $17.88 per 100?

To prove your point, why don't you provide this Committee with the actual costs of production of the 25 most frequently prescribed non-combination drugs and the *wholesale* price range of the trade name products for each of these drugs.

Response:

Parke-Davis also testified that for all practical purposes it has sold little or no prednisone to local pharmacies in recent years and that really the item should not have been continued in their catalogue. Further, Parke-Davis testified that their actual overall sales price has averaged $1.36 per 100 tablets, not the $17.88 published as their list price. Their testimony was to the effect that at average $1.36 per 100 tablets price, they barely covered overhead, handling, distribution and inventory costs. The company reported that it never turned a profit on its prednisone sales. The Parke-Davis prednisone experience is really an illustration of the point I was making on page 14 of my statement. When the market for a given drug will not support the price which the firm feels it must obtain, the company cannot remain in that market. As Parke-Davis testified, they have never been a significant factor in the production and marketing of prednisone.

We, of course, do not have production data on the 25 most frequently prescribed non-combination drugs. Individual company production cost figures are regarded in all industries as confidential, and the drug industry is no exception. In any event, it is unrealistic to use production costs as a measure of the value of any product and drugs are no exception.

Question #6:

Isn't the basic objective of drug company research to develop a patentable drug on which you in effect have a monopoly and can harge what the traffic will bear?

Isn't this the way you recover the cost of "false starts" and reap profits?

How much money did your member companies receive in royalties last year on patented drugs and processes?

Response:

We think it is clear that one of the objectives of research in any industry is to develop products which will have some chance of commercial success, whether under patent or not. And all industries, including drug manufacturing, must cover the cost of "false starts" by what is earned on commercial successes. Otherwise, the companies involved will have no choice but to go out of business.

This association does not have data on the amount of royalties received by our member companies during last year on patented drugs and processes, and therefore we cannot furnish this data as requested.

Question #7:

You say that "approximately one-half of the PMA member companies would qualify as 'small businesses' . . .".

How much research do these companies do in terms of dollars and as a percentage of total sales?

Response:

We have data on only 20 of our member firms which are in the lower half of our membership in terms of size. According to our information, these 20 firms have allocated for 1967 approximately 4.8 percent of their sales volume to research and development. In dollar terms, this amounts to aproximately 8.2 million.

Question #8:

On page 20 of his memorandum, Mr. Squibb says: "It is true their efforts duplicate each other's, their products often overlap, their sales pressures are strongly competitive, and their prices are related to what the market can bear, but this also can be said of every consumer product industry."

Now, if this is so, why shouldn't the U.S. Government apply the same common sense to drug purchasing as it uses when it buys other consumer products?

Response:

I do not see how this question about Federal Government drug purchases, in the context of S. 299, is applicable.

Our very serious problems with S. 2299 relate to the fact that this bill would regulate and control the private market place with respect to *purchases made by or on behalf of private individuals*—not with respect to purchases made by the Federal Government. The only large scale drug purchases by the Federal Government today are by the Department of Defense and the Veterans Administration. S. 2299 does not purport to control the drug purchasing procedures of federal agencies. The PMA has no quarrel with the general purchasing policies of these departments. Physicians practicing in federally operated hospitals are free to prescribe those drug products which, in their medical judgment should be used, even though a given product is not on a central supply list. Our view is that civilian beneficiaries under Social Security Act programs should be entitled to the same availability of drug supply as military beneficiaries and private physicians should certainly be no more restricted in the exercise of medical judgments than military doctors.

We do not believe the Federal Government should restrict drugs available for Social Security Act beneficiaries and regulate the prices of these products—all of which are made available through private commercial channels—any more than the Federal Government regulates the brands and prices of bread that welfare program beneficiaries may purchase from their local grocery store.

Question # 9:

Until recently, isn't it true that the manufacturer discovering or developing a drug usually selected the generic name?

Isn't it true also that his usual practice was to choose an unpronounceable or difficult generic name so that generic prescription would be discouraged and this "catchy" brand name used instead?

Response:

Under 1962 amendments, the FDA was given authority to determine officially the generic name of drug products. Prior to this enactment there was no governmental determination on generic names. Traditionally, the generic name of drug products is evolved by the scientists who work with the drug from its inception. In its early stages of development, a drug may be described only by its complete chemical name which of course is usually most unwieldy. As more and more is written about a drug by scientists the full chemical name is likely to be shortened. Usually what turns out to be the generic name has become rather accepted in the literature before a new drug is marketed. According to our information, there have been few if any instances where FDA has made an official decision on a generic name which was significantly different from the shortened chemical name already developed by the scientists working with the drug during the several years of its development.

Furthermore, any close look at generic names in general will quickly refute the implication contained in this question—that is, that generic names are always chosen to be difficult and are in fact more difficult to most people than the brand name which may be later adopted by an individual manufacturer. For example, is the generic name reserpine any easier to remember than the brand name Reserpoid? Is the brand name polycycline any less difficult than the generic name Tetracycline? Is the brand name tofranil more "catchy" than the generic name Imipramine?

Undoubtedly, there are examples of unpronounceable and difficult generic names and unpronounceable and difficult brand names. To the average layman, probably most of each category are viewed as unpronounceable and quite difficult. It does not seem, however, that there is the kind of name-developing conspiracy which the above question appears to imply.

Question #10:

Doesn't a registered trade name on a drug provide a means for continuing to get a "monopoly" price for a drug after the patent has expired?

Response:

We do not think so at all.

A registered trade name on a drug product has the same kind of values as a registered trade name on any other product—whether a food, an automobile, gasoline, or clothing—that is, to identify one company's product from all competitive products. Of course, the manufacturer of any product drug or otherwise, wants to be in as strong a selling position as possible even though a patent may have expired.

Obviously, the price that a manufacturer can get for his product will be affected by the degree of competition. The experience in the pharmaceutical industry is that when a patent expires the manufacturer who held the patent right will not continue to have a "monopoly". Of the several hundred drug manufacturers in America which market prescription drugs, the vast majority do not develop new drug products and do not hold patents on drug products they manufacture and sell. Furthermore, the so-called "me too" or strictly generic type manufacturer is not required to market his drug product under the generic name. He may, if he chooses, select a trade name for his drug product to differentiate it from products from other sources. We certainly think that the use of trademarks or brand names should not be prohibited to manufacturers of drug products, either directly or indirectly by financial pressure, any more than to any other industry.

The CHAIRMAN. At this point in the proceedings let me insert in the record a resolution submitted to the committee by Dr. H. Ashton Thomas, secretary-treasurer of the Louisiana State Medical Society. This resolution, adopted by the society, objects to what it described as "overt and covert compulsory generic prescribing." I do believe the Louisiana State Medical Society would applaud the modification I announced earlier to give doctors more flexibility in prescribing drugs for their patients.

(The material follows:)

LOUISIANA STATE MEDICAL SOCIETY,
New Orleans, August 23, 1967.

MR. THOMAS L. C. VAIL,
Chief Counsel,
Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR MR. VAIL: Because the Senate Finance Committee will discuss the matter of Generic Drugs in connection with the Social Security Amendments (H.R. 12080), we would like to submit for the record the official actions taken by the Louisiana State Medical Society in regard to this matter. We respectively submit that this resolution be included in the recorded testimony.

Sincerely,

H. ASHTON THOMAS, M.D.,
Secretary-Treasurer.

RESOLUTION OF IBERIA PARISH MEDICAL SOCIETY

Whereas (S17) Senator Montoya and (S110) Senator Aiken seek to reimburse only the cost of generic "equivalent" prescriptions (covert compulsory), and

Whereas Senator Russell Long plans a bill to compel physicians to prescribe by generic name (setting up a national formulary) for any patient whose care is subsidised in part or in whole by the federal government and going even further to require mandatory pharmacist substitution in filling prescriptions (overt compulsory), and

Whereas it has been the policy of the Louisiana State Medical Society and the Iberia Parish Medical Society, to oppose compulsory generic prescribing as an intrusion into the freedom of the physician who must bear the responsibility for the treatment of the patient by his usual and customary judgments, and

Whereas above and other provisions of these bills (regarding hospital specialists and fee schedules) have very serious implications and coroborate the previous contentions of many that the ultimate result of such legislation will be total control of all phases of medical care: Now, therefore, be it

Resolved, That the Iberia Parish Medical Society in regular session assembled this 11 day of April 1967, hereby and herewith makes known its continued opposition to overt and covert compulsory generic prescribing regardless of the status of the patient, and further

Resolved, That copies of this resolution be sent to all Louisianians in the United States Congress, and further

Resolved, That this resolution be presented to the House of Delegates of the Louisiana State Medical Society.

The CHAIRMAN. The committee will stand in recess until 2:30 this afternoon.

AFTERNOON SESSION

Senator ANDERSON (presiding). The hearing will come to order.

Our next witness will be William H. Robinson, representing the National Council of Churches of Christ in the U.S.A., accompanied by Leonard Boche, representing the Board of Christian Social Concerns of the Methodist Church; Huber F. Klemme, representing the Council for Christian Social Action of the United Church of Christ; Inabel B. Lindsay, representing the Action Group on Poverty, Executive Council of the Episcopal Church; Roger Phillips, representing the Office of Church and Society of the United Presbyterian Church in the U.S.A., and the National Presbyterian Health and Welfare Association; and John McDowell, National Council of Churches.

Dr. Robinson, I appreciate you and those who are with you working together to prepare a single statement for the committee. Your joint effort is greatly appreciated and will serve to expedite the work of the committee on this important bill.

You are recognized and may proceed with your statement.

STATEMENT OF WILLIAM H. ROBINSON, NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE U.S.A., ACCOMPANIED BY LEONARD BOCHE, BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE METHODIST CHURCH; HUBER F. KLEMME, COUNCIL FOR CHRISTIAN SOCIAL ACTION OF THE UNITED CHURCH OF CHRIST; INABEL B. LINDSAY, ACTION GROUP ON POVERTY, EXECUTIVE COUNCIL OF THE EPISCOPAL CHURCH; ROGER PHILLIPS, OFFICE OF CHURCH AND SOCIETY OF THE UNITED PRESBYTERIAN CHURCH IN THE U.S.A. AND THE NATIONAL PRESBYTERIAN HEALTH AND WELFARE ASSOCIATION; AND JOHN McDOWELL, NATIONAL COUNCIL OF CHURCHES

Mr. ROBINSON. Mr. Chairman and members of the committee, my name is William H. Robinson. I am the director of Cook County Department of Public Aid in Illinois. I am appearing before you in my capacity as chairman of the Committee on Social Welfare of the National Council of Churches of Christ in the U.S.A.

Four constituent denominations as well as the National Council of Churches requested an opportunity to appear before your committee to present testimony. Pursuant to your request that the National Council of Churches and its constituent bodies coordinate their testimony so that a single oral statement could be presented, I speak, therefore, in behalf of the National Council of Churches and four constituent bodies. The organizations are submitting in accordance with your suggestion, detailed individual statements for the record.

I speak also for two other groups, the American Baptist Convention, and the Board of Social Ministry of the Lutheran Church in America. These two concur in the statement of the national council.

Thirty-four Protestant, Anglican, and Orthodox communions constitute the membership of the National Council of Churches. The general board, which is one of the two bodies which can approve policy statements on behalf of the council, approved a resolution on social insurance and public assistance programs on June 2, 1967. The testimony I am about to give is based on this resolution as well as on earlier policy statements passed by the general board or the general assembly of the National Council of Churches. It has been specifically endorsed by the church organizations whose names appear on the cover sheet for this testimony.

The churches speak to the provisions of this bill, particularly as they relate to public assistance as a matter of conscience. We believe in the God-given worth of persons, of families, and of communities. We object, therefore, to any attempt to treat some persons as of less value than others. We find such elements in some provisions of the proposed Social Security Amendments of 1967 and we are deeply concerned.

The testimony which follows is based on the professional experience of hundreds of church-related agencies engaged in social service programs from one end of America to the other.

SOCIAL SECURITY BENEFIT INCREASE

The 12½-percent increase in social security benefits will still leave many Americans in abject poverty. This is particularly true because the increases are not weighted as much as we believe they should be in favor of the lower benefit recipients. We urge that your committee submit provisions for raising minimum payments by a substantially larger amount than provided in H.R. 12080.

We approve the provision of the bill that requires that the services performed by a clergyman in the exercise of his ministry be covered automatically under old-age, survivors, and disability insurance unless within 2 years he states that he is conscientiously opposed to coverage on religious grounds.

The coverage of agricultural labor under OASDI which was provided under an earlier version of the bill is omitted from the House-passed bill. The correction of this omission is urged since its effect is to continue a glaring social injustice to farmworkers.

The moving of adults from public assistance rolls into productive employment is an objective that we all share.

However, to do so by threatening children with even more drastic deprivation of food and clothing and shelter is not a humane way of approaching this objective.

The provisions of the public assistance amendments outrage our sense of American standards of decency for a number of reasons.

1. They remove from the mother of AFDC families the right to decide whether her children's growth and development can best be

nurtured by her going to work or by her staying in the home to provide them with the tender loving care every child needs for healthy growth. Some mothers may choose to go to work, directly or by way of a training program, and to leave their children with a day care center. Others may sincerely believe that they can make their best contribution to their children and to society by staying at home to care for them. This is not a choice that any agency of government should dictate. It is a thoroughly unjustified intrusion of government into the private decisionmaking responsibilities of a substantial number of American mothers. These provisions undermine the human dignity and sense of worth of AFDC recipients in a shamefully un-American and unethical way.

2. It is bad social policy to pursue a goal of regularly removing mothers from their normal duties of caring for their young children in their own homes where fathers are absent. Counseling services should be made available to such mothers so that when they want help to decide whether to go to work or to stay at home to take care of their children such help is available. Acceptance of such counseling services should not be a condition of financial aid. For those mothers wishing to engage in work and/or training programs, day care services of high educational quality should be provided to their children. These day care centers should be staffed with people able to provide a mother-substitute to children while under their care. Our society will certainly not benefit from having over 3 million children in the coming generation deprived of a mother's care during many hours of the day. Children growing up under such conditions will certainly provide a disproportionate share of the delinquents, the mentally ill, and the socially and economically unproductive citizens of the next generation. Our society cannot afford such a dreadful waste of human resources.

3. We do not believe that large-scale work and training programs should be developed under public welfare agency auspices. We do believe that large-scale training programs with tax incentives to encourage private industry's participation should be developed under more appropriate auspices. There should be a better network of public employment services with branch offices in neighborhoods of high unemployment. There should be a permanent administrative structure to provide employment in production of needed community facilities and services to those unable to secure employment in the private sector of the economy. Appropriations for this purpose should be geared to the level of unemployment. The program should be concentrated in geographical areas with a high rate of unemployment. It is clear that emergency appropriations of substantial proportions are needed for this purpose now.

4. A massive compulsory work program as provided in H.R. 12080 may very well seriously undermine labor standards which have been established through the years. It permits assignment of assistance workers to private employers, makes no mention of labor conflict situations, and suggests a subminimum wage level. It could easily establish a kind of peonage as an alternative to public assistance. It is hard to see how substantial "involuntary servitude" can be avoided under the provisions of this title in the bill.

5. The provision (H.R. 12080, sec. 208(d)) that the proportion of all children under age 21 who are receiving aid to families with de-

pendent children in each State in January 1967, on the basis that the father is absent from the home, cannot be exceeded after 1967, can have devastating effects on such families and children if it is not eliminated by the Senate. It will either penalize all dependent children in the State or discourage exercise of the present right of all eligible persons to apply for assistance. Unless States out of their own funds pay full benefits for dependent children in excess of 1967 proportions, some families with dependent children where the father is absent will be accepted only for general relief, which in those States where it exists is at a much lower level than AFDC and is completely from State-local funds. This will mean that a very serious inequity will occur purely on the basis of dates of application. The mother who tries desperately to manage on her own without AFDC may find that when she does apply she is in the category that cannot be aided by Federal funds. This is unjust, inhuman, and conducive to an early rush to get on AFDC rolls. Some States for various reasons may have been discouraging AFDC applicants but it is to be hoped that the seriousness of the problem may lead them to more humane attitudes. This provision will not allow States to improve their program by covering all eligible children except at the State's expense. It can be generally assumed that there will be no improvement in programs under such circumstances.

The conditions which cause an increase in proportion of children eligible for AFDC because of the absence of the father are not all in control of the States. Migration of the labor force, declining economic conditions, and similar conditions can cause a substantial increase in AFDC families in certain States. It is unjust to penalize either the families in those States or the States themselves for conditions that are in part beyond their control.

There are in H.R. 12080, title II, many provisions that the National Council of Churches and some of its constituent communions have advocated. Among these are the provision of family counseling and family planning services, day care, foster care, and other protective services and additional incentives for welfare recipients to earn some income. We deeply regret that we cannot support the provision of these services in the context of a law which in its very statement of purposes goes counter to a pronouncement of the General Assembly of the National Council of Churches adopted on December 8, 1960. This statement is as follows:

> Whereas at least five million people in the United States are dependent each month upon public assistance for the necessities of life: Be it
>
> *Resolved*, That the Churches be urged to work for availability of adequate public assistance for all needy people; the elimination of state and local requirements for public assistance; and the replacement of Federal aid for certain categories of people by a single program based solely upon need, and
>
> That the Aid to Dependent Children be modified immediately:
>
> (1) to prevent discrimination against children because of the circumstances of their birth and
>
> (2) to eliminate the requirement that employable fathers be absent as a condition of eligibility.

We urge the substitution for title II in this bill provisions similar to those in H.R. 5710 which were discarded or radically revised by the Ways and Means Committee of the House of Representatives. Particularly we urge inclusion of the provision that the States be required by July 1, 1969, to make assistance payments on the basis of the standards for needy persons which they use to determine the eligibility for public aid.

AMENDMENTS TO TITLE XIX

We have no quarrel with the general intent which seems to underlie these amendments. We do regret certain restrictive measures contained in them. The limitation of the level of eligibility for medical assistance to medically indigent persons to one and one-third times the highest amount which would ordinarily be paid to a family of the same size on cash assistance will leave many medically indigent families on the edge of poverty without aid in times of illness or accident. We urge that this limitation be raised since it will mean that 18 States will be forced to lower their present eligibility standards. This is the wrong direction to move in provision of medical services to the poor in America.

Mr. Chairman, this is a statement of the churches on the amendments.

The CHAIRMAN (presiding). Thank you very much.

Mr. ROBINSON. This is our statement on the amendments to the Social Security Act.

The CHAIRMAN. Do you have any questions, Senator Anderson?

Senator ANDERSON. You asked me if I have any questions. I have none on this. I just hope the National Council of Churches as they work in this field might check up on some of their proposals for Indian legislation with respect to other parts of the country.

You have a representative in the New Mexico area who butchers me day by day for a bill in which I tried to help the Taos Indians. I won't go into all details of it, but a great many people thought it was very fair. But the National Council of Churches has in their leadership a girl who used to be secretary to John Collyer. He's a very fine man, but she just butchers me day by day. I hope this matter on which you ask us to have charity, might reflect a charitable attitude on the part of the National Council of Churches.

The CHAIRMAN. Thank you very much.

(The statements referred to previously follow:)

STATEMENT BY BISHOP JAMES S. THOMAS, BISHOP OF THE IOWA AREA OF THE METHODIST CHURCH AND MEMBER OF THE COMMITTEE ON SOCIAL WELFARE OF THE GENERAL BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE METHODIST CHURCH

Mr. Chairman, and members of the Senate Finance Committee, my name is James S. Thomas, Bishop of the Iowa Area of The Methodist Church and member of the General Board of Christian Social Concerns of The Methodist Church.

The Social Creed of The Methodist Church approved by the General Conference of The Methodist Church in 1964 in regard to social welfare states:

"We believe that meeting human need is both a private and a community responsibility. Adequate public assistance should be made available to all persons solely on the basis of need. Every individual should provide for his own needs and share responsibility for the needs of others to the full extent of his ability, but we believe that no person in an affluent society should be demoralized because of unmet need."

The *1964 General Conference* by resolution declared:

"Social Welfare increasingly implies the concern of all persons, organized for the welfare of all persons. Continued high levels of unemployment and pockets of poverty highlight the critical need for public and private assistance to those unable to earn an adequate livelihood.

"Public programs of welfare are needed which: Provide physical necessities for the destitute; respect the integrity and dignity of persons; encourage economic independence; provide for services such as homemaking, birth control, literacy development, and cultural opportunities, offer a maximum of flexibility to meet individual needs; assign to social workers caseloads which do not exceed professional standards.

"The Church must develop specialized ministries to the blind, the physically and mentally handicapped, unmarried expectant parents, the divorced, the social deviants, and other groups of special need. Face-to-face contacts between the socially privileged and the underprivileged are seriously needed."

House file 12080 which has been passed by the House of Representatives and sent to your committee has contained within it provisions which benefit the whole society. The bill also raises issues of public responsibility for those who are unable to care for themselves as well as the very nature of the family itself. We would like to address our concern specifically for the dependent children and the family in which they are found. Other provisions of the bill have natural spokesmen with political sophistication and voting strength. On the other hand, the economically-dependent children have neither spokesmen nor political power and hence it is on their behalf that we express our concern to you.

We join with the House of Representatives in viewing the growing number of families and individuals on AFDC with concern. We see this growth as symptomatic of the larger problem of family breakdown in our society. The family in our culture is under excessive strain due in part to industrialization, urbanization, migration, and changing value systems. With the breakdown of the family and insufficient financial resources to support two household units, the result is often the need for public assistance to protect the children.

We, too, are concerned with the welfare system as it now operates, in that it seems to perpetuate economic dependency rather than help people to economically re-establish themselves. It appears that the person caught within the system is unable to find a way out. One of the contributing elements to this phenomenon is the apparent paradox that low levels of economic support tend to produce dependency rather than motivate the individual to economic independence. When the caretaker of the family of dependent children has to invest all of her energy—both physical and emotional—in the task of survival, she no longer has the capacity nor the basic security to launch out on the uncharted course of economic independence.

The process of application and justification of her need to welfare authorities, the continued public identification of her dependency by such things as food stamps, the social stigma and criticism that she feels on the part of society, all basically add together to debilitate the caretaker and to limit her ability to re-establish economic independence. The first step to helping the family with dependent children to become economically independent is to provide enough financial resources so that the family does not have to be obsessed with survival and can give attention to other elements of living.

H.R. 12080 provides several constructive elements which we would like to commend to the committee.

A. Requirement that all states establish a work-training program.

B. Requirement that all states have an earnings exemption to provide incentives for AFDC recipients.

C. Requirement of the states to furnish daycare service for family in which the caretaker is employed or involved in work-training experiences.

D. A program of emergency assistance for families for a temporary period.

E. Making available to those who request it family planning services.

F. More adequate protection of children from abuse and neglect.

We are, nevertheless, very deeply concerned about the provisions of the bill which make work-training programs mandatory in "appropriate" cases and the section of the bill which makes provision to freeze, in so far as Federal participation is concerned, the largest AFDC category at the present proportion of each state's child population. These two provisions together raise several issues which we find to be disturbing and in conflict with the best interests of the dependent child as well as our society as a whole. These issues are:

A. Through the proposed provisions, it is no longer axiomatic that the best place for the mother is in the home, but infers that the best place for her is in the market place developing economic independence.

B. Through the provisions for coercion, the amendments raise serious question as to whom has the right to decide if or when the mother of dependent children should enter the work force. It appears that it would be altogether possible for the final decision as to the children's welfare and relationship to their caretaker may be the function of welfare administration. This we firmly object to.

C. These provisions assume that the employment market can assimilate welfare recipients at the job level to which they can be trained. This assumption is questionable in that there is considerable evidence that in the urban centers the jobs are not where the people are, who are receiving AFDC. Hence the limitations of mobility of the welfare recipient is one of the serious handicaps to employability.

D. These provisions assume that people will not leave welfare dependency until they are forced to do so. This type of thinking is part of the stigma which has been erroneously used to describe the welfare recipient and has little basis in fact.

E. By placing a proportional limit on Federal involvement, the burden for families with dependent children is placed on the states. This provision does not take into account such real elements as migration and changing economic or social conditions which affect the family. Furthermore, it places considerable pressure on the states to so administer the provisions of the bill that AFDC cost will be stabilized quite outside of consideration of need.

We urge that the Senate Finance Committee give serious consideration to the following:

A. Making mandatory on the states the payment of full minimum needs under public assistance by their own definition as of January 1, 1967.

B. Making mandatory on the states the development of work-training experiences in which recipients may voluntarily participate, but which are closely correlated with existant jobs in the employment market and integrated with existing mechanism for job placement.

C. Making available adequate child-care facilities for the caretakers who request to become involved in job training and employment.

D. Providing more liberal opportunities for recipients to retain earnings while still receiving welfare assistance as a means by which they may be able to ultimately become economically independent.

E. Removing from H.R. 12080 the provision to freeze the AFDC category at the present proportion of each state's child population which forms an arbitrary limit not related to the real need of the dependent child and his family.

Submitted on Behalf of the Episcopal Action Group on Poverty by Dr. Inabel B. Lindsay, Chairman, Social Goals Subcommittee

The Episcopal Action Group on Poverty consists of several hundred clergy, social workers and other specialists in the human relations field. This is a voluntary organization which is officially recognized by the Church. This group is affiliated with the Division of Community Services of the Department of Christian Social Relations of the Executive Council of the Episcopal Church, which has more than three million members throughout the United States.

Our concerns regarding the harsh and punitive aspects of Bill H.R. 12080 are rooted in our Christian commitment to promotion of the welfare, equity and social justice to all mankind but especially to those handicapped by poverty and other crippling conditions. Our group has called upon our Church, now in General Convention at Seattle, Washington, to give guidance and active support to its members with regard to measures respecting social insurance, public welfare and income maintenance.

Our objective is to lend active support and co-operation with other groups to achieve the elimination of poverty. In this the richest nation in history, there are still approximately 30 million people in poverty. To permit this condition to exist not only reflects adversely upon our democratic principles but deprives the nation of billions of dollars in productivity. In October 1964, the House of Bishops issued a "Position Statement on Poverty" which set forth the moral imperative for Christian participation in a comprehensive War on Poverty. Our convictions, motivated by religious conscience and our commitment to work with others toward the elimination of poverty from our rich society and for the protection of the rights and dignity of all without distinction, impel us to present our grave concerns about Bill H.R. 12080 to amend the Social Security Act.

We recognize that H.R. 12080 contains many provisions which aim at social goals which we support. These include proposals to increase federal financing for certain social services such as family counseling, day care, family planning, foster care and other protective services; for research and demonstration projects; to contribute to the costs of work and training programs; for the training of social workers and their aides; and to provide for an incentive exemption on earned income. However, it is highly questionable that the social goals sought can be achieved through the coercive, harsh, punitive, repressive, and regressive methods of implementation written into the bill.

Proposals in Title I for the increase in benefits in the old age, survivors' and disability insurance payments are woefully inadequate. The proposed increase would afford a minimum payment to an individual of only $50.00 per month (or an annual income of $600.00). A more humane and more economical approach was submitted in the Administration's proposal (in the discarded H.R. 5710) for a $70.00 minimum. Even that minimum is inadequate to insure a decent level of living for those dependent solely upon Social Security benefits. The Administration recommended a 15 per cent increase, which in H.R. 12080, has been reduced to 12½ per cent. We believe the smallest increase which can be supported calls for the 15 per cent increase. Any less fails even to begin to adjust benefits to increases in the cost of living.

Expansion of the Medicare program to include the disabled was recommended by the Administration (in H.R. 5710) but is denied in H.R. 12080. The disabled are in general, equally as handicapped as the aged for entry into the labor market and should have as much protection. We urge the extension of coverage under Medicare to all OASDI beneficiaries as well as to their dependents and survivors.

Federal assistance to the states to enable them to offer medical care (Medicaid) for low income persons under 65 years old was provided under Title XIX of the Social Security Amendments of 1965. The 1967 Amendments, as provided in H.R. 12080, would introduce a cut-off point for federal financial assistance to the states. Moreover, H.R. 12080 places a major restriction on the level of eligibility for the medically indigent by requiring that the eligibility level not be more than one and one-third higher than the amount a family group of similar size would receive in cash assistance; or more than one-third higher than the average per capita income in the state, whichever is lower. Furthermore, the new amendments remove the requirement that state programs provide five basic types of services (inpatient hospital services; outpatient hospital services; other laboratory and X-ray services; skilled nursing home services; and physician services). In addition, the present program offers nine services which are optional (until 1975, when all become mandatory).

In the amendments offered by the House, states would be permitted to provide any seven of the first 14 services outlined in section 1905 of H.R. 12080. Also states would no longer be required to provide comparable services to persons under 65. This would in effect, limit or drastically reduce the care now possible in families with children.

The enactment of these limiting and restrictive provisions in Title XIX would have disastrous consequences. The high cost of medical care is impossible to meet on a low income—or even modest—budget. Meeting of medical needs would be postponed or neglected, with the result that many, who with minimal health protection, can enter or return to the labor market, would be unable to do so, and consequently might be forced to resort to public assistance for support at much greater cost to the government than the price of essential medical care. Obviously, all possibilities for preventive medical care would be lost. These very serious restrictions proposed in Title XIX are diametrically opposed to the intent of H.R. 12080, if that intent is as it seems, to remove people from the Public Assistance rolls. Obviously, increased medical costs beyond the patient's ability to pay, would increase dependence on public assistance.

The amendments to Title II of the Social Security Act pertaining to Public Assistance programs as proposed in H.R. 12080 are particularly harsh, punitive and coercive. The concerns of the House that earlier identified goals have not been achieved are justified. The public assistance programs were designed to provide basic financial support for the needy coupled with services to encourage self-support and self-dependence to the extent possible. Failure to achieve these objectives has not been the fault of operating personnel but rather has been due to grants too low to support even a minimum of health and decency; the methods of delivering services have increased feelings of worthlessness and despair and, if anything, have intensified dependency; and the complex administrative structure in most programs has prevented the investment of the time and skill essential to the provision of constructive help. Notwithstanding these deficiencies, the proposed amendments will do nothing to remedy the situation. On the contrary, these amendments will undoubtedly increase the problems, frustrations and unmet needs of those eligible for public assistance.

The most drastic and punitive changes proposed are those affecting children dependent upon or eligible for Aid to Families with Dependent Children. In the attempt to legislate morality, H.R. 12080 imposes a work or work training requirement upon all adults on the assistance rolls, including mothers and youth over 16, not in school as a condition for the receipt of assistance, unless specifically exempted. (No definition of conditions of exemption is provided). The administration of the work-training programs by the welfare agency is itself unsound and undesirable, but the provision that such programs can be delegated to voluntary or profit making organizations (with no requirement for meeting minimum standards) could have most damaging results.

This requirement that recipients accept work or training as a condition for receipt of assistance is accompanied by the recommendation that minimum wage laws be waived, and there is no requirement for conformity with labor standards.

Should potentially eligible recipients refuse to accept the work or training requirement, the following punitive measures may be invoked:

1. Exclusion or elimination from assistance.
2. Adults would be eliminated in the calculation of the budget (This would of course, have the effect of stretching an already insufficient grant to cover the entire family).
3. Relief payments could be made by voucher (denying freedom of choice or limiting the possibility of selection by comparative shopping).
4. So-called "protective payments" could be made to a third party, although the presently existing restrictions upon such payments are not provided.
5. Children could be removed from the home and placed in foster care. Assuming that the quality and suitability of foster homes would be guaranteed (though this is not explicit in the proposed amendment) this is entirely unrealistic because of the severe shortage of acceptable foster homes in all jurisdictions at present.

In the further attempt to legislative morality, H.R. 12080 proposes to reduce the incidence of children in receipt of AFDC because of illegitimacy or desertion by these measures:

1. Requirement of programs of family planning. Desirable as such programs are, there is thinly veiled compulsion in that states would be required to report the numbers to whom such programs have been made available and the "extent to which it has been accepted." Financial penalties are imposed upon states which show an increase over the percentage of children on the relief rolls over the prevailing percentage in January 1967.
2. Requirement of co-operation with law enforcement agencies to determine paternity, locate missing fathers (including use of social security records) and sharing the cost of enforcing support orders (thus further reducing amounts available for assistance to needy people)
3. Report of so-called neglect and abuse of children on the AFDC rolls and referral to foster care financed by the AFDC program. If the definition of "abuse" or "neglect" is based on the fact of illegitimacy (as seems clearly implied), this would undoubtedly serve as a deterrent to application by the parent eligible for assistance.
4. The financial penalty (referred to in paragraph 1 above) would require that federal assistance to the states be limited to the ratio of children from one parent homes to the number of such children in the total child population of the state as of January 1967. This provision takes no account of the rate of population increase, changing economic conditions (possible increases in unemployment), immigration, or other social and economic changes which any state might normally anticipate. The result would most likely be that states would have to impose more restrictive eligibility requirements or reduce the level of assistance.

The result of these punitive measures would be to further penalize already disadvantaged children, increase tensions in poverty stricken areas and probably increase crime and delinquency. Immorality of parents has a better chance of correction through programs of family counseling, and sound medical and educational services.

The most positive and hopeful provision in H.R. 12080 is that for support of social work education and training. Although the annual ceiling of five million dollars is extremely modest and could not be expected to relieve entirely the acute manpower shortage in this human relations field, it would be a hopeful beginning. In addition to the vast reservoir of unmet personnel needs in the public welfare programs, there are increasing demands for adequately qualified social work personnel in new fields such as private industry, new medical programs (including community mental health centers), anti-poverty programs and community development.

However, if the House passed Amendments to the Social Security Act in H.R. 12080 are allowed to stand, these would undoubtedly serve as a deterrent to recruitment of social workers electing a career in public welfare. Young, idealistic college students could find no fulfillment of their ambitions to further the goals of democracy and social justice in programs where they would be required to act as policemen, jailers, or punishers of "crime."

We urge the Senate Finance Committee to preserve the integrity of the Social Security Act by modifying H.R. 12080 in such ways as will strengthen, rather than weaken, family life; encourage, rather than destroy, potential for optimum fulfillment of every human being; and open, rather than block, the roads to prevention of social breakdown.

PREPARED STATEMENT OF THE COUNCIL FOR CHRISTIAN SOCIAL ACTION, UNITED CHURCH OF CHRIST

The Council for Christian Social Action is an instrumentality of the United Church of Christ. Its twenty-seven members are elected by the General Synod of this Church to study and make recommendations on issues of social justice and the common welfare. Although the Council appears here on its own responsibility and does not commit any of the two million members of the denomination except by his own consent, it does speak on the basis of the mandate of the nationally representative General Synod which, in a Call to Christian Action in Society, in 1959 called upon its local congregations and their members to pray and work "for economic institutions and practices which provide meaningful work, serve human ends, eliminate blighting poverty, prevent unemployment and harmful inflation, and bring about more equitable sharing in the goods and services which our productivity makes possible; . . . for the support and expansion of necessary public services such as . . . health programs; . . . for the provision of adequate social services for special groups such as the young, the aging, the handicapped, the mentally ill, and the victims of alcohol and drugs . . ."

The Sixth General Synod, in June 1967, among other measures to deal with poverty expressed its support of "humane and adequate policies in public welfare and social insurance programs."

The Council for Christian Social Action has not only issued educational materials and conducted consultations. It has also adopted policy statements on various questions affecting social insurance and public welfare. In a statement on "Overcoming Poverty," adopted in February 1965, the Council pointed out that the effort to eliminate poverty will require the full cooperation of the private business sector, the government, and the voluntary agencies, including the churches, in

"... directing their programs and services toward the well-being of the whole person and the whole family so that all may enjoy as their right the essentials for the good life and share the resources of this good land which God makes possible."

We then urged twelve areas of action, two of which are especially pertinent to the legislation now before this Committee:

"5. To prevent the poverty and hardship which today are occasioned or aggravated by unemployment, underemployment, accident, illness, and disaster, provision should be made for *adequate and inclusive programs of social insurance* to provide for human needs and to maintain income during these emergencies . . .

6. To prevent the poverty which exists where no member of the family unit is employable—particularly the aged, families without fathers, and families in which the father is disabled or unemployed—and adequate income and essential services must be assured not only through *social security, private or group pensions, and public assistance but also through public policies that make decent family life, housing, medical care, health services, and educational opportunities possible for all.*"

These paragraphs embody four criteria for evaluating present practices and proposed changes in the administration of social security and public welfare.

(1) One is the principle of *universality.* Our statement calls for action "so that *all* may enjoy . . . the essential for the good life" (italics added). On various occasions we have protested the exclusion of particular groups, such as

agricultural workers, from certain health and welfare services or benefits—whether through discriminatory legislation or administrative shortcomings at state or federal levels. There is no reason why public assistance should not be available to *everyone* in the population who needs it.

(2) A second principle is that *need* be the basic criterion. The Council believes that all should enjoy as their right "the essentials for the good life." In our interdependent society, where mobility is essential to the efficiency of the economy as a whole as well as to the individual's freedom, residence requirements no longer make any sense. Even less is there justification for humiliating requirements, still extant in some states and local jurisdictions, limiting public assistance to families in which there is no father, or excluding women with children born out of wedlock from assistance. The Council has spoken specifically and sharply to such practices in the sentences immediately following the passage already quoted:

> State law and local welfare administrators sometimes require that the father must have left his wife and children as a condition of their receiving assistance. Sometimes the supposed 'worthiness' of the recipient rather than his need is made the criterion of such assistance. Even in cases where indigence is related to personal delinquency, rehabilitation, rather than retribution, should be the aim if we are to break the chain of poverty which extends from one generation to the next."

(3) The third criterion is *adequacy*. Whatever may have been the case in more straitened times, in the present affluence which our country enjoys there is no excuse to deal penuriously with those who do not secure adequate incomes or amass abundant savings. Nor, especially in an age that requires increasingly skilled manpower, is it right to deprive their children by denying them the financial prerequisites for education, vocational training, and full participation in the common life. Our economic and social policies need to be directed "toward the well-being of the whole person and the whole family so that all may enjoy as their right the essentials for the good life and share the resources of this good land which God makes possible."

(4) The fourth criterion is indicated in the word *right*. If, as we believe, it is God who makes our resources possible and we are intended to share them, it ill behooves any of us to assume that out of our goodness and generosity we may choose whether or not a little of this bounty goes to those among the unfortunate whom we decide to favor or who meet some arbitrary criterion we set up. Of course, there need to be legislative codes and administrative guidelines, and these need to be reviewed from time to time. Nevertheless, the shift from the poorhouse to social security symbolizes an important advance in respect for human dignity. Even so, we need to insist that public assistance, given those for whom wages and social insurance either do not exist or do not suffice, is support to which they are entitled as joint heirs in a heritage for which no individual or group can take sole credit.

The Council for Christian Social Action, therefore, was gratified by the proposals of the President, calling for amendments to the Social Security Act. We shared a widely held hope that the Congress would take this opportunity to broaden Social Security benefits and up-date public welfare standards, in the light of the above mentioned criteria.

We recognize that H.R. 12080 as passed by the House of Representatives incorporates some much needed improvements. The increase of Social Security benefits, however modest; lifting of the taxable base, even though this should have looked ahead to further increases; the provisions that a retired pensioner can earn as much as $1680 without loss of benefits; some increases in federal financing of family counseling, family planning, day care and foster care; some provisions for the training of social workers and nonprofessional aids—these are steps in the right direction. We welcome them, but would even more gladly welcome larger steps and more of them.

We are, however, profoundly disturbed by some of the provisions in the public assistance sections of the proposed bill, Title II of H.R. 12080, as passed by the House.

For example, the requirement that the states set up *work training programs for unemployed parents and for children over 16* who get welfare assistance may be unexceptionable in itself. However, if participation in such programs is to be made *mandatory* on the part of all families receiving Aid to Families with Dependent Children, the way would be open to grave injustices.

We—and, we trust, your Committee—will also insist on satisfactory answers to a host of questions that must trouble anyone who reads this bill.

Are all children over 16 who get welfare assistance going to be required to engage in work training? Who is going to set up the standards and oversee the work? Is the work going to be of the kind and quality that contribute to the child's future usefulness? Are considerations of health, progress in school, and the total home situation to be disregarded? Who will determine exceptions, on what basis, and what appeal is there from an adverse decision?

Are all mothers to be required to participate in such programs, regardless of the needs and demands of their own children? What assurance is there that day care programs will be available? What standards governing day care centers for children in such families will be established, and by whom? Are we really prepared to *force* the poor mother to leave her children in another's care, regardless of her preferences—when society heretofore *criticized* the woman who left her children to take a job?

Is it intended that every unemployed father shall be required to participate in a work training program, regardless of factors of health, accessibility of the job, and conditions of work? Is it to be public policy to compel these people to undermine minimum wage standards and to work as strike breakers? What safeguards against such abuse are provided? Will these programs be administered and supervised by experienced agencies such as the Department of Labor, or will they be at the mercy of state and local agencies with no real understanding of what work *training* is?

Similar concern is occasioned by the provision that federal aid to any state would in future be limited by *the ratio of dependent children to the total number of persons under 21 years of age* as of January 1, 1967. What evidence is there that this ratio will forever remain constant? Is the regulation of birth and migration going to be the new prerogative of Congress or the states? Or is the proposal drawn in callous disregard of the fact that the number of needy persons in any category may vary upward or downward both in absolute numbers and in percentages?

Such policies are not, to use the language of our General Synod resolution, "humane and adequate." They are the precise opposite. One has a suspicion that the House of Representatives yielded to the arguments of persons who are more punitive than creative in their approach to the problems of unemployment and dependency. We should hope that your Committee would be both more compassionate and more resourceful in dealing with these questions. We commend the more statesmanlike approach of the Administration bill, H.R. 5710, as the minimum required to provide for the economic necessities and spiritual hopes of human beings in these years that tempt the poor to the deadly alternatives of desperation and despair.

With this in mind, we hope that your Committee will reject at least these aspects of H.R. 12080 and will give preferred consideration to not only H.R. 5710 but also to two of the many excellent recommendations offered by the Advisory Council on Public Welfare on June 29, 1966.

One of these is the establishment of a *national minimum standard for public assistance* below which no state may fall. At the very lease the states should be required to fulfill 100% of their estimate of family needs; but safeguards should be built into even such a proviso, so that states dominated by less enlightened views do not reduce their standards to what they are prepared to pay.

The other recommendation would be that we move toward a *nationwide comprehensive program of public assistance based upon the single criterion of need.* Under existing state and federal laws, large groups are not being helped. Kentucky, for example, has no General Assistance program. Work Experience and Training programs under Title V of the Economic Opportunity Act, operating in only 19 of the state's poorest counties, have brought parents hope, given children the chance to stay in school, and kept whole communities from going under. When this program was threatened by reduced funding, hundreds of fathers—who did not qualify under programs for the blind, the permanently and totally disabled, etc.—had nothing to fall back on. Unjustifiable inconsistencies exist among the states and within states as among various categories—the aged, the blind, the disabled, etc. Justice as well as efficiency would indicate that we should progress toward a simplified, comprehensive, national program of public assistance to supplement the various forms of social insurance where these are inapplicable or insufficient.

It is evident that influential groups regard these measures as too costly—or capable of being deferred until we no longer need to bear the grievous burdens of war. We, however, do *not* believe that this nation *must* or *can* choose between seeking the difficult way to a just peace overseas *and* waging the war against poverty and related problems at home. We cannot afford to neglect or delay the responsibility at our own doorstep.

In July 1966, the Council for Christian Social Action said:

"Our domestic society cannot stand the debilitating effect of prolonged destitution and unemployment, the bitter frustration which leads to a Watts riot, the sense of helplessness which imprisons many dwellers in Appalachia, or the inferior education and training which lower the quality of our common life. To develop our human resources does not diminish but rather enhances our national well-being."

We trust that this Committee and the Congress will agree!

STATEMENT OF THE NATIONAL PRESBYTERIAN HEALTH AND WELFARE ASSOCIATION OF THE UNITED PRESBYTERIAN CHURCH IN THE U.S.A., SUBMITTED BY H. ROGER PHILLIPS, ACSW

This statement has a two fold purpose:

1. To place before the Senate Finance Committee the overall commitment of the United Presbyterian Church through the National Presbyterian Health and Welfare Association to meet problems of human need in ways most likely to be of service to the individual and society. The Association represents over 400 service units in the fields of child care, health services, services for the aging, neighborhood centers, and institutional chaplains.
2. To comment briefly on what we believe are regressive aspects of HR 12080, even though the bill contains many provisions that are desirable additions or improvements in social welfare legislation.

The General Assembly of the United Presbyterian Church has committed the Church to promote and foster health and welfare concerns in our nation. It has called upon members of the Church to support local, state and national private and public programs of health and welfare, and financial assistance. The Church recognizes the importance of Federal Government participation in welfare so that physical wants in large measure will be prevented and the number of people in distress will be minimized. Emphasis is placed upon the welfare of children and affirms the principle that welfare programs should enable persons to achieve the highest potential of social functioning in keeping both with social purpose and individual need.

We offer the following comments on the bill based on the Church's actions and policy statements:

1. The intent of the proposed legislation to facilitate the movement of welfare recipients to self support and self care is a commendable goal in which we concur. It is our conviction, however, that this goal must be realized only through programs which secure and protect the basic rights of people and which preserves human dignity of the most disadvantaged among us. Unfortunately, the proposed legislation suggests a major shift in national policy in the care of dependent children and advances programs that do not meet this test. We are concerned with the conditions that the proposals would impose on those who seek aid and how these conditions will affect parents and children.
2. Certain aspects of the legislation portray a bleak and pessimistic view of human hopes and aspirations, and assumes unfairly that persons needing assistance are less responsible or moral than their more fortunate fellow citizens.
3. The only qualification for assistance should be that of need. To do otherwise labels assistance as a badge of shame and shows a lack of respect of the human dignity of the individual. For some, public assistance must be continued as it is their sole means of survival and sustenance.
4. We affirm that government has the obligation to provide opportunities for responsible participation in society by welfare recipients. Assistance should not be used to enforce a particular code of behavior or its denial be allowed to serve as punishment. Thus the provisions in the legislation that would limit the number to receive federal aid in cases where a parent is absent from the home, and the regulations dealing with illegitimacy should be removed.
5. We note that certain sections would limit responsible choices by welfare recipients. All persons should have the freedom to choose how they may express the meaning of their lives. The tests of such freedom, which we all covet, is whether it is found, possessed and capable of being exercised by the weakest and most deprived members of society. The effect of the proposed legislation would be to diminish rather than enhance and make possible the exercise of responsible freedom among welfare recipients. This is particularly true in situa-

tions where a mother's judgment on how she can best discharge the responsibilities of parenthood comes in conflict with the judgment of those who have the power to withhold aid.

6. Finally, we deplore the fact that the proposed legislation fosters an untenable division of the citizenry of this nation into the worthy and the unworthy. It infers, unjustly, that personal, moral degradation and perversity are the significant causal factors of welfare problems.

We urge the Committee to remove the coercive and repressive elements of the proposed legislation and to develop positive measures, which the bill now lacks. Funds should be provided to assure adequate assistance in all states of the nation so that dependent children will be protected from devastating deprivation and neglect, and to affirm and honor the basic work and dignity of all persons.

The **CHAIRMAN.** The next witness will be Dr. Leonard Ganser, and I believe he will be sharing his time with Dr. Robert Gibson in order to expedite the hearing and get on with our business.

STATEMENT OF DR. LEONARD GANSER, VICE PRESIDENT, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY HARRY SCHNIBBE, EXECUTIVE DIRECTOR

Dr. **GANSER.** Mr. Chairman, I am Dr. Leonard Ganser, administrator of the Division of Mental Hygiene in the Department of Health and Social Services in the State of Wisconsin.

The **CHAIRMAN.** Pardon me just 1 minute.

Senator **ANDERSON.** I merely wanted to say that Dr. Gibson, who is here, was a very wonderful helper in medicare, sound and kind and helpful. I wish to admit that publicly, and I commend you for that position.

Dr. **GIBSON.** Thank you, sir.

Dr. **GANSER.** In addition, I am the vice president of the National Association of State Mental Health Program Directors, and representing that organization here.

Accompanying me are Mr. Harry Schnibbe, who is the executive director of our association, and Dr. Robert Gibson, who, as Senator Anderson has mentioned, has been here before, and is here representing the American Psychiatric Association and National Association of Private Psychiatric Hospitals.

The Association of State Mental Health Directors represents the directors of the programs for the mentally ill and the retarded in the 50 States and territories.

We had prepared statements which we would request, Mr. Chairman, be included in the record as they are submitted. But in order to conserve time, we would like to read shortened statements representing the viewpoints of these three very interested organizations.

The **CHAIRMAN.** We will print the full statement and we will let you summarize it.

Dr. **GANSER.** Dr. Gibson will start in by reading the statement representing the viewpoint of the American Psychiatric Association and the National Association of Private Psychiatric Hospitals.

STATEMENT OF DR. ROBERT W. GIBSON, REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION OF PSYCHIATRIC PRIVATE HOSPITALS

Dr. GIBSON. Mr. Chairman, Senator Anderson, I am again honored to have this opportunity to speak to you on behalf of the American Psychiatric Association, whose 15,000 members have the primary responsibility for the medical treatment of the mentally ill in our country, and to speak on behalf of the National Association of Private Psychiatric Hospitals, whose 136 member hospitals have the primary responsibility for the private hospital care of the mentally ill.

I should like first to express the gratitude of our profession for the very significant progress that has been made by the inclusion of broad benefits for the treatment of the elderly mentally ill under Public Law 89-97. The psychiatric profession has hailed as a major breakthrough those provisions of both title XVIII and title XIX that permit treatment of the mentally ill person over 65, in a general hospital, a private psychiatric hospital, a State mental hospital, or a community mental health center. In short, these provisions make it possible for the psychiatrist to utilize the full range of modern psychiatric facilities for the treatment of the older patient.

So, gentlemen, when I speak of our disappointment with some of the provisions regarding the mentally ill, and our hopes that these provisions can be modified, I should like to make it clear that psychiatrists are appreciative of the progress that has been made in providing benefits for the treatment of mental illness in our older citizens. But we are particularly concerned by the severe restrictions of title XIX imposed on the treatment of the mentally ill person under 65.

Let me briefly review the benefits for the mentally ill under title XIX. For the person over 65, deemed medically indigent, State plans can supplement title XVIII by meeting the cost of deductibles, by going beyond the 90-day limit for a single spell of illness, and by going beyond the 190-day lifetime limitation for psychiatric care. Such patients may be treated in an institution for the mentally ill or in the psychiatric unit of a general hospital. Title XIX also provides medical assistance for persons under 65 who are in families with dependent children, are blind, or are permanently and totally disabled, and whose incomes and resources are insufficient to meet the costs of necessary medical services. Recipients under the age of 65 may receive inpatient psychiatric treatment on the psychiatric unit of a general hospital, but not in a mental institution, whether it be a public or a private mental hospital, or even a community mental health center.

This limitation is highly objectionable. Not a single State in our country has a sufficient number of psychiatric units in general hospitals to treat the persons now eligible for benefits under title XIX. Many States have virtually no psychiatric units in general hospitals. Let me be specific. The most recent surveys of the American Psychiatric Association show that there are no psychiatric units in general hospitals in Alaska and Wyoming; only one unit in Delaware, Idaho, Maine, and New Hampshire; only two units in Arkansas, Hawaii, Montana, Rhode Island, Vermont, Arizona, and New Mexico; and only three units in Nevada, South Dakota, Mississippi, and Oregon. These 17 States have only a handful of beds that could not begin to treat the patients eligible under title XIX.

Furthermore, the psychiatric unit of a general hospital provide only a limited spectrum of care. Such services are primarily diagnostic and limited to brief stay, usually measured in days. They seldom have the full range of specialized mental health professionals neede to rehabilitate the patient suffering from a psychiatric illness. Th shortage of facilities equipped and staffed to treat children is particularly severe. I want to emphasize that the psychiatric unit of a genera hospital does serve a valuable function in the treatment of the mentally ill, but it has a specialized role and cannot be considered an equivalent or a substitute for the programs of the State hospitals, the private psychiatric hospitals, or the community mental health centers.

Treatment in a public mental hospital, a private psychiatric hospital, and the community mental health center was included by the Congress under title XVIII, and the failure to do so under title XIX is fundamentally inconsistent and wholly out of tune with the new approach implicit in community psychiatry which the Congress has so vigorously supported.

We do not ask you to include more persons under title XIX. We do not even ask you to expand the benefits under title XIX. We do ask that you make it possible for eligible persons to get the treatment to which they are already entitled. To do this, you must include all the properly qualified institutions. We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.

This would mean deleting the phrase "other than services in an institution for * * * mental diseases." (Public Law 89–97, title XIX, sec. 1905(a)(1).)

I would now like to address myself briefly to title XVIII, which does provide broad benefits for the mentally ill person over 65. Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a $50 deductible, with the patient paying 20 percent, and with not top limit. But, in the case of psychiatric treatment, the patient must pay 50 percent after the deductible, and there is a top limit of $250. This limitation seriously curtails outpatient psychiatric treatment for the aged patient. Many elderly patients can be successfully treated on an outpatient basis. If such treatment is denied because of financial limitation, the inevitable result will be hospitalization. Such unwarranted hospitalization may not serve the best interests of the patient, and will most certainly add to the cost of the hospital insurance program. Thus we ask for the elimination of discriminatory provisions limiting outpatient psychiatric care for the treatment of the aged under title XVIII. In other words, we would like outpatient care for the psychiatric patient to be on an equal basis to that of outpatient care for patients, persons suffering from other illnesses.

This would mean deleting the phrase "(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses for purposes of subsections (a) and (b) only whichever of the following amounts is smaller: (1) $312.50 or (2) 62 and ½ percent of such expenses" Public Law 89–97, title XVIII, section 1833(c).

Again addressing myself to title XVIII, there is a 190-day lifetime limit placed on treatment in a psychiatric hospital. No such limit is placed on treatment in a general hospital, even if such treatment in the general hospital is for a psychiatric illness. It makes no sense to force a patient, after an arbitrary period of time, 190 days, to shift from one institution to another for the treatment of the same mental illness. And that is exactly what can happen. We realize that the 190-day lifetime limitation grew out of the fear that psychiatric treatment of the aged is generally just custodial, but the facts show that such an assumption is totally unfounded. Studies which I have conducted of aged patients in private psychiatric hospital indicated that approximately 80 percent of these patients improve sufficiently within 60 days to return to their homes. Therefore, we ask you to eliminate the 190-day lifetime limit on treatment in a psychiatric hospital under title XVIII.

This would mean deleting the phrase "(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime" Public Law 89-97, title XVIII, section 1812(b).

In conclusion, let me repeat that the American Psychiatric Association and the National Association of Private Psychiatric Hospitals, consider this legislation a momentous advance in meeting the needs of the American people. But, at the same time, we cannot rest until our mentally ill citizens are accorded the same identical benefits provided for citizens who suffer from other illnesses. We do not ask that more persons be included until under title XIX nor do we ask that more benefits be granted. We ask simply that the Congress amend the social security legislation so that all qualified institutions—State and private mental hospitals, and community mental health center—can provide the psychiatric treatment so desperately needed. We ask that title XVIII be amended to permit outpatient treatment for a psychiatric illness to be carried out on the same basis as treatment for any other illness. We ask that the 190-day lifetime restriction on treatment of the aged in a psychiatric hospital be eliminated.

At the very least, we urge that immediate studies of psychiatric utilization be made. We are convinced that these studies will show that the suggested amendments are warranted and fiscally sound. Such studies were explicitly authorized for title XVIII of Public Law 89-97.

> Section 1875(a). The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

We believe that such studies are indicated and should be explicitly authorized for title XIX. Our professional associations pledge their cooperation on making such studies.

We ask for no special privileges, but we do ask for an insurance and benefit system that would enable the profession of psychiatry to provide the right kind of treatment, at the right time, and at the right place, for all persons deemed eligible for health benefits. Our associations pledge their wholehearted support and cooperation to the Congress and to the public and private agencies in making such an equitable system fully workable and maximally effective. This is the principle on which we stand, and we hope we have your sympathetic ear.

Thank you.

The CHAIRMAN. Thanks very much.

STATEMENT OF DR. LEONARD GANSER—Continuing

Dr. GANSER. Mr. Chairman, I would like now to complete the statement of the National Association of State Mental Health Program Directors. Incidentally, the mental health officials from the State of Louisiana have actively supported the preparation of this position and are interested in it.

We propose an amendment to title XIX of the Social Security Act as follows:

In Public Law 89-97—at the end of section 1905(a)(1) after "inpatient hospital services," strike out the phrase: "(other than services in an institution for tuberculosis, or mental diseases)".

This amendment would not change the eligibility provisions of title XIX coverage.

It would not expand any benefits now available under title XIX—mental illness is now treatable with Federal assistance.

It would simply broaden the availability of treatment for those already eligible by removing the exclusion against hospitals that specialize in treatment of mental illness (or tuberculosis).

We further propose, in an effort to keep the cost of this amendment to a minimum, that its effect not be retroactive—that it apply only to those persons who become eligible for medicaid subsequent to the passage of this bill.

Covering only new admissions would put mental hospitals on an equal level under the law with psychiatric units in general hospitals, since they have very few long-term psychiatric patients.

We realize that covering only new admissions would not be the most desirable answer to the problem of improved care of the mentally ill indigent, including those who are now resident patients. However, if at this time we cover only new admissions to mental hospitals, once we have some working knowledge of the scope and cost of this problem, perhaps it will be financially feasible to cover all of the eligible persons. For the present time, however, we feel what we have proposed is a prudent first step in the right direction.

Under the present law, title XIX now provides Federal assistance for medical treatment of the medically indigent (*a*) aged, (*b*) blind, (*c*) disabled, and (*d*) families of dependent children.

Under title 19 the aged are given full inpatient psychiatric coverage in public and private psychiatric hospitals as well as in psychiatric units of general hospitals. They are also eligible for full outpatient treatment.

However, persons under 65 years of age in the other three assistance groups—the blind, the disabled, and the dependent children families—are excluded from inpatient treatment in a specialty hospital. The specialty hospitals that we are referring to, that is, private and public mental hospitals, are specifically designed and staffed and equipped to provide a continuity of care for people with all ranges and severity of mental illness and mental deficiency, and are routinely called on to treat illness too complex for the general hospital unit.

We treat the acutely ill and the chronically ill, the psychotic, the neurotic, adults and children, the alcoholic, the aged, and the otherwise disabled.

We are specialty hospitals whose treatment programs are completely focused on alleviating disorders of the mind.

It makes no sense at all to us for the Congress to prohibit the treatment of persons with mental disorders in facilities whose sole purpose is the treatment of mental disorders.

This is an inconsistency difficult for us to fathom.

It is worthwhile to note, on the other hand, that some $150 million in Federal money will be invested this year in public and private psychiatric hospitals.

For the Federal Government to lend extensive financial support to State and private hospitals and then deny access to these hospitals to recipients of Federal assistance is an imcomprehensible inconsistency.

There is a table in the text of my material which indicates the money that is going into the special mental hospitals and the mental health centers.

The provision which denies the use of the mental hospital to persons was not in the 1965 original House bill but was added by the Finance Committee of the Senate in 1965.

Our studies, as indicated on pages 6 and 7 of my statement, suggest that of the four and a quarter million persons now on categorical assistance, and of the other four and a quarter million who would be eligible for medical assistance benefits, only some 3 percent will be likely to require hospital care for mental illness.

The arithmetic of this reveals that about 253,000 persons under the age of 65 would become eligible to receive benefits if they are hospitalized in a mental hospital.

Since these people are already eligible for care, for mental illness, in a general hospital phychiatric unit, the proposed amendment adds no new benefits and includes no new persons not already eligible for medical aid under Public Law 89-97.

Any person now eligible for medical aid under title XIX and who becomes mentally ill and requires inpatient treatment can be treated for about $45 per day in one of the 20,000 beds available in phychiatric wards in general hospitals.

He can be treated, that is, if he lives near one of the general hospitals that operates psychiatric facilities; if there is space available, and if he does not require extended treatment services.

Mr. Chairman, there is another section of H.R. 12080 in which the State mental health program directors have a powerful concern and in which we recommend it be clarified either in the legislation or in the Finance Committee report. I am referring to the social work manpower and training amendment. That would be section 401 of title IV.

It is our recommendation that you make clear that organizations representing regional compacts of the States on education and mental health be eligible to receive Federal grants to improve social work training.

I am referring especially to compacts such as the Southern Regional Education Board which is directly concerned with improving social work training in the colleges and universities in 15 Southern States.

With your permission, Mr. Chairman, I would like to offer for the record a letter our association has received from Dr. Harold McPheeters, director of mental health training and research for the Southern Regional Education Board in Atlanta, Ga. I also submit a statement from Dr. Ray Feldman of the Western Interstate Commission for Higher Education.

Dr. McPheeters and Dr. Feldman explain clearly the merits of this case in their statement.

The CHAIRMAN. That will be included.

(The documents referred to follow:)

SOUTHERN REGIONAL EDUCATION BOARD,
Atlanta, Ga., September 18, 1967.

MR. HARRY O. SCHNIBBE,
Executive Director, National Association State Mental Health Program Directors, Washington, D.C.

DEAR MR. SCHNIBBE: It would be most helpful to have the Association through Len Ganser put in a few words in favor of adding "regional compacts" to the Social Works Training and Manpower amendment of the Social Security Act Amendments of 1967 (H.R. 12080). We had submitted a statement for the house hearings on H.R. 5710.

The regional compacts of course would not do any direct training of social workers. However, they are in a position to take aggressive regional action in deevloping many aspects of social work training.

(1) Promote faculty development for both graduate and undergraduate social work programs. Faculty shortages are currently a serious problem. For example, we can conduct a summer workshop on how to teach, use of instructional T.V., curriculum development, etc., for all the social work practitioners in the South who could be recruited to move from practice to teaching to help them in the change-over.

(2) Encourage and assist colleges and universities to establish undergraduate social welfare programs with matters such as organization, curriculum offerings, field experiences, faculty recruitment, etc. Many colleges now are at a loss to know how to proceed. Through region-wide meetings, guidelines and consultants we can speed up the process of developing college programs throughout the region.

Keep in mind that both SREB and WICHE are oriented to *action* to improve the training resources of the region—not mere studies and reports. Keep in mind also, that these are regions of particularly acute shortages of social workers. We are trying. Four new graduate schools of social work are being organized in our region this year (University of Houston, University of Texas at Arlington, University of Arkansas and University of South Carolina), but we need help from all sources—the Federal Government through support such as H.R. 12080 and through the efforts of regional mechanisms such as SREB and WICHE.

Sincerely yours,

HAROLD L. MCPHEETERS, M.D.,
Associate Director for Mental Health Training and Research.

STATEMENT RE H.R. 12080, TITLE 4, OF THE WESTERN INTERSTATE COMMISSION FOR HIGHER EDUCATION

The Western Interstate Commission for Higher Education, a regional educational compact of thirteen states dedicated to increase educational opportunities and to expand the supply of specialized manpower in the west through regional action.

1. Urges the passage of Title 4, H.R. 12080, providing for federal grants to colleges, universities, and an association of graduate schools to develop and expand social work education.
2. Pleads that the wording be construed or amended to provide that regional organization such as Western Interstate Commission for Higher

Education and the Southern Regional Education Board and the New England Board of Higher Education also be eligible for these grants to assist in these efforts on a regional basis.

Dr. GANSER. Mr. Chairman, the State Mental Health Directors as far back as May of 1961 publicly asked the Congress to eliminate from the Social Security Act all discriminatory provisions against the treatment of mental disorders. You, especially, I think, because of your leadership in this program, are aware of the history of these efforts.

The last vestiges of discrimination in Federal welfare programs against patients in specialty hospitals remain in section 905 of Public Law 89–97.

We believe that our proposal to remove the discrimination in title XIX against care in psychiatric hospitals is a wise and a just one.

We also understand Congress may have reluctance to legislate in an area about which complete and accurate information is not always available.

The State mental health directors have a good working knowledge of the medicare-medicaid programs in their own States. We appreciate the fact, however, that due to the newness of this law, information about the operation of the programs throughout the country as a whole may not be readily available and as a matter of fact, as you know, many States have not had time to compile their experience.

Therefore, if this committee feels that it does not have at its command sufficient information to justify amending the law, as we request, we ask that this committee make provision for a study of this problem, including the utilization of the public mental hospitals and the private specialty hospitals for title XIX eligible persons.

Precedent has been established for this type of study by section 1875 of title XVIII of Public Law 89–97.

This section directs the Secretary of Health, Education, and Welfare to carry out studies and develop recommendations with respect to title XVIII programs.

A similar section written into title XIX or even language written into the report of this committee can be a major step toward resolving this problem of discrimination against mental hospitals and the welfare recipients who require care in those special hospitals.

We thank you very much, Mr. Chairman and Senator Anderson, for giving us your time, and, if there are any questions, why, we would be very pleased to answer them.

(The prepared statement of Dr. Ganser follows:)

TESTIMONY OF LEONARD GANSER, M.D., ADMINISTRATOR, DIVISION OF MENTAL HYGIENE, STATE OF WISCONSIN, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. Chairman, I am Dr. Leonard Ganser, Administrator of the Division of Mental Hygiene, Department of Health and Social Services, State of Wisconsin and Vice President of the National Association of State Mental Health Program Directors. Accompanying me is Mr. Harry Schnibbe, the Executive Director of our Association.

I am representing the directors of the programs for the mentally ill and retarded in the 54 states and territories.

The State Mental Health Directors administer over 1100 hospitals, training schools for the retarded, community mental health centers, clinics, aftercare facilities and psychiatric training and research institutions.

1.5 million mentally disordered persons are treated in our facilities annually.

We employ 284,000 persons and our annual operating and capitol budgets total $2.3 billion, which is larger than the 1968 combined administrative budgets of the U.S. Departments of State, Justice, Labor and Post Office.

PROPOSED AMENDMENT

We propose an amendment to Title XIX of the Social Security Act as follows:

In PL 89-97—at the end of Section 1005(a)(1) after "inpatient hospital services", strike out the phrase: "(other than services in an institution for tuberculosis, or metal diseases)".

This amendment would not change the eligibility provisions of Title 19 coverage.

It would not *expand* any benefits now available under Title 19 (mental illness is *now* treatable with federal assistance).

It would simply broaden the availability of treatment for those already eligible by removing the exclusion against hospitals that specialize in treatment of mental illness (or tuberculosis).

We further propose, in an effort to keep the cost of this amendment to a minimum, that its effect *not* be retroactive—that it apply only to those persons who become eligible for medicaid subsequent to the passage of this bill. Our amendment would put mental hospitals on an equal level, under the law, with psychiatric units in general hospitals.

We realize this would not be the most desirable answer to the problem of improved care of the mentally ill indigent. We would prefer to have coverage of *all* eligible indigent. However, if at this time we cover only *new admissions* to mental hospitals, once we have some working knowledge of the scope and cost of this problem perhaps it will be financially feasible to cover all eligible persons. For the present time, however, we feel that what we have proposed is a prudent first step in the right direction.

THE PRESENT LAW

Title XIX now provides federal assistance for medical treatment of the medically indigent (a) aged, (b) blind, (c) disabled and (d) families of dependent children.

Under Title 19 the *aged* are given full inpatient psychiatric coverage in public and private psychiatric hospitals as well as in psychiatric units of general hospitals. They are also eligible for full outpatient treatment.

However, persons under 65 years of age in the other three assistance groups (the blind, the disabled and the dependent children families) are excluded from *inpatient* treatment in a specialty hospital.

They can receive *inpatient* treatment only in a general hospital.

SHORTCOMINGS IN LAW

There are several inconsistencies in the Title 10 exclusion.

First: In terms of availability of inpatient treatment service—there are probably less than 20,000 beds being used for psychiatric inpatient treatment in general hospitals.

On the other hand, in public hospitals for the mentally ill and mentally deficient there are 665,000 available beds.

Dr. Gibson has described to you the severely limited general hospital psychiatric facilities in some 20 states.

May I add to that this information: in the 3500 small general hospitals in this country—that is hospitals with less than 100 beds—there are only seven psychiatric treatment units.

If the Congress is going to offer support of treatment for mental illness, then it appears totally inconsistent to *exclude* two sources (the private and public psychiatric hospitals) that offer 35 times more available treatment capacity than the one authorized source (the general hospital).

Second: In terms of continuity of service many of the chronically mentally ill need intensive treatment over a period of time more extended than that provided in a general hospital.

As Dr. Gibson has pointed out, the general hospital provides largely diagnostic and acute treatment service.

The average length of stay in a general hospital psychiatric unit is 17 days.

Another 25% of all patients admitted are eventually readmitted for further treatment.

The "specialty" hospitals (private and public) are designed, staffed and equipped to provide a continuity of care for people with all ranges and severity of mental illness and mental deficiency.

We treat the acutely ill and the chronically ill; the psychotic, the neurotic; adults and children; the alcoholic, the aged, the disabled.

We are "specialty" hospitals whose treatment programs are completely focused on alleviating disorders of the mind.

It makes no sense at all, to us, for the Congress to prohibit the treatment of persons with mental disorders in facilities whose sole purpose is the treatment of mental disorders.

This is an inconsistency difficult for us to fathom.

ANOTHER INCONSISTENCY

It is worthwhile to note that some $150 million in federal money will be invested this year in public and private psychiatric hospitals.

For the federal government to lend extensive financial support to state and private hospitals and then deny access to these hospitals to recipients of federal assistance is an incomprehensible inconsistency.

The aforementioned $150 million will be invested in public and private psychiatric hospitals in the following manner:

	Millions
Hospital improvement grants	$18
Department of Defense dependents medical care program	[1] 13
Training (in-service)	12
Hill-Burton	4
OEO (VISTA, etc.)	8
Community mental health services (Public Law 89–749)	7
Community mental health centers	50
Community mental health staffing	40
Total	150

[1] Estimated.

HOW MANY AFFECTED BY DISCRIMINATION?

A most logical question by members of this Committee would be: "How many persons suffering from mental disorder are affected by these discriminatory provisions in Title 19, and if it were removed what would it cost to provide them treatment?

1964 figures released by the Department of Health, Education and Welfare indicated that a total number of 4,220,922 persons were receiving welfare payments under one of the assistance categories—Aid to the Permanently and Totally Disabled, Aid to the Blind, Aid to the Families of Dependent Children.

Information supplied by the states indicates that the ratio of medically indigent persons who are "related" to the three pertinent public assistance categories, but who are not now receiving any public assistance is: *One to one*.

In other words, for every blind person receiving Title 10 federal assistance, there is another blind person not receiving public assistance, but who is "medically indigent" as defined by state law.

Thus the universe of people who would become potentially eligible for assistance under this amendment is approximately 8,441,844.

To further define the potential number of persons who might apply for assistance were this amendment to be adopted, we can apply a percentage of 3% to the universe of 8 million. Figures supplied by NIMH indicate that approximately 3% of a cross-section of people under 65 years of age annually require hospitalization for mental disorders.

This arithmetic reveals that some 253,255 medically indigent individuals under age 65, eligible under Title 19, might require hospitalization for mental illness.

Under our proposed amendment these individuals would be eligible for Title 19 assistance in a psychiatric hospital as well as a general hospital.

COST OF THE AMENDMENT

The proposed amendments adds no new benefits and includes no persons not already eligible for medical aid under PL 89–97.

Any person now presently eligible for medical aid under Title 19, and who becomes mentally ill and requires *inpatient* treatment, can be treated for about $45 per day in one of the 20,000 beds available in psychiatric wards in general hospitals.

He can be treated providing: (a) he lives near one of the 465 general hospitals in the United States that operates psychiatric facilities, and (b) space is available, and (c) he does not require extended treatment.

Mr. Chairman, there is another section of H.R. 12080 in which the State Mental Health Program Directors have a powerful concern and which we recommend be clarified either in the legislation or in the Finance Committee Report. I am referring to the Social Work Manpower and Training amendment (Title IV, Section 401).

It is our recommendation that you make clear that organizations representing regional compacts of the states on education and mental health be eligible to receive federal grants to improve social work training.

I am referring especially to compacts such as the Southern Regional Education Board which is directly concerned with improving social work training at the colleges and universities in 15 southern states.

With your permission, Mr. Chairman, I would like to offer for the record a letter our Association has received from Harold McPheeters, M.D., Director of Mental Health Training and Research for the Southern Regional Education Board in Atlanta, Georgia. Dr. McPheeters explains forcefully the reasons why regional compacts of states should be eligible for this grant money.

(The material referred to has been previously submitted for the record by Dr. Ganser.)

Mr. Chairman, the State Mental Health Directors as far back as May 12, 1961, publicly asked the Congress to eliminate from the Social Security Act all discriminatory provisions against the treatment of mental disorders.

Following our action the Governor of California called upon all other governors to join him in getting the exclusions against mental hospitals removed from the Act.

Over the next several years Senators *Long* of Louisiana and *Carlson* of Kansas tried and failed to get the discriminatory provisions removed.

Senate amendments, removing the exclusions, were included in H.R. 11865, the Social Security Act Amendments of 1964.

They failed in conference with the House.

Finally in the 89th Congress (PL 89–97) most of the exclusions were removed.

The last vestiges of discrimination in federal welfare programs against patients in specialty hospitals remain in Section 1905 of PL 89–97.

There are also discriminatory provisions against treatment of mental illness in Title 18. Dr. Gibson has called these to your attention and we endorse his recommendations.

We in the state mental health programs believe that our proposal to remove the discrimination in Title 19 against care in psychiatric hospitals is a wise and just move. We also understand however, that the Congress may have a reluctance to legislate in an area about which complete and accurate information is not always available.

The state mental health directors have a good working knowledge of the medicare-medicaid programs in their own states. We appreciate the fact, however, that due to the newness of this law, information about the operation of the programs throughout the country as a whole may not be readily available.

Therefore, if this committee feels that it does not have sufficient information at its command to justify amending the law as we reqeust, we ask that the committee make provision for study of the problem.

Precedent has been established for this type of study in Sec. 1875 of Title 18 of PL 89–97. This section directs the Secretary of H.E.W. to carry on studies and develop recommendations with respect to Title 18 programs. A similar section written into Title 19 or even language written into the report of this committee, could be a major first step toward resolving this problem of discrimination against mental hospitals.

Thank you for giving us your time and attention.

The CHAIRMAN. As you know, I fought very diligently to provide additional help for people suffering psychiatric illnesses, and we did succeed in saying that we would not deny assistance to people merely because they are in these mental hospitals, and we have made some money available to the aged. How is that coming along as far as the improvement of treatment and services for these aged people are concerned?

Dr. GANSER. I think in those hospitals or in those States where the title XIX applies to mental patients in the aged group, the over 65 group, that this is proceeding relatively well, and this does include about 20 States now, including Louisiana.

The CHAIRMAN. Well, there are a great number of people who are presently just given custodial care in these institutions who might be put to some constructive use, I am told. Is that your impression?

Dr. GANSER. I think the public mental hospitals throughout the country have been used as a storehouse for people who, for a variety of reasons, are thought to be—it is thought to be necessary to get them out of the community. Many of them are truly mentally ill. Others of them are not mentally ill, but rather have some kind of what might be called social maladjustment that makes it somewhat easier to get along with them if they are in the hospital.

I believe really that this program, used productively and positively, can help that situation since it makes clear that in order to receive benefits in a mental hospital the individual must really need to be in a mental hospital.

I think the utilization review kind of aspect to it, with which you are familiar from the medicare, the title XVIII part of the law, will be of positive benefit as it begins to apply to public mental hospitals; and this, as a matter of fact, is what the public mental hospitals have needed, a good reason to be looking at whether those people really need to be there or whether some kind of alternate facility can properly take care of them or whether they should be back in the community even if it is in a marginal adjustment in the community.

The CHAIRMAN. Thank you very much, Doctor.

Dr. GANSER. Thank you.

The CHAIRMAN. Thank you and your associates.

Senator ANDERSON. I just wanted to repeat to you that I will read your statement more carefully.

The CHAIRMAN. Thanks so much.

The next witness is David Fleming, of the Southern California Pharmaceutical Association.

STATEMENT OF DAVID FLEMING, GENERAL COUNSEL, SOUTHERN CALIFORNIA PHARMACEUTICAL ASSOCIATION, ACCOMPANIED BY FRANK SCHULER, PRESIDENT, AND CECIL BLACKHURST, EXECUTIVE SECRETARY

Mr. FLEMING. Mr. Chairman and gentlemen of the Finance Committee, my name is David Fleming, general counsel for the Southern California Pharmaceutical Association. I am here today with Mr. Frank Schuler, to my right, president of the association, and Mr. Cecil Blackhurst, to my left, as its executive secretary.

We of the Southern California Pharmaceutical Association deeply appreciate the opportunity to appear here to express our views on H.R. 12080.

The SCPA is composed of independent pharmacists in the 11 southern counties of the State of California. The population of the geographic area served by our association is presently estimated from census sources to be in excess of 13 million people. Southern California has attracted, and is constantly attracting, many of our Nation's senior citizens who look forward to retirement due primarily to our climate and our recreational and housing facilities. Some 70 percent of California's senior citizens, numbering roughly 1,800,000, reside in the area served by our association.

Our very real interest is, of course, directed toward the prospect of the inclusion of drugs for the aged under title 18(b) of the Social Security Act. We are not unmindful of legislation introduced in the Senate during the second session of the 89th Congress providing for the inclusion of drugs under title 18(b); and I might interlineate, nor, for that matter in S. 1303.

Because we have a higher proportion of senior citizens in our area than in most other regions of the Nation, our members are more keenly aware of the possible effect of this legislation on their livelihood.

We estimate that the aged are recipients of from 10 to 15 percent of all prescriptions filled by our members. In a business where profits are not substantial, where labor, overhead, and inventory costs are constantly rising, this 10 to 15 percent of the total drugs sold is a significant amount. We can foresee the U.S. Government, either directly or indirectly, becoming our largest single customer. In light thereof, we are most concerned about this area of proposed legislation.

We wish to make two things clear at the outset. First, we are not opposed to the inclusion of drugs for the aged under the Social Security Act per se. Good health care should be available to all Americans and especially to our senior citizens. No one should be deprived of this gift because of financial reasons. It has been the corner pharmacist who has served the drug and health needs of his community for years on end. He knows only too well the vital importance of adequate drug care.

Second, we believe in economy—economy in government and in every problem undertaken by government. We believe that every Federal dollar spent should receive in return the most value possible. That is why we support the principle that government should purchase drugs by generic rather than by brand name. We bear in mind, of course, the need for constant surveillance of high manufacturing standards of all drugs and believe that quality control must never be forsaken when health hangs in the balance. Yet, having met these standards, there is no reason why the Federal Government or any branch of government aiding citizens in their drug care should spend more than is absolutely necessary to fulfill this goal.

Some of our members have complained bitterly to our State government in Sacramento regarding the handling of the Medi-Cal program. Under California law, our members are not allowed to fill welfare prescriptions calling for brand names with lower priced but equally as effective generic product.

Tetracyclene is an example. Most of our members use the generic rather than the brand product. We have not found complaints regarding potency or efficacy of the generic tetracyclene. Yet, the brand names of tetracyclene cost from six to eight times higher than the generic. Those extra costs are needlessly borne by our State and ultimately, in part, by the Federal Government. We have gone on record as opposing this extravagance, and, in California, we are trying to do something about it.

While we are concerned with keeping Government cost down, we are equally as concerned about the assurance of financial protection to the pharmacists.

The CHAIRMAN. Let me just ask you about that because someone contested this idea today. You say that as, speaking for the pharmacists——

Mr. FLEMING. Yes, Senator.

The CHAIRMAN (continuing). Of southern California. Your experience has been that with regard to this wonder drug, tetracyclene, as an example, that it is all the same thing, no matter which one of the manufacturers is producing it, and yet if you buy it by the brand name you are going to pay about six or eight times as much as you would buying it by the official name of the product?

Mr. FLEMING. This is our experience, Senator, yes.

The CHAIRMAN. Let's take the tetracyclene experience and apply it to an APC tablet. As I understand it an APC tablet is an aspirin tablet with a little bit of stimulant added to it—a little caffeine in it, so that it might stimulate you a little bit, such as a cup of coffee would. It is supposed to give a little additional reaction in addition to the aspirin.

If a fellow comes in and says, "Give me some Empirin tablets," you just hand him the APC tablets, it is all the same thing, but it would cost him maybe about one-eighth as much as Empirin?

Mr. FLEMING. Yes.

The CHAIRMAN. It is much more pronounced when you get into these drugs which have to be sold by prescription, as I understand it.

Mr. FLEMING. That is correct. And, as you know, Senator, we cannot, in California, fill with the generic when a brand name is prescribed.

The CHAIRMAN. Well, go to the State legislature and get a law passed. It is the same proposition as I was telling about my dad's patent medicine experience, high "Poplarlorum," and low "Poplarhirum," where you have two bottles with exactly the same thing, same sized bottles, but you cannot sell for one-sixth the price because these fellows went down to the State legislature and got a law passed that would prohibit you from selling the man the same thing for a fraction of the price, even though the poor devil might not be able to afford it.

Mr. FLEMING. This is true in California, and I understand in some 43 other States they have the same laws.

As I pointed out, our members have complained bitterly to the State welfare department about the fact that we cannot fill generic tetracycline when the brand name is prescribed. We feel this is wasteful.

The CHAIRMAN. As you know, I had no interest whatever in reducing the income of the community drugstore. So far as I am concerned, those people do a good job. If anything, I would be in favor, all things being equal, of finding a way to help the community drugstore to compete with that supermarket that has various and sundry ways to get an unfair advantage over that local drugstore.

But there should be a way that we can give the public the benefit of price competition for these products.

Mr. FLEMING. Our association is certainly in agreement.

The druggist in this country is, of course, not a pharmaceutical manufacturer. He is not an individual of great wealth or affluence. The average druggist is, instead, the epitome of the small businessman.

In most cases, he is the sole proprietor; a professional member of his business community who is active in the growth and development of the city or town in which he lives. Like so many other small businesses, he operates under the profit squeeze, with rising labor, overhead, and inventory costs. In most instances, his life savings are invested, in large part, in his business. He has no financial cushion to withstand a substantial profit loss.

We all know, I am sure, that the pharmacist's role is not to prescribe drugs, but to dispense them. He sells his stock at a markup of usually one-third and charges a standard and customary fee for the filling of a doctor's prescription. These markups and charges are, of course, competitive with his neighbor druggist down the street. He seeks only a reasonable profit for the services he performs and the investment he must make. He asks nothing more. It is in the light of this that we address ourselves to the complexities of compensating the pharmacist under any proposal for inclusion of drugs under title 18b.

The members of the SCPA have discussed at length the merits and drawbacks of the proposed system for the payment of a set fee to the pharmacist for the filling of medicare prescriptions. The fee system, it seems to us, has some distinct drawbacks. Problems arise when we try to use a common denominator for all retail druggists. In our area, the overhead and other costs to operate a store in, for example, Newport Beach, or Beverly Hills, Calif., is far greater than those for a store located in Gardena or Venice, Calif. Yet, while drugstores or pharmacies differ in overhead and operating costs, the fixed fee concept suggested and used today under State welfare programs ignores this fundamental fact.

Demographic factors must be brought into play in determining a fee schedule if fees are to be fair and just. One means of accomplishing this would be by the use of surveys eliciting the usual and customary markup in fees for each drugstore by area. The results of those surveys could be used in determining appropriate remuneration to be paid to pharmacists within a given community commensurate with their existing charges.

We should also point out that in the determination of adequate fees, the quantities of the drugs prescribed should be taken into consideration. This is especially true of senior citizens who receive, in large part, the maintenance drugs which can be prescribed in large quantities. Regular fees should be adjusted upward for the filling of large-quantity prescriptions.

These suggestions are made for the sole reason of attempting to devise a system whereby the pharmacist is allowed his usual and regular return for the dispensing of drugs under the medicare program, whether his store be in Pasadena, San Diego, Bakersfield, or Watts. Anything less than a fair return would mean that the pharmacist himself would have to pay more than his fair share of taxes to support this program. Drug needs of our senior citizens can and should be provided for; but the cost should be borne by all of our citizens. We ask nothing more than this.

Mr. Chairman and gentlemen of the committee, the Southern California Pharmaceutical Association deeply thanks you for the opportunity to present its views on H.R. 12080. It has been a privilege for us to have appeared here.

The CHAIRMAN. I appreciate your statement. I know you have been importuned by the pharmaceutical manufacturers, particularly the big ones, to take a different attitude on this matter, have you not?

Mr. FLEMING. We have been approached. Yes; we have discussed the matter with the pharmaceutical manufacturers.

The CHAIRMAN. They are good people, but I do not think they ought to blame you for the high cost of drugs when they, themselves, seek to maintain a pricing method to charge the public six or eight times what a product ought to be selling for.

Mr. FLEMING. We hope the public understands the fact, Senator.

The CHAIRMAN. Thank you very much.

Senator Talmadge, any questions?

Senator TALMADGE. No questions.

The CHAIRMAN. Dr. William A. Garrett, president of the American Dental Association. I am informed that Dr. Garrett is from Atlanta, Ga., Senator Talmadge.

Senator TALMADGE. Mr. Chairman, it gives me a great deal of pleasure to welcome my friend, Dr. William A. Garrett, of Atlanta, Ga., who is president of the American Dental Association, to our committee.

STATEMENT OF DR. WILLIAM A. GARRETT, PRESIDENT, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER

Dr. GARRETT. Mr. Chairman. Senator Talmadge, I am delighted, sir, to have you here. My name is Dr. William A. Garrett, of Atlanta, Ga. I am president of the American Dental Association. With me is Mr. Bernard J. Conway, chief legal officer of that association. We are pleased to have this opportunity to discuss that portion of section 301, title III, of H.R. 12080, which would add a new section 510 to part 4, title V, of the Social Security Act.

This new section would authorize special project grants for the dental health of children to be awarded to State or local health agencies or to other public to nonprofit private agencies, institutions, or organizations. It would be a 4-year program beginning in fiscal 1969 and Federal participation would be limited to 75 percent of the cost of such projects.

The American Dental Association supports the intent and principle of the proposal and urges this committee to give it favorable consideration.

A detailed statement of our position has been submitted and we respectfully request that it appear in full in the record. We are aware of the limitations on the committee's valuable time and we will restrict our oral testimony to the major points made in that statement.

Every member of this committee is, we are sure, aware of the seriousness of the dental disease problem. Almost no one is immune from its ravages and the Nation pays a high price for its historic dental neglect.

This has long been a matter of intense concern to the dentists of the Nation, especially since so much dental disease could be readily controlled and prevented. The gap between what can be accomplished and what is being accomplished is enormous.

In attempting to devise ways of dealing with this situation, the profession's attention has always been focused on children from low-income families. It is not possible to control dental disease solely by providing restorative treatment to all age groups within the population. If, however, we can once manage to bring a generation of children to a state of sound oral health, it will be a relatively simple matter to maintain that conditions as each child reaches adulthood and lives out his span of years.

The dental profession recognizes that achievement of this goal requires close cooperation between the private and public sectors.

It is the private sector that encompasses nearly all the professional manpower available to the Nation. Most families are quite capable of maintaining, as they do at present, responsibility for their dental health care within the private practice system. No one, as we understand the measure before you, is suggesting Federal support of dental care for children whose families are well able to afford it.

Within the private sector, the association has constantly sought better ways to organize the delivery of health services. One example of this is the rapid and most welcome development of prepayment mechanisms that has occurred in the past few years.

For the most part, this has taken the form of group dental care coverage for employees and their dependents. Approximately 35 private insurance companies are now engaged in underwriting such contracts. In addition, the profession has encouraged the State level development of dental service corporations, which are nonprofit, prepayment organizations similar to Blue Shield. At present, 30 States have chartered dental services corporations.

Though only about 4 million people are now covered by one form or another of dental prepayment, there is sufficient evidence amassed to document the feasibility of the idea and to show that it is readily acceptable to consumer groups of various kinds.

The CHAIRMAN. Doctor, I am going to have to ask you to suspend for a few moments. We are voting in the Senate on final passage of the bill. It is a big appropriation bill, and I will have to go vote. I will be back just as soon as I can. So if you will just wait, sir, I will be back.

Dr. GARRETT. Thank you.

(Whereupon, there was a short recess.)

Senator HARRIS (presiding). The committee will be in order. The chairman asked me to preside until he could return. You may proceed.

Dr. GARRETT. Thank you, sir.

The proposal before you will, in our view, give impetus to this private sector activity.

At the same time, the association has taken a number of steps to call Government's attention to actions that it could legitimately take. For example, in an appearance before this committe in 1965, the association strongly recommended that dental care for children be named as one of the mandatory services offered by the States under title XIX of the Social Security Act. Indeed, Senator Ribicoff introduced an amendment to that effect that was accepted by both the committee and the full Senate, though it was not adopted in the subsequent Senate-House conference.

The public sector's involvement in a total program of dental care for children would have two basic purposes. There are, first of all, some activities that cannot realistically be carried out on an individual basis, such as dental health education and fluoridation. And then, public sector cooperation is required for those who are needy or medically needy.

The long history of association activity on this question climaxed in late 1966 with adoption of a dental care program for children that spells out in detail what we believe should be done. A copy of that program has been made available this morning to each member of the committee.

The first step in implementation of the association program would be the establishment of a series of pilot projects designed to provide the actuarial and operational experience necessary.

The proposal contained in H.R. 12080 also provides for such pilot projects. In his testimony before the House Ways and Means Committee, HEW Secretary John W. Gardner indicated that the administration expected to establish 10 such projects in the first year, encompassing some 100,000 children.

We are, of course, pleased that the administration's thinking seems to be following along the same lines as that already elaborated by the profession. While, candidly, we would prefer to see a larger number of projects begun in the first year, we recognize that Congress must balance needs in a great many areas and allocate resources as fairly as possible. The important point, the essential point, is that a beginning be made.

It is not possible to tell from the information in the bill how much money would be allocated to this project in the first year. It is our hope, however, that the administration will request in fiscal 1969 an amount sufficient to make an adequate start.

The administrative authority contained in the proposal is, of course, conferred on the Secretary of Health, Education, and Welfare. He will, in turn, designate the HEW agency responsible for implementation.

It is our conviction that the agency so designated should be the Public Health Service. It alone combines the depth in staffing, the experience with dental activity and the professional expertise necessary to carry out this multipurpose program. This is a most vital consideration to us. Few actions could do more to insure the eventual success of this undertaking than designation of the Public Health Service as the agency with primary responsibility.

There would, naturally, need to be the closest cooperation on all levels with those agencies concerned with education and with welfare.

In addition to these comments on the dental health pilot program, the association would also like to call the committee's attention to a technical amendment that we think is necessary in section 230 of H.R. 12080. The present amendment would permit direct payment at the option of the State for physicians services rendered under title XIX. Obviously, a wider range of health practitioners than physicians provide such services. We are sure that the exclusion of dentists was inadvertent and suggest that the committee make the appropriate change.

Mr. Chairman, this concludes our testimony. On behalf of the association, may I once more express our appreciation for this opportunity to present our views. Mr. Conway and I would be glad now to respond to any questions.

(The prepared statement of Dr. Garrett follows:)

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the committee, my name is Dr. William A. Garrett of Atlanta, Georgia. I am President of the American Dental Association. With me here today is Mr. Bernard J. Conway, chief legal officer of the Association. We are grateful, Mr. Chairman, for this opportunity to appear before you to discuss section 301 of Title III of H.R. 12080 which would add a new section 510 to part 4, Title V of the Social Security Act.

This new section would authorize special project grants for the dental health of children. These would be awarded to state or local health agencies or to other public or nonprofit private agencies, institutions or organizations. The bill would establish a four-year program beginning in fiscal 1969. Federal participation would be limited to 75 per cent of the cost of such projects.

The American Dental Association supports the intent and principle of this proposal and urges favorable consideration of it by this Committee.

The authority conferred by the proposal is delegated, of course, to the Secretary of the Department of Health, Education and Welfare, who will in turn designate the agency responsible for implementation of its provisions.

It is the conviction of the American Dental Association that the agency so designated should be the Public Health Service. The Public Health Service alone combines depth in dental staffing, the experience with dental activity and the professional expertise necessary to carry out this multi-purpose program.

The Association believes this consideration to be a vital element in the success of this endeavor and believes, further, that few actions could do more to ensure that success than designation of the Public Health Service as the agency with primary responsibility.

DENTAL DISEASE STATISTICS

The scope of dental disease, as it exists today, qualifies it as one of the most frustrating of all the ills that plague us. Its most common manifestations are tooth decay and gum disease. There is almost literally no one in the country who is not suffering from one or the other. And yet, there are few diseases that are as readily controllable and preventable as are these two. The gap between what can be accomplished and what is being accomplished is enormous.

Secretary Gardner, in testimony before the House Ways and Means Committee, recited some of the deplorable statistics: "By age 5, a child has an average of 3 carious teeth. By age 15, the average youth has 11 permanent teeth damaged or destroyed." The impact of this is such that in later years "a vast percentage of Americans have suffered the loss of many or all their natural teeth."

Such dental disorders exact a heavy price. Recruits to the armed forces need extensive dental care, costing an average of $63 per recruit, before they are fully fit for duty. It is estimated that in industry there is an annual loss of 85 million manhours, valued at $250 million, because of dental disease. And these dollar figures cannot, of course, take into account the pain that is suffered or the permanent disability with regard to oral health that often eventuates. Nor do they reflect the dollar difference between what it costs to rehabilitate a long-neglected mouth compared with the more modest amount that would need to be spent for routine preventive care.

FREQUENCY OF CARE FOR NEEDY

It should be noted with regard to this last point that there is a discernible relationship between income and the frequency with which dental services are sought. Nearly 70 per cent of the children whose families earn less than $4,000 annually do not receive dental services. For children from families whose income exceeds $10,000, the statistics are more than reversed, with 80 per cent seeing a dentist on a reasonably regular basis.

The dental profession's long-standing concern over this problem is centered about children. The reason for this is that it is neither feasible nor professionally desirable to control the dental disease problem in this country solely by providing restorative treatment to the whole population. If however, we can once manage to bring a generation of children to a state of sound oral health, it will then be a relatively simple matter to maintain that condition as the child grows up and lives out his span of years.

PUBLIC SECTOR-PRIVATE SECTOR COOPERATION

The profession recognized long ago that achievement of this goal required close cooperation between the private and public sectors of the nation.

It is the private sector, first, that encompasses nearly all the professional manpower available to the nation. The vast majority of dentists actually engaged in chairside care—as opposed to those carrying out administrative, educational or research functions—provide that care within the private practice system.

Further, the vast majority of families are perfectly capable of maintaining, as they do at present, personal responsibility for their dental health care. Neither the profession nor the Administration, as we understand the proposal, is suggesting federal support of dental care for children whose families are well able to afford it. The Association does believe, however, that an income tax credit for the amount spent annually by a family in securing dental services for children would provide a useful and justifiable incentive for regular care. The Association, additionally, has long advocated complete deductibility of the cost of health and medical services.

Finally, the private sector's importance derives from the rapid and wholly welcome development of prepayment mechanisms that has occurred in the past few years. For the most part, this has taken the form of group dental care coverage for employees and their dependents. A number of private insurance companies are now engaged in underwriting such contracts. In addition, the profession has encouraged the state-level development of dental service corporations, a non-profit, prepayment organization, similar to Blue Shield, that contracts with groups for the provision of dental care benefits in the offices of private dentists. At present, 28 states have chartered dental service corporations.

While the total number of people now covered by one form or other of dental prepayment is not large, there is enough evidence already available to document the viability of the idea and to indicate a rapid growth in its acceptance in the years immediately ahead. One reason we favor the proposal before you is our belief that it will give further impetus to this private sector activity in the area of prepayment.

The public sector's involvement in a total program of dental care for children is twofold. There are, first of all, those activities that cannot realistically be carried out on an individual basis. Dental health education within the school system would be one example of this sort of activity. A second would be fluoridation of communal water supplies. This safe, inexpensive and highly effective public health measure has been of inestimable benefit to thousands of communities across the nation, reducing the incidence of tooth decay among children by as much as 60 per cent, an effect, of course, that benefits the child throughout his life.

And then, public sector cooperation is required for those children whose families are needy or medically needy. There can be no question but that we are today in a time when it is clearer than ever before that the opportunity to obtain health care is regarded as a right and that our society is pledged to the development of mechanisms effectively assuring that all Americans share fully in this right. The "medically needy" concept, probably first impressed upon the public consciousness by the Kerr-Mills law, has proven a highly useful tool in the nation's effort to improve the accessibility of health care services.

EFFORTS BY THE PROFESSION

Through the years, in its efforts to meet the challenge of dental health care for all children, the Association has been consistent in its espousal of private sector-public sector cooperation. While constantly searching for ways to better organize the delivery of health services within the private sector, the Association has made frequent representations to Congress, and the Executive branch, concerning federal activities in the area that the Association felt would be appropriate. When Title XIX legislation was first being considered, for example, the Association strongly urged that dental care for children be named one of the mandatory services offered by the states under that program.

The long history of Association activity climaxed last year in the adoption by its House of Delegates of a dental care program for children that spells out in detail what the Association believes should be done. A copy of the program has been made available to every Member of the Committee, attached to our summary statement, and it is our hope that each Member will have an opportunity to review it.

In broad terms, the program envisions a step-by-step progression toward the final goal of making fully adequate dental services available to all children. It takes note of a number of reasons why intermediate stages are essential. Paramount among them, perhaps, is the fact that there are still a good many things we need to know before we can be sure which approach, or combination of approaches, is preferable. And then, an attempt to inaugurate an elaborate program overnight would place a strain on existing resources, particularly with regard to professional manpower, that might prove disruptive.

It is pointed out in the Association's program that a soundly-based plan would not consist merely in providing chair-side care. Equally essential are such elements as dental health education, intensification of our present efforts in pure and applied research and widespread use of the known principles of preventive treatment. The profession is firm in its belief that it would be the sheerest folly to attempt a program based on just one of these elements. All are necessary.

The program envisions that a major share of the planning would be done on the local and state level. Though there is no section of the country that does not have a serious dental disease problem, the components of the problem obviously vary somewhat from place to place because of economic, geographic or population variants. Prime responsibility for planning public sector participation should be lodged with the state and local departments of health since, in each locale, it is this agency that has the necessary expertise to judge health needs. On the national level, the program assumes that responsibility for administration of the public sector would be vested in the Secretary of Health, Education and Welfare and discharged by dental health oriented personnel which are available in the Public Health Service. On all levels, of course, there would need to be the closest cooperation between such other appropriate agencies as those concerned with welfare and education.

Finally, the program notes that the great bulk of activity would remain where it is today, in the private sector. Some $3 billion a year is being spent presently within the private sector for dental care services. Public funds would never represent more than a very small fraction of this total. In our effort to extend comprehensive care to all children, we should not lose sight of the fact that most children have those services already available and if they do not avail themselves of it, it is for reasons other than economic ones.

IMPLEMENTATION

The first step in implementation of the American Dental Association Dental Health Program for Children would be the establishment of a series of pilot or exploratory program designed to provide the actuarial and operational experience necessary. The projects would be as diversified as possible, with regard to the complexion of the communities chosen, so that the information elicited would be valid when applied nationally.

The legislation before you provides for such pilot projects. In his testimony before the House Ways and Means Committee, Secretary Gardner said the Administration contemplated establishing ten projects the first year, to be located in areas of acute poverty and encompassing some 100,000 children.

The Association is, of course, pleased at this indication that the Administration's thinking seems to be developing along the same line as that already elaborated by the profession.

We would, candidly, have been happier to see a somewhat larger number of projects initiated in the first year. A larger number of projects would make it more certain, to our mind, that we will be able to elicit all of the necessary information in a reasonably brief period of time and then move ahead in an orderly, knowledgeable way. We do recognize, however, that Congress and the Administration must balance needs in a great many areas and then allocate resources as fairly as possible. The important point, the essential point, is that a beginning be made.

The ultimate success of the initial program and its value to our future progress will, of course, depend to a great extent on the quality of its administration. As already noted, the Association believes that the Secretary should assign prime administrative responsibility to the Public Health Service, as the only agency having adequate dental expertise and personnel. We also believe the Secretary should seek the advice of nongovernmental experts through the appointment of an appropriate advisory body.

SUMMARY

In summary, Mr. Chairman, may I express the Association's conviction that the problem to which this proposal is directed is a real and pressing one. Indeed, we know of no one concerned with the nation's health who does not agree that something must be done soon about the appalling rate of dental disease, especially among needy children. There will never be a more appropriate time to begin than today, when we can take advantage of the considerable impetus already developed within the profession, other private sector organizations and on all levels of government.

One of the most comforting aspects of the situation is that the solution to a major part of the problem is all but within our grasp. As I said at the beginning of this statement, the gap between what we know can be accomplished and what is in fact being accomplished is enormous. It is not a matter, as it is so often when dealing with national problems, of applying a solution that one hopes will work or that one thinks might work. We already possess most of the basic knowledge and tools. We are in a position to move ahead rapidly. What we need to do is to make a start in terms of organization and administration to assure that that knowledge and those tools are applied as efficiently and effectively as possible. The suggested amendment to part 4, Title V of the Social Security Act would enable us to make a prudent beginning. On behalf of the American Dental Association, then, may I urge this Committee to give favorable consideration to section 301, Title III of H.R. 12080.

The Association should also like to call the Committee's attention to a technical amendment that should be made in Section 230 of H.R. 12080. The present amendment would permit direct payment, at the option of the state, for physicians' services under Title XIX. Obviously, a wider range of health practitioners than just physicians are presently providing services under Title XIX. The Association understands that the exclusion of dentists was inadvertent and suggests that Section 230 be appropriately amended.

This concludes our testimony, Mr. Chairman. On behalf of the Association, may I again thank the Committee for this opportunity to present our views. We would be glad now to try to answer any questions you and Members of the Committee may have.

Senator HARRIS. Dr. Garrett, I want to thank you on behalf of the committee, you and Mr. Conway, for your presence here and for your patience this afternoon as we have had votes in the Senate.

I understand that your staff is going to get in touch with our staff on the Finance Committee to see what we can work out on the amendments you have suggested on the last page of your testimony.

Dr. GARRETT. That will be fine.

Senator HARRIS. Very well. Thank you very much for your presence.

Dr. GARRETT. Thank you so much, and please express my appreciation to Senator Long and to Senator Talmadge for their consideration.

Senator HARRIS. Right.

We will next be pleased to hear from Mr. Edward V. Sparer. I want to express to you the gratitude of the committee for your willingness and ability to work out a joint statement in behalf of the Columbia University School of Social Work, Mobilization for Youth, and Project on Social Welfare Law of New York University School of Law.

We will be glad to hear from you.

STATEMENT OF EDWARD V. SPARER

Mr. SPARER. Thank you, Senator. I should stress, I am speaking as an individual, although I am relying in great part on the experiences of the Center on Social Welfare Policy and Law at the Columbia University School of Social Work. I also speak on behalf of Prof. Norman Dorsen of the NYU Law School's Project on Social Welfare Law and others of NYU, and on behalf of Mr. Harold Rothwax of Mobilization for Youth's Legal Service Division.

I am testifying only with regard to parts 2 and 4 to title II, on public assistance, of H.R. 12080.

I have handed in a rather lengthy written statement in which I have attempted to make some analysis and argument, and not just take positions.

In the time I have for oral testimony, I will just make some comments on some of the things raised in my written submission as time permits.

I agree very strongly with the draftsmen of the House bill that there is a great deal wrong with public assistance. A great many changes, I think, are needed in public assistance. But it is my feeling that they have got the wrong ones in the House bill, and that what they have done in the bill is worsen some of the problems rather than remedy the ones which are in need of remedial action.

I would like to run over a few of the provisions of the public assistance title in the House bill.

The first concerns the freeze. It seems to me that what the freeze does is throw us back to pre-Social Security Act days. The one great advance that the Social Security Act of 1935 made over poor law traditions was its guarantee to all people who meet eligibility tests of the various States that they will be given public assistance.

What the freeze does is make it impossible to enforce that part of the Social Security Act. Obviously, all eligible people are not going to get assistance, and obviously we are going back to the poor law days of picking and choosing on an arbitrary basis who does and who does not get assistance. Almost any kind of rule can be justified so long as it is related to the freeze provision.

What is particularly striking in relation to the freeze is not only the argument concerning its constitutionality that can be raised, and not only the argument that can be raised about its conflict with the Social Security Act's purpose, but the factual errors which seem to underlie the reasoning in the House report on H.R. 12080. The House report seems to indicate that the reason for the freeze is that there has been a great growth in that portion of the AFDC program which deals with the absent parent population, children who are eligible because of an absent parent, and that the reason there has been a great growth in that part of the program is that there has been a great spread of family breakup and illegitimacy in the country as a whole. The least that can be said about such reasoning is that it is erroneous in terms of the facts it assumes to explain the growth of the AFDC program.

The figures and the sources that I cite in my written testimony show that while it is true that the AFDC population—from 1955 to 1963, for example—doubled (the number of parents, the number of families doubled, the number of children doubled on the AFDC rolls), when you compare that doubling to the number of families in the population as a whole who were headed by a single parent, you find there no comparable growth. There was only a slight increase in the number of families in the United States headed by a single parent during that period.

Similarly, while there was some increase in the rate of illegitimacy, the increase was comparatively slight (according to whatever figures that are available for 1955 to 1963) and in no way in that sense can they account for the growth in the AFDC population.

Further, according to what information I have been able to get, the number of illegitimate children while on AFDC rolls have remained relatively constant during this entire period, 16 to 17 percent.

So to suggest, as the House committee report suggests, that the growth of AFDC, the AFDC program, is due to a huge spread in the population of single-parent families and of illegitimate children is, I think, factually wrong.

The suggestion that I would like to make—I will be hard put to prove this, but it conforms to the experience that I have had—the suggestion that I would make as to the growth in the AFDC rolls in this period is that it has not got anything to do with the general increase in population of single-parent families. What it has to do with is the greater access which single-parent families have had in the course of the last dozen years to welfare departments and to making welfare applications.

There has, for example, been a large migration from the South to the North, where welfare programs are more accessible.

There has been a much greater understanding—in welfare departments, among welfare client organizations, and among social workers—of welfare rights. There is a very large shift that is taking place in access to welfare programs and in the knowledge of the relevant population concerning their eligibility to welfare, and I think that is what is accounting for the increase.

To the extent that I am right on this, and to the extent that the House committee report is factually wrong, putting aside philosophical differences and putting aside differences in the interpretation of the Constitution, it seems to me that a very grand, a very gross error is being made.

The second point I would like to make about the freeze and about certain of the other provisions in the House bill is that while it does not call directly for such measures, it seems to me inevitable that the consequence of enacting this bill into law is going to be a striking increase in the number of State eligibility rules which prohibit aid to families with illegitimate children on one basis or another.

I have tried to demonstrate within the written testimony I have handed in just why this is going to occur, and how it relates to current eligibility rules.

I think this is the kind of thing we ought to avoid, and ought to avoid very much. It does not make any sense to let a child go hungry because of the status of his birth.

I would like to comment very briefly on the work test that is created for mothers within the bill. I do not think it makes any sense.

It may be relevant to suggest that there are a great many work tests which exist right now throughout the United States for mothers on the AFDC rolls. About half the States in the Union have a work test similar to that in the House bill.

Some of the States go to what I think are extreme and absurd lengths right now. For example, there is a litigation going on in Federal court in Georgo concerning the Georgia employable mother rule. What that rule does is require, as the House bill would, a mother to accept a job when in the welfare department's opinion she should. Once she is on a full-time job, the bill goes on the require that she be cut off from all assistance regardless of how little she makes at work, and no matter how far she is below the welfare levels.

We have a good deal of experience with work tests for mothers here in Washington, D.C., by the way. As I understand the District of Columbia rule, it cuts a mother off or can cut a mother off from welfare assistance the moment the welfare department concludes she is able to work, whether she has a job or she does not have a job.

The experience that we have with such welfare rules regarding the employment of mothers is that they do not work out well at all, that they result in a great deal of harassment.

The experience that we have with the kind of rules which would be created on a Federal level by the House bill is to the same effect. For example, I was in Texas the day before yesterday, and heard the story of one mother who seemed to be perfectly eligible for AFDC. Under the Texas rules, as I understand them, she could not be denied AFDC on the basis of employment unless there was a job available and someone could take care of her children. But she was denied AFDC anyhow. That sort of thing happens every day.

Similarly, it seems to me to make no sense whatsoever to engage in the other restrictive tests put forth by the House bill on the unemployed parent section of the program.

It does not make any sense to deny aid to a family because of a long term unemployment of the father of the family. In Kentucky, for example, where I was recently, there are men who have been out of work, ex-miners who have been out of work since the 1950's.

Now, the original unemployed parent program is needed in Kentucky. These men are in the worst possible condition; they have huge families, families of eight, nine, 10 children, and they do not have any work. Their situation is almost impossible. Yet even if they do get an ADC unemployed parent program in Kentucky, these men would be ineligible under the restrictions created by the House bill, and it makes no sense.

I would like to comment in passing here on the protective payee and the vendor payment provisions of the House bill.

It is just incredible, I think, that a protective payment or a vendor situation should be created without the protection (which is presently in the law) which says that a State cannot apply that kind of status to a recipient unless it is paying the full amount of need that it ought to pay under its own definitions of need.

In the State of Florida, for example, a mother with 10 children is entitled only to $85 a month, even though she has no other income.

Now, it is impossible to judge whether or not this mother is a competent manager of affairs. It is just impossible. And it seems to me that when you remove the protection of the present law you are creating an absurd situation, one which is going to result in even more harassment of welfare clients than we have today.

It also seems to me that while it is good to be concerned with neglect laws, and it is good to be concerned with the care that is given to children by welfare clients, it is bad to use our welfare laws to provide a basis for special prosecution of neglect proceedings and other family offenses through special investigations of welfare clients.

Welfare clients, some of them, may neglect their children. Some rich mothers may neglect their children; some middle-class mothers may neglect their children. If we are going to enforce neglect laws, we ought to do it on a classless basis and not create a special approach toward welfare mothers.

Finally, to skip a whole series of things which I have gone into in detail in my written testimony and to take one of the presumably constructive steps urged in the House bill, that dealing with the partial payment remedy, it seems to me that that notion is not nearly as adequate or as helpful as many people seem to think.

First of all, I think HEW slightly exaggerates the situation when it says that it has been helpless to enforce Federal regulations in the public assistance area because the only remedy it has is the cutoff of the whole program.

The fact is that if we review the history of HEW enforcement techniques over the course of the years, with only one exception, and that exception was written into the law by Congress, every HEW enforcement effort which resulted in compliance proceedings produced action by the State to remedy the situation. Such compliance proceedings under the Social Security Act did not, in the end, necessitate the cutoff of the program.

Secondly, it seems to me that the problem in recent years with HEW has been that it has been hesitant to enforce its own rules and has used the problem of remedy as a kind of excuse.

Now, I think it is true that it is no real remedy to cut off a welfare program because a State is not enforcing part of the Federal law. I think it is also no remedy to cut off a part of a Federal program because a State is not enforcing part of that law.

What full or partial cutoffs do is make the welfare client or recipient suffer the penalty for noncompliance with the Federal law by a State. Indeed, a partial cutoff remedy may even encourage certain noncompliance. It seems to me that among the several measures which could be taken, which would be much more adequate than cutoff, partial or total, would be that of granting an enforcement right on the part of recipients to require the States to comply with the Federal law so long as they are accepting the Federal money and, perhaps, to give the clients a treble damage action if they have suffered from noncompliance.

Further, it seems to me, that if a State is going to accept Federal money for the program but refuses to comply with the Federal law, a more appropriate remedy than cutoff would be a Federal receivership designed to guarantee that the intended beneficiaries of the program are actually helped.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, sir. We appreciate your statement.

(The prepared statement of Mr. Sparer follows:)

PREPARED STATEMENT OF EDWARD V. SPARER

For the convenience of the reader, this testimony and analysis of H.R. 12080 is outlined below according to topic. The testimony is confined to Title II, Part 2 (Public Assistance Amendments) and Part 4, Section 245 (Partial Payments to States)

I. Qualification of Witness and Sources of Testimony.
II. General View of the Deficiencies and Abuses in Public Welfare.
III. The New Restrictive Provisions for the AFDC Program.
    A. The "freeze" on mothers and children eligible for AFDC.
    B. New restrictions on assistance to children of the unemployed.
    C. The new "work test" for mothers and the current status of "work tests."
    D. Apparent Congressional sanction for some versions of the arbitrary "substitute father" rules.

- IV. The New Purpose of the Public Assistance Laws Under H.R. 12080 (to reduce illegitimacy) and Its Restrictive Consequences.
- V. The "Rehabilitation" of AFDC Recipients by Treating Them as Second-Class Citizens.
  - A. The destruction of the "money payment" principle.
  - B. Expanded intrustion into the privacy of AFDC recipients as distinguished from other citizens.
  - C. Special enforcement of neglect and other laws.
- VI. The Positive Features of H.R. 12080 and Their Negative Effects.
  - A. Exclusion of AFDC recipients from home ownership repair grants under Section 208.
  - B. The earnings exemption under Section 202 and the rollback of present earning exemptions.
  - C. The relationship of certain positive provisions, such as those for expanded foster care, to the restrictive features of the bill.
  - D. The "partial payment" remedy.
- VII. Conclusions.

I. QUALIFICATION OF THE WITNESS AND SOURCES OF TESTIMONY

My name is Edward V. Sparer. I am a lawyer and teacher of the law of public assistance at the Yale Law School. I have also taught the law of public assistance at the Columbia University School of Social Work, and lectured on that subject to several hundred lawyers, caseworkers and welfare clients in various parts of the United States.

My testimony today is also offered on behalf of Professor Norman Dorsen of the Project on Social Welfare Law of the N.Y.U. Law School and Harold Rothwax, Esq., Director of the Legal Services Unit of Mobilization for Youth, Inc. The Project on Social Welfare Law has served as the principal clearinghouse for information for attorneys and others interested in current legal issues in public assistance. Its staff is engaged in various legal research projects relating to such issues. The Legal Services Unit of Mobilization for Youth has been the prime source for legal representation for welfare clients in New York's Lower East Side. Its activities have served as a model for neighborhood law offices throughout the country.

I am a consultant to, and until this month was Director of the Center on Social Welfare Policy and Law of the Columbia University School of Social Work. The Center is an institution funded by the Office of Economic Opportunity for the primary purpose of giving special legal counsel and other assistance to legal aid offices, neighborhood law offices and other lawyers giving free legal service to welfare clients, and applicants in their legal problems with various welfare agencies in the United States. Prior to my experience with the Center. I served as attorney for many scores of welfare clients in New York City.

In the course of this testimony, I shall be drawing in great measure upon the experience of the Columbia Center, its litigation activities, its research and its library (which serves as one of the two places in the United States where a majority of the public assistance manuals of the various states are collected; the other is the U.S. Department of HEW).

A most important additional source for this testimony has been the knowledge gained from my personal relationship and friendship with various welfare clients and rejected welfare applicants. They have taught me a great deal about the odious effects of restrictive welfare laws, low grants, exclusion from assistance programs, and the aspirations which they—together with other Americans—have for a decent life.

II. H.R. 12080 AND THE NEEDS OF PUBLIC WELFARE: A GENERAL VIEW OF THE DEFICIENCIES AND ABUSE IN PUBLIC WELFARE

The draftsmen of H.R. 12080 are surely correct in their view that the American public welfare system needs changing. It is a tragedy, however, that the bill omits to remedy the major abuses and failings of the system. Instead it worsens them. Among the many things presently wrong with the American welfare system are the following:

> As a result of the categorical nature of the system, and other failings, three out of every four Americans who live below the federally defined poverty levels receive no help from it whatsoever.
>
> Grant levels for those who do receive aid are almost entirely below federal poverty levels.
>
> A majority of the states do not even grant what their own state welfare departments set forth as the minimum necessary for adequate health and safety.

Even the grant which the states do allow is often miscalculated on an individual basis—almost always with the result of a smaller than legally proper grant for the recipients.

Abuse of the legal rights and entitlements of recipients is rampant. Few recipients are adequately informed of these rights. The "fair hearing" system in most parts of the most states of the country barely functions.

Federal requirements for public assistance programs, issued by the U.S. Department of Health, Education, and Welfare under the mandate given to it through the Social Security Act, are honored as often in the breach as in the observance. Enforcement efforts too often do not occur.

Arbitrary rules of doubtful legality pervade the public assistance system. As examples:

"Substitute father" rules—which deny eligibility to an ADC mother because she engages in sexual intercourse with a man (as in Alabama and other states). Other such rules which assume nonexistent income from the man still operate despite HEW prohibitions.

The "unmarried minor mother" rule (unique to Louisiana) which results in an eligibility requirement that both the *child's* father and the *mother's* father be absent from the home.

"Best interest" residence laws—which disqualify *some* newcomers who need welfare but not others, depending on the local welfare department's view of where the newcomer *should* live.

Non-supplementation rules, as in Georgia which require mothers to work full-time and then disqualify them from AFDC supplementation, no matter how little they earn.

Six-month separation rules, requiring that a six-month period pass after the desertion or separation of a father before aid will be given to the children, regardless of how clear it is that the father has deserted and regardless of how needy the children are.

Search and interrogation procedures which assume welfare clients have no Fourth or Fifth Amendment rights. One type was recently declared unconstitutional by the California Supreme Court in *Parrish* v. *Alameda County*. Many other types exist.

No "retroactive" payment rules are followed in some states, so that rejected welfare applicants who are later adjudicated to have been wrongfully rejected, cannot obtain any of the wrongfully withheld grant money—no matter what debts, pain and other harm they suffered as a result of the wrongful denial.

Numerous statutes (and in many cases, rules) treat federally matched public assistance grants under the Social Security Act not as grants at all, but as loans to be recovered the moment there is a turn in the one-time client's income.

Welfare procedures and practices merge income maintenance with so-called "service" functions where in psychiatric or "psychiatric type" examinations of mothers are made conditions of aid to children. (A rash of such cases recently occurred in one locality). Genuine service and counseling too often does not exist, for numerous reasons.

Real job opportunity programs are rare, though work "tests"—both for mothers and others—abound in welfare programs.

In various parts of the country, disability benefits (APTD) as well as AFDC are withheld almost at whim. A major federal court challenge is presently under way regarding certain of the APTD review procedures.

A type of "lawlessness" is not infrequent in welfare administration. Rules—when they are protective to clients—are simply not followed in large numbers of cases.

The state rules and manuals themselves are almost inaccessible—especially to clients—in numerous states and localities. A kind of "secret law" governs welfare administration to the extent "lawlessness" is not the key.

These things exist despite the best intentions and efforts of some welfare administrators. In major part, they are failings which grow out of the present Social Security Act. Because of them, there *are* people who starve in the United States, in a literal sense. There are many more people who undergo a kind of slow death as a result of bad food, worse housing and ragged clothes. A loss of human dignity is endured by almost all welfare clients.

H.R. 12080 is based on three totally false premises: (1) that new arbitrary restrictions on needy people should be created, rather than a broad extension of the welfare program to the millions of needy people not now eligible; (2) that more "work tests" rather than real job opportunities is what the American poor need; and (3) that more invasion of privacy and more control over the intimate details of the lives of welfare clients is appropriate (i.e., that the trend to a "second-class" citizenship for welfare clients should be accelerated). Even the seeming "positive" features of H.R. 12080 are so tied to its restrictive aspects that they "hurt rather than help." H.R. 12080, if enacted into law in place of the measures that are needed, will be a true national disaster.

I would like to comment on the particular features of H.R. 12080 in detail.

III. THE NEW RESTRICTIVE PROVISIONS FOR THE AFDC PROGRAM PERVERT THE DEMOCRATIC PHILOSOPHY UNDERLYING THE SOCIAL SECURITY ACT, POSE SERIOUS CONSTITUTIONAL ISSUES, REINSTATE DISCREDITED AND ONEROUS FEATURES OF THE "POOR LAWS" AND ARBITRARILY RELEGATE THOUSANDS OF CHILDREN TO DANGEROUS LIVING CONDITIONS

The heading chosen for this section of the testimony is strongly worded. I think, however, such language is more than warranted by the threats posed by H.R. 12080 to a democratic public assistance program and to the many human beings, primarily children, who will be seriously damaged by the bill should Congress choose to enact it.

A. The "Freeze" on Mothers and Children Eligible for AFDC Statutory and Administrative background

The Social Security Act of 1935 represented, in numerous ways, a major departure from the onerous "poor law" welfare systems which existed in the states and trace back to seventeenth century (and earlier) England. Of the several significant departures from poor law tradition which H.R. 12080 would reverse, the single most important one is the requirement of the Social Security Act that all persons who are eligible for public assistance be granted public assistance. The old poor law often gave an absolute, unchallengeable "discretion" to the local welfare officials (then called "overseers of the poor"). It created a system wherein welfare officials engaged in "picking and choosing" among the eligible applicants who were to get aid. See, e.g. *City of Albany v. McNamara*[1] for a classic exposition of this philosophy. The Social Security Act of 1935, whatever its weaknesses, was intended to end such tyrannical procedures.

From the first, the administering federal agency for the new Act (now H.E.W.) correctly took the position that the Act[2] "removes from the discretion of the [state and local] administration the right to exclude persons falling within the scope of the program, because all persons meeting the eligibility qualifications are equal before the law and have a right to receive assistance under a uniform application of the law."

Because of subsequent doubt on the part of some local officials as to the right of eligible persons to get assistance, Congress, in 1950, amended the Act "to make it clear" that all eligible persons must get assistance. 1950 U.S. Code and Cong. Service, p. 3470, 3471. Congress declared in the amended Section 402(a)(9) that "aid to families with dependent children *shall be furnished* with reasonable promptness *to all eligible individuals*" (my emphasis).

And, to prevent states from circumventing the statutory requirement (that all eligible persons be granted AFDC) by adopting restrictive eligibility tests which frustrate the Act's purposes, HEW properly adopted and at least sometimes enforced its "equitable treatment" doctrine. This doctrine, as stated by HEW General Counsel Willcox, is as follows:[3]

"* * * it should be remembered that throughout the history of the Social Security Act the position of the Administering Federal agencies (the Social Security Board and its successors) has been that, if a State chooses to utilize criteria of eligibility narrower than those permitted by the Act, the State plan is approvable only if the classification effecting such limitation is a rational one in the light of the purposes of public assistance programs."

Among other narrow eligibility criteria disapproved under this doctrine by HEW have been eligibility criteria which: exclude Indians from the program; exclude illegitimate children from the program; leave children in so-called "unsuitable homes" without aid; exclude children of domestic and agricultural work-

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[1] 117 N.Y. 168 (1885).

[2] Pt. IV, Sec. 2321, *Handbook of Public Assistance Administration.*

[3] Wilcox, Alanson, General Counsel, HEW, *Memorandum Concerning Authority of the Secretary Under Title IV to Disapprove Michigan Bill #145, March 25, 1963.*

ers from the AFDC–UP program; treat recipients differently on the basis of the *source* of their income; assume income and jobs which do not, in fact, exist. (The statutory and constitutional bases for the HEW doctrine, and the history of its approval by Congress, is traced in a recent law review note, *Welfare's "Condition X"*, 76 Yale L. J. 1222, May, 1967.)

These historic departures of the Social Security Act from poor law traditions—the requirement that *all* eligible persons be granted aid, the prohibition against unequal or whimsical picking and choosing, the requirement that eligibility criteria be *rational*, would be thoroughly perverted by H.R. 12080 as a consequence of several of its provisions—but most directly, by the "freeze" on AFDC recipients.

The nature and effect of the "freeze"

Under Section 208 of H.R. 12080, a limit is placed on federal financial participation "designed to freeze the present situation" with respect to children receiving aid because of the continued absence of a parent (but not because of the death, incapacity, or unemployment of a parent). The formula offered provides that the proportion of all children under age 21 who were receiving aid to families with dependent children in each state in January, 1967, on the basis that a parent was absent from the home, would not be exceeded for federal participation after 1967.

What is to happen to those children of absent parents who need aid but cannot be eligible for federal financial participation? Possibly some—but surely not most states will provide for them out of state funds. Possibly some states will simply deny any aid whatsoever to such children who are in excess of the permitted number—despite their eligibility under all eligibility criteria met by other such children. Very likely, some states will seek out new restrictive eligibility criteria to keep the total number down, and justify those criteria—however otherwise arbitrary—in terms of the federal "freeze".

Can the command of the Social Security Act that "*all* eligible children" be given assistance be enforced under H.R. 12080? A state which chose not to give such assistance would logically argue that the command of Section 402(a)(9) must be read in conjunction with the limitation created under the freeze. A state rule that it will consider eligible only that number of persons for whom federal matching is available would appear to be authorized under the Act.

Could the HEW "equitable treatment" doctrine, which has played so important a role in preventing arbitrary and unreasonable welfare rules (and should be playing a far more important role) serve to invalidate arbitrary exclusions that a State sought to make under the guise of keeping its AFDC programs down to present levels? Such a function would be most difficult for HEW. The new Social Security Act itself would be the justification for such arbitrary rules. And, as the House Committee Report[4] points out (p. 110), it is intended by the Committee that HEW make whatever changes "in its administrative directives under existing provisions of law" are necessary to allow the new provisions to have full effect.

The historic departure of the original Act from the poor law tradition of "picking and choosing" among eligibles would be flatly reversed. The new Social Security Act of 1967 would fully authorize such administrative behavior. The most arbitrary eligibility rule would be justifiable in terms of the new statutory directive. Meaningful concepts of "legal rights" under our welfare programs would go out the window in state after state.

I do not think I exaggerate. For AFDC children, the era in which the federal statute was a source of protection would be over.

Constitutional Issues Concerning the Freeze

While the freeze would provide federal statutory authority for arbitrary cutoffs from welfare programs, the question remains as to whether a state which attempted to act upon the new federal statute by denying aid to eligible children in excess of the permitted number would be acting in violation of the equal protection clause of the Fourteenth Amendment. I think it would.

Where a state chooses to grant assistance to some needy citizens (children or adult) and not to others, there must be a reasonable and not an arbitrary basis for distinguishing each class of citizens. Further, there must be reasonable and not arbitrary standards for determining which individual falls within each class. This much is clearly required by the Fourteenth Amendment. *Yick Wo v. Hopkins,*

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[4] Report of the Committee on Ways and Means on H.R. 12080, House Report No. 544, 90th Cong., 1st Session, Aug. 7, 1967 (The Report is referred to, throughout the text of this testimony, as the House Committee Report).

118 U.S. 356, 369; *Gulf Colorado and Santa Fe Ry. v. Ellis*, 165 U.S. 150, 155; *Brown v. Board of Education*, 342 U.S. 483.

Upon what basis is a state to classify a child as ineligible because of the "freeze"? The child denied is as needy as the child who has been accepted. His parent is also absent. He meets every substantive test met by the child granted aid. He may even be of the same age, attending the same school, living on the same block. The purpose of the Social Security Act is to relieve the need of such children. Can he be denied aid simply because the state, acting upon the so-called freeze, says it will not grant aid to him even though it will to other identically situated children?

The relevant constitutional principle, incidentally, is not different for Congress. It was succinctly stated by Mr. Justice Felix Frankfurter (*Amer. Communication's Ass'n. v. Douds*, 339 U.S. 382, 417, separate opinion, 1950):

"Congress may withhold all sort of facilities for a better life but if it affords them it cannot make them available on an obviously arbitrary basis."

No more arbitrary basis for classification could be imagined than that attemped by the proposed "freeze." This conclusion is reinforced by the shoddy reasoning which appears to have led to the so-called freeze in the first instance.

The factual errors underlying the proposed "freeze"

The reason for the "freeze", as set forth in the House Committee Report is that it is increasing family breakup and illegitimacy which have been responsible for the undesirable growth of the AFDC program. The Committee acknowledges that some growth in the program, in recent years, has been due to the adoption of the AFDC–UP program and to increases the child population (which the Committee is willing to accept) but adds that aside from these acceptable factors, "a very large share of the program growth is due to family breakup and illegitimacy."

While the Committee's statement is, in one sense, true—it assumes answers (the wrong answers) to two critical questions:

1. Is the additional growth of the program due to proportionately increasing family breakup and illegitimacy?—or—is it due, in large part, to the *increasing access* to public welfare programs of families which have all along been eligible under the federal statute?
2. Will arbitrarily denying a certain portion of all the children eligible for aid on the basis of an absent parent curb illegitimacy and assist the children denied aid?—or—will such denial have little effect on illegitimacy and seriously hurt the children denied aid?

Let us look first at question (1). If the additional growth of the program is not due to increasing family breakup and illegitimacy but to increasing access to the program by eligible persons, the apparent rationale for the House "freeze" would seem to disappear. Government programs which increase because of increasing family breakup and illegitimacy pose one problem. But government programs, everyone should agree, which increase because numbers of persons and families have been, in the past, wrongfully excluded from the program, pose a different situation. Surely the access to the program of such persons is desirable.

Some figures may be of help in determining whether the enormous increase in program (excluding the increase because of the AFDC–UP program and general population increase) has been due to a proportionate increase in family breakup and illegitimacy.

First: It is clear that there has been a great increase in the number of children on AFDC because of an absent father. From 1955 until 1963 (the latest year available to me as I write this testimony) the total number of children on AFDC rolls because of an absent father increased from 983,000 (in 1955) to 1,889,000 (in 1963). That is, the total number of such children nearly *doubled*.[5] The House Committee's Report (p. 95) indicates that the number of single parent *families* on the AFDC roll also doubled during this period.

But: The total number of families headed by a woman in the population as a whole underwent only a *slight* proportionate increase. Among whites, there was a slight decrease—9% of the total population in 1955 as compared to 8.6% in 1962 (1963 figures are unavailable to me). Among nonwhites there was an increase from 21.9% of the total number of families (in 1955) to 23.2%. The total number of married women with husbands absent actually underwent a *decrease*. Among

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[5] Figures from *The Negro Family: The Case for National Action* (the "Moynihan Report"), Table 7, (reprinted in Rainwater and Yancy), the Moynihan Report & the Politics of Controversy (M.I.T. Press, 1967, P. 100). Also see House Committee Report, P. 95.

whites, the number decreased from 5.3% in 1955 to 4.4% in 1963 (the same for 1964). Among nonwhites, the number decreased from 21.9% in 1955 to 21.2% of the total families in 1963 (and 20.4% of the total families in 1964).[5a]

Second: There has been some increase in illegitimacy in the general population.[6]

But: This increase could not explain the doubling of the AFDC rolls. Thus, in the non-white population, where the overall illegitimacy ratio is the greatest, the increase in the general illegitimacy ratio was not a doubling but rather was from slightly more than 1 out of every 5 children to more nearly 1 out of every 4 children (from 202.4 of every 1000 to 235.9 of every 1000). The white illegitimacy increase was, percentagewise, larger though with much smaller overall ratios. Also, of course, it is to be noted that many illegitimate children live in two parent families and thus illegitimacy growth, as such, does not provide an appropriate basis for explaining AFDC growth.[6a] Most relevantly, as stated in an article in *U.S. News and World Report* (9/4/67), p. 26:

"The percentage of ADC children who are illegitimate, however, has increased only slightly—from 16 percent in 1953 to 17 percent in 1964, the latest year for which figures are available."

Thus the House Committee erred in assuming that the increase in the AFDC rolls (aside from the increase due to the UP program and the general population increase) was because of an increasing trend to family breakup or illegitimacy. The number of families on the AFDC rolls nearly doubled while the number of female-headed families in the general population has increased only slightly. The number of illegitimates on the AFDC rolls has hardly increased proportionately at all.

I suggest a different explanation than that offered by the House Committee's Report for the doubling of persons receiving assistance as a result of the absence of a parent. I believe that a major reason for the increase has been greater access to welfare programs in the last ten years by single parent families. The number of such families has been large throughout this period—and before this period. With almost 1 out of every 10 white families headed by a woman and 1 out of every 4 or 5 nonwhite families headed by a woman, it is by no means surprising that large numbers of eligibles exist among such families.

Access and acceptance into the AFDC programs for Negro families however, especially in the rural South, has been (in the past and today as well) extremely difficult—despite eligibility under federal standards. Indeed, in Georgia, for the first few years of the Social Security Act, a quota system against Negroes existed. See Bell, *Aid to Dependent Children,* (Col. Univ. Press, 1965). Outlandish "substitue father", "suitable home", "six-month separation" rules have been used to deny eligibility, often illegally under their own terms. In Mississippi, even under the terms of its restricted programs, welfare hearings conducted by the State Advisory Board to the Civil Rights Commission last year demonstrated the extraordinary difficulties placed in the way of Negro families.

When one considers the (slow but existing) broadening of access to welfare in the South, the large scale migrations in recent years of southern rural Negro families to northern cities, the *comparatively* open (however inadequate) access to such programs in the North, as well as the recent growth of welfare clients' organizations, legal services, knowledge of welfare programs, the disappointing absence of job opportunities, the "rights" consciousness in various social work and clients' groups, etc.—the growth of the AFDC programs becomes more understandable. The kinds of single parent families which should have been in the program all along—but were not because of arbitrary exclusion and lack of knowledge of the program—are finding their way to it. And that is appropriate and good!

The Second Error in the Reasoning of the House Committee Report

But even if the Committee was right in assigning the reason for the doubling of the AFDC single parent category caseload to the increasing breakup of families and illegitimacy, the question remains whether it makes any sense to cut off aid from numbers of needy children in such families.

Two possible arguments can be put forward in favor of such cutoffs: (a) The children will be otherwise taken care of in adequate fashion; (b) Illegitimacy

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[5a] *Ibid.*, Tables 5 (P. 107), 2 (P. 104), 6 (P. 108).

[6] *Ibid.*, Table 3 (P. 105); also see Cappell and Cowling, *The Incidence of Illegitimacy in the United States, Welfare In Review,* P. 1 (May, 1967, published by HEW).

[6a] *Ibid.*

and family breakup will thereby be curtailed. Both arguments are thoroughly baseless. As to the notion that rejected children will be otherwise taken care of in adequate fashion, my comment will be brief. The notion is false. In New York City I have personally known children of families rejected from AFDC who have slept on public stairways because there was no rent, children who caught pneumonia because there was no money to pay for heat and children of rejected families who were just plain hungry because their families could not afford enough food. These New York children suffered terribly during the period of their welfare denial. So too do the many hungry children of Mississippi, not eligible for adequate welfare, who were the subject of the recent medical report from the Field Foundation.

The argument that illegitimacy and family breakup will be curtailed by such a freeze is equally erroneous. The House Committee Report suggests that the freeze will induce states to adopt the family planning services and other programs of the House bill. But those programs are required of the states under the terms of the bill, regardless of the freeze. More punishment to already broken families and living children who were born illegitimate cannot aid their situation. (Nor does it aid the legitimate children who will be excluded because of the freeze.)

Evidence already exists that cutoffs from AFDC because of the birth of illegitimate children does not end illegitimacy within the cutoff families. During the 1950's thousands of families were cut off ADC aid (most often, but not exclusively in the South) or denied aid primarily because of the existence of illegitimacy within the family. Usually the explanation was in terms of the notorious "suitable home" policy. Mississippi was the only state among the many engaging in such cutoffs and denials which attempted to study the effect of the cutoff or denial on the families involved. As reported by Bell *Aid to Dependent Children*, p. 101, Col. Univ. Press, 1965:

"The most significant finding of the study was the vastly increased incidence of illegitimate births following the family's exclusion from ADC."

Contrary to the reasoning underlying the House Committee's Report, it is not AFDC financial assistance which causes illegitimacy. Illegitimacy is a direct reflection of poverty, lack of good job opportunities, poor housing, inadequate education and other factors which deny opportunity to improve life conditions. *Adequate* financial assistance in AFDC is a necessity if the other factors encouraging illegitimacy are to be combatted, though such assistance is not sufficient alone. See the excellent summary of facts and source materials regarding illegitimacy in *Illegitimacy and Dependency*, Indicators (Sept. 1963) published by the U.S. Department of Health, Education, and Welfare.

The primary relationship between AFDC programs and family breakup, illegitimacy, etc., lies not in the fact of financial aid but in the fact that under most AFDC programs, financial aid will not be given unless the family *is* broken up as a result of the desertion of the father. This situation, of course, is continued and worsened under H.R. 12080 in that the bill fails to require the states to adopt the AFDC–UP as a condition of any federal AFDC aid; instead the bill makes the AFDC–UP program even more restrictive than it presently is.

A final comment on the attempt to reduce the number of illegitimate children through an AFDC "freeze". HEW has repeatedly made clear to the states that denials of benefits on the basis of illegitimate birth as such, before or after receipt of AFDC aid, is an impermissible eligibility criteria because of the "unreasonable and arbitrary classification" thereby created. Indeed, HEW's concern over such misuse of the fact of illegitimacy played a large role in the adoption of the so-called "Flemming Ruling," prohibiting states from denying AFDC aid on the basis of "unsuitable homes" unless alternate forms of aid were provided. (The reasoning of the "Flemming Ruling" was subsequently endorsed by Congress when Congress amended the Social Security Act so as to authorize application of the Ruling with a somewhat later effective date.)

Unreasonable and arbitrary classification offends not only the present Social Security Act. It is, as already noted, offensive to the Constitution. A dependent child's illegitimate birth does not alter his human need—and relief of the human need of dependent children remains the overriding aim of the Social Security Act even under the House bill. The specious reasoning underlying the proposed "freeze" only serves to further demonstrate its unconstitutional nature.

B. The New Restrictions on Assistance to Children of the Unemployed

Last month, in Hazard, Kentucky, I had occasion[7] to listen to several ex-coal miners from Perry County, Harlan County, Letcher County and other places in the Kentucky hill country. The account by Mr. J. N. is relevant to this Committee's task:

> Mr. N. has a wife and seven minor children. He had been a coal miner until the late 1950's; no more work was thereafter available. He sought other jobs unsuccessfully. For about a year and a half, he was on "government programs," i.e., W.E. & T. and "pre-vocational training." He was "taught nothing" in those programs but "foolishness" [that] was not useful in obtaining other work. He and his children survive thus far because they have a small vegetable garden and food stamps. The food from the stamp programs run out in the middle of the month. The children drink milk twice a month at most. He feels he cannot send four of the seven children to school this year because they lack necessary clothes. He does not know what to do and hopes "Washington" will help.

The story of the other men, all of whom have spent the best years of their lives in the coal mines, was the same. These men desperately want work. There is none for them. Nor is there public assistance because Kentucky has no AFDC–UP program and general assistance seems unheard of.

What then, does H.R. 12080 accomplish to meet this need? What does it do to help the ex-miners of Kentucky, their children and the thousands of other unemployed fathers who want work, cannot obtain work, and cannot support their children? The answer, as demonstrated below, is that H.R. 12080 makes matters worse, removes all hope for Mr. N. and others like him, indeed seems designed to end *any* real meaning for the program and poses, as well, serious questions concerning constitutional and administrative doctrine.

The present AFDC–UP Program

The present AFDC–UP is the program such miners as Mr. N. hope will be extended to their children. The program provides for federal reimbursement for state programs giving aid to needy dependent children who lack a parent's support due to his unemployment. No family under the present program can receive AFDC–UP if the unemployed parent refuses a bona-fide offer of employment without good cause. The program is optional with the states. No single federal definition of "unemployment" exists, although—as described hereafter—the U.S. Department of HEW will not approve a definition of "unemployment" which is arbitrary and bears to reasonable relation to common-sense definitions of unemployment and the purposes of the Social Security Act.

As of the end of 1966, less than half the states (twenty-two) had adopted the program.[8] That means that in the other twenty-eight states, an unemployed father must desert his wife and children if AFDC aid is to be obtained for them). In the twenty-two states which have adopted the program, only 48,900 unemployed parents received aid during a representative recent month.[9] Of the 48,900 unemployed parent recipients, 64,100 (or more than two-thirds) were in three states (California, New York and West Virginia). Of the other 19 states which accepted the program, more than one-half—11 states—each had less than 500 unemployed parent recipients on the AFDC–UP rolls.

In short, the AFDC–UP program has been miniscule, totally non-existent in a majority of the states, virtually non-existent in a good many of the states which have formally adopted it, and has not assisted the majority of unemployed or underemployed persons anywhere. Today the great need is to make the AFDC–UP program mandatory upon the states, and to make sure its benefits are actually available to all the unemployed parents who want to work, cannot obtain work, and cannot support their children.

The provisions of H.R. 12080

The House bill does not make the AFDC–UP program mandatory. Rather it creates a set of additional restrictions on the optional program which states must adhere to if any federal contributions are to be obtained. The bill provides

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[7] Hearings held by the Citizens Board of Inquiry Into Hunger in the United States, sponsored by the Citizens Crusade Against Poverty, Aug. 15, 1967.

[8] Figures from Table 8, P. 81, *Welfare In Review* (May, 1967, published by HEW).

[9] Ibid.

authority for the Secretary to set a federal definition of "unemployment," surely a desirable objective insofar as liberal and uniform standards are thereby set, and then proceeds to radically narrow the class of unemployed fathers who are eligible as follows:

> *First:* Since, as stated in the House Committee Report, a major objective is 'to protect *only* the children of unemployed fathers who have had a recent attachment to the work force' (my emphasis),[10] the bill excludes federal sharing for fathers who have not had at least six quarters of work (as defined in the bill) in any thirteen quarter period ending during the year before the application for assistance or who have not been eligible (as defined in the bill) for unemployment insurance during the year before applying for assistance.
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> *Second:* The bill provides that federal sharing for a father who *has* been recently attached to the work force will *not* be available when that father is eligible to receive unemployment insurance compensation or for any thirty-day period immediately *prior* to the receipt of AFDC–UP aid during which the father had been unemployed.

Before examining the requirement that the only children of fathers recently attached to the work force are eligible, it is useful to examine the issues arising around the exclusion of children of the fathers who, having been recently attached to the work force, are receiving unemployment insurance. By what logic are such children excluded?

No theory whatsoever is suggested either in the bill itself or in the report of the House Ways and Means Committee, A possible clue might be found in Section 407, the present Social Security Act, which *permits* a state to deny AFDC–UP to the children of any unemployed parent who would otherwise be entitled to such aid for any month or week such unemployed parent received unemployment compensation. As recommended by the U.S. Dept. of HEW, in its interpretation of the Act, in considering the appropriateness of using the option (Pt IV, Sec. 3424.26, *Handbook of Public Assistance Administration*):

> . . . States should review the level of benefits under its unemployment insurance program and whether those benefits take into account the presence of dependents or only the need of the unemployed wage earner.

Apparently the notion under the current law is that if a state unemployment insurance program actually extends to needs of the whole family, there is at least some reason to exclude the family from further assistance under AFDC. Alternately, a state which pays very *low* AFDC benefits (much less than its own standards of needs) and somewhat equivalent unemployment insurance, might choose to exercise the option and conserve its funds for a better spreading of the benefits under the combined programs. Thus, the present option could be exercised in a rational and fair way even though it could be exercised in an abusive way as well.

The new bill, however, alters the prior law and *requires all states to* deny AFDC-UP to any child whose father receives unemployment insurance compensation. Under the new bill, if a state chooses to expend more of its own share of funds to provide for such children in the AFDC program, it cannot. If a state which pays very low unemployment insurance benefits (such benefits, it must be remembered, are paid without regard to actual need) and wishes to supplement such benefits for *needy* children of unemployed parents, it cannot. What purpose lies in changing the present option to a requirement? The House Committee report is replete with statement of the purpose: "The number of families on AFDC is to be kept to the minimum";[11] "In short, the various provisions included in your Committee's bill are designed to get people off AFDC rolls, not put them on."[12]

The purpose of the proposed amendment in the new bill is not to better distribute assistance by considering the various effects of the provisions of both AFDC-UP and unemployment insurance on needed aid to the unemployed. Its purpose, "in short," is to cut the rolls without regard to the suffering thereby caused.

Under what theory is such a purpose directed against the children of unemployed fathers who receive unemployment insurance? It cannot be on the theory that unemployment insurance meets the *needs* of the children (which, as noted above, may have been part of the theory for the present option). Welfare bene-

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[10] P. 108.
[11] P. 110.
[12] P. 107.

fits are frequently much higher than unemployment insurance benefits; why penalize the children of the recently working father (in a bill which purports to favor them!). Moreover, receipt of unemployment compensation today, or even under H.R. 12080, does not make ineligible (for federal sharing) the children of a mother in a single parent family—why then should it make the children of a two parent family ineligible (where the second parent also has to live on the same unemployment insurance grant)?

Children of fathers who receive unemployment insurance cannot fairly be excluded from AFDC-UP on the theory that their parents are receiving *some* other outside assistance while the eligible parents are receiving no other assistance. On the contrary, applicants for AFDC-UP (and AFDC or any other welfare program) may receive social security benefits (OASDI) veterans benefits, workmen's compensation, alimony payments and other relative's support, income from stocks, bonds, work training programs and other sources far too numerous to mention here. Such additional income (as with unemployment insurance today) is usually subtracted from the projected welfare grant; the difference between such income and the family's minimum financial needs is the welfare grant. Why should children be deprived of the grant because their father receives one type of small outside income while other children receive the AFDC grant even though their parents have a larger income from an outside source?

Interestingly, in the section of the House Committee Report dealing with the impact of the OASDI benefit increase on public assistance, *the Report recognizes and apparently endorses the HEW "equitable treatment" doctrine (earlier described) insofar as that doctrine has been applied to prohibit discrimination based on source of income for the purpose of computing grant size.*[13] Yet the bill recommends total disqualification on the basis of receipt of unemployment insurance, regardless of how little insurance is received and how much more other income is received from other sources by those who remain eligible. Plainly, what the new eligibility rule amounts to is yet another arbitrary exclusion of some needy dependent children from aid while the program continues for other needy dependent children.

What is gained by such an arbitrary distinction—for what reasonable purpose it would be promulgated—and on what sensible theory—one cannot imagine. On both constitutional and humane grounds, this new restrictive provision should be rejected. The extra and equally pointless proviso in the bill, that children of unemployed fathers must wait 30 days from the date their fathers' employment was terminated before AFDC–UP can be granted—regardless of the immediacy and degree of their need—should be rejected for comparable reasons. Such children will end up in applying for temporary emergency assistance in states which have such a program. In other states they will go hungry.

The restriction against aid for children of the long-term unemployed

Not content with arbitrarily excluding the children of those fathers who were so recently attached to the labor market as to receive some small amount of unemployment insurance, the bill offers its major AFDC–UP restriction against the children of the long-term unemployed. Again one must search for a reason. Is it because some of the long-term unemployed may be "malingerers"? The present AFDC–UP program already requires any otherwise eligible person to register with the state employment service and to accept any bona fide offer of employment which he does not have "good cause" to reject. The proposed bill also seeks to guarantee that such a person is placed in a community work training program. No man who refuses work without proper grounds could remain in the AFDC–UP program.

I submit that absolutely no rational ground can be offered for excluding children merely because of their fathers' long-term unemployment. No policy other than arbitrariness itself as a policy supports such an exclusion.

Are America's long-term unemployed, by that reason alone, demonstrated to be such malingerers that their children are to be left completely without aid? [Note, incidentally, that according to the House Committee Report (P. 104) the child of the father who is eligible but *refuses* a job without good cause is not punished as drastically; that child may receive protective or vendor payments.] One should talk to the many ex-miners of Kentucky who have not worked since the 1950's, hear their stories, learn how they have sought work

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[13] P. 113.

only to be rebuffed again and again and then consider whether they are to be considered malingerers and their children left hungry. Under H.R. 12080, even should these examiners finally succeed in bringing an AFDC-UP to Kentucky, they will be excluded.

The vehemence exhibited by the draftsmen of H.R. 12080 relating public assistance to recent work history reaches its most perverted form in the disqualification of the long-term unemployed. The closest analogy I know to the distorted view of mankind expressed in H.R. 12080—that the long-term unemployed must not be aided or they will avoid all work—was expressed in 1349 in the Statute of Laborers in England. That statute prohibited under pain of imprisonment both the asking and giving of alms to unemployed able-bodied persons, or the giving of "anything to such who may possibly labor or presume to favor them in their sloth so that they may be compelled to labor for their necessary living."

The theory of the Statute of Laborers was that work existed for those who would work. H.R. 12080 punishes the children of those who could not find work. We are indeed reaching back beyond the dark ages.

C. The New "Work Test" for Mothers and the Current Status of "Work Tests"

Work requirements as a condition of public assistance for able-bodied adults is not, of course, newly introduced by H.R. 12080. As a general rule, able-bodied men are required to work or to seek work and, so too, are able-bodied women who do not have young children to care for. Some welfare officials in their zealous pursuit of work requirements, have attempted to criminally punish men who refused jobs, and some lower courts have agreed with their theories only to be rebuffed, properly, by appellate courts. See, e.g., *People v. La Fountain*, 21 App. Div. 2d 719 (3rd Dept., 1964) and *People v. Pickett*, —— N.Y. 2d ——, 278 N.Y.S. 2d802 (1967). (As indicated by the N.Y. Court of Appeals in *Pickett*, serious questions regarding the Thirteenth Amendment arise upon such criminal punishment.) Nevertheless, it is generally accepted as part of the structure of our present federal and state welfare laws, that the able-bodied are required to accept work.

A different situation exists with regard to mothers of young children on AFDC. The intent underlying our present Social Security Act is that the right to make the *decision* as to whether such mothers should work or not should not be taken away from poor mothers just as it has not been taken from other mothers in our society. In its *Handbook of Public Assistance Administration*, Pt. IV, Sec. 3401, HEW has summarized the legislative history and intent of the present act:

> The aid to dependent children program is designed to provide as adequately as possible, such assistance and service as are essential to the rearing of children in family homes. To the extent that such help is available, a mother in an aid to dependent children family is in a position to exercise some degree of choice as to what course of action she should follow with respect to seeking or continuing employment and to make a decision in consideration of her special circumstances, especially the extent to which the age or condition of her children may make her continuous presence at home desirable or necessary.
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> It was clearly indicated by statements made in the reports of the Committee on Economic Security* that the intent of the aid to dependent children program was to enable mothers to remain in their homes, so that their children would have the opportunity for parental care and the benefits of growing up in a family setting.
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> "The enactment of laws for aid to dependent children was evidence of public recognition of the fact that long-time care must be provided for those children whose fathers are dead, are incapacitated, or have deserted their families; that security at home is an essential part of a program for such care; and that this security can be provided for this whole group of children only by public provision for care in their own homes.
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> "* * * Before the adoption of these laws it frequently * * * happened * * * that she (the mother) * * * was encouraged to make the attempt to be both homemaker and wage earner, with the result in such cases that the home was broken up after she had failed in her dual capacity and the children had become delinquent or seriously neglected."
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> The transfer of mothers of young children from their homes into the labor market may increase the woman power in industry and domestic service, but whether the employment of such women represents an economic asset de-

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*Special Security Board: *Social Security in America*, 1937, pp. 233-234.

pends upon a number of factors in each case. For example, when children become ill, they are, as a rule, cared for in their own homes, and if the mother is employed she must usually either stay away from her job or neglect her sick child. The time available for domestic responsibilities is limited for an employed mother. She must either neglect her home or make inroads on her physical resources. The resulting nerve strain may affect her contribution to industry as well as to the well-being of her family. Even if, on the other hand, substitutes for the mother's care are obtained, the children will require a considerable portion of the time of some other responsible adult.

The role of the public assistance agencies is, by assistance and other services, to help the mother arrive at a decision that will best meet her own needs and those of her children. Such help will involve consideration with families of such factors as the welfare of children during the mother's absence from home and of the type of substitute child care arrangements the mother can or wishes to make if she takes full- or part-time work. Consultation services should also be available that will help the mother determine what increased costs will be involved in taking a job; for instance, clothes, lunches, transportation costs and other necessary expenses involved in the mother's absenting herself from home. In some instances, a part of the potential wages will be required to provide supervision for the children in their home or in a day-care facility. The opportunity to discuss these conditions will necessarily influence decisions since it will often be apparent that anticipated earnings will not, in all cases, provide the essentials for family life.

The Bureau of Public Assistance recommends against any policy of denying or withdrawing aid to dependent children as a method of bringing pressure upon women with young children to accept employment. Public assistance recipients should not be subjected to undue pressure and receive different treatment from that accorded other persons in the community simply by reason of the fact that they are in receipt of public assistance. In cases of families receiving aid to dependent children, children are already, in most instances, deprived of the care of one parent, and, therefore, need the protection and personal supervision of the available parent.

H.R. 12080 would reverse the purpose of AFDC. It would require mothers of young children to work as a condition of unrestricted AFDC aid whenever the welfare department *decides* she should work. If the mother disagrees and insists that she care for her own children, "the children involved could be taken care of only through protective payments or vendor payments without the need to make the usual determination that the adult is not capable of handling the funds." (P. 104, House Committee Report).

The House bill, however, would thus reverse current policy only on the federal level and in approximately one-half of the states. According to a survey conducted last year by the Columbia Center on Social Welfare Policy and Law, the other half of the states have enacted AFDC regulations which require mothers to work whenever the welfare department, under its rule, deems it appropriate.

Some of the state welfare regulations reach incredible lengths. Thus the Georgia regulation, on the one hand requires mothers to obtain full-time work whenever the welfare dept. deems in appropriate; on the other hand, the welfare department must, under the Georgia "employable mother" regulation, discontinue aid whenever the mother obtains a full-time job, no matter how little she earns. Thus the lead plaintiff in a current federal court suit challenging the constitutionality of this particular rule, earns *$24.* (twenty-four dollars) for a forty-eight-hour work week and was deemed not eligible for AFDC supplementation. She has seven children to support. Another plaintiff earns *$15.* (fifteen dollars) for a *fifty-hour* work week. She too was denied supplementation, though she has eleven children to support.

The Washington, D.C., rule, as I understand it, goes even further. Under the D.C. rule a mother who is deemed able-bodied and available for work is subject to AFDC termination even though she has not obtained a job! Nevertheless, the more typical rule does not require termination (so long as the mother seeks work when the welfare department so decides) and will provide for supplementation of salaries in the single parent family up to AFDC "need" levels. I cite some of the experiences under such rules, therefore, as an indication of the range of use and abuse that might develop under H.R. 12080 on a national basis.

New York.—New York State has a regulation which empowers the local welfare department to require an AFDC mother to work when the department deems it in the "best interest". The conclusion of the New York City welfare department, however, is that such requirements are unrealistic, damaging to the mother and inconsistent with the self-respect and independence that is the goal of the Social Security Act.[14]

Arizona.—A not untypical case of the "employable mother" sort that I have come across involved a mother of nine children who was cut off welfare (and thereby forced to take a full-time job at strenuous work for little pay). Her young children were left virtually uncared for. She appealed her earlier welfare cutoff and was restored to welfare, only to be cut off again on the claim that her work experience during her earlier cutoff proved that she was "an employable mother." A protracted appeal and hearing finally restored her to AFDC once again, but not until she and her children had endured considerably more suffering.

Mississippi.—How the "employable mother" rule works in Mississippi is best told in the words of a former AFDC recipient who was cut off because of it. Mrs. Ora D. Wilson testified at the welfare hearings in Jackson, conducted by the Mississippi State Advisory Board of the Civil Rights Commission. Mrs. Wilson stated:

> In the year 1965, I was receiving a welfare check. On the first day of June, I came to Jackson on a demonstration. I got locked in jail and stayed locked in jail for eleven days, and when I returned home, the welfare lady who had brought a check—brought my welfare check to my home—she had been mailing it every month, but this time she had brought it a day before I returned home, and she left this check with my children, with the two children. She told the two children, when I come home, to come to the office to see her. When I came home, I did go to the office. The welfare lady asked me where had I been. She came to my home, and where was I? I told her I was in Jackson at that time. And she asked me wasn't I in a demonstration? I told her, "yes, I was." She said, "Didn't you know that you didn't have any business to leave home, to leave your children?" She said, "Where did you leave your children?" I said, "I left my children. They were at home and they was in good care." She said, "You didn't have any business to go off and leave your children." And she said, "You should have been here chopping cotton for $3.00 a day instead of going off on a demonstration." Then she said, "If you will agree to chop cotton for $3.00 a day," she said, "you will get your check back in August." She said, "You will get your first check in August." This was in June. At this time, I belonged to a Freedom Labor Union in Indianola, Mississippi. This union was on strike. I refused to go back into the fields. I told her that this was a Freedom Labor Union, and this union was on strike and I refused to return to go back to the fields. She told me that if I refused to go back to the fields and chop cotton for $3.00 a day, then she would cut my check off, and she did cut it off. I didn't go back. She cut my check off.

The Mississippi hearings contained even more horrifying examples of the use and abuse of employable mother rules. In connection with Mrs. Wilson's testimony however, it might be pointed out that federal law, both under the current Act and as would be amended under H.R. 12080, definition of "good cause" for refusing work is left to the states. Mississippi has *not* chosen to define "good cause" as including the existence of a labor dispute and strike at the site of the offered employment. At the least, a federal definition of "good cause," including labor disputes, ought to be promulgated under new legislation.

One might comment on the examples of wrongful decision-making under current "employable mother" rules by urging that the right to have a "fair hearing," guaranteed in the Social Security Act, is an adequate remedy for abuse. Unfortunately, the "fair hearing" is a most inadequate remedy. As demonstrated by the Arizona case cited above, the "fair hearing" is not held and decided until long after the damage is done.

Moreover, a decision as to when it is "appropriate" for a mother to be required to work and when it is not, is a decision made with regard to vague standards necessarily involving large amounts of discretion. The moment that discretion is placed in the hands of someone (the welfare worker) other than the mother, it becomes extraordinarily difficult for the mother to challenge it. This is especially true when the mother is an isolated welfare client, ignorant of the rules and her legal rights, and afraid to endanger the grant upon which she depends for the food and shelter for her children. These factors have led one of

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[14] See Testimony of Commissioner Mitchell Ginsberg of the New York City Department of Social Services, before this Committee, in August 1967.

the leading legal scholar-researchers in the welfare field to conclude that the hearing system does not offer mothers protection against the employable mother rule. See Handler, *Controlling Official Behavior in Welfare Administration* (May, 1966, Calif. Law Rev.).

On what ground should the intent of the 1935 Social Security Act—that of allowing the AFDC mother to decide herself whether it is best for her to stay home and care for the children or leave them with others to go to work—be changed. Protecting the right of the mother to decide such a question is traditional within our society. When mothers, both middle class and poor, *choose* to work to advance a career for themselves and/or add to the family income, something basically different has occurred than when an impoverished mother, against her will, is *required* to leave her children with others so that she might work at exhausting, menial activity for the purpose of continuing her children's AFDC grant.

Of course, employment of mothers who have skills which will bring them substantial earnings is frequently socially desirable. However, social researchers have also found that the employment of mothers with no such skills, *who want to remain in their homes and care for their children and who go to work because of financial necessity*, puts sharp strains on family life and may cause severe damage to the children. For an analysis of such research, see Hoffman, *Effects of Maternal Employment on the Child, Child Development* (1961). For research demonstrating the importance of home care of young children as compared to custodial care, see Spitz, Rene, *Hospitalism, an Inquiry into the Genesis of Psychiatric Conditions in Early Childhood* * * * in Psychoanalytic Study of the Child. For research indicating the predictability of increased rates of juvenile delinquency by children whose mothers don't adequately supervise them, see Glueck. Unraveling Juvenile Delinquency (Commonwealth Fund, 1950); Craig and Glick, *Ten Years Experience With the Glueck Prediction Tables*, Crime and Delinquency, (July 1963); also Monahan, *Family Status and the Delinquent Child*, Social Forces, (March 1957).

Some final comments in connection with the new "work test" for mothers:

> Experience with the WE&T and CWT programs is mixed. The remark of the ex-miner in Kentucky, cited earlier, that he was "taught nothing" is not unusual. The Mississippi welfare hearings, soon to be the subject of a published report, contain extensive first-hand reports of abuse in the program.
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> The House Committee Report (P. 105) points out that under H.R. 12080 it is possible to pay workers in community, work and training programs, including those "with private employers" *less* than is required by the minimum wage laws and the prevailing community rates on the ground that the workers are "learners". This is a dangerous approach which subjects the workers, the programs and the community labor standards to great potential abuse. Again, the Mississippi hearings offer striking examples of the reality of this danger. The "learner" exceptions ought to be removed.

It is not work requirements for mother and others on public assistance that is needed. It is genuine work *opportunities* that would radically alter the situation of the American poor. The job opportunities are desperately desired. So too is day care. Indeed, in New York City last week, mothers demonstrated because day care facilities are being closed down. *New York Times*, Sep. 13, 1967, P. 41.

Nothing in H.R. 12080, however, creates real job opportunities. *The notion is to test the recipient*—to see if she is "deserving" of our magnanimity and charity. It is a vile and degrading approach. The Elizabethans spent all their "poor law" energies developing one humiliating "work test" after another. In the middle of the American urban crisis, a crisis quite related to such degrading approaches, it is time to be done with them and create a serious job opportunity program.

D. The apparent congressional sanction for some versions of the arbitrary "substitute father" rules that would be given under H.R. 12080

Among the most onerous features of many current state AFDC programs have been the various "substitute father" rules. Some of these rules make children ineligible for aid on the ground that their mother is engaged in a sexual relationship with a man. The Alabama rule to this effect is currently the subject of a federal court challenge. Other "substitute father" rules are somewhat more subtle, just as damaging in their effect. The rule recently in effect in California (changed this past summer under the pressure of a federal court action) is a good example.

The California rule required that that income of a "man assuming the role of a spouse" as well as that of a stepfather be assumed as available to a mother and children applying for AFDC whether or not such income was in fact available and whether or not the mother could legally require support from such man. The extreme results of the rule are illustrated in the *McPherson* case, brought to federal court.

Mrs. McPherson, prior to marrying Mr. McPherson, had three children by men who deserted. Her life appeared to be in a hopeless bind. In 1966, however, she met Mr. McPherson, they courted and after a few months, married. All was fine except that Mr. McPherson was an army sergeant and was shipped to Vietnam shortly after the marriage. He earned comparatively good pay there, including his combat pay, but refused to authorize the Army to deduct and send to Mrs. McPherson more than an allowance for herself as his wife. Though Mrs. McPherson implored him and the Army to send money for the children, they refused. Sgt. McPherson was not ready to support the children and the Army stated that, under its regulations, it would not deduct an allowance for stepchildren without the stepfather's agreement.

Mrs. McPherson took the logical step and applied for AFDC. The Alameda County Welfare Department turned her down, pointing out that Sgt. McPherson earned above welfare levels and that, under the rule, the money was automatically assumed available to Mrs. McPherson. It did not matter that she was without the money. It did not matter that no method was available to Mrs. McPherson whereby she could legally require the Sergeant to contribute to the children. She took a "fair hearing" and the California state department affirmed the local decision.

A federal court action was instituted on several theories. While the action was being prepared, however, Mrs. McPherson's personal situation became too desperate for her. She filed for a divorce, having learned that such a step would make her eligible for AFDC, and thus the goal of the Social Security Act—the strengthening of family life—was realized through the California rule!

Meanwhile, the federal action proceeded and, during its pendency last summer, it was made moot by a change in the California rule. Mrs. McPherson's complaint had alleged, among other things, that the California substitute father and stepfather rule violated an HEW regulation which became effective on July 1, 1967 and said in part (§§ 3124, 3131 Pt. IV, *Handbook of Public Assistance Administration*):

> Reduced assistance payments based on assured receipt of support payments or any other income that is not, in fact, available, are inconsistent with the welfare agency's responsibility for meeting need and strengthening family life.
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> * * * * * * *
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> Effective July 1, 1961, the State plan must assure that * * * the agency will not delay or reduce public assistance payments on the basis of assumed support which is not actually available.

An unclear section in H.R. 12080 threatens to reverse the new HEW regulation and restore matters, at the option of the States, to where they were during the pendency of the *McPherson* case. Section 202(b) of H.R. 12080 would amend Section 402(a) of the Act so as to state:

> That the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, *or of any other individual (living in the same house as such child and relative) whose need the State determines, should be considered in determining the need of the child or relative* claiming such aid * * *.

Under the new § 402(a), it would seem quite possible for California to revert to the former situation wherein Sgt. McPherson's income could be assumed as available even though it was not. Since Sgt. McPherson was not separated from the home in the AFDC sense (even though away in the Army), California could determine that his income should be counted. Similarly, the income of any man thought to be "around the home" and therefore "in the home" (under the old California rule and the current rule in many states) might be counted regardless of that man's legal liability to support, his actual support, the actual availability of his income, etc.

Perhaps I misread the bill. I hope so. But I urge this Committee to clarify the matter.

IV. THE NEW PURPOSE OF THE SOCIAL SECURITY ACT (REDUCTION OF ILLEGITIMACY) AND ITS POSSIBLE CONSEQUENCES

One of the laudable objectives contained within H.R. 12080 is the reduction of the incidence of illegitimacy through the offering of family planning services to those on welfare. Yet, for the reasons I shall attempt to clarify hereafter, there is serious reason to believe that this laudable objective will be effectively used by those who have a different purpose—the exclusion of families with illegitimate children from the AFDC program. Reduction of illegitimacy through family planning services would be far better accomplished through a separate family planning service, a service that is not tied administratively to welfare income maintenance programs and that is not directed only to those who are or might become welfare clients.

Let us look first at the relevant provisions of H.R. 12080 and then at certain possibilities under those provisions. For the purpose of reducing the incidence of illegitimacy, H.R. 12080 would require the states, as a condition for federal approval and funding for AFDC, to provide "for the development of a program" for each appropriate person receiving aid (or living in the same home as a person receiving aid, if his needs are taken into account in determining the family financial need) "with the objective of * * * preventing or reducing the incidence of illegitimate births." The relevant section goes on to say that states are further required to provide for the implementation of such programs by assuring that * * * in all appropriate cases family planning services are offered to them," and "in appropriate cases" by providing aid to families with dependent children in the form of payments in the manner described in section 406(b)(2). See Section 208(a) of H.R. 12080. Section 406(b)(2) provides for "protective payee" and "vendor" payments in various situations, and, presumably, would not be applicable in cases involving family planning issues unless the mother thereby shows "such inability to manage funds that making payments to [her] would be contrary to the welfare of the child." (Section 406(b)(A) of the Act).

So far, the relevant provisions of H.R. 12080 seem to provide for what the draftsmen apparently wanted: a non-coercive family planning service. But what else might happen? Might, for example, a state adopt *eligibility* rules which:

1. Terminated AFDC aid whenever an illegitimate pregnancy occurs?
2. Denied AFDC aid to any mother who had illegitimate children (with possibly, an added provision that the child was born during the time that the family planning service was in operation)?

I have no doubt that some states *will* adopt such rules. Several states already have eligibility rules which are quite close to the first example. Certain state substitute father rules already provide that the occurance of an illegitimate pregnancy is "*prima facie*" evidence of the existence of a continuing "marital" relationship and that unless the mother thereupon disproves the existence of such a relationship, aid is terminated. Other states, in the past, used the fact of illegitimate children in an applicant's or recipient's family as evidence that a home was "unsuitable" and thereupon denied or terminated aid. While the latter practice was, by and large, formally terminated as a result of the "Flemming Ruling", the former type of rule (and many variations of it) have been used as substitutes. In the case of both types of rules, much of the sentiment responsible for them grew out of a desire to keep AFDC from mothers who had illegitimate children).[15]

Today, not only is the type of "unsuitable home" rule (referred to above) considered inconsistent with and in violation of the Act, the legality of the "substitute father" rules (referred to above) is in extreme doubt.[16] The crux of the case against the legality of such rules is found in the contention that the illegitimate status of a child (and/or the sexual relations of a mother) is, as such, completely unrelated to the purpose of the Act: giving financial assistance to needy children deprived of the support of their father. Under H.R. 12080, however, such matters would seem to be not at all unrelated to the *new* Social Security Act.

Would not certain state welfare departments argue that the Act now requires them to adopt "a program for the reduction of illegitimacy, that illegitimacy is rampant because the erring mothers know they can get AFDC for their illegitimate children, that the only excuse for such mothers (if any) has been the absence of family planning services, that the State now provides such services

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[15] See, for example, the extensive discussion of this point in Bell, Aid to Dependent Children (Col. Univ. Press, 1965).

[16] The leading court challenge, presently awaiting decision, is *Smith* v. *King* (Civil Action No. 2495-N, USDC, M.D. Ala.).

as part of its program and that—given all of these facts—the State has not been arbitrary and unreasonable" in its decision to include within its "program," in order to make it effective, a rule which cuts off aid to mothers who fail to utilize the State service (and nevertheless engage in immoral sexual relations)?

This is exactly what many states would argue. And their argument would have considerable force, *especially when one considers the "freeze" also promulgated under H.R. 12080 for the purpose of ending the growth of the AFDC program because of illegitimacy.* That the result of such rules would be the inhumane punishing of children because of their illegitimate birth (a fact which, obviously, the children are not responsible for) is another matter. The relevant point here is that the ability of HEW to prohibit such rules under its "equitable treatment" doctrine would be undermined and various States would be greatly encouraged to adopt such eligibility rules as part of their "program." That some counterarguments to the intent of the Act can be made, that serious constitutional arguments can be made (see, *e.g.*, the outline of such arguments in Dorsen & Rudovsky, *Equality for the Illegitimate?* 8 Wel. L. Bull. 13 (May 1967, NYU) is also aside from the point. We would, under the cited provisions of H.R. 12080, see a new birth of the very kinds of eligibility rules Congress ought to be condemning.

Let us consider one further issue under the new family planning provisions. Could a State *coerce* a mother into making use of contraceptives provided through the family planning service. It is true that coercion does not seem to be the *intent* of provisions. Thus the House Committee Report (p. 98) states:

"Family planning services are to be offered to the recipient and, in accordance with statements on this subject previously issued by the Secretary of Health, Education, and Welfare, can be accepted or rejected in accordance with the dictates of the individual's religion or conscience."

Nevertheless, there are various ways in which coercion can be effected so long as the family planning services are offered by the same (welfare) departments which administer the income maintenance programs. One easy way, of course, is through the type of restrictive eligibility rules mentioned above. To effect coercion, however, such rules are not needed. Welfare clients are often in fear that there will be an adverse effect on their eligibility (or treatment, generally, from the welfare department) if they do not do what their caseworker suggests. Suggestions made by caseworkers are often—and inevitably—tainted with coercive effects. But there is still another method of effecting coercion which is (arguably) authorized under H.R. 12080. Section 201(a)(1)(B) of H.R. 12080, in the same sentence which directs that family planning services be offered "in all appropriate cases," goes on to direct that protective payee or vendor form of payments shall also be directed "in appropriate cases." What are the latter type of appropriate cases? The language of Section 201(a)(1)(B) is not helpful. Section 406(b)(2) of the Act, even under H.R. 12080, would require (except where job refusals are involved) a finding that the mother "has such inability to manage funds that making payments to her would be contrary to the welfare of the child. . . ."

But the requirement is easily rationalized, especially in states which have maximum family grants. The rationale would be: Mrs. A is getting all the money we can give her. She refuses to use (or has not used) contraceptives we offered. She just became pregnant again, causing her to spend money on the new child that might otherwise go to the other children. She does not belong to a religion which forbids such contraceptives (or she does, but obviously isn't religious because she engaged in out-of-wedlock intercourse). Therefore she is not able to manage funds, runs an unsuitable home, etc. We will put her on vendor payments or name someone else as payee until she accepts our family planning.

The rationale is next extended to the person who has *not* become pregnant but who *might*. She is told: Better accept our "services", we might have to put you on vendor payments.

Reduction of illegitimacy is a proper goal of government spending. Family planning is terribly needed for many Americans. Family planning services ought to be provided by the government. But such goals and such services ought not to be part of our income maintenance laws—where they could provide the rationale for excluding illegitimates from income maintenance. Services should be part of a separate and genuinely voluntary program.

V. "REHABILITATION" UNDER H.R. 12080: ACCELERATING THE TREND TOWARD SECOND-CLASS CITIZENSHIP FOR WELFARE CLIENTS

Welfare clients and the very poor have long been regarded as second-class citizens. At one time, our Supreme Court considered "paupers" as "a moral pestilence."[17] Children of the poor could be indentured without even as much as notice to their parents.[18] Criminal punishment could be meted out to those who assisted persons to cross state lines,[19] and the non-resident poor could be forcibly returned to the state of origin or even, if they crossed county lines within their state of origin, to their county of "settlement".[20] Statutes in some states, as late as the twentieth century, denied the right to vote to those who received welfare.

Second-class citizenship still characterizes the status of welfare clients. They are subject to invasions of privacy that we would consider imposing on no other group of citizens. During the early 1960's in many places, and still in some places today, they were subjected to "midnight raids" on their homes for the purpose of discovering whether they had male visitors.[21] In some states welfare mothers are, today, expected to produce affidavits from "neighbors, ministers and grocerymen" to prove that they are not engaging in sexual relations with anyone.[22] In New York City today it is still possible for a welfare caseworker to visit the home of a client, without notice, and ask any neighbor who happens to be visiting for her name and an explanation of her presence. The right of welfare clients to move freely across state lines is still impeded (although recent federal cases are beginning to topple our long-standing residence laws). Behavioral control is implicit in numerous aspects of the caseworker-client relationship.[23] And, among other things, the family law imposed on welfare clients is distinctly different and more onerous than the family law for the rest of the population. See especially tenBroek, *California's Dual System of Family law: Its Origins, Development and Present Status.*[24]

What limited protection the welfare client has for his right to equality stems from two sources: The Constitution and the Social Security Act of 1935. The latter Act sought to guarantee the welfare client's self-control over the spending of his grant, confidentiality in his relations with the welfare department and some significant measure of equality with other citizens in his relation to the law. These guarantees have never been fully realized and that has been one of the reasons for the continuing failure of our welfare system. Now, H.R. 12080 would undermine them further.

A. The Restriction of the "Money Payment" Principle

One of the principal measures taken by the Social Security Act for the purpose of guaranteeing the welfare client's equality has been the "money payment" requirement. By requiring that grants be given in the form of money to the recipient, to spend as he sees most proper, the Act recognizes the right of the poor to live their own lives. By breaking with the "vendor" payment system of the state financed programs, the Act sought to protect the welfare client from the status of incompetent ward. As explained by HEW (Pt. IV, Section 5120, Handbook of Public Assistance):

> The provision that assistance shall be made in the form of many payments is one of several provisions in the Act designed to carry out the basic principle that assistance comes to needy persons as a right. The right carries with it the individual's freedom to manage his own affairs; to decide what use of his assistance check will best serve his interests; and to make his purchases through the normal channels of exchange * * * *The Social Security Administration's interpretation of "money payments" recognizes that a recipient of assistance does not, because he is in need, lose his capacity to select how, when, and whether each of his needs is* [*to*] *be met.* (My emphasis.)

The first (and continuing) inroad on the money payment principle was made by the *practice* of all too many welfare workers who, despite the statute and regulations under it, have dictated the use of the grant in a degrading and often silly manner. The second inroad, reasonably defensible, came with the exception made in the statute for medical vendor payments. The third came with the "protective payee" amendment of 1962, but that too was not onerous in light of the statutory limitations on its use.

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[17] See *City of New York* v. *Miln*, 36 U.S. (11 Pet.) 357, 369 (1837).

[18] *Ackley* v. *Tinker*, 26 Kan. 485 (1881).

[19] A California statute to this effect was declared unconstitutional in *Edwards* v. *California*, 314 U.S. 160 (1941).

[20] Such still exist in the laws of some states, *e.g.*, Mississippi.

[21] For an examination of the legal issues posed in such raids, see Reich, *Midnight Welfare Searches and the Social Security Act*, 72 Yale L.J. 1347 (1963).

[22] *E.g.*, Georgia and Alabama.

[23] See *e.g.*, Schorr, *The Trend to Rx*, School of Social Work, Jan., 1962.

[24] 16 & 17 Stanford Law Review 257–317, 614–682, 900–981 (1964–65).

H.R. 12080, however, throws the door wide open to the destruction of the money payment principle. In striking contrast to the original Act, the notion underlying H.R. 12080 seems to be that recipients do not have the capacity to manage their own grants. Instead of leaving the "protective payee" procedure optional with the states, it makes adoption of the procedure mandatory (in contrast with its failure to make the AFDC-UP program mandatory). It further imposes the requirement that states also adopt a vendor payment procedure for analogous cases. It then removes the major protections against undue use of these techniques as set forth in the 1962 amendments by:

Removing the requirement that "protective payee" (or now vendor) payments be limited to 5% of the caseload (thereby assuming large numbers of recipients might warrant such payments).

Eliminating *all* protections against undue use of these payment procedures where there was a job refusal without "good cause" (thereby not only eliminating from the budget the mother who disagreed with the welfare department as to whether she should work, but automatically eliminating her right to make decisions over how to spend the grant for her children).

Eliminating for *all* cases the prohibitions against use of these procedures in states which do not pay grants meeting the state's own standards of financial need.

The last provision indicates the absurd lengths to which the draftsmen of H.R. 12080 have gone. The very common sense notion underlying the 1962 amendment was that if a state fails to grant a mother that minimum amount which the state itself has concluded is necessary to live in (the lowest acceptable level of) decent standards, then the state is hardly in a position to judge whether the mother is a capable manager.*

If, for example, as is the case in the State of Florida, the maximum grant a mother with ten children may receive is $85 (eighty-five dollars) per month, and that mother has little or no other income, how can anyone possibly judge whether that mother is an incompenent manager? Any such effort is ludicrous. Worse—such an effort would rub salt in the already open wound caused by the impossibly miniscule grant.

It would be far more sensible for Congress to reject the destruction of the money payment system and mandate instead that states pay grants equivalent to the federally defined poverty levels or, as a lesser alternative, mandate (the administration proposal) that states pay grants equivalent to what the states themselves define as the minimum standards of financial need. Then, at least, we will have given welfare clients some money to manage.

B. Further Invasions Into Confidentiality

The Social Security Act, as it currently reads, requires that welfare agencies safeguard—keep confidential—information received from welfare clients and placed into the case records. There are numerous exceptions to this requirement already in existence. Again, the major exception is found in practice which violates the current safeguards. (Should the Committee be interested, this witness would be placed to supply illustrations.) The statute provides other exceptions (i.e. the so-called "Jenner amendment", and the NOLEO amendment). HEW, through its "implied waiver" doctrine, holds that welfare clients implicitly waive welfare department confidentiality with regard to social service agencies to whom they make application. (Under the latter doctrine, some state and local welfare agencies have opened case-records to such "social service" agencies as prison parole bureaus, probation departments, juvenile courts, and public housing authorities—which might use the negative information to evict the clients, etc.)

The range of in-practice violation of confidentiality requirements and "implied waiver" exceptions have convinced me that it is not loosening of confidentiality restrictions that is needed, but a great tightening and enforcing of such restrictions to safeguard the privacy of clients. *This is especially true in a welfare program which directs caseworkers to make deliberate attempts to solicit all kinds of highly personal information from clients so that good casework services and counseling may be offered to them.*

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*The House Report plaintively noted that only seven States have thus far approved "protective payee" plans (p. 102). Of course, that is almost half the eligible number. Only seventeen states give grants which match the State's standard of financial need. The Report also complains that only 50 recipients in these seven states are currently being subjected to protective payee status. Perhaps, however, that indicates how foolish and inappropriate the H.R. 12080 provision is.

What then does H.R. 12080 propose? It seeks to establish court and police department reporting mechanisms with regard to virtually every area of potential family mal-functioning. To illustrate in the words of the House Committee Report (p. 100):

> Thus, for example, if an AFDO mother is not caring properly for her children, the matter would quickly come to the attention of the courts and appropriate action taken, including the possibility of placing the children in foster care * * *. Your Committee believes that some children now receiving AFDO would be better off in foster homes or institutions than they are in their own homes.

The specific language of H.R. 12080 would seem to be virtually limitless in the range of matters that might be the subject of joint welfare department and court or welfare department and police discussion. Thus the AFDO plan, under H.R. 12080, must:

> (18) provide for entering into cooperative arrangements with appropriate courts and law enforcement officials * * * (B) with respect to any other matters of common concern to such courts or local agency administering the State plan.

Section (A) of Clause (18), omitted in the quote above, would cover paternity, support, desertion and abandonment matters. Clause (B) requires discussion on *any* family matter which might possibly have been the subject of state legislation, or at least so it seems.

Here is a major weapon of coercion created by H.R. 12080 against welfare clients. The welfare worker, following case counseling techniques, delves into any and all aspects of the client's personal and family life. Any errant revelation—errant, at least, in the caseworker's eyes—must then be corrected or it may become a subject for police investigation, court-probation report, and neglect or other proceeding. It needn't matter, of course, whether there is any real substance to the client's "deviancy." Substance is a matter to be determined later, only if the client fails to "cooperate" now. And "confidentiality" and "privacy" are, of course, irrelevancies under the new law.

Why an AFDO mother would wish, in any way whatsoever, to cooperate with any so-called counseling efforts by welfare caseworkers or others escapes this witness. Even should she "trust" her caseworker of the moment, could she have confidence that the caseworker assigned to her [next month] will not reveal the notes made by her present worker? I cannot see how.

C. Special Enforcement of Neglect Laws

Through its destruction of the money payment principle, H.R. 12080 advances the assumption that welfare mothers are incompetent to manage their grants and their families. Through its undermining of the safeguards requiring confidentiality, and its creation of welfare department-police-court cooperation regarding any and all aspects of the client's life, H.R. 12080 incorporates some of the worst aspects of totalitarian methodology into the American public assistance system. Through its direction to welfare and police agencies to give special enforcement of neglect laws against welfare clients, H.R. 12080 completes a program of second class citizenship for the welfare client and undermines the general legal structure as well.

As noted by the House Committee Report (p. 100), "cooperative agreements" between law enforcement agencies and welfare departments are to provide the basis for using the information (gained through a breakdown of confidentiality safeguards) for the purpose of prosecution of the neglect laws and other family control laws against AFDO recipients.

Neglect laws, were they not so vague, could be a valuable part of our legal system. Specifically enforced against our very poorest citizens only, they are an abomination. Whatever the uncertainties of constitutional adjudication on discriminatory enforcement of the law, such enforcement is deeply offensive to a democratic society. A rich mother may neglect her child (as anyone with social knowledge can testify), and so may a middleclass mother, and so may a non-welfare but impoverished mother. All classes include parents who indulge in child neglect. Indeed, virtually all parents neglect their children to one extent or another, depending upon who defines neglect.

In a different but analogus context, the Supreme Court has noted (*Skinner* v. *Oklahoma*, 316 U.S. 535 [1942]):

> When the law lays an unequal hand on those who have committed intrinsically the same quality of offense * * *, it has made an as invidious

a discrimination as if it had elected a particular race or nationality for oppressive treatment.

H.R. 12080 would single out a particular class—the very poor, the most helpless—for oppressive treatment. Such invidious discrimination has no place in our society.

VI. THE NEGATIVE EFFECTS OF THE "POSITIVE" FEATURES OF H.R. 12080

Several provisions are contained within H.R. 12080 which appear to be positive and helpful in their intended operation. This is particularly true of the provision for "temporary emergency assistance," even though it is drawn on a narrow and limited basis.[*] Some of these seemingly helpful provisions have marked drawbacks, however. Thus:

A. *Home Repair Grants.*—It is astonishing that the provision for federal matching of home repair grants (Section 209a of H.R. 12080) specifies that such grants are for only Titles I, X, XIV, and XVI and omits Title IV. Has stereotyping of AFDC recipients gone so far that the draftsmen were unaware that some AFDC recipients also own homes? Surely this omission should be corrected.

B. *Work Incentives.*—In great contrast to the "work tests" discussed earlier, work incentives provisions are an important way (together with job opportunity programs) to assist those genuinely employable welfare recipients into employment. It is unfortunate, indeed, that the incentive chosen for AFDC recipients was not the standard used in other titles of the Social Security Act (for the Blind), in the Economic Opportunity Act and in the Elementary and Secondary School Act; that is, the first $85 per month and one-half the remainder. The difference between the latter standard and the proposed one (the first $30 per month and one-third the remainder) is, of course, considerable—for many cases, perhaps, the difference between a token and a real work incentive.

The small incentive offered by H.R. 12080 is particularly unfortunate for that significant minority of AFDC recipients who are presently benefitting from the higher incentive and whose standard will be "rolled back" under H.R. 12080. In addition, it is most unfortunate that, as noted by the House Committee Report, the work incentive will not be applied so as to benefit those non-welfare recipients who are presently at or slightly above the welfare line (but who, under the incentive program, would actually be making less than welfare recipients). The failure to include such persons will create a divisiveness that will surely be more detrimental than the $160 million per year that the Committee Report (P. 107) estimates will be saved by their exclusion.

But, of course, as the Report adds (P. 107), H.R. 12080 is "designed to get people off AFDC rolls, not put them on."

C. *Foster Care.*—More money, of course, is desperately needed for the many children who are in need of good foster care and not getting it. The H.R. 12080 provisions are objectionable because they are part and parcel of the restrictive program of the bill. The provisions of the bill are based on the notion that it is the AFDC family which is the problem, and not our woefully inadequate welfare and job programs.

D. *Partial Payments to States.*—It is true that the only penalty, under present law, for non-compliance with the Social Security Act is suspension of federal funds for the entire program. (Although, I believe, HEW likes to exaggerate the ineffectiveness of this remedy as an excuse for its failure to institute non-compliance proceedings; in fact, in the past, in almost all situations where non-compliance proceedings were instituted under the Social Security Act, the State ended up by complying rather than by abandoning federal funds for the whole program.)

H.R. 12080 aims at broadening the remedy by allowing HEW to withhold payments for *that part* of the program which is in non-compliance. As an example, the House Committee Report (Pp. 112–113) gives non-compliance in Title XIX because of State failure to pay the reasonable cost of hospital care; the remedy would be to cut off federal funds for the financing of hospital care, rather than the whole program.

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[*] The provision ought not be optional with the states (but mandatory), ought not be limited to 30 days in any 12 month period (considering the slowness of some state welfare programs, a maximum of at least 60 days would seem appropriate) and ought to be coupled with a requirement that states institute a "declaration" (affidavit) procedure for determining initial eligibility instead of the cumbersome and time-consuming investigations presently utilized in most localities.

But that is an equally inappropriate remedy. Once again, it is the recipient who suffers. Further, it is not unreasonable to assume that the "partial payment" remedy might *encourage* some states to violate federal standards. Thus, where a state wants to take even more drastic action againsts those eligible for AFDC because of a deserting father than is permissible under H.R. 12080, it would have less fear that such action would result in withdrawal of federal matching funds for those eligible due to death, incapacity or unemployment. Consequently, the state might be encouraged to act regardless of the federal requirements. The proper remedy is twofold: (1) In the event of State non-compliance, a direct service program by the federal government ought to be offered in that state. (This, in my view, is the only way to make sure that the poor are actually protected; by acting in non-compliance, the State has forfeited its responsible role); (2) Court remedies ought to be expressly opened to recipients for the purpose of compelling compliance by a State program which *is* receiving federal funds despite its non-compliance. (This, in my view, is the only way to guarantee compliance in the numerous situations we have today where HEW simply does not act.) I agree with those others who (I believe) have urged before this Committee that multiple damages be granted to recipients in such non-compliance suits.

CONCLUSION

For all the reasons I have stressed heretofore, I believe that Title II, Part 1 of H.R. 12080 ought to be rejected in toto by this Committe. At the least, the administraiton-sponsored bill (H.R. 5710) ought to be adopted by this Committee with whatever positive features exist in H.R. 12080 added. More appropriately, a bill ought to be designed and adopted along with the recommendations of the 1966 Report of the Advisory Council on Public Welfare. *Having the Power, We Have the Duty.*

The CHAIRMAN. We will next hear from Mr. Bernard Diamond, chairman of the Government and Professional Relations Council, American Association of Bioanalysts, and State organizations of independent laboratory directors, accompanied by Bernard C. Kaplan, of New Jersey; John Egan, of Connecticut; and Robert S. Bourbon, counsel.

STATEMENT OF BERNARD I. DIAMOND, CHAIRMAN, COMMITTEE ON GOVERNMENTAL AND PROFESSIONAL RELATIONS, AMERICAN ASSOCIATION OF BIOANALYSTS, ACCOMPANIED BY ROBERT S. BOURBON, COUNSEL; BERNARD C. KAPLAN; AND JOHN J. EAGAN

Mr. DIAMOND. Senator Long, thank you very much.

We appreciate and thank you for this opportunity.

My name is Bernard I. Diamond, director of the Diamond Laboratories, an independent bioanalytical laboratory in Philadelphia, Pa.

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. I appear before you with counsel, Robert S. Bourbon, Esq., of Silver Spring, Md., sitting to my right, and Bernard C. Kaplan and John J. Egan, at the request of and representing the following organizations:

The American Association of Bioanalysts,
The Maryland Association of Bioanalysts,
The New York State Association of Clinical Laboratories,
The New York State Society of Bioanalysts,
The New Jersey Association of Clinical Laboratory Directors,
The Oklahoma Association of Bioanalysts,
The Pennsylvania Association of Clinical Laboratories,

The California Association of Clinical Laboratories,
The Rhode Island Association of Clinical Laboratories,
The Massachusetts Association of Clinical Laboratories,
The Illinois Association of Clinical Laboratories,
The Ohio Association of Bioanalysts,
The Michigan Association of Bioanalysts,
The Connecticut Association of Clinical Laboratories,
The Texas Association of Clinical Laboratories, and
The Florida Association of Medical 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 curriculums, and those who hold similar commissions in the armed services or governmental laboratories.

We do not appear here in opposition to the principles of H.R. 12080, in perfection and expansion of social security program coverage, but rather to present our position concerning and in supplementation of H.R. 12080, as it may affect, or may be made to effect modification of the basic law relating to laboratory participation.

We were pleased and it was our privilege to offer testimony before this committee on May 13, 1965, on behalf of the American Association of Bioanalysts, urging that independent laboratory services be included in the Social Security Amendments of 1965, being now Public Law 89-97. A copy of that statement is on file with this committee. The 1965 testimony is offered to support and supplement this statement as an adequate presentation of the arguments for the inclusion of the independent laboratory as a member of the integrated health team.

The Congress provided, in title XVIII, subparagraphs 10 and 11, section 1861(s) of the Medicare Act for coverage in the medical insurance program of diagnostic tests performed in independent clinical laboratories; that is, independent of a physician's office and of a participating hospital. Two conditions are imposed in title XVIII:

1. The independent laboratory must be licensed pursuant to State or local law, or be approved by the State or local agency as meeting the standards established for such licensing or approval; and
2. The independent laboratory must meet the standards found necessary by the Secretary of the Department of Health, Education, and Welfare, to assure the health and safety of individuals with respect to whom tests are to be performed.

Both the medicare program and the regulation of independent laboratories thereunder have come a long way since their consideration by this committee and the Congress in 1965.

On December 16, 1966, the Department of Health, Education, and Welfare issued regulations, published as required in the Federal Register entitled, "Conditions for Coverage of Services of Independent Laboratories." Enumerated therein are the specific requirements to be met by independent laboratories to qualify their services for reimbursement under medicare.

These regulations have been revised, both formally and by way of policy statements of interpretation from time to time since then. It may be said, in the main, that the Department of Health, Education, and Welfare has made efforts to cure certain inequities caused by the "conditions," as they apply to the independent laboratory.

Some very serious problems remain, however, under these regulations.

We are fully aware of the magnitude of any request made for change in this bill, and of the practical burden assumed by us in that connection, after the overwhelming vote for its approval received in the House of Representatives this year. We are cognizant that the Congress cannot supervise all of the detail involved in the administration of legislation as complex as the medicare program.

Section 405.1312 of the conditions for coverage of independent laboratories provides for an exception to and from control and regulation for hospitals, pathologists, and certain physicians, creating an imbalance in favor of such hospital, pathologist, and physician laboratories, in that such entities do not now have to demonstrate their proficiency, as must all other independent laboratories, across the board, without exception.

We should like to call to the attention of the committee the results of a survey made by Dr. Morris Schaeffer, director of laboratories for the city of New York and published in the April 1967 issue of Health Laboratory Science, a publication of the American Public Health Association, entitled, "The Clinical Laboratory Improvement Program in New York City."

This detailed study showed that hospital, pathologist, and M.D.-directed laboratories have shortcomings, of a type which were earlier advanced as reasons necessitating regulation of the independent laboratory alone.

It will be remembered that the independent laboratory is now fully regulated under medicare and is and will be constantly required to prove its proficiency, in addition to fulfilling numerous other continuing qualifications.

Recently there has been substantial national publicity, on the basis of the statement of Dr. David Sencer, before the Special Senate Subcommittee on Antitrust and Monopoly, that in excess of 25 percent of all clinical laboratory tests in Federal hospitals and dispensaries are unsatisfactory. Such hospitals, as the regulations now stand, are not subject to the stringent control required of the independent laboratory.

We are not before this committee pleading for less control for the independent laboratory. What we do ask is that the same protection be extended to the patient public whether the work be performed in an independent laboratory, pathologist laboratory, hospital laboratory, or a physician's laboratory, maintained primarily for his own patients.

We respectfully submit that it was the intent of Congress to provide the best laboratory services available to medicare beneficiaries, regardless of where or by whom such services are performed. Patient welfare is protected only if all laboratory work is publicly supervised, whether performed in a medicare approved independent laboratory, a pathologist or hospital laboratory, or the laboratory in a physician's office.

We join the Secretary of Health, Education, and Welfare in a common desire to improve the work of the clinical laboratory and to safeguard the public against incompetence. We join all members of the health team in our deep concern for the health and safety of the public. It is illogical to exempt from medicare regulations the physician's office, where laboratory work is performed without the same type of control required of the independent laboratory.

May we ask what persuasive reasons exist to permit the many thousands of physicians in private practice and the vast majority of the Nation's hospitals to be reimbursed for laboratory services under medicare, where the Department of Health, Education, and Welfare has no direct control over the quality of the work performed or the type of operation maintained by them?

We recommend the following:

(*a*) That the Congress, in its present consideration of H.R. 12080, reexamine, with particularity, its intent with reference to exemptions made heretofore of physician and hospital laboratories.

(*b*) Consistent with the recommendations set forth in (*a*) hereinabove, that the Congress consider the following amendatory legislation:

Following the words, "No diagnostic tests performed in any laboratory," after subparagraph (9) 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 or a hospital."

We therefore recommend and request your consideration of the foregoing remarks and suggested amendatory legislation, as they pertain to regulation of laboratory services under the medicare program.

Thank you, very much.

The CHAIRMAN. Thank you very much, sir. I appreciate your statement very much, sir.

Mr. DIAMOND. Thank you, Senator.

The CHAIRMAN. Senator Morse is with us today. Senator Morse, we are happy to have you here, and it seems like old times to have you at the same committee table.

I was honored to serve with you on the Foreign Relations Committee and the Armed Services Committee. We are very much interested to know what your views are on this matter.

STATEMENT OF HON. WAYNE MORSE, A U.S. SENATOR FROM THE STATE OF OREGON

Senator MORSE. Mr. Chairman, with permission from the members of the committee, I wish to make a very brief statement for the record, which really amounts to a statement of introduction of Mrs. Loretta Daniel, of Eugene, Oreg. She will be a witness before this committee today representing the Aid to Dependent Children Association, Lane County, Oreg., Fourth Congressional District. She is accompanied by Mrs. Vi Mosey, another very active worker in my State in behalf of the Aid to Dependent Children Association of Lane County.

These two women are highly intelligent, dedicated representatives of parents among the economically poor of my State. Each one of them has experienced poverty and hardship. Each one of them knows what it means to be poor. Each one of them lives and works with people whom H.R. 12080 is supposed to help.

Mrs. Daniel, speaking for both of them and for the Aid to Dependent Children Association of Lane County, Oreg., will call attention to the shortcomings of H.R. 12080, as seen through the eyes of those people of my State and of every State who are entitled to a better legislative program than H.R. 12080 provides.

You will find Mrs. Daniel, as she points out in her statement, a supporter of many provisions of the bill, but a pleader, with justification, in my opinion, for improvement of the bill by this committee and by the Senate. She will testify for correction of what she believes to be the inflexibility and limitation of the education portions of the bill. She will state her case, setting forth her disappointment that the initiative and incentive factors are not encouraged but are penalized and stifled by the limitation of earnings.

She will point out that the freeze of the number of aid to dependent children cases in each State will not contribute to the lessening of the case load but will in reality mean cutbacks in the grants so sorely needed to bring necessary help to poverty striken parents in our Nation. She will point out other shortcomings of the bill, and I agree with her.

I am proud to have her appear as a witness before this committee, because she and her associate, Mrs. Mosey, bring to this committee an inspiring grass roots philosophy of mothers qualified to speak for the poor because they have come from them. Their plea is a plea for social justice and for improved legislation that will provide better opportunities for children in American homes whose parents need just economic assistance from their Government in order that they may better provide for their children through taking advantage of job training programs and other economic opportunities for self-improvement, about which Mrs. Daniel will testify.

I am very proud of both Mrs. Daniel and Mrs. Mosey, and I am pleased to make this statement concerning them for the record of this hearing.

Lastly, Mr. Chairman, I ask permission to file with the committee for printing in the record a statement submitted to the Committee through me by the Aid to Dependent Children Association, Lane County, Oreg., giving a summary of the work of the Committee and the work of the self-help, self-improvement program sponsored by the association.

In this summary, the association sets forth some of its problems and needs. It is an inspiring report concerning the work of dedicated men and women who obviously are motivated by a social conscience that recognizes we are our brothers' keeper.

They conclude their report with this observation, "Moral: If you do not train people for gainful employment, you will pay for them in Welfare Cases and loss of Tax Revenue!"

Their report gives those of us in positions of legislative responsibility much to consider.

I ask that their three-page report be made a part of the record of these hearings.

I want to say to you, Mr. Chairman and members of the committee, again, I am indebted to you for your never failing courtesy, and I shall look forward to the results of your deliberations and for the recommendations that you make to the Senate. Thank you very much.

(The report of the A.D.C. Association of Lane County, Oreg., above-referred to, follows:)

To Senate Finance Committee:

The A.D.C. Association of Lane County, Inc., Oregon, wishes to state that: In the past year we have been organized as a Self-Help, Self-Improvement group. We feel for our particular needs this is the answer.

Throughout the country today many groups have started and are starting on the same road.

At the present time we are scheduling sex education classes for the children from the Fifth Grade level up. We are scheduling birth control films and speakers for the adult portion of our membership. We are planning social and cultural enrichment programs for our children including art, dancing, drama and music. These programs can all be put into operation immediately without additional funds. Our programs are being provided with maximum support from the Community. Our one drawback has been the lack of transportation to and from the meetings for our members. From the time of the institution of our Association, the local O.E.O. Office has provided a monthly budget of about $300.00 to meet our needs for gas, mileage, office supplies and postage.

We have produced evidence in our Community supporting the need for remaking lives which until recently have had no hope but to hope. We have seen the futility of wishing and dreaming—realizing that our dreams are merely a temporary escape from a harsh reality we must face again and again. We are awake now—we are active now; actively engaged in solving some of the problems that confront us daily. Yet we are part of this Society—we belong!! We are establishing the means to show the Community that we can and will reconstruct our lives, strengthen the future for our children, and prove to the Community, and ourselves, that we can lead productive lives so that what talents and energies we have will not be wasted, but will be used for the benefit of all.

In December of 1966 our Association drew up a list of changes we felt were necessary to improve Public Welfare in Oregon. From this list Four (4) bills were presented to the Oregon Legislature. These Bills did not ask for increases in grants despite the fact that they were living on 1953 standards. They did not ask for increases in the Housing allotment. The Bills were requests to actually improve the standards of Welfare Recipients without increasing the Welfare Budget or the Tax Payers burden.

Our bills asked establishment of Scholarships to Community Colleges to provide Technical and Vocational training for Welfare Recipients and their families. The Oregon Legislature could not find it in their budget to appropriate funds for this bill. Our lobbyists asked that the bill be sent out of Committee without funding and they would raise the money from the General Public. This money would be matched by the Federal Government 3 to 1. The bill was approved by the Federal office and passed by the State Legislature by unanimous votes, both in the Senate and in the House of Representatives. This September we have made three (3) Scholarships available to the Welfare Recipients and have pledges for many more.

Another bill that allowed Welfare Recipients to share Housing, where proper facilities were available, has proved to be valuable in moving the Scholarship applicants from the rural areas to the vicinity of the Community Colleges.

We lost two bills at the Legislature that we felt were most important to our cause.

We wished to have Recipients trained as Case-Aids to work with the Welfare Department and allied fields of Health, Education, and Welfare to relieve the over burden of paper work, and to act as a laision between recipients and the Caseworkers. We asked that these people be trained on the job and in school and we aimed at their Certification and accreditation. They tried desperately to get one other bill passed, however we were stopped by Federal Regulations. We asked that recipients be allowed to earn in addition to their grants. For instance in such States where recipients are on standards less than 1967 we realized it was impossible for the taxpayers to assume the burden of the increase. We therefore suggested that recipients be allowed to earn in addition to their grants up to what is specified as minimum standard of living. We also asked that the earnings could be used to purchase prosthetics and dental services not provided by the State medical plan. The reasoning behind this was to make the recipients socially acceptable as well as physically fit.

We were striving toward providing more incentive and encouraging Self-Help and Self-Improvement. We were asking our Legislature to give us the key to open the doors out of our narrow Welfare World.

We found our problems to be diversified—we had emotional, physical, educational, and social handicaps. It was a big order for a small group. However we were pleased to discover there were people right in our Community who cared and were willing to volunteer their services. Surprising enough the physocologists, teachers and instructors of the Arts were willing to give of themselves. We have been and intend to continue using existing agencies of the Community to further our Social and Cultural Advancement.

We realize that we are fortunate in the amount of volunteer services available, however we are aware that our conditions do not exist throughout our entire State or the County.

These recipients can desire changes they can strive for self-help and self-improvement but they do not have the power to change their sub standard food or housing allowances nor can they control the fact that they are incapable of managing the transportation to and from schools, the cost of hot lunches, the cost of clothing necessary to go to work, the cost of the dental care or the cost of dental plates which make them socially fit to attend school or acquire jobs in the labor market.

We think the intent to encourage local Welfare Departments to force recipients into the labor market is unrealistic, since the States cannot afford the services your amendments are requiring them to adopt if the Federal participation will be decreased by 1969.

We feel that rather than create new mandatory regulations the Federal Government should insist that all States accept the responsibility for maintaining able children in the schools up to age twenty-one (21). The Federal Government should insist that all States bring the food standards up to more realistic levels. That housing allowances be increased according to the areas and that all States adopt medical and dental programs to provide for healthier future citizens.

If the Federal Government cannot see fit to do this, would they not then at least consider allowing the recipients to earn in addition to their grants that amount that is the difference between the grant and the Department of Agriculture Standards for minimum income? As the recipients earn the extra money they can make the transition from the Welfare rolls to full employment.

We cannot and do not assume that we have the answers to poverty. We do not know that the investments made in retraining the underprivileged have proven to be worth the investment.

Report from 1966 manpower development training

Unemployed and welfare cases trained	2,000
Gainfully employed after training (75 percent)	1,425
Average annual earnings of trainees (after training)	$4,000
Total wages added to State economy for 1 year	$5,700,000
Total cost of training ($536 per trainee)	$1,072,000

(Cost of Training is repaid in taxes and removal from Welfare roles during only one (1) year of employment.

Moral!!!! If you do *not* train people for gainful employment, you will pay for them in *Welfare Cases* and loss of *Tax Revenue!!*

Thank you.

A.D.C. ASSOCIATION OF LANE COUNTY, INC.

The CHAIRMAN. Thank you very much, Senator.

Now, we will hear from Mrs. Loretta Daniel of the A.D.C. Association of Lane County, Eugene, Oreg.

We have a letter from the Oregon Social Welfare Association, and we will put that in the record at this point.

(The letter above-referred to, follows:)

OREGON SOCIAL WELFARE ASSOCIATION, INC.,
Salem, Oreg., September 18, 1967.

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

SIR: The Membership of the Oregon Social Welfare Association, Inc. through its Board of Directors protests certain sections of HR 12080, Title II, as being punative and not in the best interest of the people of this country. We refer specifically to those sections of the bill which would

(1) require all adults on assistance, including mothers and out of school youth over 16 to engage in work and training as a condition of receiving public assistance. The proposal apparently includes exemption from minimum

wage requirements and further provides such penalties as removal of the adult from the assistance budget, discontinuing assistance, or even possible removal of the children by court and placement of the children in foster care.

(2) limit the number of children in each state who could be assisted from federal funds when the need of the children resulted from a broken home. This would penalize children and deprive them of their basic needs of food, shelter, clothing, education and medical care.

(3) so define unemployment that most unemployed fathers in this state would not qualify for Aid to Families with Dependent Children. The majority of families receiving aid under this Title dealing with unemployment are farm workers essential about eight months of the year to the harvest of crops but unemployed the balance of the time. This group of people, essential to our economy, are not covered by unemployment compensation nor do they share in many other social and economic benefits of society.

While we recognize that there are elements of HR 12080 which are highly desirable, we do not believe that the legislation as now written should be permitted to become law so long as it contains policies both coercive and repressive

Sincerely,

Mrs. LUCILLE S. PUGH, *President*

STATEMENT OF LORETTA DANIEL, REPRESENTING ADC ASSOCIATION OF LANE COUNTY, INC., OREG.

Mrs. DANIEL. Mr. Chairman and members of the committee, I am Loretta Daniel, and I represent the ADC Association of Lane County, Oreg., Fourth Congressional District. Our association wishes to commend your motives in the educational portion of the amendments to H.R. 12080. However, we feel that there are certain points which are either unclear, inflexible, or unfair.

The stress placed on educating those with work experience rather than those with no work experience seems, in our opinion to be unrealistic since it is obvious that the parent without work experience is the one most in need of assistance. Granted both need further training but who is to decide how to separate the wheat from the chaff?

It is our belief that every human being wishes to provide for his children. Therefore, when a parent appears to shun that responsibility he is either lacking in education, in emotional balance, or is physically incapable. In any case, he is in need and that is the responsibility of the community, the State, and the Federal Government. He deserves equal opportunity.

Community work and training programs have no minimum standards, no goals of dignity. There should be some specifics for job development and some aim toward technical and vocational training.

There should be more encouragement of the recipients into long-range training programs to give them accreditation and certification. There is no sense in training a human being for an obsolete job.

Cutting the parents' food allotment if he refuses to work would cause regression in the programs of many States, including Oregon. Oregon has been solving most of her problems but not by penalizing the children's welfare or their parental care. We see this as one more contributing factor toward a constantly increasing juvenile delinquency rate, illegitimacy, and prostitution.

Illegitimacy is stressed throughout your amendments—is illegitimacy restricted to the poor? Or is illegitimacy, delinquency, and immorality a cancer in all levels of our society? Illegitimacy cannot be cured on the basis of information alone. When there is nothing left to prove a man's masculinity or a woman's femininity but production of children, then the illness is in the society around them. Illegitimacy cannot be cured by fear and punishment.

As there are homicidal maniacs, we don't doubt that there are maternal maniacs who would be willing to have children in order to stay on welfare. It is hard for us to believe that there are many women in this country who would be willing to have 10 illegitimate children at 86½ cents a day per child and 30 cents of that must go for hot lunch at school.

To support birth control programs and then to set a limit of 1972 as to how long the Federal Government will participate is defeating the very purpose you set out to achieve. Since there is no assurance that the States will continue the program after that time.

Educational guidance toward vocational, technical, trade schools, colleges and universities should be mandatorily started much earlier than high school level, not only to eliminate second and third generation untrained, unskilled welfare recipients, but to prevent new cases from occurring. According to W. Willard Wirtz—Facts You Should Know About Labor and Vocational Education, March 1963:

> Thirty percent of our high school children are presently in vocational technical programs and are being trained for careers.
>
> Twenty percent will finish a 4-year college or university.
>
> Fifty percent will remain unskilled and untrained.

The stress on education obviously should be placed before this 50 percent reach maturity. If 50 percent of our younger generation are leaving school untrained, then the present poverty class alone is not entirely responsible for the increase in welfare's rising costs.

We would suggest that rather than enforce new rules and regulations, more stress should be placed on States being obliged to encourage education and the development of full potential by the mandatory adoption of keeping children on grants while attending any type of training program or school which will make them self-supporting and give them a chance for meaning.

The $30 limitation on earnings is, in our opinion, one of the gross injustices of the entire amendments.

With the allowance of earnings under the OEO program and under the Elementary School Act set at $85 a month, it would seem that if you are among those fortunate few who secure temporary employment under either of these programs, you are given special privilege. If you have enough initiative and ambition to scrub $85 worth of floors, you are only allowed to retain $48.30. It would appear, therefore, that we have now set up a caste system among the very people you are attempting to help. Under this system you are suppressing initiative and encouraging dependency on programs.

With programs comes dependency and which dependency comes poverty because dependency stifles initiative.

The person who finds his own job must be encouraged rather than penalized because he is not dependent and shows indications of finding his way out of poverty. He should be encouraged in every possible way. Toward further education, toward upward mobility. In his attempt to find upward mobility the recipient must be assured of financial support until he has reached a minimum of financial independence.

If there is not incentive enough to warrant the recipient striving to earn, then he will be encouraged to cheat or stay where he is and make no progress. Why not use the bait of old-fashioned incentive—money.

It is a proven fact that people appreciate those things they earn. They have little or no respect for what is technically a handout.

The amount a man contributes to his own well-being is in part a portion of the self-respect and integrity he has regained.

The part-time job for many is their first step out into the labor market, this flame of independence must be nurtured, protected, and respected—these are the people who could find their way to full citizenship; they only need a hook and line, they can catch their own fish.

In earning and being allowed to retain, the recipient is encouraged to become a consumer of goods and he also becomes a taxpayer and, therefore, contributes to his own welfare.

The blind and the disabled are allowed to earn and retain $85 a month. Is not the parent of dependent children in just as vital a position inasmuch as they are the main influence on the next generation in their keeping and their actions and reactions are reflected in those children.

The parent who is given the chance to substantially supplement the family income is given the decision of financial responsibility and achieves independence and self-esteem.

With extra earnings, family environment could be improved, cultural enrichment could be provided, nutritional standards could improve, and clothing could be on a par with nonpoverty children.

Furniture could be repaired, curtains could be bought, upholstery could be cleaned.

Cultural enrichment could include music lessons, dancing and community and social participation.

Nutritional improvement would be achieved with the addition of red meats, fresh fruits, and fresh vegetables.

Clothing is an essential part of every child's and adult's well-being and their feeling of social acceptance. The proper clothing imparts a feeling of unity with the society around him.

In 1935, the Federal Government chose to establish a service as a temporary measure to provide for the Nation's underprivileged. That service has mushroomed into a monster, an albatross, so to speak, around the neck of the American taxpayer. Are we to eliminate the responsibility merely by saying we will help so many and no more? Who is to judge which are full citizens and which are not?

The influx to the Northwest makes it impractical to set a standard on the number of AFDC cases for all time.

The lumber industry and its fluctuating market, seasonal layoff and declining industrial importance has and will continue to influence the welfare rolls in Oregon. No doubt other areas have their own particular problems.

Freezing the number of people on the AFDC rolls would cause some recipients to hesitate leaving the program for any sort of employment for fear they could not return if the job were not successful. Again, fear is replacing independence.

Many large businesses in this country are subsidized directly or indirectly by the Federal Government. If the underprivileged children of our country are not worth subsidizing, then there is nothing left of the American philosophy. Even small businesses are financed by the Federal Government and they have a certain percentage of risk and failures.

Elimination of AFDC families from the provision for home repair is illogical inasmuch as it is apparent that any AFDC family that owns or is buying their own home should be encouraged as much as possible. These are the homes where stability is a natural feeling—where the owning and the caring for one's home is a responsibility. Again, we are discouraging independence, initiative, and ownership and encouraging dependency, indolence, and slum housing. The investment in AFDC homeownership repair would alleviate the necessity of finding suitable housing at a time of low-rent housing shortage.

Many homes could be saved from slowly degenerating into a hovel with timely repair.

Children reflect their surroundings. A home that is in good repair with all necessities functioning, tends toward lending a feeling of well-being to the occupants.

Is it not as important that children in their own homes are in the proper surroundings as it is required of foster homes?

In summary, we are pleased with many portions of the amendments and we are displeased with the inflexibility and the limitation of the educational portions.

We are sorely disappointed that initiative and incentive are not commended, but penalized and stifled in the limitation of earnings.

We feel the freeze on the number of AFDC cases in each State will not contribute to the lessening of the caseload but will in reality mean cutbacks in the grants in order to satisfy the taxpayer who is in revolt throughout the Nation.

Home repair is again an example of suppressing initiative and stifling individual upward mobility.

You cannot force a man to fish for his own food. Nor is it logical just to keep him from his attempt to catch his own food. All that can be done is to provide him with a hook and line.

Thank you.

The CHAIRMAN. Thank you very much for your statement today.

The committee now stands in recess until 10 o'clock tomorrow.

Whereupon, at 4:20 p.m., the committee adjourned to reconvene at 10 a.m., on Friday, September 22, 1967.)

SOCIAL SECURITY AMENDMENTS OF 1967

FRIDAY, SEPTEMBER 22, 1967

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

The committee met, pursuant to recess, at 10:10 a.m., in room 221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Hartke, Williams, and Carlson.

The CHAIRMAN. The hearing will come to order.

On Tuesday of next week the committee will reconvene for the final round of questions for the Secretary of Health, Education, and Welfare, the Honorable John W. Gardner and his staff.

We will take up the bill in executive session the following week and begin to mark it up for floor action.

In deference to later witnesses I hope that all witnesses will stay within the time allotted to them. This morning we are pleased to have as our first witness the Honorable Joseph D. Tydings, the Senator from Maryland.

Senator, we are pleased to have you here. We know what you have to say will make a deep impression on the committee.

STATEMENT OF HON. JOSEPH D. TYDINGS, U.S. SENATOR FROM THE STATE OF MARYLAND

Senator TYDINGS. Mr. Chairman, members of the Finance Committee, I appreciate this opportunity to appear before the Senate Finance Committee to testify regarding the scoial security bill, H.R. 12080. I want to restrict my testimony to certain aspects of the welfare provisions of the bill. Many portions of the bill are, I believe, excellent and quite farsighted, and do great credit to the House Ways and Means Committee. The new provision that welfare recipients will not lose from welfare payments 100 percent of any money earned provides a significant and useful incentive for welfare recipients to go to work. Recognition of the importance of providing family planning services and day-care centers for young children of working parents is also quite farsighted. These and similar programs, if carefully developed and if applied without coercion or threat of punitive sanctions, could vastly improve the lives of those on public welfare, and could bring substantial benefits to the welfare system generally.

There is, however, a considerable danger in H.R. 12080, as it is now drafted. That danger is that the bill appears to overlook the inadequacy of existing services in areas such as family planning, day-care centers and job training. And, without acknowledging that these services are untested or nonexistent in most parts of the country, the bill appears to force welfare recipients to use the services without regard to their adequacy, or indeed, to their very existence or to questions of individual conscience. I believe that changes can and should be made in the bill to remedy these shortcomings—and many are more problems of presentation than of substance—which would significantly strengthen the bill.

First, of all, I want to discuss the provisions of the bill dealing with family planning services. As recently as 3 or 4 years ago, the concept that Federal, State, or local governments should make available family planning information and services to families who could not otherwise afford them was extremely controversial. Indeed, not too many years ago this subject was never even mentioned on the floor of the Congress. But in a brief period of time there has been a substantial shift of opinion among the political and religious leadership of the country. It is now widely recognized that no single factor more certainly dooms low-income families to continued and deepening poverty than unwanted chidren which they cannot afford. And the unwanted child is himself trapped in the vicious circle. I think you gentlemen realize how often dependency on public welfare starts with the unwanted child. I believe there is now a substantial consensus in this country that the Government can and should properly make family planning assistance available to those who truly want it but cannot afford it. There is no reason why only the middle income class and the higher income class should be able to plan their families. The poor should have the same opportunity.

Yet, in spite of this new consensus, the Federal Government has done distressingly little to provide voluntary family planning services to low-income families. We know, gentlemen, that there are 5 million women of child-bearing age in this country who want to plan their family to restrict the number of children, but cannot afford to obtain family planning services. Last year, only 700,000 of these 5 million women obtained family planning services from all of the private and public sources combined in this country.

Based on the experience of planned parenthood, we know that it costs approximately $20 a year to provide family planning services for a woman who wants them. To reach the 5 million women who need and want these services, we need to expend more than we have in the past.

But the total HEW expenditures for such services last year was only $5 million, which was less than the total expenditures from private groups such as planned parenthood. Research and training also received Federal support at about the same level of expenditures for services.

Gentlemen, I think it is time to shift the emphasis from research in family planning and go to work on providing the services. Let me tell you what they did in Baltimore. The Baltimore City Health Department 3 years ago in women's ward of Baltimore General Hospital, the city hospital, put in a family planning clinic and offered services to those mothers who wanted them. There was no compulsion, no coercion—the health department just provided poor women with the same opportunity to plan their family that those mothers who were fortunate enough to go to the private hospitals and who had higher standards of income could provide from their own pocketbooks.

Do you know what happened in Baltimore after the first full year this program was in effect? Our birthrate dropped by some 2,000 children. Now these 2,000 children, gentlemen, had they been born, would have been born in families who didn't want them, who couldn't afford them. They would have been caught in the welfare spiral, the delinquency spiral, the inadequate upbringing spiral. In just 6 years those 2,000 children in the cost of new classrooms alone in Baltimore City would have been over $3 million, not to mention the additional cost of those who get involved in delinquency or welfare. Through this simple program instituted in the Baltimore City hospitals we anticipate saving the taxpayers millions of dollars.

I don't think there is any way that we can expend funds that will produce greater returns to the taxpayers of this country than providing family planning services to the poor who want those services and who should have them. I am talking about the mothers of illegitimate children as well as mothers that have the blessings of matrimony in the family.

The CHAIRMAN. But if half those children were drawing welfare payments at $30 a month——

Senator TYDINGS. Right.

The CHAIRMAN. That would cost you $3,600,000 a year over a 10-year period.

Senator TYDINGS. That is right.

The CHAIRMAN. Not even considering accumulated interest costs of it, that would cost you almost $4 million.

Senator TYDINGS. That is right.

The CHAIRMAN. For this continued period.

Senator TYDINGS. That is right. I have received one study which shows that for every $1 spent in this area, the prospective return to the taxpayer in savings is anywhere from $100 to $200.

The CHAIRMAN. Senator Tydings, after all the argument about it, the more it is discussed, the more people finally conclude that a mother really has some right with regard to whether she is going to have another child or not.

Senator TYDINGS. Exactly, Senator. H.R. 12080, on its face, appears to promise additional family planning services. But my feeling is that unless changes are made in the bill, that the promise is going to prove illustory. The first shortcoming of the bill is that no funds are specifically earmarked for family planning services. For fiscal year 1969 the bill increased the funding of the maternal and infant care program of HEW's Children's Bureau by $15 million. There appears from the committee report to be an informal understanding that this sum would be spent on family planning services.

Gentlemen, those informal agreements aren't worth the paper they are written on. We had such an agreement last year from HEW and when the time came for action, nothing happened. Let me tell you the facts.

At the end of the 89th Congress last year, Under Secretary of HEW Wilbur Cohen stated, in an open letter to me, that the Department intended to spend $20 million in fiscal year 1968, $25 million in fiscal year 1969, and $30 million in fiscal year 1970 for family planning programs and, accordingly, that there was no need for many of us to press legislation which we had in the Congress which would have earmarked special funds for family planning services in the HEW appropriations—so we dropped the effort.

This letter, and it is in the appendix to my testimony here, was sent on October 20, 1966, when the total amount of money available for health programs was already evident. But when the chips were down, nowhere near that $20 million would be spent by the entire Federal Government for family planning in fiscal year 1968.

Why did the agreement evaporate? Basically, when the chips were down and the squeeze came, there was no one in HEW who would stand up and really scrap and say "We need these funds to give to the State health departments and the city health departments in the field of family planning," and there were plenty of people pressing for cancer and plenty for heart and plenty for lung programs, and everything else, but no one in there fighting for this program.

And that is why I feel that this committee has got to specify that that $15 million budget increase for the Children's Bureau will be clearly earmarked for family planning services, period. In other words, the Congress has got to write it in the legislation that this is what the Congress wants. This informal agreement or informal understanding is going to evaporate just like that letter evaporated, gentlemen, unless you write it into the law.

The second problem that I would like to discuss with you is that the funds the bill envisions for family planning services are pitifully small for the need. Now I realize the present budgetary constraints, but if we want to provide the family planning opportunities for those 5 million women in the lower economic classes who want to plan their family and want to limit the size of their family, then we are going to have to have expenditures greater than $15 million. If you wanted to try and provide the ability for family planning for the entire 5 million, you would have to designate in this bill in the area of $100 million.

I don't know whether you can go that far with all the budget problems that you have, but I will say this. There are no other allocations of funds that you are going to make or that any other committee of Congress is going to make in domestic programs, war on poverty, or anywhere else, that are going to have the benefits that funds allocated in this field have.

I think that this legislation is a golden opportunity. This committee can write into this bill really the first really definitive provisions which can really start making a dent.

Gentlemen, we are never going to get into this war on poverty, we are never going to make a real dent in the problems in the cities until we give the same opportunty to plan their family to the poor women, the less fortunate that those who are more fortunate have. You have, I think, a real opportunity here. I think the country wants it. I think the country will support it; and I think that the benefits will accrue, which would accrue from your wisdom, will be felt for generations to come.

The other area that I would like to discuss with you in the bill is its reference to day care centers and the responsibility of States to require women who receive welfare to put their children in day care centers and go to work. Let me say this.

I am a very strong day care advocate. My sister is on the board of the day care operation in Baltimore. I help raise funds for them. I think that day care centers are vital. I think that the first part of this legislation as it came out from the House is wonderful—its emphasis on day care centers, constructing day care centers and funding them, and so forth.

But there is one Achilles heel in this legislation. The very dangerous problem here, gentlemen, if you try to coerce or require a woman to take her child to a day care center when there isn't a proper day care center, and if you make the States receipt of welfare funds contingent on their setting up day care centers, you are likely to have, instead of day care centers which take care of children, slipshod warehouses for children where they are virtually imprisoned in a building without any of the benefits which we who fight for day care centers envision.

A day care center is a real opportunity for a child, if it has trained people there who take care of the children, who try to educate them and put them to work doing constructive things. But if you just shove them into a prisonlike warehouse, which you set up all of a sudden to get additional funds, gentlemen, that is self-defeating. I know I wouldn't want any child of mine going into that sort of an operation.

There is no question that if you have day care centers and they are good and they are operated well, the mothers are eager to get their children in. But the problem with this bill as I see it, it says that the State in order to receive these funds has got to provide day care centers and then that the mothers have got to put their children in them.

Let's be practical, let's be realistic. Is the State that hasn't done anything to date in this field going to start suddenly expending funds to do the job properly and really set up day care centers, or will they just throw up buildings or rent out anything they can to take advantage of those funds?

We must deal in the realm of the practical and the possible. Presently, more than a million and a quarter children under school attendance age now are receiving public welfare. We have got day care accommodations in this country for about 400,000 children, and many of those are inadequate. What are you going to do with almost 1 million children, gentlemen? You can't just put them in any old shack. It doesn't work that way.

My concern is that that part of the bill is completely unrealistic. When you provide the facilities, when you provide facilities and set up the day care centers, the mothers will flock to them. If you can go out and get a job and put your children in a responsible day care center, you are going to do it. It is much easier on you. But no self-respecting mother is going to put her child into simply a pen with a group of others. The whole concept just won't work.

I think the way the bill is drafted it virtually assures in many States that what is going to happen is that the State will just rent bare prisonlike rooms where the children will be warehoused like so many cardboard boxes while their mothers work. You put a child in this sort of environment in their crucial formative years and you are going to have far worse problems of delinquency and antisocial conduct as these children grow than we have already.

I have tried to make the point extemporaneously which I have made in more detail in my prepared testimony. I think day care centers are wonderful. I think that we should work for them. I think we ought to build more. But set up the type of mandatory requirements that this bill has, to require one and a quarter million children to go in day care centers when you only have day care centers, at most, for 400,000 is completely self-defeating.

Mr. Chairman, I am delighted at the opportunity to address you. I am delighted that the Finance Committee is made up of the Senators it is, because I am sure that you understand the problems that I have tried to emphasize.

The CHAIRMAN. Thank you very much, Senator Tydings. The thought occurs to me that if the States can solve their own bureaucratic problems between State agencies and put the responsibility in the right State agencies, a lot can be done. I should think that an orderly way of going about providing day care in appropriate cases—I don't think you can achieve much if the mother has 10 children there to try to put that mother to work and put someone to work looking after those 10 children. She might as well just stay there with them. But where mothers have children let's say from ages 4 or 5 on up, let's start at age 4, let's say children between 4 and 14, they could be cared for. Start with those who don't have too many, just one or two—if you then put them under a good department of education, in the administering I think they could do a better job of it than the average welfare agency.

Senator TYDINGS. Senator, I think you are right. Let me say this. This summer I spent a good deal of time with the mayor of Baltimore down in the inner city. We met with a number of women in public housing projects and in other areas.

The one area of help they requested the most was the establishment of day care centers. Time and time again the women would say, "If we just had more day care centers, so many more of us could go to work."

But there are ways to do it and there are ways not to do it. The way that you are describing is the proper way, because at the same time you could let the mother go to work, and if you put the child in a proper day care center, that child would be getting benefits. The child is getting educational benefits. He is learning things that he wouldn't be able to learn otherwise. But if instead of doing it properly that way, if, instead, you retrogress and just put them in a warehouse with a lot of other little children, with one master looking down and cracking the whip every now and then, it is self-defeating.

My concern for the second part of the bill the way the House came out, is that it is going to foster that second type rather than the first.

The CHAIRMAN. The supervisor in my State has questions with regard to the Headstart program. Why don't you just give the States some money if they have the organization for it, and most State departments of education did. They had the teachers, they had the organization and knew how to go about it.

They say, "Why didn't you just give us the money to establish kindergartens for children 5 or even 4 years of age. We could have done it very easily."

In this particular area, I would think that if you have the right people handling it, the logical people to begin with, the people who know something about schools, kindergartens, and things of that sort——

Senator TYDINGS. There is no question that the logical people are the educational people.

The CHAIRMAN. I would think there would be a whole big new burden to have the welfare department going into the school business. It might be better to have the education department doing it.

Senator TYDINGS. It would be disastrous, Senator. You have an opportunity if you educate the child. The emphasis ought to be in education, not in welfare. The first part of the theory and philosophy of the House bill is so sound and so progressive and makes so much sense, and then it seems as though almost in the second part they say "Well, we had better cut across the field here, we had better not go all the way," and they cut back all of the progress they make in the first part.

The CHAIRMAN. It would seem to me if we could make enough progress to where perhaps in the first 6 months of next year we might reduce the number of children of working mothers, that is the number of mothers who are drawing welfare by about 100,000, from 900,000 to about 800,000, and provide day care for that number and then hope to reduce it by another 100,000 in the next 6 months of next year, we would be making very good progress.

I for one don't visualize this, just bringing it to the mothers on relief.

Senator TYDINGS. You can do more. You will reduce the number of children on welfare the minute you designate in this bill funds for voluntary family planning services. You can do more than all other programs put together.

I could get people over from the city of Baltimore and other places who can give you far more dramatic evidence than I have, but believe me, gentlemen, with just a few words and a few specific lines in this bill saying that so many millions of dollars shall be spent for family planning services, period, you are going to make tremendous steps.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. You said awhile back here that the House bill was unrealistic. What would be realistic?

Senator TYDINGS. I think it would be realistic, Senator, if instead of requiring the mothers to send their children to a day-care center in order to receive welfare, say that if there were adequate day-care facilities in the State available, then the mother could use them, or words such as that.

What I am concerned with is that the States, in order to get the money, will put up structures and call them day-care centers when they are not. You see, we know how many day-care centers there are, or centers for children in the United States now. You know also that you have got on welfare, under school age, children who it will be logical to go into the day-care center who are on welfare. You know we have got a little less than a million and a half.

What I am afraid of is that the mothers are going to be coerced to put their child into what is not really a day-care center but it is just a stockade, in order to receive welfare, and I think that would be completely self-defeating. I think if you have it at all, the bill must specify that day-care centers must meet minimum standards. But you really don't have to have anything mandatory in the bill, Senator Anderson, because welfare mothers desperately want day-care centers in areas of poverty.

I know that because I have talked to them. The demand they make on you the most is funds for day-care centers. That is why I feel the bill is not realistic.

The CHAIRMAN. Senator Williams.

Senator WILLIAMS. Senator Tydings, I have been very much interested in your remarks, and I am sure we are all in complete agreement that under no circumstances do we want to foster a program to set up these day-care centers in warehouses or in stockades. But can you think of any Governor of any one of our 50 States who would condone such a practice as that? I just can't picture any Governor doing it.

Senator TYDINGS. Senator, in the bureaucracy that grows up, and it is not just in the States, it is in the Federal Government as well, there are frightful things that happen. I wouldn't blame it on the Governor, but I would say I can very readily conceive of it. You have too many people come to you to correct injustices all the time. I know too much about bureaucracy in this country to say that such a thing couldn't happen. It could. In fact, it would be stacked in that direction.

Senator WILLIAMS. It could happen, but it would have to be approved by a responsible State agency, and I think we could safeguard against this. I just wonder if any of our Governors or any of our State administrators of the welfare program are quite that inhuman.

Senator TYDINGS. I wouldn't limit it to the States, Senator Williams, nor would I limit it to those being inhuman. I would say it is in the nature of the bureaucracy. And I find this just as much in the Federal system as in the States. There are a great many injustices occurring all the time.

I receive about 150 letters a week, presenting cases which at least my constituents think are extreme injustices vented upon them by Federal bureaucrats, and I spend a great deal of my time and my staff effort in trying to correct these problems. In many instances there are grave injustices. My concern is that this bill points in that direction.

I think if it stays this way, the system is set up to create injustice.

The CHAIRMAN. Senator Carlson.

Senator CARLSON. Senator Tydings, I just want to state that I appreciate very much your appearance here this morning. You have certainly been working with some of these problems, and you have a great city in your State which gives you an opportunity to do so.

The statement and the testimony you have given will be very helpful to me at least in writing the bill in executive session. I appreciate your appearance.

Senator TYDINGS. Thank you very much, Senator Carlson.

Thank you very much, gentlemen.

The CHAIRMAN. In connection with your testimony, there is an article in this morning's Washington Post of considerable interest. Judge Bowen ruled in your State——

Senator TYDINGS. That is right.

The CHAIRMAN. That a woman who bears two or more illegitimate children has violated the child neglect statute by failing to provide a suitable moral environment for their upbringing. That, of course, will be very much discussed, and it may result in quite a controversy and uproar among some of those who have some of the more liberal thoughts on the idea of civil liberties. But it is a very serious problem I will ask that that be put in the record at this point.

(The article referred to follows:)

[From the Washington Post, Sept. 22, 1967]

IN PRINCE GEORGES—ILLEGITIMACY IS RULED CHILD NEGLECT BY COURT

(By Peter A. Jay)

Prince Georges Circuit judge *ruled yesterday that the eight children of three unmarried mothers are legally neglected solely because they were born out of wedlock.*

The decision, handed down by Judge Perry G. Bowen after an all-day hearing, paved the way for criminal prosecution of the mothers, *sent a shock wave through the State Welfare structure* and set the stage for an appeal that may reach the U.S. Supreme Court.

In his interpretation of Maryland's child neglect law, Bowen held that *a woman who bears two or more illegitimate children has violated the statute by failing to provide a suitable moral environment for their upbringing.* No other proof is needed, he ruled.

Following his ruling, Bowen further jolted attorneys from the American Civil Liberties Union and NAACP legal Defense Fund, representing the mothers.

"A stronger dose of medicine is required," the judge said, and in the future he may "require (unwed mothers) to learn methods of birth control and practice them, at the risk of losing their children if they do not."

Bowen ordered the Prince Georges Juvenile Services Bureau to investigate the circumstances in which the eight children live and ruled they could stay with their mothers until the case is resolved on appeal.

He could order the children placed in foster homes.

The three women were charged with criminal child neglect by Prince Georges State's Attorney Arthur A. Marshall Jr. in a welfare crackdown last May when they came to his office seeking his signature on a routine form.

Mothers seeking welfare payments for the children of absent fathers must have the prosecutor's signature to show they sought to find the missing parent.

The charges were temporarily dropped, at Bowen's suggestion, until neglect couud be legally established. Yesterday's ruling cleared the way for renewal of the charges.

Assistant State's Attorney Vincent J. Femia, who began the crackdown, said after Bowen's decision that the State would draw new warrants against the three mothers.

Singling out the three defendants, among hundreds of women in similar circumstances in Prince Georges County alone, was arbitrary and unconstitutional, NAACP attorney Leroy Clark argued.

Present in the Upper Marlboro courtroom for the controversial case were State Welfare director Raleigh C. Hobson, Prince Georges director Virgil A. Hampton and social workers and poverty aides.

Hobson, who earlier predicted that a ruling such as Bowen's would wreck the State's aid to dependent children program that provides welfare assistance to 24,500 families a month, had no comment. Welfare officials estimate that up to half these families have one or more illegitimate children.

Clark, ACLU Attorney J. Franklyn Bourne and Frank M. Kratovil, a court-appointed lawyer representing the defendants, said they would appeal immediately either to a special three-judge panel or the State Court of Appeals.

The CHAIRMAN. Thank you very much. If you want to comment on this, you may.

Senator TYDINGS. My parting remark is again in this field of family planning, to make available the services on a voluntary basis for the poor mothers, the mothers who don't want any more children and cannot afford to obtain the services themselves. It is very important.

The CHAIRMAN. Thank you very much.

(Senator Tydings' prepared statement, with attachment, follows:)

PREPARED STATEMENT OF SENATOR JOSEPH D. TYDINGS, A U.S. SENATOR FROM THE STATE OF MARYLAND

Mr. Chairman, I appreciate this opportunity to appear before the Senate Finance Committee to testify regarding the Social Security bill, H.R. 12080. I want to restrict my testimony to certain aspects of the welfare provisions of the bill. Many portions of the bill are, I believe, excellent and quite far-sighted. The new provision that welfare recipients will not lose from welfare payments 100% of any money earned provides a significant and useful incentive for welfare recipients to go to work. Recognition of the importance of providing family planning services and day-care centers for young children of working parents is also quite far-sighted. These and similar programs, if carefully developed and if applied without coercion or threat of punitive sanctions, could vastly improve the lives of those on public welfare, and could bring substantial benefits to the welfare system generally.

There is, however, a considerable danger in H.R. 12080, as it is now drafted. That danger is that the bill appears to overlook the inadequacy of existing services in areas such as family planning, day-care centers and job training. And, without acknowledging that these services are untested or non-existent in most parts of the country, the bill appears to force welfare recipients to use the services without regard to their adequacy or to questions of individual conscience. I believe that changes can and should be made in the bill to remedy these shortcomings—and many are more problems of presentation than of substance—which would significantly strengthen the bill.

I. First of all, I want to discuss the provisions of the bill dealing with family planning services. As recently as three or four years ago, the concept that federal, state or local governments should make available family planning information and services to families who could not otherwise afford them was extremely controversial. There has been a substantial shift of opinion among the moral leadership of our country. It is now widely recognized that no single factor more certainly dooms low-income families to continued and deepening poverty than unwanted children which they cannot afford. And the unwanted child is himself trapped in the vicious circle.

Yet, in spite of this new consensus, the federal government has done distressingly little to provide voluntary family planning services to low-income families. But the total HEW expenditure for such services last year was only $5 million, which was less than the total expenditures from private groups such as Planned Parenthood. Research and training also received federal support at about the same level of expenditures for services.

There appears from the Committee report to be an informal understanding that this sum would be spent on family planning services.

At the end of the 80th Congress, Undersecretary of HEW Wilbur Cohen stated, in an open letter to me, that the Department intended to spend $20 million in FY 1968, $25 million in FY 1969 and $30 million in FY 1970 for family planning programs and accordingly that there was no need for Congress to earmark special funds for family planning services. This letter (Appendix A) was sent on October 20, 1966 when the total amount of money available for health programs was already evident. But it is now evident that nowhere near $20 million will be spent by the entire federal government for family planning in FY 1968. Why did this "informal understanding" evaporate? Basically, I believe, it evaporated because family planning services are a new program and lack batteries of bureaucrats dedicated to maintaining or expanding those services. In the inevitable bureaucratic in-fighting for the limited funds available, the new program always loses unless the funds for that program are clearly earmarked and are available only for that program. I believe that the 89th Congress was mistaken to accept Undersecretary Cohen's statement that earmarked funds for family planning service were unnecessary. I hope that this Committee will make sure that the 90th Congress doesn't make this same mistake and that, at a minimum, the $15 million budget increase for the Childrens' Bureau provided for FY 1969 will be clearly earmarked only for family planning services.

The second major shortcoming of the bill is that *the funds it envisions for family planning services are pitifully small compared to the need for such services.* As I have indicated, annual expenditures of at least $100 million are required to provide services to the 5 million women who need and want those services. According to Welfare Administration figures, 800,000 women of child-bearing age are now receiving public welfare. I believe it would be foolishly short-sighted if we were to focus our attention only on providing family planning services to those women already on welfare. I believe voluntary family planning services are the most effective means we have for assisting families to remain self-supporting, by aiding them in spacing their children so that they want and can support each child when it is born. This legislation offers a golden opportunity for us to ensure against future expansion of welfare roles by assisting low-income individuals who want to practice family planning. I urge the Committee to authorize $30 million in FY 1970 and FY 1971 in addition to the $15 million authorized for the Childrens' Bureau in FY 1969. This added authorization would make available, by FY 1971, $75 million each year which, when supplemented by local funds, should reach all those who need but cannot now afford family planning services.

The third major shortcoming of the bill is that *it does not sufficiently emphasize the voluntary, non-coercive, non-punitive nature of the family planning services which are to be offered.* Although a careful reading of the House Ways and Means Committee report on the bill makes it clear that these programs will be wholly voluntary, I believe that this principle is so important that it must be spelled out explicitly in the text of the legislation. This Committee has already heard testimony from religious leaders and secular groups urging that the voluntariness principle be written clearly into the legislation regarding family planning services. Unless these assurances are given, I believe that the consensus, to which I referred earlier, regarding the moral propriety of government provision of family planning services will be endangered. And I believe, as a fundamental moral principle, that no one should in any way be coerced to employ family planning practices. Accordingly, I urge the Committee to add the following language to H.R. 12080:

"Family planning programs under this Act shall be carried out only under regulations promulgated by the Secretary of Health, Education and Welfare. Such regulations shall provide that each program must contain and be supported by reasonable assurances that—

(1) no individual will be provided with any medical supervision or supplies which such individual states to be inconsistent with his or her moral, philosophical, or religious beliefs;

(2) no individual will be provided any medical supervision or supplies unless such individual has voluntarily requested such medical supervision or supplies; and

(3) the use of family planning services shall not be a prerequisite to the receipt of services from or participation in any other program of financial or medical assistance."

II. A number of other aspects of H.R. 12080 suffer from even more serious shortcomings than those I have discussed regarding family planning, notwithstanding the admirable aims of those provisions. The provision regarding mandatory placement of children in day-care centers while their mothers work or obtain job training would be admirable if it were done on a voluntary basis. But as a mandatory program, it is both unnecessarily punitive and wholly impractical.

The provision is impractical because we cannot wave a magic wand and produce the quantity of buildings or equipment or trained personnel to establish acceptable day-care centers to handle anywhere near all of the children now receiving welfare payments. The provision is unwise and unnecessarily punitive because, by requiring states to establish day-care centers for all welfare children we will almost inevitably prompt creation of places where children are stored rather than cared for. We will punish the parent by depriving the children of adequate care, and in the end all society will be the losers.

According to statistics compiled by the National Committee for Day Care of Children, there are presently accommodations for about 400,000 children in day-care centers throughout the United States. (This figure refers only to facilities licensed by states generally certifying conformance with minimum health standards, and does not necessarily mean that the staff of such centers is trained to handle children or that the center has adequate facilities for play or training.) There are presently more than 1¼ million children under school attendance age now receiving public welfare. Thus simply to accommodate these children, existing day-care facilities must be increased three-fold.

I believe that an increase in the number of and improvement in the quality of day-care facilities in this country is long overdue. But we must not fool ourselves into believing that establishment of adequate centers is an inexpensive proposition—a cheap way to save welfare funds. The National Committee for Day Care of Children—experts in this matter—estimate that minimum annual cost of adequate day-care is $1200 to $1500 per child. This is the range of annual cost per child in the Children's Development Centers run by the OEO Head Start program. Using the lowest figure, of $1200 per child, we are talking about $1.5 billion each year for the 1¼ million pre-school age children now on welfare.

These cost estimates are not exaggerated or extravagant. Children—particularly pre-school children—need considerable attention, guidance and affectionate relations with adults. This means that trained staff is needed, not to mention facilities, equipment, food for the children and so forth. We cannot take children from their mothers and place them—with 30, 40 or 50 other children—into bare prison-like rooms where they are warehoused, like so many cardboard boxes, all day while their mothers work in order to remain on the welfare rolls. If we do this to children in their crucial formative years, we must expect them to grow with serious and irreversible anti-social personality blights. We must expect the gravest kind of social delinquency to result as these children grow to adults. This will happen if we store children in "bargain basement" warehouses deceptively labelled as "day-care centers."

H.R. 12080 offers no assurance that this will not happen and, because this is a mandatory program, I think the bill virtually assures that in many states this will happen. The bill sets no standards of care—no teacher-child ratio, no minimum qualifications for those caring for the children, no minimum expenditures for play equipment or teaching materials—which must be met in these day-care centers. The bill simply requires states to establish something called "day-care centers." In fact, many states do not now even require licensing and inspection of day-care centers, and many of those which do prescribe only minimal sanitation standards not care or staff qualification standards. How many states will be willing to spend even the 15 to 25% matching funds required for establishing anything but "bargain basements" to warehouse children while their mothers work.

Imagine the cruel dilemma this situation would create for a mother on welfare. Should she abandon her children for 8 to 10 hours each day to a cheerless child warehouse, where incalculable harm will almost certainly be done to their growth, or should she give up the welfare payments which are essential for her to feed and clothe her children? We may save some welfare funds by forcing a mother to leave her children in a "warehouse" and work during the day. But in a few short years, society will pay a vastly greater price when the results of this deprivation—in anti-social and criminal conduct—come home to roost.

I believe this dilemma can be avoided, and our system of public welfare immeasurably strengthened by changing this program from mandatory to voluntary, so that mothers can choose whether they will work outside their homes during the day and leave their children at day-care centers. In addition, we must specify minimum standards of facility quality and child care which state day-care centers must meet to be eligible for federal assistance. If we adopted this non-coercive approach I think a surprisingly large number of mothers on welfare would voluntarily participate. At present we have too few adequate day-care centers to test my supposition. And the present rule which deducts 100% of earnings from welfare payments is a strong incentive against work. But, with great wisdom, H.R. 12080 abandons this 100% tax on earnings. And if the bill would also make possible the funding of new child day care centers, for voluntary use, I believe that a large number of women will go into gainful employment, confident that their children are being well care for while they work. But in many other cases, a mother's most important place is in the home attending to the needs of her children. This too is work which is vitally important to the health of our society, and this basic fact is overlooked by any mandatory requirement that a mother leave home and work during the day.

I want to make one additional brief point. I urge the Committee to change the provision in H.R. 12080 which freezes the number of children eligible for relief payments based on the January 1, 1967 relief rolls. I believe this arbitrary cut-off is wholly unjustified. In my own state of Maryland, I am informed that January 1, 1967 was a relatively "low" period for these payments, and that an additional 4,000 children have since come into the state and are receiving welfare assistance. What is the State of Maryland going to do with these children if there are no funds to feed or clothe them? I sympathize with the goal that we must reduce welfare costs, but we cannot do it by ignoring the human costs of our actions, or by drawing an arbitrary line to deny benefits to some while others similarly situated receive funds. I hope the Committee will delete this cut-off provision from the bill.

APPENDIX A

DEAR SENATOR TYDINGS: Thank you for your letter of October 10 and for your interest in S. 3008 which would enable the Department to develop programs in family planning.

We have indicated in testimony in both the Senate and the House of Representatives that family planning programs can be developed as an integral part of comprehensive health services within the States. S. 3008 assures that comprehensive public health services, in which family planning would be included, can be developed through a flexible State grant program administered by the Public Health Service. This would be accomplished in two ways: first, by providing non-categorical formula grant support to localities and States for utilizing Federal assistance to meet their most important health problems, and secondly, by means of project grants for health services, development which would enable the Public Health Service to award "grants to any public or non-profit agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance, (2) stimulating and supporting for an initial period new programs of health service, or (3) undertaking studies, demonstrations, or training designed to develop new methods or improve existing methods of providing health services." Project grant awards may be made to public agencies such as State, county or metropolitan health departments, universities, hospitals, and to nonprofit private voluntary organizations such as universities, hospitals, and voluntary agencies.

In his recent testimony before the House Committee on Interstate and Foreign Commerce, the Surgeon General, Dr. William H. Stewart, in response to specific questions by Representative Samuel N. Friedel, indicated that both the formula grant to States for comprehensive public health services and the project grant for health services development can be used to support family planning activities. For the purposes of supporting programs under S. 3008 in the field of family planning, our present plans contemplate $20 million in fiscal year 1968, $25 million in fiscal year 1969, and $30 million in fiscal year 1970. We will review these figures in connection with our next year's program. In addition, funds are also being made available for family planning through Title XIX of the Social Security Act, Medical Assistance Program; Maternity and Infant Care project grants; and formula grants to the States for Maternal and Child Health Services.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

The CHAIRMAN. Our next witness is the Congresswoman from the 17th District of Michigan, the Honorable Martha W. Griffiths.

Congresswoman Griffiths is a distinguished member of the House Committee on Ways and Means. As such, she contributed greatly to the deliberations on the House side that culminated in the bill we have before us today.

Mrs. Griffiths is well qualified to provide this committee with an insight to the motivations which prompt certain changes in the approach to the welfare payments for families with dependent children. Mrs. Griffiths, we are honored that you could take time from your busy schedule to be with us today. I know that the Committee on Ways and Means of the House on which you serve is involved at this time with consideration of the President's tax proposal. We appreciate your taking the time from that and other important matters to come and give us your judgment on the issues before us.

STATEMENT OF HON. MARTHA W. GRIFFITHS, A U.S. REPRESENTATIVE IN CONGRESS FROM THE 17TH DISTRICT OF MICHIGAN

Mrs. GRIFFITHS. Mr. Chairman and members of the committee, thank you very much for letting me appear here this morning; but if what I read in the paper is correct, I feel that you need help. Admittedly, I find that a House Member's appearing in the Senate on any such mission borders on giving aid and comfort to the enemy. Nevertheless, I think that you need assistance.

Only 12 women in America have a right to vote on this bill; and of those, only two have a right to offer an amendment; yet this bill affects and provides for women perhaps more than any other bill that passes this body. As one of the women with a right to offer an amendment, I would like to express my complete confidence in the welfare provision of the House bill.

It is my understanding that an ex-State official has appeared here and said that we cannot require a parent to work or take training or if he fails to do so permit his children to starve. There is nothing in this bill that will permit or require a child to starve because of the foolishness of his parents. All children will be provided for. But let me put the official's proposition in its true light. What he is really saying is that America should offer each person a choice: "Either work or if you don't like that, don't work, the rest of us will provide for you." If every person chose not to work, we could all starve together. It is a form of togetherness that I oppose.

ADC was set up by a compassionate nation to provide for people who had no work. This idea that you could make a choice—work or the rest of us will provide for you—is, to me, incredible.

Part of this Nation's problem is the vast number of broken homes and illegitimate children. In my opinion we are increasing our problem, if we say to women, "Now you may either stay here with your husband and let him support the children, or you can leave him and we will take care of you; or if you don't want to bother to marry the father of your child, we will take care of you anyhow.

It is my opinion that to offer such a choice to any woman is certainly to disadvantage her children who need the loving guidance and the discipline of a father. Therefore we will find I trust that the home situation turns out better if we offer work or work training to the mother, and take care of her children in a day-care center, and if she knows from the beginning that if there is work, she must work.

Finally, I find it difficult to believe that you are doing any young girl a favor by confining her to welfare payments. She and her children or child would be far better off if she were educated, given work training and a job and made self-reliant.

Let me read to you the opinion of a woman employed as the head of the division of recorder's court which attempts to collect child support payments in Detroit. I might point out that I sat as a judge in this court, and this particular division is one of the best divisions in America. She said:

> As the program is currently being administered, it is my belief—and this is one shared by many in a position to know—that in many, many instances ADC is causing a very real destruction of the family unit and especially the Negro family unit. May I point out a few of the things which cause me to make this statement:
>
> 1. When ADC was "born," I'm sure you know, it came into existence to replace our old Mother's Pension plan with the idea of making it possible for a widowed mother to remain with her children at least until they were of school age. Gradually more and more cases of divorced or separated and unwed mothers became grantees. When I started in my present employment, a mother, who had a living husband, to be eligible for ADC had to have had an estranged separation from her husband for a period of at least one year. This period has now been reduced to three months. This reducation of time for the period required to become eligible has not only encouraged an attitude on the part of women that they need not make any concessions in trying to work out marital differences; that they need not, in short "take anything" from their husbands, but it has also made it ridicu-

iously easy for a couple to participate in what we call a "separation of convenience" which carries a tinge of fraud and collusion if they have over-extended themselves with easy credit. By maintaining an outward appearance of a separation a couple can supplement their income with an ADC grant. Cases of this type often come to our attention, but prosecutions on the basis of fraud are few as they defy proof with the many restrictions currently placed on ADC in its investigating methods.

2. Ten years ago ADC had what was termed a "suitability clause" which covered many things. As an illustration, if an ADC mother conceived a child while receiving a grant, her case was closed at least on a temporary basis and she had to resort to the regular welfare channels which still provided support but at a subsistence level. This is no longer true. In fact, at the present time her grant is only discontinued (if then) if she conceives a child by her own husband or by some other man by whom she had had a previous child in such sequence that is can be described as being a "continuing relationship." Under present interpretation (in Michigan at least) of policy set forth by HE&W, a woman may remain eligible for an ADC grant if she has a child every year as long as it is by a different man, and although she is in many cases a married woman, the father of her child may live in her home—as long as he is not her husband—for a period of three months if the couple can show any intention of securing a divorce from the present husband and marrying. I have even known of one such situation where an ADC worker referred such couple for "marriage counseling". The idea of ADC placing its apparent blessing on cases of this type seems to come pretty close to subsidizing blatantly immoral relationships, to say nothing of making a contribution to the destruction of a sound family unit.

3. Until January, 1967, ADC contributed what was termed a "maximum grant" and in some instances this amount did not meet what they calculated to be the needs of the family group. As one of the few remaining requirements of eligibility for an ADC grant, a woman must make an effort to prosecute an available husband and/or father for support. Up until January, if the maximum grant was less than the needs of the family, the contribution made by the man supplemented the ADC grant until the "needs" figure was met. As a result, if a woman made the necessary effort to force a reluctant father to pay child support, the amount she received in her ADC checks increased when her efforts met with success and support was, as a result, collected.

Such is no longer the case. Each woman receives the total amount of her needs regardless of whether the responsible male parent makes any contributions at all or not. Cases are known to our Division (and let me remind you this Division collects more money than any other Division of any court in the country) where the husband and father has earned as much as $8,000 to $10,000 per year, and his wife and children have been supported by ADC through negligence on the part of the woman to take the necessary steps to enforce support.

4. While in many instances it is unquestionably desirable for a mother to remain home with her children rather than going out to work, especially when her job skills and earning abilities are limited, almost no pressure is exerted on women to seek gainful employment.

At the time the youngest child (sometimes there is only one child involved) reaches age 12, if a "childcare plan" is available to the mother, she is asked to seek employment. But gentlemen, look at the narrow definition of a child-care plan. If for example, the child's maternal grandmother lives in the same building, but not in the same rental unit, this does not constitute an acceptable child care plan and the mother is not expected to look for work outside her home.

This bill makes a great forward step in requiring the States to permit a welfare recipient to draw welfare, while working. It acknowledges that the welfare alone is, in many cases, not enough and that the person should be able to retain some of the welfare money and still work.

There is some truth to the women's complaint that the jobs they are offered are dead-end jobs. But Mr. Chairman, that is true of every job for every woman in America, and for a very large number of men. Nevertheless, in this buoyant economy, everyone can work or can be trained to work should be given a chance.

I urge you to leave the welfare provisions of this bill alone. If you want to offer some constructive amendments, however, I would like you to take mine as outlined in H.R. 9715.

Thank you for permitting me to appear here.

The CHAIRMAN. Thank you very much for a magnificent statement, Congresswoman Griffiths. May I say that it is very refreshing to hear from the kind of lady that is respected and admired by all of the people where she lives, by all her neighbors as well as the community.

Some of this testimony causes me to wonder just who it is that is losing their minds around here. I have always supported the program to provide assistance for those who, through no fault of their own, were unable to help themselves, but the idea of just doling out tens of millions or more to people as a substitute for doing their duty to themselves and their children to me is just patently ridiculous.

Now as you so well pointed out here, we ought to be trying to encourage every person to be a good citizen. Through my lifetime, even prior to the time we had any program of this sort, I have observed the noble work of very fine women who were left in distress because of the death of their husband, and who went to work and made a tremendous contribution to their society and their community. They do fine work of the highest caliber, selling real estate or working for others or doing whatever was necessary to provide opportunities for their children, and they become the breadwinners, because there is no one else to be the breadwinner for the family. It is certainly distressing to me to see how some of these welfare organizations simply accept the word passed from one to another in these conferences that, "We are going to be against this". They reject the very idea of suggesting that before you put these people on welfare, for the rest of their lifetimes, that you might do well to see if you can't find some opportunity for them.

We have people coming here testifying they should not be expected to work. My impression about this is that we don't force anybody to work, that you don't have to work but you just don't get paid for not working.

Mrs. GRIFFITHS. And part of the problem with this world is that men have taken care of women and children for such a long time that they don't really complain.

Now, I had a letter signed by 26 women in their 50's, who were scrubbing floors in an office building, and it said, "Why should I pay taxes to support a girl 18 bearing illegitimate children?" Perhaps men can answer that, but a woman can't answer that question. I can scrub floors at 50 but I can also scrub them at 18.

The CHAIRMAN. As you know, there are a great number of women who are working today who would be happy to provide employment to someone to do some housework for them while they are working, not that they are above doing the housework. It is just that they don't have enough time to take care of their houses as well as they would like to, if they were there all the time.

Mrs. GRIFFITHS. Many of these women, Senator, would be able to do excellent jobs at anything. They need to be given a chance, and we really never have provided that before. But we have a buoyant economy today. We have a tremendous labor shortage. If we can't help now, we will never be able to do it.

The CHAIRMAN. I haven't had the opportunity to study the provisions of your bill. I will certainly study it in detail.

When I started out as a young fellow practicing law, we practically starved the first year or so, and we worked very hard for everything we made. The tab to being a success came very slowly during that first year. I should think it would be well to put some of these young lawyers to work employed by the Federal Government to run down some of these fathers who decline to support their children.

Mrs. GRIFFITHS. We considered that in the House, and the cost of doing it is greater than is the cost of welfare.

The CHAIRMAN. Well, it occurred to me that even if the cost were more, it might be worth it. Senator Anderson?

Senator ANDERSON. Mrs. Griffiths, you sort of shock me very deeply as to this work.

Mrs. GRIFFITHS. I really feel everybody is happier working.

Senator ANDERSON. I think so. I want to ask one question on this particular bill.

Last summer I investigated some project. One project was a training school for maids in domestic households. Fourteen or fifteen of the girls graduated. One of them took a job in a hotel, but none of them took jobs as maids. The reason was that they said they had to have a minimum salary of $64 a week, and I thought that maybe $64 a week was a pretty good salary.

Mrs. GRIFFITHS. Senator, in Detroit I believe the going pay would be $70 for a 5-day week for a maid.

Senator ANDERSON. Would be what?

Mrs. GRIFFITHS. $70. I would like to point out that there are no training classes in Detroit for laundry workers, although laundry workers are paid more than the minimum wage, and this is a job which women do well. Still there are no training lessons for this. At the present time in the city of Detroit, a window washer draws between $150 and $200 a week. You have a very difficult time finding window washers.

Senator ANDERSON. I appreciate your statement. You have done a very fine job.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. Mrs. Griffiths, I think this is one of the best statements we have had before our committee, and I certainly appreciate your being here, and I am sure and I know your statement deserves, and I am sure it will receive, the careful consideration of this committee.

I am wondering if a further study, if it would not be well if you had incorporated in the record at this point a copy of the bill which you say you sponsor.

Mrs. GRIFFITHS. I will be delighted to. My bill specifically refers to the way social security should be given to women. You see at the present time women really have very few rights. A woman worker has very few rights under social security. I even think that she should be permitted to leave her social security to her widower.

Senator WILLIAMS. Yes. Well, I suggest that that be made a part of our record for consideration at the proper time.

Mrs. GRIFFITHS. Thank you very much. I will be glad to.

(The bill, H.R. 9715, follows:)

90TH CONGRESS
1ST SESSION

H. R. 9715

IN THE HOUSE OF REPRESENTATIVES

MAY 8, 1967

Mrs. GRIFFITHS introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend title II of the Social Security Act to permit the payment of benefits to a married couple on their combined earnings record, to eliminate certain special requirements for entitlement to husband's or widower's benefits, to provide for the payment of benefits to widowed fathers with minor children, to equalize the criteria for determining dependency of a child on his father or mother, and to make the retirement test inapplicable to individuals with minor children who are entitled to mother's or father's benefits.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

PAYMENT OF BENEFITS TO HUSBAND AND WIFE ON BASIS OF COMBINED EARNINGS RECORD

SECTION 1. (a) Section 202 (a) of the Social Security Act is amended to read as follows:

"(a) (1) Every individual who—

"(A) is a fully insured individual (as defined in section 214 (a)),

"(B) has attained age 62, and

"(C) has filed application for old-age insurance benefits or was entitled to disability insurance benefits for the month preceding the month in which he attained age 65,

shall be entitled to an old-age insurance benefit for each month beginning with the first month in which such individual becomes so entitled to such insurance benefits and ending with the month preceding the month in which he dies.

"(2) Except as provided in subsection (q), such individual's old-age insurance benefit for any month shall be equal to his primary insurance amount for such month as determined under section 215(a), or as determined under paragraph (3) of this subsection if such paragraph is applicable and its application increases the total of the monthly insurance benefits payable for such month to such individual and his spouse. If the primary insurance amount of an individual for any month is determined under paragraph (3), the primary insurance amount of his spouse for such month shall, notwithstanding the preceding sentence, be determined only under paragraph (3).

"(3) If an individual and his spouse are living in the same household (as determined by the Secretary on the basis of evidence available to him), and each of them is entitled to benefits under this subsection (or section 223), or one of them is so entitled and the other would upon satisfying subparagraphs (A) and (C) of paragraph (1) be entitled to benefits under this subsection, then the primary insurance amount of such individual, and the primary insurance amount of such spouse (who shall be deemed to be entitled to benefits under this subsection, whether or not satisfying such subparagraphs, beginning with the later of the month in which such spouse attains age 62 or the month in which such individual became entitled to benefits under this subsection), for any month, shall each be equal to the amount derived by—

"(A) adding together such individual's average monthly wage and such spouse's average monthly wage, as determined under section 215(b),

"(B) applying section 215(a)(1) to their combined average monthly wage determined under subparagraph (A) (subject to the next sentence) as though such combined average monthly wage were such individual's average monthly wage determined under section 215(b), and

"(C) multiplying the amount determined under subparagraph (B) by 75 percent.

In no event shall the combined average monthly wage of such individual and his spouse be greater than the average monthly wage that would result under section 215 (b) with respect to a person who became entitled to benefits under this subsection (without having established a period of disability) in the calendar year in which the primary insurance amounts of such individual and spouse are determined under this paragraph, and who had the maximum wages and self-employment income that can be counted, pursuant to section 215 (e), in all his benefit computation years. The primary insurance amount of an individual and his spouse determined under this paragraph shall not be increased unless there is an increase in the primary insurance amount of either of them pursuant to provisions of this title other than this paragraph.

"(4) (A) Paragraph (3) shall also apply to an individual and his spouse who are not living in the same household for any month with respect to which both such individual and such spouse have indicated, in such manner and form as the Secretary shall by regulations prescribe, that they desire to have their primary insurance amounts determined under paragraph (3).

"(B) Paragraph (3) shall not apply—

"(i) for any month with respect to which an individual or his spouse indicates, in such manner and form as the Secretary shall by regulations prescribe, that he or she does not desire to have his or her primary insurance amount determined under paragraph (3), or

"(ii) for purposes of determining the amount of any monthly benefits which (without regard to section 203 (a)) are payable under the provisions of this section other than this subsection on the basis of the wages and self-employment income of an individual or his spouse."

(b) (1) Section 202 (e) (2) of such Act is amended by striking out "shall be equal to 82½ percent of the primary insurance amount of such deceased individual" and inserting in lieu thereof "shall be equal to the larger of (A) 82½ percent of the primary insurance amount of such deceased individual for such month as determined under section 215 (a), or (B) 110 percent of the primary insurance amount of such individual as determined under subsection (a) (3) of this section (assuming for purposes of this clause that such subsection was applicable) for the month preceding the month in which he died".

(2) The paragraph of section 202 (f) of such Act redesignated as paragraph (2) by section 3 (b) of this Act is amended by striking out "shall be equal to 82½ percent of the primary insurance amount of his deceased wife" and inserting in lieu thereof "shall be equal to the larger of (A)

82½ percent of the primary insurance amount of his deceased wife for such month as determined under section 215(a), or (B) 110 percent of the primary insurance amount of his deceased wife as determined under subsection (a) (3) of this section (assuming for purposes of this clause that such subsection was applicable) for the month preceding the month in which she died".

(c) Section 203(a) of such Act is amended by striking out the period at the end of paragraph (3) and inserting in lieu thereof ", or", and by inserting after paragraph (3) the following new paragraph:

"(4) when the primary insurance amount of the insured individual is determined under section 202(a) (3), such total of benefits for any month shall not be reduced to less than the larger of—

"(A) the amount determined under this subsection without regard to this paragraph, or

"(B) the amount appearing in column V of the table in section 215(a) on the line on which appears in column IV the amount determined under subparagraph (B) of such section 202(a) (3) for such individual and his spouse (or, if the amount determined under such subparagraph (B) does not appear in column IV, on the line on which appears in column IV the next higher amount)."

(d)(1) Section 215(f)(1) of such Act is amended by inserting "(or section 202(a)(3))" after "determined under this section".

(2) Section 215(f)(2) of such Act is amended—

(A) by inserting after "the year preceding such year" in subparagraph (C) the following: "and subparagraph (D) of this paragraph does not apply";

(B) by redesignating subparagraphs (D), (E), and (F) as subparagraphs (E), (F), and (G), respectively; and

(C) by inserting subparagraph (C) the following new subparagraph:

"(D) as provided in paragraph (3) of section 202(a) of such paragraph is applicable (but disregarding any increase which might result under the second sentence of such paragraph solely from changes in the maximum wages and self-employment income that can be counted in the years involved); or".

(e) Section 223(a)(2) of such Act is amended by inserting after "section 215" the following: "or under section 202(a)(3)".

(f)(1) The amendments made by subsections (a), (b), and (c) shall apply only with respect to monthly insurance benefits under title II of the Social Security Act for and after the second month following the month in which this Act is enacted.

(2) In the case of an individual or his spouse who became entitled to benefits under section 202 (a) or section 223 of the Social Security Act prior to the second month following the month in which this Act is enacted (but without regard to section 202 (j) (1) or section 223 (b) (2) of the Social Security Act), the average monthly wage of such individual or spouse, as the case may be, for purposes of section 202 (a) (3) (A) of the Social Security Act, shall be the figure in the column headed "But not more than" in column III of the table in section 215 (a) (1) of the Social Security Act in effect immediately prior to the enactment of this Act on the line on which in column IV of such table appears the primary insurance amount of such individual or spouse, as the case may be, for the month in which this Act is enacted, unless the average monthly wage of such individual or such spouse, as the case may be, is, after the enactment of this Act, redetermined under section 215 (b) of the Social Security Act.

ELIMINATION OF SPECIAL REQUIREMENTS FOR ENTITLEMENT TO HUSBAND'S INSURANCE BENEFITS

SEC. 2. (a) Section 202 (c) (1) of the Social Security Act is amended—

(1) by striking out ", of a currently insured individual (as defined in section 214 (b))" in the matter

preceding subparagraph (A) and inserting in lieu thereof "of an individual";

(2) by adding "and" at the end of subparagraph (B);

(3) by striking out subparagraph (C); and

(4) by redesignating subparagraph (D) as subparagraph (C).

(b) Section 202(e) of such Act is further amended by striking out paragraph (2), and by redesignating paragraph (3) as paragraph (2).

(c) Section 202(p)(1) of such Act is amended by striking out "subparagraph (C) of subsection (e)(1),".

(d) Section 202(s)(3) of such Act is amended by striking out "Subsections (e)(2)(B) and (f)(2)(B)" and inserting in lieu thereof "Subsection (f)(2)(B)".

(e) The amendments made by this section shall apply only with respect to monthly insurance benefits payable under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after the month in which this Act is enacted.

ELIMINATION OF SPECIAL REQUIREMENTS FOR ENTITLEMENT TO WIDOWER'S INSURANCE BENEFITS

SEC. 3. (a) Section 202(f)(1) of the Social Security Act is amended—

(1) by striking out "and currently" in the matter preceding subparagraph (A);

(2) by adding "and" at the end of subparagraph (C);

(3) by striking out subparagraph (D); and

(4) by redesignating subparagraph (E) as subparagraph (D).

(b) Section 202(f) of such Act is further amended by striking out paragraph (2), and by redesignating paragraphs (3), (4), and (5) as paragraphs (2), (3), and (4), respectively.

(c) (1) The paragraph of section 202(f) of such Act redesignated as paragraph (2) by subsection (b) of this section is amended by striking out "paragraph (5)" and inserting in lieu thereof "paragraph (4)".

(2) The paragraph of section 202(f) of such Act redesignated as paragraph (4) by subsection (b) of this section is amended by striking out "paragraph (4)" and "paragraph (3)" and inserting in lieu thereof "paragraph (3)" and "paragraph (2)", respectively.

(d) (1) Section 202(k) of such Act is amended by striking out "or (f) (5)" wherever it appears in paragraphs (2) (B) and (3) (B) and inserting in lieu thereof in each instance "or (f) (4)".

(2) Section 202(p) of such Act is amended by striking

out "clause (i) or (ii) of subparagraph (D) of subsection (f) (1), or".

(3) Section 202 (s) (2) of such Act is amended by striking out "Subsection (f) (4)" and inserting in lieu thereof "Subsection (f) (3)".

(4) Section 202 (s) (3) of such Act (as amended by section 2 (d) of this Act) is amended by striking out "Subsection (f) (2) (B) of this section, so" and inserting in lieu thereof "So".

(e) The amendments made by this section shall apply only with respect to monthly insurance benefits payable under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after the month in which this Act is enacted.

BENEFITS FOR WIDOWED FATHERS WITH MINOR CHILDREN

SEC. 4. (a) Section 202 (g) of the Social Security Act is amended to read as follows:

"Mother's or Father's Insurance Benefits

"(g) (1) The widow, widower, and every surviving divorced mother (as defined in section 216 (d)) of an individual who died a fully or currently insured individual, if such widow, widower, or surviving divorced mother—

"(A) is not married,

"(B) is not entitled to a widow's or widower's insurance benefit, "(C) is not entitled to old-age insurance benefits, or is entitled to old-age insurance benefits each of which is less than three-fourths of the primary insurance amount of such individual,

"(D) has filed application for mother's or father's insurance benefits, or was entitled to wife's or husband's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which such individual died,

"(E) at the time of filing such application has in her or his care a child of such individual entitled to a child's insurance benefit, and

"(F) in the case of a surviving divorced mother—

"(i) at the time of such individual's death (or, if such individual had a period of disability which did not end before the month in which he died, at the time such period began or at the time of such death)—

"(I) she was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or

"(II) she was receiving substantial contributions from such individual (pursuant to a written agreement), or

"(III) there was a court order for substantial contributions to her support from such individual,

"(ii) the child referred to in subparagraph (E) is her son, daughter, or legally adopted child, and

"(iii) the benefits referred to in such subparagraph are payable on the basis of such individual's wage and self-employment income,

shall (subject to subsection (s)) be entitled to a mother's or father's insurance benefit for each month, beginning with the first month in which she or he becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: no child of such deceased individual is entitled to a child's insurance benefit, or such widow, widower, or surviving divorced mother becomes entitled to an old-age insurance benefit equal to or exceeding three-fourths of the primary insurance amount of such deceased individual, becomes entitled to a widow's or widower's insurance benefit, remarries, or dies. Entitlement to such benefits shall also end, in the case of a surviving divorced mother, with the month immediately preceding the first month in which no son, daughter, or legally adopted child of such surviving divorced mother is entitled to a child's insurance benefit on the basis of the wages and self-employment income of such deceased individual.

"(2) Such mother's or father's insurance benefit for each month shall be equal to three-fourths of the primary insurance amount of such deceased individual.

"(3) In the case of a widow, widower, or surviving divorced mother who marries—

"(A) an individual entitled to benefits under this subsection or subsection (a), (b), (e), (f), or (h), or under section 223 (a), or

"(B) an individual who has attained the age of eighteen and is entitled to benefits under subsection (d),

the entitlement of such widow, widower, or surviving divorced mother to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under section 223 (a) or subsection (d) of this section, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223 (a) or subsection (d) of this section unless (i) he or she ceases to be so entitled by reason of his or her death, or (ii) in the case of an individual who was entitled to benefits under section 223 (a), he or she is entitled, for the month following such last month, to benefits under subsection (a) of this section."

(b) (1) Section 202(b)(3)(A) of such Act is amended by striking out "(f) or (h)" and inserting in lieu thereof "(f), (g), or (h)".

(2) Section 202(e)(3)(A) of such Act is amended by striking out "(f) or (h)" and inserting in lieu thereof "(f), (g), or (h)".

(c) Section 202(f)(1)(C) of such Act (as amended by section 3(a)(2) of this Act) is amended to read as follows:

"(C) (i) has filed application for widower's insurance benefits, or was entitled to husband's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which she died, or

"(ii) was entitled, on the basis of such wages and self-employment income, to father's insurance benefits for the month preceding the month in which he attained age 62, and".

(d) Section 203(c)(3) of such Act is amended to read as follows:

"(3) in which such individual, if a widow or widower entitled to a mother's or father's insurance benefit, did not have in her or his care a child of the deceased husband or wife entitled to a child's insurance benefit; or".

(e) The amendments made by this section shall apply only with respect to monthly insurance benefits payable under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after the month in which this Act is enacted.

CRITERIA FOR DETERMINING CHILD'S DEPENDENCY ON HIS MOTHER

SEC. 5. (a) Section 202 (d) (3) of the Social Security Act is amended—

(1) by inserting "or his mother or adopting mother" after "his father or adopting father" in the first sentence; and

(2) by striking out ", if such individual is the child's father," in the second sentence.

(b) Section 202 (d) (4) of such Act is amended by inserting "or stepmother" after "stepfather" each place it appears.

(c) Section 202 (d) of such Act is further amended by striking out paragraph (5), and by redesignating paragraphs (6) through (10) as paragraphs (5) through (9), respectively.

(d) (1) The paragraph of section 202 (d) of such Act redesignated as paragraph (9) by subsection (c) of this section is amended by striking out "under paragraph (9)" and inserting in lieu thereof "under paragraph (8)".

(2) Paragraphs (2) and (3) of section 202(s) of such Act are each amended by striking out "(d)(6)," and inserting in lieu thereof "(d)(5),".

(3) Section (5)(l)(9) of the Railroad Retirement Act of 1937 is amended—

(A) by striking out "(3), (4), or (5)" in the third sentence and inserting in lieu thereof "(3) or (4)"; and

(B) by striking out "paragraph (8)" in the sixth sentence and inserting in lieu thereof "paragraph (7)".

(e) The amendments made by this section shall apply with respect to monthly insurance benefits payable under title II of the Social Security Act for months after the month in which this Act is enacted, on the basis of applications filed in or after the month in which this Act is enacted.

RETIREMENT TEST INAPPLICABLE TO CERTAIN WIDOWS AND WIDOWERS WITH MINOR CHILDREN

SEC. 6. (a) The first sentence of section 203(b) of the Social Security Act is amended by inserting "(except a benefit payable under section 202(g))" after "any payment or payments under this title".

(b) The third sentence of section 203(b) of such Act is amended—

(1) by striking out ", or a person who is entitled to mother's insurance benefits,"; and

(2) by striking out "or such person, as the case may be,".

(c) Section 203 (d) (2) of such Act is amended—

(1) by striking out ", or from any mother's insurance benefit to which a person is entitled,";

(2) by striking out "or mother's insurance benefit or benefits"; and

(3) by striking out "or person entitled to mother's insurance benefits".

(d) Section 203 (e) (1) of such Act is amended by inserting "(unless entitled to a benefit under section 202 (g))" after "such individual".

(e) Clause (A) of the last sentence in section 203 (f) (1) of such Act is amended by inserting "or was entitled to a benefit payable under section 202 (g)" after "was not entitled to a benefit under this title".

(f) The first sentence of section 203 (h) (1) (A) of such Act is amended by inserting "(other than a benefit payable under subsection (g) thereof)" after "any monthly insurance benefit under section 202".

(g) The amendments made by this section shall apply with respect to monthly insurance benefits under title II of the Social Security Act for months in taxable years ending after the date of the enactment of this Act.

The CHAIRMAN. Senator Carlson.

Senator CARLSON. Mrs. Griffiths, I appreciate very much your appearance here this morning, because I had the great honor and privilege, as also did Senator Anderson I believe, of serving on the House Ways and Means Committee for about 10 years under the able leadership of a great American, the Honorable Robert Doughton, or North Carolina. It is a great committee because you have and you do devote more time to your work dealing with taxes and social welfare than we who are members of the Finance Committee who have to sit on other committees, such as Banking and Currency, Foreign Relations. Our work is split up. So I not only enjoyed myself there but it was a great education. I deeply appreciate your appearance here this morning. You have been very helpful.

Mrs. GRIFFITHS Thank you very much. One of the things that we learned, in spite of the requirements in the law previously, was that the employment security commissions never carry these people on the employment rolls, the employable rolls, so that you have great difficulty in getting jobs for them.

I would like to emphasize again to you that I think every person has a right to work, and I think that they should be given that opportunity, and I don't think anybody has a right to say to the rest of us, "If I don't care to work you have to support me." Thank you very much.

The CHAIRMAN. Thank you very much, Congresswoman Griffiths.

Our next witness is Mr. John K. Pickens, representing the American Nursing Home Association. I have a letter here from Senator Frank Moss.

Senator Moss says:

> Representatives of the American Nursing Home Association have been in consultation with me and members of my staff concerning the provisions of Amendment No. 294 which I proposed to H.R. 12080 now pending before your Committee. The Association has suggested several modifications to my amendment. The changes they suggest are listed on the attached sheet.
>
> I understand that when the Association testifies before your Committee they will present these suggestions to you. This letter is to advise the Committee that these modifications have been discussed with me, and that I have no objection to them.

The CHAIRMAN. I will put the entire letter into the record plus the suggested amendment.

(The material referred to follows:)

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., September 21, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR RUSSELL: Representatives of the American Nursing Home Association have been in consultation with me and members of my staff concerning the provisions of Amendment No. 294 which I proposed to H.R. 12080 now pending before your Committee. The Association has suggested several modifications to my Amendment. The changes they suggest are listed on the attached sheet.

I understand that when the Association testifies before your Committee they will present these suggestions to you. This letter is to advise the Committee that these modifications have been discussed with me, and that I have no objection to them.

The Association also is concerned with the use of the term "reasonable cost" fearing that the principles of reimbursement for Title XVIII will simply be adopted for Title XIX. As I stated in my testimony before the committee, this was not intended by my use of the term and I think it would be unfortunate if this were the outcome. Under Title XIX, unlike Title XVIII, the States administer the medical care programs and determine and make the payments for care. It seems to me, therefore, that States should be allowed some latitude to develop their own methods of determining reasonable cost as long as these methods meet the requirements of the Title. However, if the Committee should decide to adopt my Amendment, I am sure the Committee's own views and intentions with respect to the method of reimbursement can be made quite clear in its report.

With kind regards,

Sincerely,

FRANK E. MOSS,
U.S. Senator.

MODIFICATIONS TO AMENDMENT NO. 204 SUGGESTED BY THE AMERICAN NURSING HOME ASSOCIATION

1. On page 4, following Line 9, add the following: "(28) provide for a periodic review, not less than every five years, by the State agency (together with an advisory committee composed of representatives of the professions, occupations, institutions and associations, involved) of the State nursing home code or licensure provisions and regulations with recommendations for improvement thereof to the appropriate State authorities."

2. On page 5, delete material in parenthesis in Lines 13 and 14, the period at the end of Line 15, and add the following: "as determined by the department or agency in the State having responsibility for regulation of lending institutions within such State."

3. On page 8 following Line 21, add the following: "(G) meet standards relating to environment, sanitation, and housekeeping at least equal to those established for certified extended care facilities on the date of enactment of this Act."

4. On page 8, delete Lines 22 through 25 and Lines 1 and 2 on page 9 and substitute the following: "(2) The term qualified nursing home does not include any nursing home which by December 31, 1969 does not fully meet provisions of the Life Safety Code (21st Edition, 1967) of the National Fire Protection Association applicable to nursing homes and related institutions."

STATEMENT OF ED WALKER, PRESIDENT, AMERICAN NURSING HOME ASSOCIATION, ACCOMPANIED BY DAVID R. MOSHER, REGIONAL VICE PRESIDENT, AMERICAN NURSING HOME ASSOCIATION; REV. AUGUST HOEGER, EXECUTIVE DIRECTOR, EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, AND BOARD MEMBER, AMERICAN NURSING HOME ASSOCIATION; ALFRED S. ERCOLANO, EXECUTIVE DIRECTOR, AMERICAN NURSING HOME ASSOCIATION; AND JOHN K. PICKENS, GENERAL COUNSEL

Mr. WALKER. Mr. Chairman and members of this committee, my name is Ed Walker and I am president of the American Nursing Home Association. I am a nursing home administrator and am owner of three facilities that are certified as extended care facilities. I am also a registered pharmacist.

On behalf of the members of the American Nursing Home Association I want to express our gratitude to you for this opportunity to testify on the need for specific amendments to the Social Security Act and in particular on the titles XVIII and XIX programs.

The CHAIRMAN. May I just say that Senator Harris had hoped to be here to express greetings to Mr. Walker, but although he is a very hard-working member of our committee he is not able to be here at this moment. He has done a lot of good work for us. He wants to welcome you. May I say that he is meeting with his Commission to discuss the riots in Detroit, New Jersey, and elsewhere, and what might be done about them.

Mr. WALKER. Thank you very much for the message, sir.

The American Nursing Home Association is a nonprofit organization of more than 7,000 licensed nursing homes with in excess of 350,000 beds. Our members come from both the proprietary and nonproprietary fields and we believe that essense both of these types of facilities have the same common goal; mainly, that of providing quality nursing care for the aged, chronically ill, and the convalescent.

We have come here in a spirit of continuing the cooperating we have given this committee and other committees in the House and Senate as well as officials of various governmental agencies in the past.

We have sought to keep our direct testimony brief and to the point, and we assure you that we will be happy to answer any questions we can or submit additional statements that you may desire.

We have asked two of our members to testify today. Both are well qualified in the nursing home field. Our first witness will be Mr. David R. Mosher, owner and administrator of three facilities certified as extended care facilities in St. Petersburg, Fla. Mr. Mosher is a former president of the Florida Nursing Home Association and presently is serving as a member of the board of directors of the American Home Association. He will testify and present our recommendations for amendment on the definition of a "spell illness" under title XVIII; the ruling of HEW on supplementation under title XIX; the amendments proposed by Senator Moss, of Utah, and Senator Kennedy of Massachusetts; as well as the proposed new benefits provision of State plans under title XIX.

Our second witness will be the Reverend August Hoeger, executive director of the Evangelical Lutheran Good Samaritan Society, which owns and administers 105 nursing homes providing various levels of service in the Midwest and West. Reverend Hoeger, also a member of our board of directors, will testify on the titles XVIII and XIX reimbursement programs, on the proposed amendment to require funding of depreciation, and on compulsory area health planning.

I also have with me Alfred S. Ercolano, executive director of the American Nursing Home Association, and John K. Pickens, our general counsel. Neither of these gentlemen will testify but will be available to you to answer questions you may ask.

As a matter of recognition, we also have present in the room Mr. Phillip Newberg, who is president of the Minnesota Nursing Home Association and a friend of the good Senator McCarthy. Also Mr. David R. Walker, who is owner-administrator of a new extended care facility and nursing home in Joplin, Mo., the first new facility of its type there; Mr. Frank Zalenka, assistant executive director; and Mrs. Nancy Vega of the staff.

Mr. Chairman, I would like to present at this time our first witness to give testimony, Mr. David Mosher.

Mr. MOSHER. Mr. Chairman, my name is David R. Mosher. I appear here on behalf of the American Nursing Home Association. I am a nursing home administrator and the owner of three nursing homes in

St. Petersburg, Fla., certified for extended care under the title XVIII program.

Nursing homes, whether certified as extended care facilities under medicare or operating as skilled nursing homes under title XIX provide a tremendous cost-saving service for the Government.

Those certified as ECF's are saving the Social Security Administration, the Federal Treasury, and ultimately the American taxpayer, tens of millions of dollars.

Serving as they do for postacute hospital care, these nursing homes are helping to curtail the medicare beneficiary's stay in a hospital. In so doing, they not only are providing this posthospital convalescent care at great savings in per diem costs to the medicare program, they also are relieving sorely needed hospital beds for patients in need of acute care and at the same time reducing the demand for additional costly hospital construction.

Parenthetically, I would recall for this committee that estimates have been made for a national average hospital per diem cost this year of $57 while nursing home costs, even under the demands of medicare, are averaging only one-third to one-half this daily rate. I also would remind the committee that every day a medicare patient convalesces is, in effect, costing the hospital money.

I offer this testimony for two basic reasons:

First, I believe that nursing homes offer a tremendous potential as a "safety valve" protecting against the rising cost of institutional health care not only for the medicare or title XIX patient but for the patient of all ages who, after surgery or serious illness, needs nursing care and a period of convalescence without all the other costly services and facilities that a hospital must maintain.

Secondly, I offer this testimony in reference to earlier testimony you received concerning the fact that the extended care program under medicare is far exceeding the estimated cost of the program at the time Medicare was being considered by this committee in 1965.

To this latter point I would make these further observations. First, of course, is that assuming the proper functions of admission and discharge from nursing homes and of utilization review committee in both hospitals and nursing homes, every day a patient spends in a nursing home represents a major savings over the cost of staying in a hospital. Second, no realistic estimates ever were made of the cost of the ECF program and to some extent there was little basis or experience to make such estimate. Certainly the estimate of $25 million was not a realistic estimate based on SAA's own projections of the anticipated utilization of ECF benefits.

Last October, the staff of the American Nursing Home Association was told by a spokesman for SSA that the total hospital admissions estimated for 1967 under medicare was 4,221,000, and that, based on estimates of the number of ECF admissions per thousand of hospital admissions, the ECF admissions would total 220,000. Using SAA's estimate—which we said at the time we felt was low—of 38 days average length of stay and an average of $18 a day cost of ECF care, would have resulted in a projection of a cost for the program the first year well in excess of $150 million, not $25 or $50 million.

The facts are that experience has proved that the number of admissions is running well above projections of last year and the average length of stay is higher than anticipated.

On length of stay, I also would point out to you that a study made by the American Nursing Home Association in cooperation with Mutual of Omaha of 2,793 cases in 160 nursing homes involving patients admitted to these facilities after at least a 3-day stay in a hospital indicated an average nursing home stay of 122 days. Of these patients in the study, who used the nursing home as a "halfway house" for convalescent-restoration stay between the hospital and a return to his own home, the average length of stay was 78.5 days. The study was not conclusive but it did raise a question as to the length of stay average projected by SSA.

Mr. Chairman and members of the committee, I did not want to belabor this point of the potential cost saving that nursing homes pose for both the title XVIII and title XIX programs, but I did want to bring it to your attention.

I want to say at this time that throughout my testimony I will use the terms "nursing homes," "extended care facilities," and "ECF's" interchangeably. I do this with a certain deliberation because I want to remind you that until January 1, 1967—a little over 8 months ago—we had no ECF's or extended care facilities. Nursing homes, as of late May 1967, accounted for 230,000 of the then 281,000 beds certified as ECF's and for 3,094 of the 3,963 institutions certified as ECF's.

We are proud that the Nation's nursing homes have responded so well to this new program which you and I know is extremely complex. If the program is complex in its totality, you can imagine how complex it must be to the individual facility and the individual administrator beseiged as they have been with the whole new system of reimbursement, new conditions, and standards to meet an entirely new aproach to patient utilization.

We, as members of the association, have consistently sought to cooperate with both the Congress and those in Government agencies on whose backs has fallen the responsibility for implementing these programs.

Our problems are many with both title XVIII and title XIX programs but we are not going to take the valued time of this committee outlining all of them. However, we do feel a necessity to explain some because they have a direct bearing on our recommendations for amendments to H.R. 12080, the subject of these hearings.

Not the least of these problems is the reimbursement formula—a formula which in its present form jeopardizes the continued health and expansion of the nursing home field which is dominated by proprietary and nonproprietary church-operated facilities that do not depend on Government grants for construction or operation.

The problems that have emerged since the inception of the medicare and title XIX nursing home programs have not been problems with the basic legislation but with the implementation of this legislation as being interpreted by the Department of Health, Education, and Welfare.

Consistently, we have sought to cooperate with not only Congress but with HEW in the developing of rules and regulations that would assure successful implementation of these programs.

Much of our effort has been futile.

We have seen HEW, by administrative fiat, literally amend legislation through issuance of rules and regulations.

By the issuance of so-called letters of instructions to State agencies and fiscal intermediaries, HEW has actually changed and amended from day to day rules and regulations worked out through consultation with national organizations—and HIBAC.

We do not know if some of these rules and regulations issued as State agency letters and letters to fiscal intermediaries without regard to the Federal Administration Procedures Act and without publication of them in the Federal Register were first presented to Health Insurance Benefits Advisory Council, that many of them have been issued without prior consultation with national organizations as provided for under the Social Security Administration Amendments of 1965—Public Law 89–97. Let me cite a few examples:

SPELL OF ILLNESS

Directing your attention to the definition of a "spell of illness" presently proposed by HEW in State Agency Letter No. 65. This letter will affect State title XIX programs by increasing the costs thereto both to the individual States and to the Federal Government while working a hardship upon the patient.

In section 1861(a), "spell of illness" is defined as commencing with the first day a patient enters a hospital, uses his hospital and extended care benefits, and ending 60 consecutive days thereafter on which he is neither an in-patient in a hospital or an extended care facility.

An "extended care facility" for the purposes of "spell of illness" is defined in section 1861(j)(10) as a facility "which is primarily engaged in providing to inpatients (*a*) skilled nursing care and related services for patients who require medical or nursing care or (*b*) rehabilitation services for the rehabilitation of injured, disabled, or sick persons." Congress specifically defined an "extended care facility" for the purposes of "spell of illness." Now Social Secruity Administration has radically altered Congress' definition.

The Social Security Administration defines "extended care facility" so as to prolong a "spell of illness" as a facility which is in charge of a licensed practical nurse—who need not be a graduate of a State approved school—with aides, orderlies, or attendants on the other two shifts. Such a facility fails in the essential element that it be primarily engaged in skilled nursing care and services for patients who require medical or nursing care. State agency letter No. 65 adds a great deal of confusion to the health care field. More important, however, are the results which follow. This definition denies our aged people medical benefits Congress intended them to have.

Let's take three examples. Patient A who is 75 years old and living in a custodial home, a typical retirement type home. He can get around, but he needs someone to be certain that he eats his meals and takes his medicine. Patient A has a severe heart attack. He goes to the hospital for 90 days. He is then transferred to an "extended care facility" for 100 days. He then goes back to the custodial home where he has lived for the past 2 years. He can never again become eligible for medicare benefits under letter No. 65 because there is 8 hours a day of "nursing service" available.

Two years later he falls and breaks his leg. Under letter No. 65 he can obtain no medicare benefits because this residential care home is defined as an ECF or skilled nursing home because it has an LPN as a charge nurse. The travesty lies in the fact that this residential care home is considered by SSA to be an ECF solely for the purpose of not breaking his "spells of illness." SSA under its other rules would never certify this residential care home as a skilled nursing home for participation in title XVIII or title XIX programs. In those instances, SSA would judge this residential care home to be below the standards required of a facility for it to be certified as an ECF or a skilled nursing home.

Patient B is 68 and lives in his own home. He is not well but is able to take care of himself. He has a serious heart attack. He is in the hospital for 90 days. He goes to an "extended care facility" where he remains for 100 days. Thereafter he is transferred to a nursing home where he remains for 60 days. He then goes home and 10 days thereafter he falls and breaks his leg. He is not eligible for medicare.

Patient C is 70 years of age. He has a serious heart attack. He goes to a hospital for 90 days and is then transferred to an "extended care facility" for 100 days. He then goes home and during the next 60 days he exhausts his 100 home health care visits under part A. On his 61st day he falls and breaks his leg. He is eligible for medicare benefits.

Patient C is eligible for medicare because he had such resources that after being discharged from an extended care facility, he could be taken to his own home. He could receive 100 home health care visits and his new "spell of illness" would start 60 days from the date that he was discharged from the ECF. In other words, an individual is not required to have a 60-day "spell of health."

State agency letter No. 65 makes one's medicare benefits turn on his station in life or on the circumstances under which he is living at the time that he enters the hospital. The individual who needs medicare benefits the most is denied them.

In each of these three instances we have a new illness but because of the technical misrepresentation placed on the word "extended care facility" by SSA two of these elderly people have what amounts to a cancellable health insurance policy where it seems certain that Congress did not intend such a catastrophe to happen.

Our objections to letter 65 are threefold. First, it nullifies the definitions of Congress and causes undue hardships to those who need medical care most. Second, it defines a "facility primarily engaged in skilled nursing care" as one that is not rendering skilled nursing care. We have fought for over 10 years to raise standards of professional care which SSA now downgrades. Third, it makes "spell of illness" turn in part on one's station in life. We thought medicare did away with any kind of a means test.

I might digress for a moment. Under State agency letter 65, it is DCF. Under the other rules of SSA it is not DCF, and both things are true at the same time.

Senator **Anderson**. What do you recommend? Some of us have worked really hard on those original provisions. The Department has changed the rules, but what do you recommend now on this?

Mr. **Mosher**. I will come to our recommendations, Senator Anderson, in just a few minutes, when I conclude this portion of the testimony.

Of course, the intent of the situation here is to get an amendment which relates "spell of illness" to actual disease or illness or sickness rather than to relate "spell of illness" to a physical control, which is the way it is now. Let me give you this actual recommendation as we have suggested.

"Spell of illness" should be defined in terms of a new medical illness. Accordingly, we suggest that section 1861(a)(2) on "Spell of illness" be amended to read as follows (amendment is italicized):

"(2) Ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility, *under title XVIII for the same medical illness.*"

In other words, if he goes back to his own residential home or his retirement home, this is not a DCF thing, and he should then be able to become eligible again after a 60-day period.

There is a very interesting thing here. If in the case of another patient in a similar series of circumstances this patient is able, patient C, to go to his own home and there to partake under part B of the provisions for private nurses to come into his home for up to 60 days, and if on the 61st day he falls and breaks his leg, he is eligible for medicare, even though he has had no "spell of health." There is just no relationship between these two things. And that is why we make the recommendation.

The next topic I would like to speak to you about beginning on page 10 of my testimony is in regard to the supplementation under title XIX, supplementation of fiscal benefit or additional payments.

SUPPLEMENTATION

The Department, in defining requirements for State plans under supplement D (sections 5320 and 5330) provides that supplementary payments to providers of services are outlawed or prohibited. These regulations accomplish this by providing, in part:

> D-5320 REQUIREMENTS FOR STATE PLAN
>
> A State plan for medical assistance must provide that:
>
> 1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of service in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.
> 2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structures.
>
> D-5330 CRITERIA FOR THE ADMINISTRATION OF THE PLAN
>
> 3. The State Agency requires compliance by providers of service with the fee structures as a condition of participation. The state agency: (a) establishes written policies prohibiting billing at higher rates or in additional amounts.

In adopting this regulation (5320 and 5330) the Secretary states that he relies on the following excerpts from sections 1902(a) (1), (4), (13), and (19).

Section 1902(a) of the Social Security Act reads:

> A State plan for medical assistance must—
>
> (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; . . .
>
> (4) provide such methods of administration . . . as are found by the Secretary to be necessary for the proper and efficient operation of the plan; . . .

(13) . . . effective July 1, 1967, provide . . . (B) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan; . . .

(19) provide such safeguards as may be necessary to assure that . . . such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

Not one of the quotations extracted from the above sections, individually or all of them collectively, give the Secretary such authority. When these sections are read in full, they make the case for HEW authority even weaker.

In enacting title XIX, Congress did not adopt any policy against supplementation of State payments to nursing homes or other providers of service covering the cost of care for indigent patients. Subsequent to the issuance of supplement D in July of 1966, the Secretary has given the States 1 year in which to do away with supplementary payments.

In our several discussions with representatives of the Department, these representatives have given the position that (a) supplementary payments encouraged smaller indigent payments by the State than would otherwise be paid, and (b) all indigent patients should receive the same care.

The CHAIRMAN. Let me just ask you about that, since you are on that subject. Let's assume that someone who is important to me—be it my mother or an aunt or uncle—finds himself in need of medicare. If I want to contribute something so that they can have a private nurse or so that they can have a little additional attention or have a little better room, why shouldn't I be permitted to do that?

Mr. MOSHER. I know of no reason at all.

The CHAIRMAN. I would be the first to agree that what we have here, that the minimum, if it is not supplemented, ought to be adequate to a person's needs; but if my relative or my loved one has been accustomed to living a little better than that and has some resources or has some relatives who work to help, why can't they pay something and provide something better for them?

Mr. MOSHER. It is our understanding that this was intent of Congress; that through these letters from HEW this has now been eliminated for a 1-year period, as of January of next year.

I agree 100 percent that you should have this option. As it stands now, your loved one either must take the lowest common denominator or else must have no benefits which they have previously paid for. You have got these two alternatives, and you either take the entire burden on yourself and your parent or else you are reduced to the lowest common denominator of a welfare patient in our state receiving $100 a month under title XIX.

Senator ANDERSON. That is not under medicare. That is what we call medicaid.

Mr. MOSHER. Title XIX, yes, sir.

Senator ANDERSON. Not medicare at all.

Mr. MOSHER. Under medicare the payments are made on a reasonable cost basis which we have discovered does not cover all costs, very substantially does not cover all costs.

Senator ANDERSON. But a relative can contribute for additional service, can he?

Mr. MOSHER. A relative can contribute to make up for a private room, and this is an option for a private-care setup. Now when you get off of medicare onto title XIX or medicaid—this option—this option is no longer available because of the rulings of HEW.

The CHAIRMAN. Let's just get that straight so we understand it. Would this be the situation where a person is under medicare to begin with, and then subsequently exhausts their medicare benefits and then goes on to medicaid?

Mr. MOSHER. Are we proposing that, sir?

The CHAIRMAN. Would this be one of those situations?

Mr. MOSHER. Yes.

The CHAIRMAN. Might it be?

Mr. MOSHER. This is possible; yes.

The CHAIRMAN. It is possible that a person would be entitled to medicare treatment. Now after they have exhausted their rights under medicare, the State might have a program under the medicaid.

Mr. MOSHER. Right.

The CHAIRMAN. Where one could nevertheless have nursing-home and extended-care facilities available to them, I take it?

Mr. MOSHER. Right; yes, sir.

The CHAIRMAN. Now, in a case of that sort, if the relatives had been helping this person by providing some additional facilities or some additional care, and they went on to the medicaid part of it because they had used up their entitlement under medicare, at that point you would have the Department telling you that they could not be permitted to have what their voluntary contributions to their relatives might gain them?

Mr. MOSHER. This is correct, sir.

The CHAIRMAN. And you would contend that they ought to at least be able to have the benefit up to a certain figure?

Mr. MOSHER. That is right.

Let me cite an example of the way it works in the State of Florida. And this is pretty poor, but nevertheless the State of Florida, as it is presently proposing a title XIX program, is raising the payments which it now gives nursing homes from $100 per month to $200. Now, $200 will not provide a very good level of care. It is impossible. The State welfare board recognizes this and has for 5 years allowed supplementation up to $300, that is, $100 to $300 from family, friends, and other sources.

Now under title XIX, if this ruling stands, the level will be reduced to the $200 average payment under the bill, and the welfare board has just recently recognized a cost of care in Florida up to $375, allowing supplementation today under this new policy up to $375. But if this stands, the welfare board has said these are the kinds of costs we see, and they will be reduced to $200, and I can tell you that the only thing that will be available will be old homes, poor homes that we are phasing out, and the lowest-common-denominator type of treatment. You just can't do it in a new facility. I cannot do it in any of mine. It costs me in excess of $300 a month just to give the service.

To show you how widespread this is, approximately 21 States allow supplementary payments in one form or another. They are not all the same. Florida is one of these that I have mentioned.

In many States, such as my own State of Florida, where State payment is only $100 a month but additional supplementary payments of $200 a month are allowed for a total of $300 a month—and the new welfare department policy allows $375—no nursing home could afford to take welfare patients if the $100 a month were not supplementary. Representatives of HEW testified 2 years ago during hearings on Public Law 89–97 that most welfare payments were below cost. Many State legislatures have not been able as yet to increase their payments for the care of indigents to provide for rising costs.

Another example of increased costs beyond the control of State legislators was the coverage of nursing homes on February 1 of last year by the Fair Labor Standards Act for the first time. Since nursing homes receive no jurisdictional exemption under the minimum wage law, all nursing homes are now subject to it.

In most Southern States complying with the minimum wage law will require a 30-percent increase in the payment of wages for unskilled employees; namely, kitchen and laundry help as well as aides and orderlies. The increase in wages in these classifications always result in a forced increase of wages among the professional help such as licensed, practical or vocational nurses, and registered nurses.

The increase in coverage of nursing home workers has caused the increase of State minimum wages in the northern and western sections of the country (which were already higher than Federal wages) and proposals in other States of an increase later this year.

Nursing homes were already under the impact of increased costs in attempting to be ready for medicare and title XIX. All of these factors make it virtually impossible for the States presently allowing supplementation to pick up the additional millions necessary if supplementation is prohibited of States who do away with supplementation. All States are now undergoing budgetary problems and seeking new sources of revenue to meet the expanding programs. Florida is no exception.

Representatives of HEW have testified that provision of House passed bill (H.R. 12080) limiting the eligibility level for medical assistance to 133 percent of maximum assistance payments, the existing programs in 14 States will receive less Federal assistance. Is the Department to be allowed to say that any State cannot make up some of this difference by allowing supplementation?

I do not wish to leave the impression that in the State of Florida, as an example, if supplementation were eliminated the State would have to find the funds for the $200 supplementary payments now allowed. If Florida implemented title XIX, the Federal Government would pick up a substantial share of its $200 supplementary payment. However, Florida would still have to appropriate several million dollars each year as its share.

I have read the testimony of the commissioner of welfare of Louisiana, Hon. Garland Bonin, before this committee on September 11. I agree with his testimony and will not attempt to cover the same points he did.

We suggest the following amendment at the end of section 1909 (a)(14):

> *Provided, however,* That no State plan shall be required to contain any provision prohibiting supplementary payments to private or nonprivate institutions on behalf of recipients of medical assistance under a State plan.

The **Chairman.** May I say I find considerable appeal to the idea of letting people supplement care that is available to aged persons. I suppose inasmuch as the medicaid must be related to need, that there would be a lot of people who can't come under it. You could qualify them pretty easily, most of them, if you just figure the level of income they have, saying if they have $300 or more income a month or something of that sort, that they become eligible.

In other words, they become medically indigent pretty quickly after they have passed their productive years, don't they?

Mr. **Mosher.** This has been the pattern, although medicare under the title XIX program has really prevented a lot of this depletion of capital which we used to see, where in 6 months you could be well off and 6 months later you could be broke because of a long illness. This has been a very fine benefit of the medicare program.

That is not true today as it was just a year ago, but still the principle does hold.

The **Chairman.** That once they have exhausted their medicare benefits, their resources go in a hurry then,, don't they?

Mr. **Mosher.** Yes, sir.

The **Chairman.** And so if they are not eligible for title XIX when they first exhaust it, they become eligible in short order, their resources are exhausted.

Mr. **Mosher.** We have a two-pronged thing occurring now. These 21 States who have supplementation have relatively low benefits which they are bringing up, but it is going to take time to gear up into this, and we would feel that if supplementation was to be totally outlawed, that it should be phased out over a 3- to 5-year period like the Government has done on many other programs.

The opposite problem is that certain States that have gone into title XIX with many benefits, such as New York and California, for instance, are having fiscal problems which may force them to seek supplementation also as a way out. We have got these two things which, if it is just cut off, is going to create choas in the field.

Senator **Anderson.** I might say that many people who worked with the so-called King-Anderson bill tried to present their point of view and explain it, but you folks fought us all the way through. We didn't have the benefit of your advice. You didn't say a word about it because you were opposed to the whole program, isn't that right?

Mr. **Mosher.** I don't believe this is right, Senator.

Senator **Anderson.** I do.

Mr. **Mosher.** To continue then, this relates to the Moss amendment No. 294, which, as the letter which you read at the beginning of the hearing indicates, we have discussed with him, and these things are out of the immediate working together.

THE MOSS AMENDMENT

The Moss amendment writes minimum standards into State plans in some areas and provides for Federal minimum standards of professional care in nursing homes under title XIX. We have reviewed these provisions carefully and have suggested several amendments which we believe will improve the Moss amendment.

We oppose requiring the States under title XIX to adopt a "reasonable cost" reimbursement formula such as has been developed by HEW under title XVIII. We understand that Senator Moss likewise has serious misgivings concerning the title XVIII formula as it now stands.

We believe the States should be allowed to experiment with various reimbursement formulas. If a reasonable cost formula is ever adopted for title XIX it should consider the fact that nonproprietary homes need a growth factor and a proprietary home a return on investment. It should require the consideration of the following factors, among others:

(1) Replacement of plant and equipment;

(2) Modernization and growth, specifically provisions through earnings for the long-range amortization of the principal of indebtedness incurred to finance modernization and growth;

(3) Research and comprehensive health planning;

(4) Reasonable rentals and reasonable interest-type returns on properties and money capital where supplied by the providers;

(5) Provisions for uninsurable risks and other business-type responsibilities, where these cannot be shifted and are borne by providers; and

(6) Reasonable return on invested capital (equity capital undepreciated.)

The Moss amendment would provide for only one level of care under title XIX namely, skilled nursing care. Over 50 percent of welfare patients throughout the United States need some nursing or other care but they do not need skilled nursing or intensive care. If title XIX provides for only one level of care, as the Moss amendment does (and as the present proposed HEW regulations do), there will be no Federal assistance program for over 50 percent of the present welfare patients.

I would like to repeat that. If this goes through as it is now proposed, there would be no Federal assistance program for over 50 percent of the present welfare patients in nursing homes who do not need skilled or expensive care and who are now receiving custodial or some other lower level care.

The CHAIRMAN. I am going to stop you at that point. I will come back to you in just a moment.

(Discussion off the record.)

Mr. PICKENS. Mr. Chairman, I would like to answer Senator Anderson's question. He is partly right when he asked: Did the association not oppose the King-Anderson bill? Up until 1964 they did.

However, in 1965 the association cooperated with the House Ways and Means Committee and suggested several amendments, and they also cooperated with the Senate Finance Committee in 1965. As a matter of fact, we suggested the fire and safety regulations be written into title XVIII. We suggested that one way of controlling the costs in title XVIII which will allow the patient to swap one hospital day for two nursing-home days, and we had several other amendments. You are correct, Senator, that prior to that time we had not supported King-Anderson, but we did vigorously in 1965.

Senator ANDERSON. I wasn't going to argue about it. I did know that we had opposition. When we had the votes we had cooperation.

Mr. MOSHER. If I could return to consideration of the Moss amendment and some of its implications, prior to title XIX, these patients were being taken care of under the Kerr-Mills program. This new approach will cost the State governments several millions of dollars to establish their own welfare programs for over 50 percent of their present welfare patients. We are certain that Congress did not intend this, but rather that the whole program go together.

We have discussed this problem with Senator Moss and he recognizes that other levels of care below that provided for in his amendment (or under the proposed HEW regulations) are essential.

We propose an amendment to section 1119 of the act which would provide for additional levels of care under the present titles I, X, XIV, or XVI on the basis of the matching formula under title XIX as a vendor payment program. This would save the Federal Government money as some of these patients would otherwise be cared for in skilled nursing homes. Many States would be unable to provide other welfare programs with the result the tendency would be to place all of these patients in skilled nursing homes. No matter what kind of care, she would just be shoved up the line and they would all suddenly become skilled nursing home patients.

All of our suggested amendments appear as an appendix to my statement. I discussed this one in connection with the Moss amendment. However, as I have pointed out, it is essential in view of the present proposed regulations under title XIX even if the Moss amendment were not adopted.

We have suggested an amendment on line 9, page 4 of the Moss amendment to require the States to periodically review—not less than every 5 years—their nursing home codes and regulations and license laws and with a view toward recommending improvements thereto. We have suggested the creation of an advisory committee composed of representatives of the professions, occupations and associations involved to assist them in this review.

We have suggested an amendment on lines 13 and 15 of page 5 to the language in the parenthesis to allow the State agency, charged with regulating lending institutions, to determine if interest rates for loans to nursing homes are excessive for purposes of "reasonable cost." We believe such an agency is in a better position to determine this than the Secretary.

We have suggested striking out paragraph (d)(2) commencing on line 22 of page 8 and substituting two new paragraphs, paragraphs (d)(2) and (3). The present language would permit the Secretary to promulgate fire and safety as well as physical environmental regulations, we have substituted the present physical environment standards required of extended care facilities. The Department has spent some 18 months in devising these standards in consultation with national health care organizations. They were reviewed by HIBAC. They were published in the Federal Register and comments solicited. Since the goal is to fix minimum standards for the States, it seems a waste of time and effort not to accept the standards recently adopted after 18 months' work.

In connection with the fire and safety standards, we have suggested the use of sections 132, 136, 137 (for new construction) 234 and 235 (for existing construction) of chapter 10 of the Life Safety Code (21st edition, 1967) of the National Fire Protection Association for similar reasons. It is already worked out. This association which is composed of State fire marshals and others have worked on fire and safety codes for several years. These particular sections fix standards of fire and safety for new construction as well as present construction in the nursing home and hospital field. We just say use these.

With the amendments which we have suggested, we believe the Moss amendment to H.R. 12080 will better achieve the desired goals.

Mr. Chairman, we turn now to amendment No. 298 to H.R. 12080, as proposed by Senator Kennedy of Massachusetts, regarding the proposed licensing of nursing home administrators. We have two amendments, if I may stop for a moment here, or two approaches to this bill. I shall try to make clear that we really only take one or the other.

If the intent of the amendment No. 298 were to improve the care provided in the health-care and medical-care facilities of the Nation at the same time that it protects the Federal interest in such facilities, then we would subscribe to such a concept. However, amendment No. 298 falls far short of that goal in that it fails to provide for the licensing of the administrators of all health and medical-care facilities. We believe that amendment No. 298 should be amended to so provide.

If we are going to license anyone in the health-care field, then we ought to take the whole field, starting with hospital, nursing home, laboratory, clinics, et cetera, et cetera.

On the other hand, if the committee is not at this time favorably disposed to provide for the licensing of hospital administrators, nursing home administrators, rehabilitation-center administrators, et al, then, while taking exception to the discrimination contained in amendment No. 298 by its narrowly singling-out nursing home administrators, we believe that the procedure contained therein can be greatly improved in such a way that it will better accomplish the realization of the principle involved.

Specifically, we believe great improvement can be made in the following:

(1) The immediate establishment of a State board which has the duty and authority to administer a program for the licensing of nursing home administrators—page 2 of amendment No. 298, lines 18–20; and

(2) The composition of the proposed State board—page 2 of amendment No. 298, lines 20–24.

We do not believe that the proposed State boards should be established until some criteria has been developed for the following reasons:

(*a*) At the present time, there exists no substantial agreement, neither in the academic world nor in the world of medical care, as to what constitutes the organized body of knowledge which defines nursing home administrations.

(*b*) In similar manner, there exists no substantial agreement as to the identifiable skills which are required of the nursing home administrator.

(*c*) Without the prior determination and identification of such a core of knowledge and concomitant skills, it would be imprudent, if not obstructive, to permit the immediate establishment of such State boards whose duty and function it would be (1) to develop, impose, and enforce standards, which standards shall be designed to insure that nursing home administration will be individuals who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators—page 3 of amendment No. 298, lines 1–8; and (2) to develop and apply appropriate techniques, including examinations and investigations for determining whether any individual meets such standards—page 3 of amendment No. 298, lines 9–11.

The late G. K. Chesterton once said: "Presumably it is the purpose of every reform to save the world. Unless you know both what you are saving it from and what you are saving it for, the process will not get you very far." Mr. Chairman, we submit that Mr. Chesterton's warning is apropos to amendment No. 298.

Unless we know from what we are saving nursing home administration and for what we are saving it, the commendable end sought by amendment No. 298—namely, the upgrading of nursing home administration to a profession and the insuring of better patient-care in the facilities thus administered—can suffer a grievous setback if not be altogether frustrated.

To this end, we suggest that amendment No. 298 be amended to provide:

(1) That before the States are required to establish Boards for the purposes set forth in the proposed section 1906, that the President through the Secretary of HEW be charged with convening and activating a National Advisory Council for the licensing of nursing home administrators; and

(2) That said Council be charged with the following tasks: (*a*) to study and identify the core of knowledge that should minimally constitute training in the field of institutional administration which shall qualify an individual to serve as a nursing home administrator; (*b*) to study and identify the experience in the field of institutional administration that a nursing home administrator should be required to possess; (*c*) to study and develop model techniques including examinations and investigations to be utilized in determining whether any individual possesses such an identifiable core of training and such an identified aggregate of experience; (*d*) to study and develop criteria for waivering individuals engaged in nursing home administration prior to the adoption of a State plan to license nursing home administrators; (*e*) to study and develop appropriate programs of training and instruction designed to enable all individuals, with respect to whom any such waiver is granted, to attain the qualifications necessary in order to meet the model standards identified by such Council; (*f*) to study, develop, and recommend programs of training and instruction for those desiring to pursue a career in nursing home administration; (*g*) to complete the aforementioned tasks in 1 year subsequent to the first meeting of such National Advisory Council by submitting a written report to the President through the Secretary who in turn shall be required to forthwith commit such report to be printed and to be disseminated to the Congress, to the States and to all affected national organizations, and then go to a licensing program.

To this end, namely, the establishment of such a National Advisory Council, we recommend that the public interest be provided for; that the Federal and State interests be separately provided for; that the interests of the profession of nursing home administration be provided for; that academic interests be provided for; and that the interests of nursing homes be provided for.

To this end, we recommend that the composition of such National Advisory Council be as follows:

(1) A representative of the Federal Government. Here we would suggest the Chief of the Nursing Homes Branch, Division of Medical Care, Public Health Service.

(2) A representative of State welfare commissioners to be designated by the American Public Welfare Association.

(3) A representative of the State health officers to be designated by the Association of State and Territorial Health Officers.

(4) A representative of the American College of Nursing Home Administrators to be designated by the college.

(5) A representative of universities which have been and are engaged in providing training in nursing home administration.

(6) A representative of ANHA to be designated by ANHA.

(7) A representative of the public to be designated by the Secretary.

(A total of 7.)

To this end, we also suggest that amendment No. 298 be amended to authorize that there be appropriated such sums as may be necessary to enable the Secretary to establish such a National Advisory Council and to enable such a National Advisory Council to discharge its designated tasks.

In addition to taking exception to the immediate establishment of such State boards as provided for in amendment No. 298, we take exception to the composition of such State boards as set forth on page 2, lines 20–24, of amendment No. 298, namely, that * * * such Board must be so composed that its members will be representative of the professions, occupations, and institutions directly concerned with the care and treatment of the chronically ill or infirm aged individuals, and will be representative of the public."

We submit that just as would-be medical physicians are judged to be qualified by already licensed physicians and that just as applicants to the bar are judged by those who are already members of the bar, so nursing home administrators should be judged by already established nursing home administrators. This is a sound principle and one that should be applied here.

We suggest that the composition of the proposed State boards follow that of the proposed National Advisory Council with the obvious exclusions of representatives for the Federal Government and for both the American Public Welfare Association and the Association of State and Territorial Health Officers.

In short, we suggest that the envisioned State boards be composed of representatives of the State government, of the public, of the American College of Nursing Home Administrators, of academic institutions engaged in programs of training and instruction and in nursing home administration, of the State nursing home association.

To retain the composition presently provided for in amendment No. 298, for such State boards would be to place representatives of professions and occupations the practitioners of which would be supervised by the nursing home administrator in a particular State. Similarly, it would place representatives of those for whose services the nursing home administration might contract in a position to determine who are to be the nursing home administrators in a particular State.

In summary, then, we suggest that amendment No. 298 be amended as we have indicated for if such a National Advisory Council were established and activated and its task properly discharged in 1 year, then two most desirable and necessary results could be accomplished: first, the transition of the State from a nonprogram to a program of licensing nursing home administrators would be made with a greater degree of efficiency, and some national standards, too; and second, as a consequence, the subsequent task of the proposed State boards would be rendered immeasurably more effective.

Finally, to return to an earlier note, namely, an effort to improve the health and medical care provided in all of the Nation's facilities by licensing the administrators of all health and medical-care facilities, we suggest that if the committee is favorably disposed to this larger and grander concept, then similar procedures as outlined above should be provided for licensing all health-care administrators.

The next item is definition of custodial care or this care below skilled or ECF care.

DEFINITION OF CUSTODIAL CARE

We know that Congress was concerned lest the medicare program be used to provide custodial care. We share that concern. However, intermediary letter 257 may well destroy the entire medicare program. There are several built-in protections against custodial care in the title XVIII program. Among them are the requirement for 3-day hospitalization and physician certification as well as the requirement for utilization review. In order to be eligible for an extended care facility, the facility must have a utilization review program. Extended care facilities have spent countless hours and money to develop those programs as they were required to do.

Without consultation with providers of service, SSA has issued intermediary letter 257 defining custodial care. This definition is completely unrealistic. Let us take the example under the definition of a patient who had been in an extended care facility for 30 days. The Utilization Review Committee certifies that he needs additional benefit days under the program. At the end of an additional 20 days, the patient is discharged from benefits under the program by the Utilization Committee. Under the instruction to the fiscal intermediary contained in letter 257, the intermediary may review the record of this patient at any time after discharge and determine that all or part of this patient's stay of 50 days in the ECF was custodial and the intermediary then can disallow benefits and payment. The facility is left in the position of attempting to collect from the patient as a private pay patient. If the facility is unable to collect, the resulting bad debt will not be considered a bad debt under the medicare reimbursement formula, because custodial care is not covered by the program.

It places the medicare recipient in the untenable position of not knowing at any time whether the care received under physician and Utilization Review Committee certification will be paid for by the Federal Government. It places the provider of service in the position, at any point, upon admission or at discharge of not knowing whether payment for the services rendered will ever be made by anyone. A patient is admitted to a nursing home after discharge from a hospital upon certification of a physician. Such a patient is discharged upon orders from the physician. Is the only answer to the provider's dilemma a request for a reasonable advance deposit from each potential medicare recipient on admission? This is about all that we have left.

Below are listed some of the criteria the intermediary is directed to consider:

> The intermediary's evaluation should always include a consideration of the following factors.
>
> A. Length of Stay in the Institution: The longer a patient remains in an institution, the greater is the likelihood of a custodial care situation * * *.
>
> B. Diagnosis: In evaluating this entry, reviewers should look to see whether the diagnosis represents a condition which, once it is stabilized, usually required only custodial care, or one that would normally involve a wide range of skilled services entailing the continuing attention of trained personnel.
>
> C. History of Inpatient Usage: The inability of an individual to remain out of an institution may also be an indication of a custodial care situation * * *.
>
> D. Adverse Utilization Review Decision: A decision by a utilization review committee that further stay is not necessary does not, of course, mean that prior to the committee's determination the patient had been receiving custodial care. However, it would raise a presumption that care in the prior period may not have been covered * * *.

Here we reach an impasse.

> E. Effect of Discharge or Death: A patient's discharge from an institution after a relatively short period would tend to indicate that the care furnished him was not custodial. Similarly, the death of a patient shortly after his admission to an institution would tend to indicate that the care furnished the patient was not custodial in nature.

This places the fiscal intermediary and SSA over the Utilization Review Committee on which there is at least one physician and in some instances, and substitutes an agency regulation for the medical decision of the physician and other members of the Utilization Review Committee.

In requiring the establishment of Utilization Review Committees to review medical illness medicare patients, Congress certainly did not intend for medical decisions seriously arrived at to be retroactively overridden by a fiscal intermediary attempting to interpret letter 257 hastily conceived. The utilization review regulations were promulgated after some 18 months consideration by knowledgeable people in the profession, consultation and consideration by HIBAC, and publication in the Federal Register asking for comment. Letter 257 attempts to amend this without complying with the procedures of title XVIII or of the Administrative Procedure Act.

Mr. Chairman, we want to reiterate our serious objections in the present title XIX wherein it fails to provide for another level of care less than that of skilled nursing care.

We suggest that the committee consider amending title XIX to provide for a program of care which would utilize the present formula for matching funds under title XIX and which care would be provided in facilities that were (1) licensed; and (2) had a licensed nurse employed full time. This care would be provided to recipients with respect to whom there was a timely physician certification of need for special living arrangements and that such arrangements were not available to the recipient in his own home under a program supervised by a licensed home health care agency.

Finally, Mr. Chairman, we search for but can find no rationale whatever to justify the provision in H.R. 12080; namely, section 224 on page 153, required services, under State medical assistance plan, that the States may have the option of providing any seven of the 14 stipulated services in the present law.

At the present time five services are presently required, and they are the basic core of the whole medical setup. This new provision we cannot understand at all.

The five services presently required by title XIX are the basic core of a medical program. In addition, under the present law, the States may add to these five and, in doing so, receive additional Federal matching funds. Thus, under the present title XIX, there is nothing to preclude the States from providing all 14 services if they have the money, and, in fact, there is Federal encouragement for them to do so.

Hence, our difficulty in comprehending this provision for option in H.R. 12080. We urge the elimination of this provision.

Mr. Chairman, again I want to thank you for this opportunity to present the views of the Nation's nursing homes on this important legislation. If we can be of any further service to this committee in its deliberations, we shall be happy to do so. I personally wish to thank you for the opportunity of appearing.

The CHAIRMAN. Gentlemen, you still have an additional statement, here on the nursing home problem, and the amount of time that we had allotted to hear the American Nursing Home Association has been exceeded. I will have to ask that we print those statements in the record, and that it be briefly summarized. Just hit the high points, and I will assure you that we will read them and we will have our staff go over them with us and we will pick out the recommendations and see that they are considered. If you will just touch on the high points that you have got in your statement, we will see that that is considered. We will print them in full in the record for the benefit of all committee members.

Reverend HOEGER. Thank you, Mr. Chairman.

The CHAIRMAN. That is one reason I insisted on expanding the staff of this committee, so we would have adequate people to study these recommendations and see that they are considered by others.

Reverend HOEGER. My name is August Hoeger, a Lutheran clergyman and executive director of the Evangelical Lutheran Good Samaritan Society.

Senator ANDERSON. Senator Moss, I know, has been very much interested in his amendment. For the record do you favor the Moss amendment with the agreed-upon changes?

Mr. MOSHER. Yes.

Senator ANDERSON. Thank you very much.

Reverend HOEGER. By the way, this Good Samaritan Society is a nonprofit organization. We operate 120 facilities, most of them nursing homes, primarily in the Midwest and 15 States and the western part of the United States. We have a total capacity of over 9,000 beds.

My testimony was to deal primarily with the reimbursement formula. We feel very strongly that the formula, based on reasonable cost, is simply not workable. It doesn't return to us our cost and it is far from reasonable.

The Miller amendment, which was watered down a great deal in the Senate-House conference committee before it was finally approved, provided very little relief for the proprietary homes in that they have 7½ percent of equity, but this relief was nullified by the fact that HEW has now declared that depreciation cannot be counted as part of this net equity so they have almost 7½ percent of nothing in many cases.

For the nonproprietary homes, the nonprofit homes, the amendment did nothing. In one sense if this formula stays as it is, the nonproprietary nursing homes are simply going to be legislated out of existence. There is no way that we can make our mortgage payments simply from the reimbursements that we receive from this formula on the basis of depreciation that we receive.

Senator ANDERSON. Is that taking into consideration the allowances for depreciation?

Reverend HOEGER. Right; the depreciation over, say a 40-year period we will never be able to pay off our mortgage, usually on a 20-year basis. There hasn't been too much hollering and screaming yet because we are still on this interim financing. When the final accounting comes, most homes will realize they simply cannot live under this particular formula as it is now adopted.

Senator ANDERSON. We had several programs of depreciation in the tax bills. What about accelerated depreciation?

Reverend HOEGER. Well, I am not an accountant so I would not be able to answer that with any authority, but I still don't believe that it would be possible to maintain, especially under accelerated depreciation, where you receive your principal payments in the early part of the stage, and your loan is amortized and the principal payments become much larger toward the end of that loan period, and it would make it very difficult.

Senator ANDERSON. Could you have one of your accountants check to see if accelerated depreciation will do you any good?

Reverend HOEGER. Yes; we surely will do that.

Senator ANDERSON. I think it might be.

Reverend HOEGER. The nonprofit as well as the proprietary fields have always depended upon some margin of income above cost for them to continue to exist. If we are going to improve ourselves, if we are going to expand them, if we are going to feel free to innovate new ideas, and so forth, there has to be a margin above costs in order to do these things and, of course, the way the principal formula is written, why we are hamstrung just exactly to our operating costs plus this depreciation, and we see no way possible of even continuing to exist under the present setup.

The burden of my testimony, and I am just cutting it completely short, with the idea that it is recorded in its entirety in the record of the day, is that something simply has to be done and our basic recommendation would be that the entire matter would be switched to a reimbursement formula based on reasonable charges rather than reasonable costs.

Realizing that this cannot be done overnight, that in order to make the present situation possible to even live with, we would recommend the basic changes that were in the Miller amendment, in the present cost-reimbursement formula as found on pages 4 and 5 of my testimony today, and we believe that if these amendments were at least used, why it would be possible to live with the reimbursement formula as it now stands.

We also, Senator Anderson, have to be against your bill regarding funding of depreciation; because if this depreciation money which we do receive is funded, and recalling we use this money to pay off our indebtedness if it were funded, we would not even have this to make mortgage payments, so we feel that the funding of depreciation we definitely have to be opposed to.

Senator **Anderson**. You recognize there are some problems? A hospital built with funds which the Federal Government provides, and there is depreciation of the total investment——

Reverend **Hoeger**. This was going to be the burden——

Senator **Anderson**. I don't say it is wrong but there are problems

Reverend **Hoeger**. Right. This was going to be the burden of my testimony; that I believe the cost-reimbursement formula was designed for hospitals which have little capital indebtedness, usually they are community owned, their capital funds were provided by the Government or fundraising campaigns to begin with, and the problems would be quite different from nursing homes, either proprietary or nonproprietary, where the vast majority of the capital funds were borrowed private capital.

Senator **Anderson**. Mr. Chairman, I am very sure that we will make a study of this as well. This is a difficult problem. It relates to the investment of private money versus somebody who gets grants from the Federal Government. It makes quite a little difference between the two. I think we ought to study this.

The **Chairman**. Does that conclude your statement?

Reverend **Hoeger**. If I could just say one of our great difficulties now is that even after 2 years after the bill has been enacted and after the program is going for 9 months, HEW has still not worked out, or at least has not released its guidelines for reimbursement. We have no idea where we stand even at this time. I think this is a very difficult situation for us.

Senator **Anderson**. Could I just explain this question I raised awhile ago about health. I am not complaining about your attitude.

One reason we are not farther along on the other bill is that we delayed it for years and years and years. This is somewhat new.

Mr. **Walker**. Mr. Chairman, we thank you for your graciousness and your attention.

The **Chairman**. Thank you, gentlemen. We will carefully study these recommendations, and our staff will assist.

(Material submitted for the record by the American Nursing Home Association follows:)

Amendments Suggested by the American Nursing Home Association; Suggested Amendments to the Moss Amendment

I. AMEND MOSS AMENDMENT (NO. 394)

1. By adding the following new paragraph at end of line 9, on page 4.

"(28) provide that a periodic review, not less than every five years, of the state nursing home code, licensure provisions as well as standards of care for private or public institutions or other regulations by the state agency involved (together with an advisory committee composed of representatives of the professions, occupations, institutions and associations) with recommendations for improvement thereof to the appropriate state authorities."

2. By striking out language contained in the parenthesis on lines 13 and 14 of page 5 and insert the following:

(as determined by the department or agency in the state having responsibility for regulation of lending institutions within such state).

3. By striking out paragraph (d)(2) beginning on page 8, line 22 and substituting two new paragraphs; paragraphs (2) and (3):

"(2) the term 'qualified nursing home' does not include any nursing home which, by the effective date of this section, does not meet the physical environment provisions of the Conditions of Participation for Extended Care Facilities effective July 1, 1966 (HIM-3, 3-66); and

"(3) the term 'qualified nursing home' does not include any nursing home which, by December 31, 1969, does not meet Chapter 10, Sections 132, 136, 137, 234 and 235 of the LIFE SAFETY CODE (21st Edition, 1967) of the national Fire Protection Association applicable to nursing homes.

4. *"Amendment to provide more than one level of care in nursing homes (to stand alone or to supplement the Moss Amendment)*

"Amend Title XI of Act by adding at the end thereof the following new paragraph: "Sec. 1119. In the case of any State which has in effect a plan approved under Title I, X, XIV or XVI for any calendar quarter (beginning after June 30, 1967), the total of the payments to which such State is entitled for such quarter, and for each succeeding quarter in the same fiscal year (which for purposes of this section means four calendar quarters ending June 30), under paragraphs (1) and (2) of sections 3(a), 1003(a), 1043(a), and 1603(a) shall, at the option of the State be determined by application of the Federal medical assistance percentage (as defined in section 1905), instead of the percentages provided under each such section, to the expenditures under its State plans approved under Titles I, X, XIV, and XVI, which would be included in determining the amounts of the Federal payments to which such State is entitled under such sections, but without regard to any maximum amounts per recipient which may be counted under such section, but only in the case of those recipients with respect to whom there is a timely physician-certification of need of special living arrangements in a facility which (1) is licensed by the appropriate state agency and (2) has a registered professional or licensed practical nurse employed full time (and on call at all other times), in charge of nursing service, with a qualified attendant up, dressed and on duty at all other times and that such arrangements are not furnished or available to such recipients in other appropriate licensed institutions, or in a distinct part of an extended care facility or nursing home, or in their own homes, under a program supervised by a licensed home health care agency, such recipients will require skilled nursing home care."

OTHER AMENDMENTS

II. "SPELL OF ILLNESS" AMENDMENT

Amend Section 1861(a)(2) by striking out the period and adding "under Title XVIII for the same medical illness." Subsection 1861(a)(2) would then read as follows:

"(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility, *under Title XVIII for the same medical illness.*"

III. SUPPLEMENTATION AMENDMENT

Amend Section 1909(a)(14) by striking out the period at the end thereof and add the following:

"provided, however, that no state plan shall be required to contain any provision prohibiting supplementary payments to private or non-private institutions on behalf of recipients of medical assistance under a state plan."

IV. AMENDMENTS TO KENNEDY AMENDMENT (NO. 298)

1. *Technical Amendments*

Amendments #298 is amended (1) by striking out the word "operators" in lines 7, 11 and 14 on page 2, in lines 4, 8 and 19, on page 3, in lines 2, 4, and 6 an page 4 and inserting in lieu of such word the word "administrators," (2) by striking out the word "operator" in lines 17 on page 2, in lines 13 and 25 on page 3, in line 14, on page 4, in line 17 on page 5 and inserting in lieu of such word the word "administrator."

2. *Amendment establishing a National Advisory Committee*

"d(3) There is hereby established a National Advisory Council (hereinafter referred to as the Council) which shall consist of seven (7) persons appointed by the Secretary without regard to the civil service laws. The Secretary shall, from time to time, appoint one of the members to serve as chairman. There shall be one representative of State Health Officers, State Welfare Commissioners, American College of Nursing Home Administrators, American Nursing Home Association, a representative of universities which provide training in nursing home administration who are outstanding in their field and a representative of the public. The Chief of the Nursing Home Branch, Division of Medical Care of the United States Public Health Service shall be an exofficio member of the Council. In making such appointments the Secretary shall consult with the organizations and associations of the representatives involved.

Each member shall hold office for a term of three (3) years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, three at the end of the second year, and three at the end of the third year after date of appointment. A member shall not be eligible to serve continuously for more than two terms.

"(4) Members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 USC 73b–2) for persons in the Government service employed intermittently.

"(5) It shall be the function and duty of such Council to assist the State Board on a continuing basis in carrying out their functions and duties under Section 1906(a) (26). It shall also be the function of the Council (a) to study and identify the core of knowledge that should constitute minimally the training in the field of institutional administration which shall qualify an individual to serve as nursing home administrator; (b) to study and identify the experience in the field of institutional administration that a nursing home administrator should be required to possess; (a) to study and develop model techniques including examinations and investigations to be utilized in determining whether any individual possesses such an identified core of training and an identified aggregate of experience; (d) to study and develop criteria for waivering individuals engaged in nursing home administration prior to the adoption of a state plan to license nursing home administrators; (e) to study and develop appropriate programs of training and instruction designed to enable all individuals, with respect to whom any such waiver is granted, to attain the qualifications necessary in order to meet the model standards identified by such Council; (f) to study, develop and recommend programs of training and instruction for those desiring to pursue a career in nursing home administration; (g) to complete the functions in (a) through (g) above by July 1, 1968 and submit a written report to the Secretary which report shall be submitted to the State Boards to assist them in their duties and functions under Section 1906(a) (26).

"(6) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education and Welfare as the Council may require to carry out its functions."

STATEMENT OF REV. AUGUST HOEGER, EXECUTIVE DIRECTOR, EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY AND BOARD MEMBER, AMERICAN NURSING HOME ASSOCIATION

Mr. Chairman and Members of this Committee, my name is August Hoeger. I am a Lutheran clergyman and Executive Director of the Evangelical Lutheran Good Samaritan Society. Ours is an independent, non-proprietary, religious charitable organization which owns and administers 120 facilities—mostly nursing homes although some are homes for the aged and hospitals—principally in the Middle West and Western parts of the United States. Our total capacity is approximately 9,000 beds. The Good Samaritan Society was started by my father in 1922 with the opening of a home for the handicapped in Arthur, North Dakota.

Although my father and I are Lutheran ministers, the Society is not owned or controlled by the Lutheran Church. The Society is directed by a 15-member voluntary board elected by the Society membership. It is made up of prominent, concerned Lutheran clergymen and laymen from eight states.

I wish to discuss the inadequacies of the present reimbursement formula based on "reasonable costs". It does not return to us our costs and it is far from reasonable. It was conceived as a solution to reimbursement problems in the hospital field where most facilities have little, if any, capital indebtedness and are community-owned and operated. While the solution may work in the hospital field, it is inappropriate as a formula in the nursing home or extended care facility field where most of the facilities are proprietary and non-profit, church owned or independent.

Although the Good Samaritan Society is non-proprietary, our problems are substantially similar to those of proprietary nursing homes. Both types of facilities depend upon income-above-cost to continue to provide services—if you wish to call a "profit", do so. In the case of the non-proprietary facility, this "profit" is needed to improve and expand existing facilities and to create new facilities. In addition, the present depreciation factor is not adequate to allow non-proprietary homes to make mortgage payments. Under the present reimbursement formula, many non-proprietary nursing homes, most with long distinguished histories, will be legislated out of existence. In the case of the proprietary home, this "profit" is the well-earned return on the investment which created the facility and the reward for continued efficient operation and maintenance of the facility.

The reasonable cost reimbursement formula encourages waste and inefficiency just as did the discredited cost-plus theory which was so widely used in other areas of Government procurement during World War II. The Title XVIII formula by its failure to return income-above-cost to the proprietary and non-proprietary home alike, discourages, even prevents, both types of facilities from meeting the needs on and exigencies of day-to-day operation.

Without exception, the 120 homes owned and administered by the Good Samaritan Society were built and expanded with borrowed private capital, just as proprietary homes are built and expanded by privately borrowed funds. The Society has not been the beneficiary of any large grants or donations from church organizations. We have had to borrow private capital to expand and to build new nursing homes. No non-profit nursing home or other institution can grow and continually improve its service solely by getting its cost back. Therefore, it has relied upon income-above-cost to repay the debts which created the facilities and to continue to improve and expand its services.

To treat nursing homes, proprietary or non-proprietary, fairly and alike requires one of two approaches: either a reimbursement formula based on a limited reasonable charges theory must be adopted or a formula similar to the so-called 1966 Miller Amendment which passed the Senate, with the support of many of the Members of this Committee, must be enacted. As you know, the 1966 Miller Amendment was watered down substantially in the Senate-House conference. It did very little for non-proprietary institutions. The Department of Health, Education, and Welfare by its interpretation of equity capital has made it meaningless for proprietary nursing homes. It has done this by subtracting depreciation from the equity a proprietor builds in his facility. The result is that even though the mortgage on a $500,000 nursing home, for example, had been paid off over the period of the life of the mortgage, the 7½ percent of equity capital could be 7½ percent of nothing if whatever equity is built up is taken away by depreciation.

The concept of reasonable cost reimbursement should be discarded. In its place there should be a formula based upon reasonable and customary charges for private paying patients in the particular area. There is only one answer to the spiraling hospital costs and that is greater use of nursing homes and extended care facilities. As you know, the nursing home program undertaken a few years ago by the Veterans Administration has been eminently successful. It has aided in curtailing health costs in the Veterans program.

At the present time, the Veterans Administration has a reimbursement formula based on 33⅓% of hospital cost of the Veterans hospital in the area. There is presently pending a bill in Congress to increase this rate to 45%. This is a recommendation of the Veterans Administration.

Therefore, Mr. Chairman, I am asking this Committee to undertake a consideration of a reimbursement formula based upon reasonable charges. I realize, however, that this cannot be done overnight and that, therefore, while such an approach is being studied, we must attempt to improve upon what we have. I urge this Committee to revise the present reimbursement formula along the following lines:

(1) Reasonable costs for extended care facilities should include a return on the greater either of cost or the current fair market value of the facility determined in accordance with the principles of the American Institute of Appraisers or similar appraisals sufficient to attract capital investment.

(2) In determining reasonable costs, the Secretary should consider, among other things, the need of extended care facilities for

a. Replacement of plant and equipment.

b. Modernization and growth, specifically provisions through earnings for the long range amortization of the principal of indebtedness incurred to finance modernization and growth.

c. Research and comprehensive health planning.

d. Reasonable rentals and reasonable interest-type returns on properties and money capital where supplied by the providers.

e. Provisions for uninsurable risks and others business-type responsibilities where these cannot be shifted and are borne by proprietors and

f. The payment of a return greater than that customarily paid to public utility companies because of the recognition that extended care facilities operate in a competitive field.

g. The Secretary should also consider the customary charges prevailing in the area for private paying patients.

(3) Insofar as any of these factors are applicable either to proprietary or to nonprofit facilities, the Secretary should consider such factors in determining reasonable reimbursement for proprietary and for non-profit facilities, notwithstanding the fact that such application may result in different reimbursement for one type of facility than for the other.

(4) In determining a reimbursement formula and allowance for costs, all legitimate business expenses or costs (including but not limited to compensation to owners) should be allowed in accordance with the regulations of the Internal Revenue Service and Armed Services Procurement Regulations. Services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control should be includable as an allowance for cost at the cost to the provider as long as the charge by the supplier is in line with the charge for such services, facilities or supplies in the open market and is no more than the charge made under comparable circumstances to others.

(5) The Secretary shall develop contractual methods to be offered to providers on a voluntary basis for the purpose of encouraging operating efficiencies without sacrificing high standards of health-care.

It is my contention that were the present formula amended to include the above, then the inadequacies of the present cost plus formula (which permits little or no profit to proprietary facilities as well as no true growth factor to non-proprietary facilities and which, therefore, is unable to meet the great need for nursing home beds) would be overcome and funds for the construction of nursing home beds would be available.

Mr. Chairman, in testimony before this Committee on Tuesday, August 22, of this year, Social Security Commissioner Robert M. Ball urged the reinstatement as a part of H.R. 12080, Section 129, Part 3 of H.R. 5710, as found on pages 57–62 of the Bill. In addition, Senator Anderson has introduced S. 283 which deals with the same subject matter, namely, the coordination of Medicare reimbursement with State Health planning which would make planning mandatory and which would require the funding of depreciation.

At an appearance before the House Ways and Means Committee, we testified at length in opposition to this proposal. ANHA takes exception to including nursing homes that are of a non-governmental character and whose coming into existence was not nor is not owed to public monies under requirements similar to those of Section 129 because:

(1) Such a requirement would have the effect of depriving the privately financed facility, both proprietary and non-proprietary, of their own capital; and

(2) Nursing homes do not now utilize and therefore do not compete for costly but highly specialized equipment.

We will not read this testimony today; however, we do ask that our testimony before the House Ways and Means Committee be accepted by this Committee as part of our statement today and, thereby, be made a part of the record of these hearings.

As stated previously in my testimony, even the present depreciation factor is inadequate to retire indebtedness. If even this factor were funded, there would be no hope of making mortgage payments and, in fact, no monies would be available for mortgages.

Earlier we testified that (1) the reasonable cost formula under Title XVIII was a formula which was difficult to apply to nursing homes because it was designed to apply to hospitals; and (2) that our problem was not entirely with the basic legislation but with the interpretation given by HEW; and (3) that these were combining to threaten the continued existence, let alone the expansion of nursing homes who were providing vital services at a saving of millions of dollars to Government and to the individual. We are submitting copies of correspondence which was had between a vice-president of ANHA, Mr. Harold G. Smith of Louisiana, and Mr. Thomas Tierney, Chief, Bureau of Health Insurance, Social Security Administration. We ask that these be made a part of the record of these hearings. We ask that this be done because this correspondence vividly underscores what we have said earlier.

The Bureau of Health Insurance is having difficulty understanding how the Title XVIII formula applies to nursing homes. As you will note, Mr. Smith addessed his questions, which go to the essence of the problem of cost reimbursement, to Mr. Tierney on 22 June 1967. Mr. Smith did not receive a reply until 5 September 1967, 2½ months later. It is our understanding from conversations with the Bureau that several attempts were made to answer these printed questions, but had to be discarded.

Mr. Chairman, what is the provider to do with this formula when the Bureau is unclear as to what to do under it?

On the first page of his reply, Mr. Tierney writes:

> . . . . "where intermediaries have effected a settlement with a provider based upon the reimbursement principles and guidelines issued or where they have exercised sound judgement in applying generally accepted accounting principles in areas in which detailed implementing instructions or interpretation of the reimbursement principles were not available, the intermediary's decisions will be acceptable and will be supported by the Social Security Administration."

But on the last page of his reply, Mr. Tierney writes:

> "Where a fiscal intermediary 'allows' certain or all costs at the end of the year in the 'retroactive process', and subsequently there is a disallowance of certain costs, the resulting liability would be the responsibility of the provider."

This, it seems, adequately describes the plight in which nursing homes find themselves.

On page 2, Mr. Tierney writes that:

> "Higher charges to post-hospital extended care facility patients may not be made over regular nursing home patients for routine services in order to recover higher costs where a facility has been certified in its entirety. With respect to routine services, it is the Administration's position that all patients in the extended care facility are considered to receive the same level of services (extended care)."

On page 3, in reply to Question 6, Mr. Tierney writes:

> "Expenses incurred by a provider in meeting the standards of participation cannot be allocated directly to the program. The program will pay only its proportionate share of total patient care costs in the extended care facility. If the costs of care are higher because of the higher requirements of the program, the program will pay its part of the higher costs."

Thus, if the standards of the Medicare program require the services of a Physical Therapist (as it does) and this therapist is required for the 20 Medicare patients in the 100 patient facility, the program will pick-up only ⅕ of the costs of providing the physical therapist and either the provider or the other non-Medicare patients will assume the other 4/5ths of the cost.

On page one, Mr. Tierney writes:

> "The year-end settlement process may not necessarily involve the specific steps outlined in your letter. The method for determining 'reasonable costs' as a limitation of actual costs has not been developed as yet and it is in this process that several of the steps you listed are involved."

Again, on page 5, he writes:

"We appreciate your concern with the issues relating to the reimbursement of the providers of the care. It is recognized that there are important issues which have not as yet been resolved and our staff is working to develop the most equitable solutions to these problems that it can."

Mr. Chairman, the ECF program began on January 1 of this year. It is now nine months later. This program was enacted on July 30, 1965. It is now better than two years later.

In the two years that have elapsed since Medicare was enacted, there have been many directives from SSA as to how we shall provide services but not one page as to how the provider shall finally be reimbursed for his services. Is it not reasonable, therefore, that we should oppose any amendment to Title XIX which would require "reasonable costs" as the method of reimbursement under that program?

As we read the provisions of the Moss Amendment (No. 204), it does not provide for "reasonable costs" for nursing homes. The original Moss Bill did provide for amending Section 1902(a) (13) (B) so as to require the States to pay "reasonable costs" to nursing homes. Although the language beginning on line 24 of page 4 of the Amendment No. 204 amends Section 1905 and refers to nursing homes, it does not amend the basic section on reasonable costs, Section 1900(a) (13) (B). If it is intended to, we are opposed to it.

As I have stated, the "reasonable cost" formula developed by HEW under Title XVIII is not satisfactory and is unworkable. We believe that the states should be allowed to experiment with various reimbursement formulae. After all, the states fund a substantial portion of the Title XIX program whereas they do not the Title XVIII program. If a reimbursement formula has not worked out satisfactorily in the Federal area, then it should not be hastily forced on the States.

On behalf of the American Nursing Home Association, I wish to thank you for the privilege and opportunity of appearing before this Committee, and for your consideration of these views.

APPENDIX NO. 1

REMARKS BY THE AMERICAN NURSING HOME ASSOCIATION IN TESTIMONY BEFORE THE HOUSE WAYS AND MEANS COMMITTEE ON SECTION 129, PART 3, H.R. 5710, WHICH REMARKS ALSO APPLY TO S. 283 (INTRODUCED BY SENATOR ANDERSON (NEW MEXICO), "GRANTS TO STATES FOR PLANNING TO MEET NEEDS FOR HOSPITALS AND OTHER HEALTH-CARE FACILITIES"

"Turning our attention, therefore, to Section 129, Part 3, let me state at once that the American Nursing Home Association takes exception to including under this Section's requirements nursing homes that are of a non-governmental character and whose coming into existence either was not or is not due to public monies.

"There is universal agreement among accountants that depreciation is an item of operational cost. Further, the record of testimony concerning the reimbursement formula for Title XVIII is characterized by almost complete accord that depreciation should be an includable item of cost.

"We are, therefore, confronted with a situation wherein the Department of Health, Education, and Welfare is saying in effect that even though an allowance for depreciation is a bona fide cost item, it shall be allowable only if it is mandatorily funded and its expenditure made subject to the decisions of a planning agency.

"There then arises the following question: If, as is universally agreed, depreciation is a legitimate reasonable cost item, under what circumstances then can the funding of depreciation be justifiably made mandatory and placed, so to speak, at the community's disposal.

"The American Nursing Home Association submits that if it is at all possible to justify the mandatory funding of depreciation, it can be justified only when the item being depreciated was purchased with community funds in the first instance.

"According to a Public Health Service Survey* published in June 1963, 87 per cent of all nursing homes in the United States are proprietary whose existence was not the result of Federal or other public monies. Eight per cent of America's nursing homes are non-profit church affiliated institutions all but a few of whom were likewise built with private funds.** The remaining 5 per cent are community-

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*National Center for Health Statistics, Series 12, #1.

**Between 1962–1966, only 400 nursing homes were constructed with Hill-Burton funds at an average cost of approximately $13,000/bed. This is to be contrasted with an average cost of $7–8,000/bed in nursing homes constructed with private capital.

owned facilities built with public monies. Therefore, approximately 95 per cent of all nursing homes in the United States were constructed with private capital.

"It is our contention that if not all nursing homes, then at least those whose construction was not owing to public funds should be removed from the requirements of Section 129, Part 3.

"Let me emphasize at this point that the American Nursing Home Association has supported and supports the general principle of the traditional areawide planning that has heretofore existed. However, let me emphasize even more strongly that the American Nursing Home Association is not prepared to support the radical change in the approach to areawide planning that is embodied in H.R. 5710, namely, that areawide planning be placed in the hands of a ". . . State Agency (designated by the State) which (A) provides for health-care facility and equipment planning *in all political subdivisions of the State. . . .* (B) *coordinate* its activities with other agencies engaged in health service planning and participates in (an) *interstate and regional health-care facility program. . . .(or provides reasonable assuranc that it will oordinate)*"[1] (pp. 60-61, H.R. 5710).

"Mr. Chairman and Members of this Committee, if we read pp. 60 and 61 correctly, then where heretofore areawide planning has been voluntary, community-staffed and community-oriented it now shall become mandatory, implemented from the State Capitol and ultimately directed from some regional headquarters embracing several states within its jurisdiction, presumably an HEW regional headquarters, since such is the only presently in existence.

"Mr. Chairman and Members of this Committee, ANHA is not prepared to surrender county and municipal authority, much less a state's autonomy. As representatives of congressional districts which contain counties and municipalities and as representatives of a particular state, we do not believe that you are prepared to do so either.

"However, assuming for purposes of clarification that you may be so prepared, ANHA respectfully submits that the factors which make planning desirable do not at this point in time apply to nursing homes in general.

"The factors frequently put forth to support planning are summarized and included in the Section-by-Section Analysis of H.R. 5710 as prepared by HEW and I quote therefrom on page 28:

> 'Unnecessary duplication and inefficient use of health care facilities and equipment is wasteful in terms of public moneys and scarce health personnel and is a significant factor in the accelerating costs of health care.'

"Again, Secretary Gardner in his statement before this Committee on Wednesday morning last stated on page 31 as follows:

> 'None of us wishes to see these Federal funds utilized in competitive drives to put a radio-isotope laboratory, a cobalt bomb for cancer treatment, facilities for open-heart surgery, or other costly but highly specialized equipment in every hospital, large or small, regardless of practical requirements.'

"I would like to point out (1) that the 95 per cent of nursing homes referred to above do not compete for Federal funds nor for public monies; (2) that nursing homes do not utilize, let alone compete, for costly but highly specialized equipment; (3) that the scarce health personnel for whom nursing homes compete are primarily nurses. In respect to these, ANHA submits that the solution to this problem is not to compel funding of depreciation, but rather to embark upon programs which will increase the number of nurses and supporting nursing personnel. I will return to this problem later in my remarks.

"Before leaving this provision in H.R. 5710, I would like to add to these remarks quotes from The Executive Proceedings of The Senate Committee on Finance Discussing Proposed Hospital Insurance Reimbursement Guidelines With Officials of The Department of Health, Education, and Welfare, May 25, 1966, as found on page 102 of the Committee Print and ontained within Mr. Ball's Commentary On Analysis Prepared By Staff of the Committee on Finance "Proposed Medicare Reimbursement Formula". The quote is as follows:

> 'Funding is desirable in principle and consideration of enacting of legislation to make it a requirement appears warranted. *There are certain issues with regard to compulsory funding that would have to be studied. Proprietary institutions are a special problem since compulsory funding may be considered to have the effect of depriving the proprietor of his own capital*[2]—capital may have been invested in a used-up asset and returned in the form

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[1] Emphasis supplied.

[2] Emphasis supplied.

> of depreciation, but he would be unable to recoup his investment which would be tied up in a fund. . . .'

"Mr. Chairman and Members of this Committee, I submit, with all due respect to Mr. Ball, that not because Mr. Ball, himself, says so but because elemental justice requires it that the proprietor of an institution which was not constructed with Federal or other public monies should not be denied the use of his own funds as would be the case if the proposed Amendments to Section 129, Part 3, as presently found in H.R. 5710 were to be enacted.

"I am not at all certain that even when the facility was constructed with public monies that Section 129 should be enacted. A further examination of the record of the hearings of the 89th Congress reveals a continued reluctance on the part of HEW to require funding of depreciation. Let me quote again Mr. Ball from the same source as above:

> '. . . Few localities now have effective planning organizations. A requirement that there be effective planning before funds could be spent might tie up the depreciation—funds of much of the hospital system until a network of acceptable planning agencies is brought into existence. It should also be noted that a requirement of funding does not mean depreciation funds will constitute the major source of capital; in Cleveland, one of the few areas where such a requirement has existed for many years, *over a 10-year period capital expenditures were 4.3 times total funded depreciation.*'[*]

"The inclusion by HEW of mandatory funding in the present H.R. 5710 represents a significant change in the thinking of HEW from what it was in May 1966, less than 10 months ago—and even less than that if one were to assume that H.R. 5710 was months in preparation.

"Mr. Chairman and Members of the Committee, objectivity has always required that when one puts forth a proposal embodying a change in the status quo, that he submit along with such proposal the need for the proposed change and the factors which have caused the change in his thinking.

"Is it improper for us to inquire whether there now exist many localities that have effective planning organizations when only 10 months ago few such localities existed?

"Is it improper for us to inquire whether there now exists a network of acceptable planning agencies when only 10 months ago no such network existed; whether, therefore, there no longer exists the danger that the depreciation funds of much of the hospital system might be tied up because of the lack of such a network existed; whether, therefore, there no longer exists the danger that the depreciation funds of much of the hospital system might be tied up because of the lack of such a network when only 10 months ago such a danger clearly existed?

"Is it improper for us to inquire whether the prolonged experience of Cleveland which demonstrated that funded depreciation was not a deterent to capital expenditure is no longer demonstrable and significant when only 10 months ago it was singularly so?

"In short, is it improper for us to inquire if Section 129 does not indeed represent a reach for excessive authority on the part of HEW that is at least premature if not entirely unwarranted?

"In summary, then, the American Nursing Home Association takes exception to including nursing homes that are of a non-governmental character and whose coming into existence was not nor is not owed to public monies under the requirements of Section 129 because:

> 1) Such a requirement would have the effect of depriving the proprietor of his own capital;
>
> 2) Nursing homes do not now utilize and therefore do not compete for costly but highly specialized equipment; and
>
> 3) The solution to the problem of scarce health personnel, namely, nurses, for which nursing homes do compete is in no way related to the mandatory funding of depreciation."

The CHAIRMAN. Senator Gaylord Nelson is with us. He is busy with other committee activities elsewhere. He came here to introduce one of our witnesses, and I would propose that Senator Nelson introduce the witness. Senator Nelson has been doing some very fine work investigating matters relating to drugs, quality, pricing, and we hope to

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[*] Emphasis supplied.

benefit from some of the work that he has been doing in this field as we undertake consideration of this bill.

Senator Nelson, we are pleased to have you.

STATEMENT OF HON. GAYLORD P. NELSON, A U.S. SENATOR FROM THE STATE OF WISCONSIN

Senator NELSON. Mr. Chairman, Senator Anderson, I appreciate your courtesy, since I do have some other commitments.

Mr. Chairman, the witness leading this panel, Dr. William S. Apple, has been a close friend of mine for some 20 years. He is the very distinguished executive of the American Pharmaceutical Association.

Prior to coming here he was head of the department of pharmacy at the University of Wisconsin. He is also president of the American Council on Pharmaceutical Education.

He is a representative of the U.S. pharmacists on the Council of International Pharmaceutical Federations. He has received a great number of distinguished honors and I would ask the chairman, in order to avoid repeating all of the biographical credentials, if the list could be inserted in the record prior to Dr. Apple's testimony. I am very pleased to have the opportunity to introduce this very disguished authority.

The CHAIRMAN. Will you make that available to me, Senator Nelson? I would like to know about Dr. Apple's credentials, which are very impressive. Thank you very much, and I will see that this is made a part of the record.

(The biographical sketch of Dr. William S. Apple follows:)

BIOGRAPHICAL SKETCH WILLIAM S. APPLE, PH. D., EXECUTIVE DIRECTOR, AMERICAN PHARMACEUTICAL ASSOCIATION

William S. Apple, Ph. D., Executive Director of the American Pharmaceutical Association, grew up, was educated in and has spent his working life in the profession of pharmacy.

Dr. Apple is serving his third term as the elected administrative official of the national professional society, having been elected to the APhA post first in 1959, and re-elected for another three-year term as Executive Director in 1962 and 1965. He served in the APhA Headquarters as Assistant Secretary from 1958 to 1959.

Born in Spokane, Washington, in 1918, Dr. Apple was reared in Duluth, Minnesota. He attended Wayne State University and then transferred to the University of Wisconsin. It was at Wisconsin that he received his Bachelor of Science degree in Pharmacy, his Masters degree in Business Administration and his Doctor of Philosophy degree. He continues his pharmacy registration in Wisconsin, where he was both a practitioner and consultant.

He served as Head of the Department of Pharmacy Administration at the University of Wisconsin prior to assuming his APhA duties in Washington. Active in Wisconsin pharmacy activities, Dr. Apple served as Vice-President, President and Chairman of the Board of Directors of the Wisconsin Pharmaceutical Association.

Dr. Apple entered the U.S. Army in 1941 as a Private and rose to the rank of Lieutant Colonel. He served on the staff of Fleet Admiral Nimitz in the Pacific Theater.

Dr. Apple is President of the American Council on Pharmaceutical Education. He is a Charter Board Member of Community Health, Inc. He is the Representative of United States pharmacists on the Council of the International Pharmaceutical Federation and a member of the Board of Directors of the American Association for World Health, Inc. and the U.S. Committee for the World Health Organization. He represents the National Health Council on the American Association of Junior Colleges–NHC Committee on Health Technology Education.

Until recently, he served several terms as Vice-President and a member of the Executive Committee of the NHC. He is Chairman of the Pharmacy Committee on Public Health Service Medicare Traineeship Program.

His professional and honorary society memberships include Phi Lambda Upsilon, Rho Chi and Phi Kappa Phi. His awards include: *American Druggist* Man of the Year (1960), J. Leon Lascoff Memorial Award (1961), Rho Pi Phi Man of the Year (1961), Colegio de Quimico Farmaceuticos de Chili (1961), Wayne State University Distinguished Service Award (1962) and the Hugo H. Schaefer Medal (1966). The University of Wisconsin recognized his "eminent professional services" in 1965 with its Citation, and the University of Long Island awarded him a Doctor of Science (Honorary) degree in 1966. He has been named recipient of the 1967 Remington Honor Medal, presentation of which is scheduled for November 29, 1967, in New York.

His home is in Falls Church, Virginia, where he resides with his wife, the former Lucille Josephs. Mrs. Apple, like her husband, comes from a pharmacy family.

The CHAIRMAN. Now we will hear from the American Pharmaceutical Association. We will hear from Dr. Apple.

Dr. Apple, before you begin your testimony, I want to take this opportunity to thank you publicly for the very fine advice and assistance that the American Pharmaceutical Association has given to me and the members of the staff of this committee, in trying to procure high-quality drugs at reasonable prices. I think that all pharmacies can be proud of the fine job that you and members of your association are doing.

STATEMENT OF DR. WILLIAM S. APPLE, EXECUTIVE DIRECTOR, AMERICAN PHARMACEUTICAL ASSOCIATION, ACCOMPANIED BY ROBERT F. STEEVES, DIRECTOR, LEGAL DIVISION, AMERICAN PHARMACEUTICAL ASSOCIATION, AND DR. EDWARD G. FELDMANN, DIRECTOR, SCIENTIFIC DIVISION, AMERICAN PHARMACEUTICAL ASSOCIATION

Dr. APPLE. Thank you, Mr. Chairman.

For the record, I am Dr. William S. Apple, director of the American Pharmaceutical Association, accompanied by Dr. Edward G. Feldmann, the director of our Scientific Division, and Mr. Robert F. Steeves of our Legal Division.

The CHAIRMAN. You referred to your group as doctors. May I ask what degrees those include?

Dr. APPLE. These are Ph.D.'s, Mr. Chairman.

The CHAIRMAN. In pharmacy and pharmaceuticals, Ph.D.'s in what field?

Dr. APPLE. In the field of pharmacy, yes, sir, pharmaceutical chemistry in the case of Dr. Feldmann.

The CHAIRMAN. Thank you very much.

Dr. APPLE. Mr. Chairman and members of the committee, we are pleased to have this opportunity to present our views of the Nation's pharmacists on the social security amendment and the proposals relating to drugs. The American Pharmaceutical Association is the national professional society of pharmacists composed of individual practicing pharmacists, pharmaceutical educators, scientists and technologists, and pharmacy students. Our total membership is about 45,000.

The American Pharmaceutical Association was founded in 1852 and the first objective in its constitution states it shall exist for the following purpose:

> To improve and promote the public health by aiding in the establishment of satisfactory standards for drugs, and to aid in the detection and prevention of adulteration and misbranding of drugs and medicines, and to take such steps as an Association and in cooperation with other organizations as will assure the production and distribution of drugs and medicines of the highest quality.

There is universal agreement in our country today that prescription drugs are an essential element of modern medical care. Congress has underscored its acceptance of this fact in recent years by enacting a number of statutes to both improve the quality and expand the availability of prescribed medication. While others are disturbed by the continuing interest of Congress in the quality, availability, or cost of drugs, we welcome congressional interest because we still believe that what is best for our country and its people will continue to be good for the profession of pharmacy.

We urge this committee to adopt amendment No. 266 which concerns itself with the Federal expenditures for drugs and pharmaceutical services in existing Government-supported programs. We urge adoption because the amendment provides a more rational basis for prescribing and a more equitable basis for reimbursement for pharmaceutical services than exists today in most Government-supported programs.

There is an obvious distinction between Government-supported and Government-operated programs for the general public. Federal financial support for programs which benefit deserving or needy segments of society can strengthen our competitive enterprise system, but Government-operated programs can have the reverse effect. For example, private practicing pharmacists today are being denied the opportunity to serve Veterans' Administration and Office of Economic Opportunity beneficiaries.

We strongly support the "freedom of choice" principle incorporated in amendment 266 and which also appears as section 277 of the House-passed social security bill (H.R. 12080). The Senate on several previous occasions has adopted similar provisions. Senator John J. Williams of Delaware sponsored the last such amendment adopted by the Senate when H.R. 6675 was under consideration in the 89th Congress. At that time, the House did not concur. Since the House now has incorporated the provision in its own proposal, the Senate has the opportunity to make sure that its original recommendation is enacted.

This "freedom of choice" provision will assure that what Congress intends to be a Government-supported program does not become a Government-operated program.

Amendment 266 does not prescribe a procedure whereby drugs and pharmaceutical services are to be dispensed by the Government. On the contrary, the amendment only delineates the nature and extent of Government support for privately operated programs.

For the past few months, we have been participating in the workshops and discussions conducted by the Department of Health, Education, and Welfare's task force on prescription drugs. On May 31, 1967, Secretary Gardner, in announcing the establishment of the task force, stated: "The task force has no prior commitment to recommend for or against the inclusion of prescription drugs in the medicare program."

Amendment 265, not 266, is concerned with covering prescription drugs for medicare beneficiaries outside the hospital. Our association has already gone on record in support of adding drugs and pharmaceutical services to part B of title XVIII. The mission of the task force is directed toward the objective of 265, not 266. We emphasize this because drugs and pharmaceutical services are now covered—and have been covered—under several other titles of the Social Security Act, including titles XVIII-A and XIX.

Amendment 266 does not extend this existing coverage for drugs and pharmaceutical services to any new categories or recipients. It does make a rational attempt to deal with the great cost variances between many drugs containing identical therapeutic ingredients. We support amendment 266 because one of its virtues is that it provides a mechanism for handling the controversial issues of quality versus cost and brand name versus generic name. Under amendment 266, these issues will be transferred from the political arena to a committee of distinguished medical and pharmaceutical authorities. We think this makes good sense and, perhaps, is the only hopeful way of resolving the differing viewpoints intelligently.

The controversy over the equivalency or lack of equivalency of comparable drug products containing the same therapeutic ingredients involves highly complex and sophisticated considerations that can best be evaluated by a panel of experts. Congress chose this same route in 1965 in establishing controls over stimulant and depressant drugs.

The Commissioner of Food and Drugs, and authorities in the medical and pharmaceutical sciences, seem generally agreed that the likelihood is remote that a drug product meeting the established standards under Federal drug laws will not preform clinically as expected. Compliance with the established standards of potency and purity can be determined by laboratory analysis.

Literally, there has been a raging controversy in this country for more than a decade over the cost and quality of drugs. Because of the intense interest in these subjects shown by Congress and the public, we believe that conclusive evidence would be available showing a lack of clinical equivalency of drug products which meet established standards—if it existed.

We agree with Senator Russell Long that quality of health care should not be sacrificed for economic considerations. Some witnesses have suggested that quality might be sacrificed for economy under amendment 266, unless comparative equivalency of all drug products currently on the market is established by clinical testing. We do not agree. We seriously question whether this country should utilize its limited scientific manpower for this purpose and thereby risk postponing the discovery of new drugs, such as those that could mitigate or even eradicate the scourge of cancer, just to settle what is basically an economic controversy.

The Congress is well aware of the critical health manpower situation which now exists in our country. The shortage is most acute among clinical pharmacologists who are qualified to test drugs. The few who are qualified are hardly motivated to expend their precious time settling economic arguments when they could be devoting themselves to unlocking the secrets of medical science for the benefit of mankind.

There is also the ethical and moral consideration of using human beings to settle a controversy of this character, especially when less costly procedures are available. For example, we have not taken full advantage of all the data already being generated. FDA's adverse drug reaction reporting program could be developed into a much more sophisticated and useful system for analyzing clinical performance of all marketed drugs without further exposing a single patient.

If a drug or a drug product did not perform as expected, FDA could transmit this information to the Formulary Committee established by amendment 266 while also initiating appropriate corrective action. Such a system would benefit all patients by providing a continuous monitoring of the vast quantities of drugs used in actual clinical practice.

We have followed the testimony presented by representatives of the Administration and can only conclude that they must have misunderstood the purpose, operation and impact of amendment 266. In fact, we think that this amendment parallels very closely provisions of existing law which Administration witnesses supported in prior years.

Under title XVIII of the Social Security Act, we have some 5,000 formulary systems in operation governing the use of drugs in hospitals for medicare beneficiaries. The basic drug list in section 1861(t) of the present medicare law (Public Law 89-97) is, for all practical purposes, the same as that proposed in amendment 266.

We do not see the question of deciding which therapeutic agents to include in the Federal Formulary as a formidable task. Expert committees of the official compendia regularly make and have made similar decisions for more than a century. The American Pharmaceutical Association carries on the revision and publication program of one of these compendia—The National Formulary.

On the effective date of amendment 266, payment would automatically be authorized for more than 1,000 of the most significant drugs for human medical use. The Formulary Committee could then add or delete drugs from the basic list, as it found necessary. There is no requirement in the amendment that every drug and drug product on the market be reviewed. When a question arises, the burden of proving the rationale for subsequently adding a drug or drug product would be on the advocate.

This concept already bears congressional sanction in medicare. The pharmacy and therapeutics committee of a hospital serving medicare beneficiaries may add any additional drug or drug product to those already included in the official compendia and other drug books listed in section 1861(t), but there is no requirement that additions be made.

We have asked our affiliate, the American Society of Hospital Pharmacists, to submit a detailed statement to the committee explaining the organization and operation of the hospital formulary system as it exists in thousands of hospitals today.

Under title XIX of the Social Security Act, several public assistance programs also utilize a formulary-type system. Many incorporate such provisions as the maximum amount of the drug that can be prescribed and the maximum allowable cost basis for generic or non-proprietary drugs. Originally, many of the States went into formulary-type systems without adequate medical and pharmaceutical consultation. More recently, States have relied on the expert advice of the medical and pharmacy professions.

Many States have found that formulary-type systems permit them to gain better control over drug expenditures and to simplify the administration of their drug programs.

Under present law, we have many people with limited access to information involved in establishing formularies. For example, we have thousands of hospital formularies and 50 potential formularies for State public assistance programs. We submit that the committee of distinguished medical and pharmaceutical experts envisioned by amendment 266, with the resources and information of the Public Health Service, the Food and Drug Administration and the National Institutes of Health, can do the job more effectively and efficiently. States and hospitals could utilize the work of the Federal Formulary Committee in developing regulations for their own health care programs.

If a drug furnished a medicare beneficiary in a hospital does not meet the criteria of section 1861(t), no payment is made under present law. Amendment 266 proposes a more equitable and less compulsory approach.

As we read amendment 266, if a State public assistance program authorized a drug or drug product costing more than the Federal Formulary allowance, the Federal Government would still contribute its share of its established reasonable cost. This is certainly less complicated than some of the existing procedures in State public assistance programs. In the State of Illinois, for example, the attending physician, after having tried the drugs listed in the Illinois Drug Manual, must submit a written request with supporting medical facts to the Illinois State Medical Society for approval to use a nonlisted drug or drug product.

If a State public assistance program provides a drug that has not been included in the Federal Formulary, no payment will be made. However, exclusions or denial of requests for inclusion of drugs in the Federal Formulary would not be arbitrary. Amendment 266 provides for judicial review. We would support a change in the language of the amendment so that the judicial review process parallels that incorporated in the Food and Drug Act for stimulant and depressant drugs.

We realize that the Food and Drug Administration today cannot guarantee the absolute safety and efficacy of our Nation's drug supply. This may shock the public, but it comes as no surprise to us. We doubt that there can ever be an absolute guarantee of safety and efficacy. Errors do occur in the manufacture and distribution of drugs, as they do with other products. The use of drugs, however, dictates that we constantly strive for zero defects, and a number of recently initiated programs are demonstrating that where there is the will there is a way.

For example, FDA has an increasingly effective surveillance program to identify drug products that do not meet established standards. All concerned are working with FDA to make its program to remove these products from the distribution system more effective.

The fact is that with the passing of each day we are achieving more confidence in the Nation's drug supply. We can discuss the matter of quality more knowledgeably and intelligently, and this permits us to move ahead and discuss cost considerations with proper concern for—but not fear of—quality considerations.

We are not, as a Nation, yet prepared to assure every individual of optimal medical care. What is a heroic medical procedure in some rural hospital may be routine at Charity Hospital, Johns Hopkins, or the Mayo Clinic. While our goal is ever higher levels of medical care for all citizens, our manpower and fiscal resources are not unlimited and our systems require further perfection.

Just recently, a young girl died in this city because the medical team treating her could not obtain the money to finance treatment with an artificial kidney machine. Periodic treatments would have saved her life and a machine was available in another hospital in this city. But, reports indicate that this treatment would have cost $12,000 per year.

This example is certainly more dramatic than the usual case with drugs, though we have all heard of instances where rare, expensive drugs have been flown to a patient in need, free of cost, by a pharmaceutical manufacturer. But, in the case of drugs, the argument appears to be that we must pay whatever cost charged—reasonable or unreasonable—for the drug product the physician selects without regard to the alternatives—whether rational or not—on the theory that perhaps some other drug or brand of drug might not work. And we are expected to accept this thesis notwithstanding the apparent lack of scientific support.

Under amendment 266 the scientific judgment to pursue such a policy with a given drug would be vested in the committee of distinguished medical and pharmaceutical experts. If this panel has reasonable evidence to suggest that the therapeutic effect or quality would vary among various products of a given drug, amendment 266 provides that all such products may be included. Yet, where the evidence suggests that a lower cost product will perform as well as the highest cost product, the Government and taxpayers would not be committed to share the additional costs incurred.

We see no substance to the argument that amendment 266 would curtail incentives for medical and pharmaceutical research. In order to arrive at such a conclusion, one must assume that the 17-year patent protection does not exist or is not long enough to provide the economic incentive that it has provided in the past. The formulary system approach in medicare and its wide acceptance by hospitals has not, to our knowledge, decreased the incentive for pharmaceutical research. In fact, the importance of having a unique, single source, patent-protected product in a Government-supported program might actually provide an increased incentive.

The Congress has an opportunity, through amendment 266, to help the Nation's physicians carry out the American Medical Association's policy of "supplementing medical judgments with cost considerations" in prescribing drugs for their patients. Physicians are turning to pharmacists for information and guidance about the differences in cost between brands of the same drug as well as the differences in cost between brands and generics.

Under present law, every batch of antibiotics is certified by the Food and Drug Administration. As a result of recent competition, the price differential between brand and generic antibiotics is rapidly disappearing. Congress now has the opportunity through amendment 266 to promote a similar result for many other drugs.

The evolution is already in progress in the marketplace to eliminate significant price differentials between brand and generic name drugs.

First, a number of drugs which has enjoyed patent protection in the past have proven themselves as the "drugs of choice" in treating certain conditions. After the patent expires, lower cost products by other firms become available, especially when the original manufacturer maintains the earlier pricing level. These lower cost products sometimes come from the most well-known pharmaceutical houses in the country. Merely because the patent period expires does not make the basic drug any less useful in medical practice and, hence, considerations of cost become significant.

To us, it does not make sense that the Government would commit itself to paying the cost of a higher priced product under these circumstances. In fact, the higher priced product might only find a market where the Government, or insurance, or someone other than the patient, was paying the bill.

Second, medical experts have testified for generic prescribing and emphasis on generic names of drugs to improve patient treatment and medical care. Sometimes, a physician will prescribe a different brand of the same drug without knowledge that he is, in fact, prescribing the same drug. Allergies, contraindications, and side effects also are more easily considered in relation to generic terminology than through brand name designations.

Third, we fully expect that pharmacists—the professional practitioners trained in drug information and action—will have greater participation in helping prescribers select appropriate drug therapy in the years ahead. We fully expect that pharmacists will prefer, and will encourage the medical profession to utilize the scientific terminology of established names. We firmly believe that a pharmacist can provide greater help, more objective help, in drug selection at less cost than the various sales promotions of the pharmaceutical firms. The pharmacist is available at the time the selection is being made—as close as the telephone—and has frequent contact with prescribers in his community and a familiarity with a wide range of drugs and drug products, not just those of a particular firm.

We do not condemn the brand name area in pharmaceuticals. It probably was of tremendous help in bringing the benefits of an explosive period in medical and pharmaceutical breakthroughs to the American people at a time when advances were very hard to assimilate rapidly. However, we do believe that we are now seeing the last vestiges of that era and, as pharmacists, we have no regrets over its demise.

We are pleased to see that amendment 266 envisions a professional fee for the professional services rendered by pharmacists. This association has advocated the professional fee as the preferred method of calculating remuneration for our practitioners for many years. Leading practitioners of pharmacy employ it in their daily practices; more and more States are incorporating it in their public assistance programs, and the Department of Defense has adopted it in its civilian health program for the uniformed services. For those who ponder whether the professional fee can be implemented nationwide on a State-by-State basis, the Champus program, currently operating, is a model for study.

The professional fee places the economics of our profession on an independent and rational basis. There is no relationship to the cost of the drug prescribed and the pharmacist's compensation is not tied to increases or decreases the manufacturer, wholesaler, or other distributor makes in the cost of the product dispensed. The pharmacist is also freed of personal, economic conflicts in assisting patients and prescribers in drug selection.

While some of our older practitioners still utilize the markup system, the transition to the professional fee in private practice will soon be completed. The benefits to the public are so obvious that the professional fee method commands the attention of anyone concerned with the cost of pharmaceutical services.

For illustrative purposes, let us assume that we have two pharmacists—one utilizing a $2 professional fee per prescription order dispensed and one utilizing a 40-percent margin. A prescriber orders two drugs for a patient—the first drug costs the pharmacist 60 cents and the second $18. If the patient obtains the drugs from the pharmacist on the professional fee system, the cost will be 60 cents plus $2, or $2.60 for the first, and $18 plus $2 for the second, for a total cost of $22.60.

If the patient obtains the drugs from the pharmacist on the markup system, the first would cost $1 and the second $30 for a total cost of $31. The pharmacist maintains the same records and perform the same services in each case yet the markup provides 40 cents in one case and $12 in the other.

Overall, a pharmacist should neither gain nor lose economically, regardless of which system is utilized. However, the markup system unduly aggravates the economic burden of patients who require the more expensive drugs and, at the same time, places the pharmacist in an impossible position to justify the charges for his professional services.

We also agree with and support the billing allowance concept for nonprescription drugs. This proposal takes proper note of the increased paperwork and costs involved in providing these drugs to public assistance beneficiaries. In some cases, these nonprescription drugs are essential to the proper treatment of the patient though not all States authorize payment for such drugs.

In summary, we support amendment 266 because we believe it will improve the quality of medical care for social security beneficiaries without increasing the cost of pharmaceutical service. We believe that the system established by the amendment can be administered fairly and successfully and that it will provide a stimulus for improving pharmaceutical technology and research.

We thank you for the opportunity to present our views.

The Chairman. Thank you, Dr. Apple.

As I understand it, years ago if you had a prescription you took it down to the drugstore and the pharmacist would get out his ingredients and make the thing up for you. He would tell you to come back or wait around while he mixed it up.

Nowadays these prescriptions all come ready prepared from different manufacturers; for the most part the pharmacist has a bottle of capsules there. It is his job to be sure that he does not give you the wrong thing—that he gives you what was prescribed by the doctor. Isn't that about the way it works for the most part nowadays?

Dr. APPLE. Yes, Mr. Chairman. The transformation in the last two decades has been one from a profession of manipulative skills to a profession of scentific knowledge. What we can provide with our brains becomes far more important than what we do with our hands.

We still do considerable compounding of some prescriptions that must be made up extemporaneously, but that is not the emphasis of our activity today.

The CHAIRMAN. But to be a Ph. D. in that field, as you and your associates are, you have to go to college and get a number of degrees, in order to know just what these drugs are and what they are made from, what their chemical components are.

Dr. APPLE. Our education has increased to the point where today it takes a minimum of 5 years and approximately 1 year of internship training to receive a license as a pharmacist. In some States our education minimum is 6 years.

I am sure, Mr. Chairman, and Senator Anderson, you can see that the emphasis is on what we know and how we can utilize that information as members of the medical team to improve the quality of health care.

The pharmaceutical industry has done a tremendous job of finding chemotherapeutic agents to attack specific diseases. We are zeroing in with bulls-eye accuracy on many diseases. I am sure you recognize that the more accurate you become in your shots, the more potent is their effect. Drug use today requires more care on the part of the person who prescribes them, on the part of the person who dispenses them, and on the part of the patient who utilizes them.

The CHAIRMAN. I have a pamphlet here from which I asked questions about the products of manufacturers. I think you recognize this, a listing of the proprietary names and trade names of official drugs, "To assist pharmaceutical educators, drug manufacturers, practicing pharmacists, and pharmacy students, as well as other members of the health professions in identifying drugs official in the United States Pharmacopeia XVII and National Formulary XII by their proprietary or other trade names," copyright 1965.

It has APA, American Pharmaceutical Association, 2215 Constitution Avenue NW., Washington, on it. Is that a publication of your association?

Dr. APPLE. This is the publication of the scientific division of our association; yes, sir.

The CHAIRMAN. Did you put this out to help doctors as well as pharmacists find out just what they are prescribing?

Dr. APPLE. Dr. Feldman can tell you about the calls we get from physicians and medical schools. They use the publication as a teaching aid in medical schools as well as in pharmacy schools.

The CHAIRMAN. Would you explain it?

Dr. FELDMAN. Mr. Chairman, I would direct your attention to the statement which appears on the front cover where it says "members of the pharmacy profession as well as other members of the health professions in identifying these drugs." That would include physicians and others.

The CHAIRMAN. I have had pharmacists, outstanding pharmacists in my State tell me that sometimes a doctor will write a prescription, and the patient will come over and the pharmacist will say that he might not have that particular product.

Looking on page 26, for example, here is a mouthfilling name testosterone, pellets, and sterile suspension NF (androgenic hormone). That goes under the names Andronaq, Andrusol, Malestrone, Mertestate, Neo-Hombreol-F, Oreton, Oreton Micropellets, Sterotate, Testobase Aqueous, Testosteroid, and Testryl.

I have been told by a friend of mine who is an outstanding pharmacist in Louisiana that if someone came in with a prescription for one of these names here, and he didn't have that, he might call the doctor and say, "Doctor, I don't have that here on the shelf but I have about four other products that are the same thing. There is no real difference in them." And the doctor would say, "Well, fine, you give him this one" or "Give him that one."

Are you familiar with those kinds of experiences of druggists who tell the doctor, "Doctor, we don't have that but we do have this manufactured by another manufacturer"?

Dr. APPLE. I think the pharmacist experiences that everyday.

The CHAIRMAN. And has it been your experience that with regard to that type of situation, that the chemical properties of those medicines would all be the same where they all appear under the same name.

Dr. APPLE. If I needed that particular drug, and the pharmacist or physician in conference decided to give me the one manufactured by Merck instead of the one made by Schering or Organon, I would have complete confidence in it.

The CHAIRMAN. In other words, Food and Drug should test all of these things, check them to make sure they are all what they are supposed to be. It is the job of the druggist to also have responsibility for what he buys, isn't it, to know he is not just buying something that is stirred up in a tub in a backroom or in a garage.

Dr. APPLE. Mr. Chairman, yesterday a witness before your committee indicated that the members of the Pharmaceutical Manufacturers Association manufacture and sell 95 percent of all the drugs, prescription drugs made. Since these are among the finest firms in the country, we are starting with 95 percent of our entire drug supply meeting the highest possible standards an industry can voluntarily achieve. Frankly, there isn't much left of our drug inventory that is being made about which we need be concerned.

The CHAIRMAN. So those people were testifying for 95 percent of all the drugs manufactured right there. Now as a practical matter, this fellow who manufactures some tablets can sit and claim his are the best. Do you think that anybody could continue to represent his drug firm if he said his aspirin wasn't as good as Bayer's?

Dr. APPLE. I will have to take the fifth amendment counsel advises me.

The CHAIRMAN. I have talked to some drug salesmen, and I think you can get a more frank answer from a former drug salesman than you can from one who is presently working for a drug company. My impression is what they try to do is make some rounds and leave free samples for the doctor and try to persuade a doctor that his line of drugs is the best—that the doctor ought to prescribe all of the Squibb products or prescribe all of the Merck products or prescribe all of the products of that particular manufacturer.

Dr. APPLE. He would be a poor salesman if he didn't try.

The CHAIRMAN. Doesn't a salesman who goes around speaking for one of these manufacturers undertake to try to sell the doctor the idea that his drugs are the very best and that you ought to prescribe his entire line of products?

Dr. APPLE. That is what he is employed to do. I think he would be a poor salesman if he didn't try to sell the idea that he represents the best product. That is why we indicated in our testimony that some of these decisions can be made impartially by the pharmacist if he is compensated on a fee basis.

The CHAIRMAN. Yes. Let me ask you this. If drugs products are manufactured to the USP or NF standards, should there normally be any difference in therapeutic effects?

Dr. APPLE. Normally, there shouldn't be, and we haven't seen any conclusive evidence that there is.

The CHAIRMAN. You have participated in most of the sessions of the Health, Education, and Welfare Drug Task Force. Do you think there is any important reason for Congress to wait until the findings of this task force come before it before acting?

Dr. APPLE. Mr. Chairman, I have attended and participated in a number of the workshops. I would say that HEW certainly is to be commended for organizing these workshops. They have brought together for the first time scientists, pharmacists, physicians, educators, manufacturers, and lay persons with legitimate interests to discuss the problems that might be attendant to including drugs under title 18(b).

The discussion have been very fruitful in terms of exchanging information on the problems the various groups are studying, what they would like to see studied, and concepts, but we still support your amendment and think that there is no reason why the work of the task force can't go on.

I hear talk that assumes that the task force isn't going to be in favor of your amendment when they finish their study. I think this is foolish. While we don't know what the conclusions will be, in light of all the things that we have heard at task force meetings we can certainly continue to support your amendment.

The CHAIRMAN. Do you believe that this amendment would benefit the community pharmacists, and if so, would you explain how and why it might benefit the community pharmacist.

Dr. APPLE. If it benefits the patients he takes care of, the public he serves, obviously it is going to benefit him. Directly it has some benefits in that it will permit the pharmacist to exercise professional judgment—a right for which he has qualified through a hard-earned education. It will compensate him without any tie-in to prices that are established by manufacturers.

There are many drugs that do not have to be prescribed. Your amendment will continue to allow for self-medication and provides a billing allowance to the pharmacist for the first time. The pharmacist spends considerable time with the public, counselling people about the drugs they want to use for self-medication today, he receives no recognition or remuneration for this professional service. But, we see more advantages in terms of what the amendment will do for medical care than just for our profession per se.

The CHAIRMAN. Would not this amendment make it possible for the druggist, when he has several drug available to him, all of them being the same thing, to pick one that is the least expensive, add his professional fee to it, and since he charges for the less expensive of the two plus his professional fee, and thereby save the customer money. At least if the Government was paying for it, it would save the Government a lot of money.

Dr. APPLE. It will do exactly that, Senator.

The CHAIRMAN. Are there a considerable number of drugs which deteriorate with time?

Dr. FELDMANN. Yes; there are, Mr. Chairman. As a matter of fact, we find that this is a growing consideration as drugs become more complex in both their chemical properties and more sophisticated in the types of dosage forms in which they are incorporated.

The CHAIRMAN. What would be a good example of a drug that will deteriorate in time.

Dr. FELDMANN. Some of the antibiotics will lose their potency, certain biologicals.

The CHAIRMAN. Just name one that occurs to you; penicillin?

Dr. FELDMANN. Penicillin; yes.

The CHAIRMAN. The thought occurs to me that if you have two or three different types of manufacturers of penicillin, all the same thing, wouldn't this bill make it easier to turn over that inventory, to simply keep no more on hand than necessary. The pharmacist could simply sell them as they went along rather than have one sitting up there made by a lesser known manufacturer, which he didn't get as many calls for, to where it is deteriorating so that when you do get a call for it, it is not of the quality that it would be if you turn your inventory over.

Dr. APPLE. We would agree completely with this, Senator. It just makes commonsense that if you were stocking 20 identical products but each having a different name, that your inventory turnover is going to be slower, and, therefore, if it includes products that deteriorate, you are going to have a larger expense.

The CHAIRMAN. Assuming that these people selling this particular drug that I referred to as one example of a great number of the different names for one product, assuming that you can't find any real difference between them. Let's just pick a manufacturer. Suppose you said that you thought that Schering was a good manufacturer and the price was right, and you bought this drug by the name of Oreton. Now would not the bill help keep down the druggist's costs. Instead of having to stock 12 of these things all called by a different name, he could just stock one or two of them, which the druggist thought was of good quality, and when the call came for that, hand that one out.

Dr. APPLE. That would certainly happen in the case of all the prescription orders the pharmacist received from the recipients involved under the basic program, and the benefit would certainly spill over into the general public area. The information the pharmacist conveys to the prescriber and the acquaintance of the prescriber with the particular drugs that are approved by the Formulary Committee that is established in your bill, form an educational process in itself. So the very basic effect that you have outlined, Mr. Chairman, certainly would occur.

The CHAIRMAN. We had a witness here for the pharmaceutical manufacturers who said that his company manufactures aspirin sold under the name of Bayer, Bayer Aspirin, a very well known product. Now I, as a lawyer recall from my days in law school that the Bayer Co. spent a great deal of money prosecuting at least one other manufacturer of aspirin tablets, to try to keep them from calling their product by the name, aspirin. They wanted to make them call it acetylsalicylic acid if I recall correctly, the idea being that if somebody wanted something for a headache and he asked for aspirin he couldn't buy anything but Bayer's product.

If they had won that lawsuit—and they didn't—could that have made it easier for Bayer Aspirin to charge a higher price than the other fellow?

Dr. APPLE. I think it would have. We all know that there is a significant difference in the cost of branded food products versus nonbranded food products because of advertising and promotional expenses. This was brought out in several of the hearings and investigations of the Congress. And, of course, one of the reasons for branding an item is the advantage you have of price leadership.

The CHAIRMAN. Why does your organization believe that a formulary is necessary?

Dr. APPLE. Well, we believe that a formulary, the Federal Formulary or the list, is needed as a mechanism to convey information to the prescriber. While he is not interested in cost per se because the Government is picking up the tab for the prescription, he is interested in knowing what drugs he is authorized to prescribe.

By the same token, the pharmacist has to know what drugs he is going to be authorized to dispense so that he can order his inventory accordingly.

The CHAIRMAN. As you know, there has been consternation among some of those in the drug industry when they saw the statement by George Squibb, whose father and grandfather were outstanding members of the pharmaceutical industry prior to the time that Mr. Squibb himself went into that business. Mr. Squibb knew a lot about it. He indicated that the pricing methods in this industry have no parallel in other industries.

Now I don't know whether that is entirely correct or not. I do gain the impression that in most cases where people want to sell a product without having to compete—without having to compete in prices—that where that exists, such as in the insurance business, that you have these insurance agencies which fix rates and which are supposed to say what they can and can't charge so the rates are all the same for the same types of insurance policies—in things of that sort, in cases like that, where they don't want to compete pricewise for the market, they are subject to regulation by some agency of government. In other words, if they don't want to compete pricewise, then they all charge the same rate, but somebody in Government tells them what it can be, such as the airlines who might charge the same rate for traveling between two points, railroads, buslines, but somebody tells them what the price of that is to be if they are not going to compete pricewise.

Would this not in some respects be a case of people in competitive industries trying to find a way not to compete on price, even though their products are identical in many instances?

Dr. APPLE. We are as disturbed, sir, as anyone else. When we testified before the House Committee on Small Business, we stated that certain agencies of the Government can buy the same product at one-tenth or one-twentieth of what the pharmacist can buy that same product. Yet the pharmacist is told that he can't dispense any of the prescriptions being written for Government beneficiaries because he charges too much.

Even if the pharmacist, for example, was to give away all of his services and offered to dispense every Veterans' Administration prescription for free, the Veterans' Administration would say "We can still save money by doing it ourselves through Government pharmacies because we can buy our inventory at a fraction of what you are paying for yours."

We have a terrible situation in this country today. The same thing is now happening under the OEO programs. The pharmacists can't compete because the OEO centers can buy their inventories through the Veterans' Administration.

The CHAIRMAN. Then, with regard to this one drug which I just picked out and listed a lot of trade names, these drug manufacturers will come to you and seek to sell the product, but they will not bid for the business against people who are manufacturing the same products, selling it by different names. They might charge you as much as 10 times what they sell it for to the Government or to some hospital for. And then, when you try to provide the same drug to your customers, they say "No, we can't buy it. It is too expensive."

The reason being that these drug manufacturers had bid for the business when they sold it to the Government and they didn't bid for it when they sold it to you. As a matter of fact, they went to the State legislatures, as I understand it in 44 States, and got laws passed that when a doctor writes down that name, Andronaq, you can't sell him anything but that product made by the Central Co.

Dr. APPLE. As a matter of fact, several of our pharmacists faced with this dilemma in certain communities have attempted to do cooperative buying and have asked firms to bid for their business, but the firms won't bid when a community pharmacist wants to buy.

The CHAIRMAN. So they go to the State legislatures and get a law to prohibit competition in selling the product, and then on the other hand, when Government agencies know better, they just decline to buy it except on a bid basis. In that instance they do get it for a very reasonable price, which in some cases might be 10 percent of what you have to pay for it.

Dr. APPLE. Yes, that is true. In some cases they may even be selling on bid below their actual, marginal production costs.

The CHAIRMAN. Of course, now none of us really seek to make them lose any money, do we? I want them to make money and I think you do too. You do business with them, but at the same time you don't want them to keep your people from making a legitimate profit in a legitimate business either.

Dr. APPLE. No. That is why, Mr. Chairman, we advocate the patent system. We support it in this country. We think drug manufacturers are entitled to have an opportunity to recover their investment in seeking out a new agent that is going to benefit society. All we say is that there comes a point in time when that cost is recovered, and at this point the price ought to level off. It ought not be kept up artificially. Pharmacists should be able to buy their inventory as cheap as the Government can buy its inventory, except for the actual accountable savings in purchasing large quantities, but this is an insignificant differential.

The CHAIRMAN. Do you know of any other industry where someone who does some research and gets a patent is entitled or even contends that he is entitled to some premium price or some higher price than competition would permit, after that patent has expired?

Dr. APPLE. I don't, sir.

The CHAIRMAN. In other words, if I were to invent a better yoyo or a better mousetrap than somebody has today, and had the benefit of a patent and made money out of it for 17 years, wouldn't it be recognized that from that point forward I had to compete for the business, and the fact that I might have done some research. It had been to my advantage for 17 years—others couldn't produce that product—but after that anybody could produce it. Do you know of any other industry where someone contends that you have to buy his product because he did some research in the area?

Dr. APPLE. Basically, our patent and trademark system provides protection. The trademark provides leadership time. As the manufacturer's patent is about to expire, normally, he takes over the function of becoming the price leader in the market. With the benefit of the trademark, he keeps a good share of the market. This is how he extends the effect of his ingenuity in the first place.

The CHAIRMAN. Thank you very much. Senator Anderson.

Senator ANDERSON. I don't have any questions on the drug business but just on the consumption. I am in such good health now that I have only five different sets of pills a day. I don't have any questions.

The CHAIRMAN. Senator Hartke.

Senator HARTKE. Let me ask you, Dr. Apple, did you say you are opposed or rather that you are glad to see the brand name era come to an end?

Dr. APPLE. That is right, sir.

Senator HARTKE. Do you want it eliminated completely?

Dr. APPLE. I was talking in the context of drugs under medical care.

Senator HARTKE. Should we just treat it under medical care because this is one part of it. Are you in favor of brand names or are you opposed to brand names?

Dr. APPLE. In the case of prescription drugs, our association has officially taken a position that the nomenclature system of either nonproprietary names or brand names are both acceptable in our society, in a free enterprise society.

In the context of a situation where the brand commands a price differential over and beyond the patent period of time, this era we are glad to see come to an end.

Senator HARTKE. Are you in favor of brand names or opposed to them?

Dr. APPLE. Senator, I would have to say that I could argue that position either way.

Senator HARTKE. You do not know whether you are in favor of or opposed to them, is that what you are telling me?

Dr. APPLE. Pardon?

Senator HARTKE. You don't know?

Dr. APPLE. No; it is not a question of knowing.

Senator HARTKE. Don't you want to say?

Dr. APPLE. It is not a question of not wanting to say. It is a question of——

Senator HARTKE. Why don't you say?

Dr. APPLE. It is a question of saying do I love my sister more than my brother.

Senator HARTKE. You mean brand names are in that category, that they are like the difference between a sister and a brother?

Dr. APPLE. Well, there are many nomenclature systems. If we are talking about nomenclature in terms of marketing you have it in one context. Nomenclature, in terms of a scientific system of identification of a particular medicament prescribed for a patient, is another context. The American Medical Association, the official compedia and FDA are part of the U.S. Adopted Names Council, which is concerned with the names drugs are given. We publish both names in our books. It is not a question of wanting to live with one system or the other. It is wanting to live with the best of both systems.

Senator HARTKE. That is not philosophy. Do you know whether you are in favor of brand names or against them?

Dr. APPLE. We favor the prescribing of a drug by its established name, sir.

Senator HARTKE. But you do not want to say about brand name? If you don't want to just tell me.

Dr. APPLE. In terms of the association's official policy, we recognize both nomenclature systems.

Senator HARTKE. I thought you said you were glad to see the brand name era come to an end.

Dr. APPLE. That is right, in terms of the price——

Senator HARTKE. Why are you glad to see something that does not make any difference come to an end if there is a difference? I do not want to see a brother or a sister come to an end, I mean one of the two.

Dr. APPLE. Senator Hartke, I have to answer you this way. There is a great deal of confusion as the——

Senator HARTKE. I am not confused. Now, what I want to know very simply, there are brand names and there are generic names. You understand the difference, I understand the difference. Now, are you in favor of the brand names or do you want the brand names to come to an end? If you do, all right. It leads you down a peculiar trail and I do not blame you for wanting to take it. I understand why you are hesitant because I think once you say that you are into an area which you yourself will never defend. You see you put yourself out of business, but it is all right. I am warning you now that once you make that statement, that is where you go. I will take you right down the trail and I do not want to mislead you, but it will take you down the trail where you ultimately will socialize the Nation. Now, if that is what you want. I am telling you where it will take you. If you are opposed to brand names just say so because I will take you to where you will have to destroy your own business and the free enterprise system.

Dr. APPLE. Senator, one of the largest drug manufacturers in the United States is in your State. It is one of the largest manufacturers of generic drugs in the United States. There are some products that cannot be given a brand name under our laws. For example, Eli Lilly firm has made Phenobarbitol for years. It is an official name. There is no brand name for it.

Senator HARTKE. I am not asking you anything about phenobarbitol. I did not ask you about Eli Lilly. I asked you a very simple question whether you want to eliminate brand names.

Dr. APPLE. I say brand names can be eliminated very easily without hurting the medical care of the people of our country.

Senator HARTKE. Are you in favor of it?

Dr. APPLE. I certainly am.

Senator HARTKE. You want to eliminate brand names throughout the hole industry, is that right, or just in one industry, just in one section of it?

Dr. APPLE. We were talking about drugs as I understood your question.

Senator HARTKE. I am talking about drugs, I understand, but you want to eliminate brand names, all brand names in drugs, everything.

Dr. APPLE. I think we can do this in the case of drugs.

Senator HARTKE. Are you in favor of that? Do you want to eliminate all brand names in the whole drug field?

Dr. APPLE. We only have brand names for some drugs, Senator. We do not have brand names for all drugs.

Senator HARTKE. I understand that. Phenobarbital, all right; aspirin, you have brand names for aspirin, don't you?

Dr. APPLE. No.

Senator HARTKE. You don't have a brand name on aspirin?

Dr. APPLE. Not for aspirin.

Senator HARTKE. Well, you have Bayer's aspirin, St. Joseph's aspirin.

Dr. APPLE. Bayer's is the name of the manufacturer. That is like saying Lilly's phenobarbital.

Senator HARTKE. What is the name of your pharmacist, or are you just a director. You do not have a pharmacy. Did you ever have a pharmacy?

Dr. APPLE. Did I? Our family has had pharmacies.

Senator HARTKE. What was the name of the pharmacy?

Dr. APPLE. Northern Lakes Pharmacy in Phillips, Wis.

Senator HARTKE. And you advertised that as one of the best drugstores in the country, didn't you?

Dr. APPLE. No, we did not.

Senator HARTKE. Didn't you advertise it as giving good quality service?

Dr. APPLE. We did not advertise.

Senator HARTKE. You did not advertise at all. Did you sell Bayer aspirin?

Dr. APPLE. We certainly did.

Senator HARTKE. Did you give a customer information at the time when he came in saying, "I want Bayer aspirin," did you say, "I can sell you my own brand cheaper"?

Dr. APPLE. Yes; we carried Rexall's and we sold more of that than Bayer's.

Senator HARTKE. A man walks up to the counter and says, "I want Bayer aspirin." What do you say, "Aspirin is all alike; I can sell you other kinds cheaper"?

Dr. APPLE. Very frequently; yes, sir, because we were a Rexall agency.

Senator HARTKE. Oh, you were promoting Rexall. I think that is the answer. You did not get a kickback from Rexall, did you?

Dr. APPLE. Oh, no. Then, later we switched to Walgreen's.

Senator HARTKE. Did you get any special discount?

Dr. APPLE. We did not get any from Bayer, either. The point is that we were selling aspirin.

Senator HARTKE. Why did you switch from Rexall to Walgreen's?

Dr. APPLE. We switched from Rexall to Walgreen's because the Walgreen people did a better job serving our area.

Senator HARTKE. And this is the substance of it. In other words, here you had two people supplying items to you. They did a better job. Was their product any better quality?

Dr. APPLE. The products were both under generic name—aspirin.

Senator HARTKE. But was the product of any better quality?

Dr. APPLE. I do not think so.

Senator HARTKE. Was it priced the same?

Dr. APPLE. Was the price the same? Both of them were less than the Bayer aspirin; yes.

Senator HARTKE. Was the price the same?

Dr. APPLE. Not exactly.

Senator HARTKE. Did you charge the same price?

Dr. APPLE. I would have to—you are talking 20 years ago in my lifetime.

Senator HARTKE. But you see, what I am talking about is the fact that you bought that Walgreen's aspirin for 6 cents a box and you bought Rexall at 7 cents a box and in charging 10 cents you made 4 cents a box on those aspirin of the one you bought cheaper; did you not; and you still used the name of the drug. In other words, you may say aspirin is the same, but I will tell you there are a lot of people still throughout this country, for example, who buy Bayer aspirin and insist on Bayer aspirin, although everyone through the country I know has been told time and time again that aspirin is aspirin no matter what. A rose by any other name tastes just as sweet. I mean this has not changed the habits of people, has it? You think it should and you want to correct it. Now, why are you complaining about the Veterans' Administration buying these items cheaper?

Dr. APPLE. We have a basic idea in government, at least as I understand it, that we let the people do what they can for themselves. If they cannot do something and it is essential for government to take over the function, that is just fine under our system of democracy. We happen to think that the pharmacists of the United States are just as competent to dispense prescription orders to the veterans in their communities as the Federal Government is. For many years we have had that type of a program, and then suddenly it was shifted to Government-operated dispensaries. The Government took over the pharmacists' function in society through its own installations.

Senator HARTKE. Is the price to the consumer cheaper through the Veterans' Administration pharmacy, to the consumer?

Dr. APPLE. The consumer in this case is the individual veteran. He does not pay in either case.

Senator HARTKE. Is it cheaper to the Government?

Dr. APPLE. Yes; exactly. That is the whole thing.

Senator HARTKE. Why don't we institute a national system of pharmacies then throughout the United States for the whole program of medical care for the aged?

Dr. APPLE. Well, unless there are some changes in the prices the Government can purchase at versus what the pharmacists can purchase drugs at, there will be a nationalization of the pharmacies in the United States.

Senator HARTKE. But isn't this the net result of what you are asking us to do here today?

Dr. APPLE. No; it is just the opposite. I will be glad to give the Senator a copy of my testimony before the House committee, in which I went into detail on this.

Senator HARTKE. I will be glad to look at it.

Dr. APPLE. I know the pharmacists of Indiana would appreciate your looking into it because they have been especially hurt by the taking over by the Veterans' Administration of part of their practice.

Senator HARTKE. I understand what they are complaining about. What about the OEO? Do you think that those people are receiving it at a greater cost to the Government or a lesser cost?

Dr. APPLE. It is obviously a lesser cost to Government because any Government agency can buy——

Senator HARTKE. I thought you were interested in the people coming in and the consumer having this at a lesser cost.

Dr. APPLE. I must have misunderstood the Senator.

Senator HARTKE. Are you not interested in the consumer getting these drugs at the lowest possible cost?

Dr. APPLE. Well, the consumer, if you are talking about an OEO installation——

Senator HARTKE. It does not make any difference.

Dr. APPLE. Is not paying for the drug.

Senator HARTKE. What difference does it make whether it is OEO or anyplace else? It goes into the human mouth or into the arm or wherever else you put the shots. The whole point of it is that the consumer is not the OEO; it is not the Government, it is not the Veterans' Administration. The consumer is a human being; isn't that true?

Dr. APPLE. Yes, sir.

Senator HARTKE. Now, what you are talking about is providing for him the lowest possible cost and the Administration giving him the benefits of the medical treatment, isn't that correct?

Dr. APPLE. That is right, sir.

Senator HARTKE. Then why, if that is true, and you have said that it is cheaper for him to go through OEO, is it cheaper for the Government to do it the way they are doing it? If it is cheaper for the Veterans' Administration, why shouldn't we take the next step and provide for those people under the Government-sponsored program of medicare?

Dr. APPLE. Well, as I indicated, this is the way we are going, and if the pharmaceutical industry continues to aid and abet our going this route, they will not have any pharmacies to sell any of their products.

Manufacturers will be selling all their capacity to the Federal Government at the marginal-bid basis on which they claim they are losing money, so in the final analysis, we will not have a pharmaceutical industry.

Senator HARTKE. I think we come to different conclusions by the same route and I am not going to try to change your mind.

Let me ask you this question. Do you think the task force is doing a good job?

Dr. APPLE. As I indicated earlier, I think the task force is doing a good job in the workshops that I have participated in. Now, to what extent their research activity is getting tooled up, I have no idea.

Senator HARTKE. Do you think it should be abolished?

Dr. APPLE. Oh, no.

Senator HARTKE. Do you think it should be continued?

Dr. APPLE. I think the work of the task force should be continued. For example, I have been consulted about several studies by people in the task force inquiring if they should undertake these studies. Some may take 2, 3, or 5 years. I think studies are fine. I was once a university professor. I believe in basic and applied research. While it contributes ideas and information to society, I also recognize that we continue to live day by day.

Senator HARTKE. I do not want to get into a discourse on academics. What I am trying to find out is whether this task force is doing any good. You say it is doing good. Why shouldn't we wait for a completion of either report then? Do you think they can't come up with a report? Did you listen to Dr. Goddard? Did you read his testimony?

Dr. APPLE. I have read his testimony carefully.

Senator HARTKE. Do you agree with Dr. Goddard?

Dr. APPLE. I don't about the use of clinical pharmacologists to determine drug equivalency, when we have such a sparsity of these individuals in our society today. The University of Michigan just announced that it is going to establish a clinical pharmacology training center with a $1 million grant from the Upjohn Co., and it is looking for Government funds. I would certainly not want to take a man with 15 to 20 years of scientific training, and have him devote his time and energy doing what would certainly be an unmotivating and unappealing task of determining the equivalency of drugs that have been on the market under one name or another for 20 years, when he has an opportunity to look for a cure for cancer or some of the other serious diseases that are crippling our society today.

Senator HARTKE. I understand it is not a question of priorities. There is no question about that, but somebody has to make these determinations. You cannot let just anyone make a determination of the equivalency of drugs.

Dr. APPLE. We have a world of statistics and information to rely on regarding equivalency. We have 5, 10, and 15 years' use of these drug products in society where the human beings that have taken them have provided the clinical laboratory. Now, we need to accumulate, correlate and examine that information. If we can then say that one drug is different from another or better than another, I would be willing to listen.

Senator HARTKE. Are you interested in having that type of study made?

Dr. APPLE. We have recommended it time and time again. We have offered to participate in it.

Senator HARTKE. If this could be done within a year's time do you think that would seriously interfere with the operation of this program?

Dr. APPLE. The Food and Drug Administration is doing that on a day-to-day basis right now.

Senator HARTKE. I am asking you if we had a study done and report back within a year do you think that would be a fair approach? After all, when is this supposed to go into effect, July 1, 1970? If you just delayed the amendment which is proposed by my distinguished friend and colleague and terrific battler, if you just had a report made on the basis of his amendment for 1 year, to report back to this committee, do you feel that that would seriously interfere with the program which is supposed to go into effect July 1, 1970, which would still be approximately 2 years away from the completion date of the proposed study?

Dr. APPLE. Senator, you are saying that this research would only take about a year to do, and you have a 2-year interval before the bill takes effect?

Senator HARTKE. That is right.

Dr. APPLE. Well, under the terms of the bill, the Formulary Committee, which includes the Food and Drug Commissioner, would have access to the results of that research and he could bring it before the committee and say, "Look, as a result of our scientific research we have found this drug is not equivalent to this drug. Therefore, the committee should include both of them in the Federal Formulary."

Senator HARTKE. Would you be in favor of such a study for a year or opposed to it?

Dr. APPLE. We already have it going on now.

Senator HARTKE. I say would you be in favor of such a study or are you opposed to it?

Dr. APPLE. We favor the study.

Senator HARTKE. And if such amendment were introduced you would support it, right?

Dr. APPLE. We certainly would not favor an amendment to postpone the bill.

Senator HARTKE. Not to postpone the bill. If you postpone the enactment of the amendment which you have testified in favor of for 1 year, did not take any action pending this study for 1 year, would you be opposed to that or in favor of it?

Dr. APPLE. We would be opposed to it, sir.

Senator HARTKE. Why?

Dr. APPLE. Because the factual information is now being accumulated, and there is a source to receive it in the amendment, and that is the Formulary Committee, the group of distinguished committee members who are going to have to finally evaluate its findings anyway.

Senator HARTKE. I have no further questions.

The CHAIRMAN. As I understand what you are saying about this formulary business—looking again at these things—like this testosterone business. If you found that of the drugs you have listed, some are not the same as others, then what you would do would be simply to list those separately, is that correct?

Dr. APPLE. I am sorry, Mr. Chairman?

The CHAIRMAN. Suppose you found these two drugs are not equivalent. Then you would simply list—suppose you said the Neo-Hombreol and the Oreton Propionate is different from the others, then you would simply list those two separately under a different designation?

Dr. APPLE. That is correct.

The CHAIRMAN. One thing does concern me a little bit. Can something we done to simplify some of these very complicated names which are the official names of drugs? In other words, can these generic names be simplified so that it would be easier for people to know what they are, or to write them down?

Dr. APPLE. We are doing a very good job in this area, Senator, since 1961. The American Medical Association, the United States Pharmacopoeia, the National Formulary and other interested groups have formed a USAN—United States Adopted Name—procedure for actually helping the industry and others find better and simpler generic or established names. Recently, the Food and Drug Administration became part of this USAN Council, so we have everybody—the industry, the medical profession, the pharmacy profession and the Food and Drug Administration working toward this objective.

The CHAIRMAN. So that we can expect to have these names simplified and more pronounceable in the future, is that correct?

Dr. APPLE. We would hope so, sir.

The CHAIRMAN. Now, have you seen that Squibb memorandum and if so, what do you think of it?

Dr. APPLE. I have heard a lot about it, sir. I have not read it.

The CHAIRMAN. Do any of your associates have any comments on that? Well, what would be your impression or your associates' impression from what you have read about the memorandum relating to George Squibb's statement about the pricing methods in the drug industry?

Dr. APPLE. I am sure that there are many people besides George Squibb, perhaps even myself, who could have written a similar broad overview of the general problem that both the industry and the profession are faced with in recent years. I think that anyone who is associated with these activities during his lifetime develops an overview of the problems they see. As I understand it, this memorandum merely reflects this individual's best judgment as to what he sees the problems to be. It is based on his lifetime of experience.

The CHAIRMAN. Can you tell me some of the major drug manufacturing companies which manufacture drugs by their generic name as well as by the trade name?

Dr. APPLE. As I indicated to you, the Eli Lilly Co. in Indianapolis, Ind., of course, is one of the major manufacturers. I might say they are very proud of the generic drugs they have made for years and continue to make.

The CHAIRMAN. I am told that two of the largest manufacturers of generic drugs are the Eli Lilly Co. and the Squibb Co.?

Dr. APPLE. Squibb, Parke, Davis, and others. Many of the companies have some generic drugs. Of course, every drug is made originally as a generic. It is only when the label is put on it that it ever acquires a brand name.

The CHAIRMAN. I see. Then do you have any reason to believe that when these concerns manufacture drugs in their plants to be sold under the generic name there is any difference in quality whatever between that drug sold under the generic name and the drug that they are selling under the trade name?

Dr. APPLE. I know of no company that would do anything like that. Their motive is to produce the highest-quality drug they possibly can. I cannot think of any drug manufacturer in this country that would put out a generic and a brand name of different quality.

The CHAIRMAN. It would be immoral and unethical if they did it, wouldn't it?

Dr. APPLE. I would say, sir, that the pharmaceutical industry has a greater public responsibility than to entertain a thought like that.

The CHAIRMAN. In other words, it is their responsibility when they sell a drug, whether under the brand or generic name, to give you the best quality that they are capable of producing and putting into the package?

Dr. APPLE. It is also the most economical method of producing things.

The CHAIRMAN. So the drug product just runs off the production line and those you want to sell by the brand name you simply put one label on and those you want to sell by generic name you put on another label?

Dr. APPLE. Our food and drug laws require the same standards to exist regardless of what you call the drug. I do not know why people find it difficult to understand this. Our food and drug laws, and all the improvements made in them in recent years, are not predicated on the nomenclature argument. They are predicated on bringing to the American people the highest quality medicaments.

The CHAIRMAN. When you buy this drug from a company that has two products, one selling by brand name and the other by generic name, what is the difference in price, or is there any?

Dr. APPLE. Well, this will vary, of course, from product to product, depending on the marketing structure. But as we know, testimony has already been presented to Senator Nelson that in the case of Prednisone, for example, you can buy it under its brand name from two major manufacturers at approximately $16 a hundred, or you can buy it from two equally prominent manufacturers under brand name for approximately $2.25 and you can buy it at generic prices anywhere from 95 cents on up.

The CHAIRMAN. That is a tremendous variation. Well, thank you very much for your testimony here.

Dr. APPLE. Thank you, Senator.

The CHAIRMAN. The next witness which I would like to hear is Mr. Santiago Polanco-Abreu—I am not as good at my Spanish as you are, Mr. Polanco—of Puerto Rico.

He is the Resident Commissioner representing the Commonwealth of Puerto Rico.

I understand you have a brief statement to submit to the committee, and we will be glad to receive it.

STATEMENT OF HON. SANTIAGO POLANCO-ABREU, RESIDENT COMMISSIONER OF PUERTO RICO

Mr. POLANCO-ABREU. Mr. Chairman, I appreciate the opportunity to appear before the Senate Committee on Finance to give my views and those of the government of the Commonwealth of Puerto Rico on the Social Security Amendments of 1967.

First of all, let me say that H.R. 12080 in its general aspects has my full and enthusiastic support. Most of these provisions have been needed for a long time, and the 1967 amendments will greatly strengthen the law and more fully provide for the Nation's people in accordance with the basic purposes of the act.

However, the application of the social security law for Puerto Rico since 1950 has in many respects been inadequate and difficult for the Commonwealth government to work with. We have had three basic difficulties stemming from limitations on public assistance.

(1) We have had to work with an absolute dollar ceiling of Federal contribtuions of $9.8 million.

(2) We have had to match dollar for dollar as against the Federal share, and, in fact, in order even to approach meeting needs, we have had to exceed that figure.

(3) We have had to accept an average limitation on grants to about one-half of that applied to the States. However, since the first two limitations have so handicapped our efforts to comply with the general purpose of the act, this latter limitation has not yet affected us.

The House Ways and Means Committee has solved a basic difficulty imposed by the absolute Federal ceiling in that the dollar limit for Federal financial participation in public assistance for Puerto Rico will be raised from the present $9.8 to $12.5 million for 1968, $15 million for 1969, $18 million for 1970, $21 million for 1971, and reach an absolute ceiling of $24 million by 1972. An additional $2 million may be certified for community work and training programs. I hope that these provisions will be maintained, because they are essential. Our difficulties under the public assistance 50–50 matching formula remain, and the effect of this formula, which is not applicable to the States, will result in continuing hardship to many people in Puerto Rico who depend upon public welfare in order to exist.

We are working on programs to help these dependent people and to create jobs for them, and to train them so that they may take these jobs. Our success is illustrated by the fact that we are dropping from our relief rolls approximately 6,000 recipients per year as they become self-sustaining citizens.

I point this out to show that a liberalization of the 50–50 matching formula will not result in a heavily increasing flow of Federal dollars for this purpose. Still, the average payments to needy families in Puerto Rico in 1966 was only $13.50, as compared to $39.09 in Mississippi. When it is considered that Puerto Rico is a high-cost-of-living area, even higher than Washington, D.C., the woeful inadequacy of this help becomes apparent.

Certainly the problems and hardships of poor, handicapped, and sick American citizens living in Puerto Rico are not different from those of citizens living on the mainland. Certainly our blind are no less blind, our disabled no less disabled, our dependent children and impoverished elderly no less needy, our sick no less sick, than those residing in the States. Certainly the Federal Government cannot be less concerned about the desperate needs of the afflicted and the impoverished American citizens in Puerto Rico than it is about those residing in the States.

I urge the committee to liberalize the matching formula for Puerto Rico so that the application of the public assistance provisions may take on more meaningful significance.

The House bill imposed a maximum ceiling on Federal payments for the medical assistance program under title 19 of $20 million per year for Puerto Rico. It also reduced the Federal medical assistance percentage for Puerto Rico from 55 to 50 percent. The effect of these provisions, if retained, is going to be the withdrawal of medical assistance from many in Puerto Rico who need it most, even though the financial standards for medical assistance in the island are exceedingly conservative. The people of Puerto Rico who need this help will not be able to believe that Congress intended this result.

Accordingly, it is my most urgent hope that the Senate Finance Committee will remove the $20 million ceiling of Federal participation for medical assistance, allow the law to remain as it is at present in this respect, and that a new matching formula of 60 percent Federal to 40 percent Commonwealth contribution be established.

I believe that this will be in the national interest, since it will bring higher medical standards for a section of the Puerto Rican people and therefore by obvious implication for all the Puerto Rican people. In this world of close-quarter living, the health of a few is the concern of all.

May I call the committee's attention now to the requirements of free choice by individuals eligible for medical assistance. The House bill granted Puerto Rico a reprieve in the application of this provision until after June 30, 1972. But even this was an arbitrary date.

I appreciate that the Ways and Means Committee showed this special consideration for Puerto Rico's special circumstances. I believe, however, that since no one can predict with any authority the probable effects of the establishment of free choice in Puerto Rico, a careful study should be made. Consequently, I urge the Senate Finance Committee to require in the law that the Secretary of the Department of Health, Education, and Welfare provide for such a study and then, according to his findings, become the determining authority regarding the feasibility and effective time of free choice in Puerto Rico. I would suggest that such a study be completed by June 30, 1971.

As I understand it, when the social security laws were first enacted there was a deliberate exclusion under old age and survivors insurance of the Nation's policemen and firemen. I believe this exclusion was based on the fact that the policemen and firemen of some States preferred their own pension systems which they felt might be jeopardized if social security coverage was extended to them. I understand that the policy was that upon request, the firemen and policemen of any particular State could be included and that this has been done with regard to some of the States.

The policemen and firemen of Puerto Rico have asked me to introduce legislation to give them social security coverage, and last February I introduced H.R. 4902 which would accomplish these results by amending section 218(p) of the Social Security Act merely by including after the word "Washington," the words "or the Commonwealth of Puerto Rico."

Since it would impose no controversy, this would be an appropriate amendment to the bill under consideration, this would be an appropriate amendment to the bill under consideration, and I hope that the committee will include this provision before it reports H.R. 12080.

I would like to call the committee's attention now to one of the most glaring injustices in recent legislative enactment. I refer to the so-called Prouty amendment of 1966, which in recognition of the needs of our elder citizens provided that persons 72 years or older may receive a minimum monthly public annuity. Puerto Rico was included in the original Prouty amendment, but for some reason beyond my comprehension elder citizens in Puerto Rico were deprived of this assistance during the House and Senate conference.

Certainly, our aged are no less aged than their continental counterparts, nor are they less needy. Since the rate of tax for the social security fund is the same for Puerto Ricans as it is for State residents, I should think that our older people should be treated alike. This is so obvious that it defies argument.

I hope the committee will correct this appalling injustice forthright and extend the provisions of the Prouty amendment to Puerto Rico.

Perhaps though I may make a suggestion for the improvement and reduction in the costs of the Prouty provision. It seems apparent to me that a $40 monthly pension would have little meaning or value to a person of wealth, or even to those in the moderate middle class. Thus, while asking that the Prouty provision be extended to Puerto Rico in full, perhaps consideration should be given to making this help available only to persons 72 years or older who have an annual income of less than $5,000. What I am concerned about is providing minimum living standards below which no person in his twilight years should be asked to endure.

Mr. Chairman, to supplement my oral statement, I should like to present for the record a more detailed written statement to amplify the points that I have raised here. Additionally, I should like to present for the record a series of charts and tables which are relevant in the committee's study of these points.

And, finally, I would remind the committee that Puerto Rico's people are among the most industrious of all U.S. citizens. They are proud; they ask no privilege. At the same time, many are plagued by a poverty over which they have no control. They need the full help of the social security laws to which the people of Puerto Rico make full financial contribution and which are really designed to give social protection to all the people.

Thank you, Mr. Chairman, and Senator Hartke, thank you very much.

The **Chairman**. Thank you, sir.

(The supplementary statement of Hon. Santiago Polanco-Abreu follows. The charts and tables referred to previously, were received by the committee and made a part of the official files.)

SUPPLEMENTARY STATEMENT BY SANTIAGO POLANCO-ABREU, RESIDENT COMMISSIONER OF PUERTO RICO

SUMMARY OF RECOMMENDATIONS

1. *Comment.*—Section 248 of H.R. 12080 continues the 50–50 federal Commonwealth contributions for public systems. With Puerto Rico's heavy case load, this is a severe limitation on the number of recipients who can benefit by these various programs and the amount of monthly payments to be received by them.

Because of the financial strain on Commonwealth funds imposed by the requirements of the public assistance programs, monthly payments are only averaging approximately $13.50, which is a mere fraction of average monthly payments by these programs by the States of the Union. This extremely low payment in Puerto Rico amounts to little more than a token of help. Average payments in Mississippi are $39.00.

Recommendation.—Adopt for Puerto Rico the same method of determining the matching formula as that employed with regard to public assistance in the States.

2. *Comment.*—H.R. 12080 increases the benefits of Section 302 of the Social Security Act for certain uninsured individuals, aged 72 and over, from $35 to $40, and for couples from $52.50 to $60.00.

Residents of Puerto Rico were excluded last year from participation in this new program. H.R. 12080 continues the exclusion of the aged in Puerto Rico, even though Puerto Rico contributes equally to the Social Security Fund.

Recommendation.—It is recommended that Section 602 of the Social Security Act be amended to include residents of Puerto Rico who are otherwise eligible. In the alternative, the inclusion of residents of Puerto Rico may be limited to persons 72 years old or over who have an annual income of less than $1,000.

3. *Comment.*—H.R. 12080 establishes an absolute ceiling of $20 million federal participation for medical assistance in Puerto Rico under Title XIX, and raises the Commonwealth matching share from 45 per cent to 50 per cent. Such ceiling and the imposition of a difficult matching formula can only serve to have an adverse impact on eligibles in Puerto Rico who need medical assistance. It is very likely that medical assistance may have to be withdrawn from many who are presently eligible even though financial standards for medical assistance are conservative.

Recommendation.—The $20 million ceiling for medical assistance should be removed and a new matching formula of 60 per cent federal to 40 per cent Commonwealth contribution should be established.

4. *Comment.*—Section 222 of H.R. 12080 permits States and Puerto Rico to enter into agreements under Title XVIII, Part B (Supplementary Medical Insurance) under which Puerto Rico could purchase insurance premiums for all eligible individuals who receive medical assistance under its Title XIX plan. If Puerto Rico fails to do this, it would lose Title XIX funds in an amount equivalent to the cost of providing medical services to those 65 and over and to those eligible for social security disability benefits which would otherwise have been paid under the Supplementary Medical Insurance Program. Puerto Rico does not have the necessary resources to "buy in" for this large group. Consequently, Puerto Rico would lose a significant amount of Title XIX funds.

Recommendation.—It is recommended that Puerto Rico be exempted from this requirement.

5. *Comment.*—Section 227 would require Puerto Rico to amend its Title XIX plan to permit by 1972 free choice of physicians and medical facilities for those eligible for medical assistance. Although we are in full agreement with the principle of free choice, the structure of the existing medical assistance and severe financial limitations make uncertain the date on which Puerto Rico may be able to institute free choice.

Recommendation.—It is recommended that studies be undertaken by the Department of Health, Education, and Welfare to determine whether it is feasible and advisable in Puerto Rico to implement the free choice provision by 1972. The Secretary of Health, Education, and Welfare should be the final determining authority upon the completion of the study by June 30, 1971, as to when free choice should be effective. The 50-50 matching formula applicable to Puerto Rico under Title XIX should be changed to 60 per cent federal and 40 per cent Commonwealth.

6. *Comment.*—The Commonwealth of Puerto Rico strongly supports the amendments in H.R. 12080, which will extend and improve the Child Welfare Program and the proposal for a social work manpower and training program.

7. *Comment.*—When the social security laws were adopted, there were indications that many of the States' firemen and policemen felt that social security coverage for them might impose jeopardy to their established retirement programs. Thus it was felt that the firemen and policemen of any particular State could ask for inclusion in the social security coverage and that the policy would be to grant them such inclusion on a state-by-state basis.

The policemen and firemen of Puerto Rico have now asked to be included in social security coverage.

Recommendation.—H.R. 12080 should be amended to provide for social security coverage for the firemen and policemen in Puerto Rico.

II. GENERAL DISCUSSION

A. Public welfare in Puerto Rico

For almost 70 years Puerto Rico and the United States have existed in political association under the same flag. That the relationship has proved to be a great success is attributable, in no small part, to the recognition by the Executive and by the Congress that it is to the economic, international, and moral advantage of the United States to have Puerto Rico grow and prosper, and to have the United States citizens in Puerto Rico share in the ever-increasing abundance of the United States economy. To help to achieve this goal, no federal income tax is imposed on corporations and individuals in Puerto Rico, while at the same time the benefits of grants-in-aid programs and other federal assistance measures are generally extended to the Island. This policy is reflected in Sections 3 and 9 of the Puerto Rico Federal Relations Act, so far as federal tax laws are concerned and in the many statutes establishing federal aid and assistance programs. In virtually all of these programs Puerto Rico is offered the opportunity to participate as fully as any of the States.

If we look at the great strides Puerto Rico has made in the last twenty-five years, we can immediately see the wisdom of this policy. The strenuous efforts of the people of Puerto Rico and the far-sighted policies of the federal government have together achieved the following successes: measured in constant dollars, per capita income has almost quadrupled and is now $1,000; the real Commonwealth Gross Product increased 52.5 per cent in the last five years; employment in industry has risen from a level of 50,000 in 1949 to 130,000 in 1966; the percentage of children enrolled in school has been raised from 50 per cent to 85 per cent, with a resulting drastic drop in illiteracy; life expectancy has risen from 46 to 70 years. Indeed, our successful experiment in innovative political association has enabled the United States to support its foreign policy goals by pointing to Puerto Rico as an example to emerging nations of rapid economic development within the framework of democratic principles. It has also created, through augmented purchasing power in Puerto Rico, a significant market for stateside goods—$1.4 billion annual sales makes it the fifth largest extra-continental market. Indeed, Puerto Rico buys more U.S. goods than any Latin American country and is second only to Canada in this hemisphere.

However, let me quickly dispel any impressions that we have already achieved the Great Society in Puerto Rico. Per capita income in Puerto Rico is $1,000, compared to approximately $1675 in the poorest state and the national average of $2700. 12.3 per cent of the labor force was unemployed as of January 1967, and a substantial segment of our people are underemployed. We have come a long way, but the road ahead is still long and arduous.

When we compare the federal policies, as outlined above, to the policy reflected in the public welfare programs under the Social Security Act, we are immediately struck by the great variance. Whereas under most federal programs Puerto Rico participates on a level with the States, under Title I, IV, X, XIV and XVI of the Social Security Act—the programs providing financial and other assistance for the aged, the blind, the disabled and the dependent—the amount of federal participation in Puerto Rico is strikingly conservative. Under H.R. 12080 an absolute ceiling for federal contributions in Puerto Rico is raised gradually for these programs, from the present $9.8 million to $24 million in 1972, but Puerto Rico is required to match 50–50, as opposed to the more liberal formula which is applicable to the States.[1] For fiscal year 1966, federal payments under these programs totaled $3,192,688,000. Puerto Rico received $15,758,000 which amounts only to 0.5 per cent of the total.

The federal participation and matching limitations on Puerto Rico were imposed in 1950 when the public welfare assistance titles were extended to Puerto Rico. Perhaps there were valid reasons at that time. But at the present time it is difficult to understand the basis for this treatment. Certainly the problems and hardships of poor, handicapped, and sick American citizens living in Puerto Rico are no different from those of citizens living on the mainland.

The fact that Puerto Ricans do not contribute to the general revenues should not be a controlling factor in public welfare and medical assistance policy deci-

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[1] Similarly, under Title XIX Puerto Rico must match an absolute 50 percent rate. This restriction was imposed in H.R. 12080 as it passed the House.

sions. Puerto Rico contributes to the general welfare of the United States in many equally important ways. Also, I submit that this factor has little relevance in the context of public welfare programs. By definition, we are talking about a category of people who are unable to contribute to the federal revenues, whether they reside in Puerto Rico or in any of the States. This is recognized in the Social Security Act itself. States with the greatest needs receive extra payments. It would, indeed, be a strange system that determined welfare eligibility by the amount of federal taxes the prospective recipients were fortunate enough to be paying!

Perhaps there is a belief that it costs much less to live in Puerto Rico. This is contrary to the facts. For example, the cost of living in Puerto Rico is higher than here in the District of Columbia.

If the reason for the limitations was a fear that open-ended federal public welfare assistance in Puerto Rico would involve never-ending and increasingly large federal payments, I can summarily dispel that notion. The results of our Operation Bootstrap program prove that it is not Puerto Rico's fate to be forever an economically-impoverished island; and there is every reason to believe that the economic and social successes which I previously noted will continue. Of great pertinence is the fact that our successes thus far are directly reflected in the public welfare program. In the last three years we have averaged a reduction of 6,000 cases per year. Finally, there is also the very practical limitation of matching requirements. Even if Puerto Rico's share were reduced from 50 per cent to 20 per cent, the pressing needs in other sectors such as health and education and the comparatively low government revenues would limit the amount which Puerto Rico would be able to devote to public welfare.

This is not to say that Puerto Rico has not and will not continue to maintain a strong effort in the field of public welfare. The Government of Puerto Rico has consistently appropriated more funds for its public welfare program than the available federal ceiling amount, and it has consistently contributed a greater percentage than most States. In addition, for fiscal year 1966 Puerto Rico expended $15.4 million under federal medical and financial assistance welfare programs, an average of $6.64 per $1000 of total personal income in Puerto Rico.[1] Comparing this with the state average of $4.86 and noting the fact that only eight states had a higher rate, we can see the great effort being made by the Commonwealth of Puerto Rico.

Thus, I submit, there is now no rational basis for the severe matching formula in Puerto Rico, and I respectfully urge this Committee to modify that formula.

III. EXCLUSION OF RESIDENTS FROM PROGRAM OF CASH BENEFITS FOR PERSONS AGED 72 OR OVER WHO DO NOT QUALIFY FOR SOCIAL SECURITY

As the members of this Committee are aware, residents of Puerto Rico were excluded from the benefits of the "Prouty Amendment" of last year (Section 302, Social Security Act, as added by PL 89-368) by the Conferees of this Committee and the Senate Finance Committe. This step was apparently motivated by the desire to cut the costs of the measure in order to increase its chance of passage.

I need not reiterate my judgment of the morality or rationality of this action. Every consideration I have previously mentioned in this statement with respect to the treatment of Puerto Rico in the public welfare provisions of the Social Security Act is equally applicable to this exclusionary action. There is something fundamentally wrong with a federal measure which arbitrarily deprives a group of elderly American citizens of desperately-needed benefits, while at the same time extending these benefits to aliens who happen to reside in the various States.

H.R. 12080 proposes an increase from $35 to $40 for single individuals, and from $52.50 to $60.00 for married couples. It contains no provision to extend these benefits to the elderly American citizens of Puerto Rico, thus increasing the cruelty of the discrimination. I respectfully urge that this Committee take this opportunity to end this discrimination. In the alternative, the inclusion of residents of Puerto Rico may be limited to persons 72 years old or older who have an annual income of less than $5,000.

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[1] These two figures are actually much higher. In the first half of fiscal year 1966 Puerto Rico did not report to HEW a considerable amount of medical assistance funds it expended under Titles IV and XVI because the ceiling on federal payments precluded federal matching of these funds.

IV. THE EFFECT OF H.R. 12080 ON PUERTO RICO'S MEDICAL ASSISTANCE PROGRAM

A. Limitations on Federal participation

The bill as it passed the House imposed a ceiling for federal contribution in Puerto Rico for medical assistance of $20 million and raised Puerto Rico's matching share from 45 per cent to 50 per cent, or dollar-for-dollar against federal contributions.

The need for medical assistance in Puerto Rico is great because of the number of low-income families who must depend on this help. It is always difficult where there is such need, to formulate programs within an absolute and inflexible ceiling. Similarly, the 50–50 matching requirement would impose severe financial strain on Puerto Rico's resources available for medical assistance programs.

The Government of Puerto Rico would not want to abandon individuals requiring medical services and will have to pay their entire medical costs. Since Puerto Rico does not have the resources to bear the costs of intended improvements in medical services, the only solution would be a drastic and across-the-board reduction in the quality of medical assistance.

A solution to this problem would be the elimination of the ceiling and an adjustment of the matching requirement from 50–50 to 60 per cent federal and 40 per cent Commonwealth.

B. Section 222: "Permissive" State purchase of supplementary medical insurance

Section 222 will force Puerto Rico to forfeit a further segment of its Title XIX funds, again with no real choice on its part. Under this Section, federal payments under Title XIX will be shut off for the costs of medical assistance to the elderly (65 and over).

Puerto Rico cannot conceivably "buy-in" SMI insurance for its Title XIX beneficiaries who are eligible. Our experience has been that most of the elderly in Puerto Rico who are theoretically eligible for SMI insurance have not purchased it because of their inability to pay the $50 deductible and the 20 per cent balance. If Puerto Rico were to buy-in for them, it would have to pay also for the deductibles and the balance. The cost would be prohibitive.[1]

At present, Puerto Rico is providing the equivalent of SMI services through its Title XIX plan. It is not doing so because it objects to private medical practice, or because it is trying to save money at the expense of the federal government, or for any other questionable reason. It is doing so because at the present time is the only workable system in Puerto Rico. Penalizing Puerto Rico for doing its absolute best is clearly unjustified. Puerto Rico must be exempted from this provision.

C. Section 227—free choice

The House bill established an arbitrary date July 1, 1972, for the implementation of the free choice for the selection of physicians and medical facilities and services in Puerto Rico. Puerto Rico's economic circumstances are entirely different than the economic circumstances prevailing in the States.

We are in agreement with the free choice principles embodied in Section 227. If it were at all possible for us to meet this requirement, we would be welcoming it right now. For we, too, want to offer our citizens without means the same medical services available to their more fortunate neighbors. We realize the comfort and confidence that comes from exercising such choice.

But we need to evaluate this new policy in Puerto Rico, to determine the probable effects of this change, to restructure our Medicaid Program in accordance with the findings, and to raise the necessary revenues. I respectfully request the Committee to provide for studies by the Department of Health, Education, and Welfare to determine the feasibility of the implementation of the free choice provision in Puerto Rico in 1972, and that the 50–50 matching formula applicable to Puerto Rico under Title XIX be modified to provide gradual increased federal participation until the 60–40 matching formula is reached.

V. CONCLUSION

With respect to the benefit increases and broadened coverage under the Old-Age, Survivors, and Disability Insurance Program, the Commonwealth of Puerto

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[1] The cost is estimated at $7,905,000.

Rico has no objection. In fact, we strongly support the President's recommendations. We also welcome the improvements to the Title XVIII Medicare Insurance Program, which will increase the coverage and services in Puerto Rico, as well as throughout the Nation.

But with respect to the public welfare amendments in H.R. 12080, we must respectfully request that this Committee amend the bill by modifying the difficult matching formula so that more needy can be helped more effectively so that mere token payments can be done away with. With respect to the new Title XIX requirements, we must respectfully request that they be made feasible in Puerto Rico.

In conclusion, I should point out that our task in fighting poverty and sickness in Puerto Rico is difficult.

We are gravely concerned about the problems faced by families in Puerto Rico with incomes so small that they are prevented from participating in our efforts for continued progress and from enjoying this progress to its full potential. In 1963 there were 143,000 families in Puerto Rico with incomes under $1500, which constitutes 30 percent of an estimated total of 479,850 families.

A look at the age composition of the population in Puerto Rico shows it is predominantly young, a fact that poses special problems for our anti-poverty effort. Median age in 1960 was 18.5 years, while in the continental United States it was 29.5. Forty-three percent of the population was under 14 years in 1960 and 5.2 percent was 65 years or over, as compared to 31 and 9.2 percent respectively for the corresponding age groups in the United States.

A large population of low-income families in Puerto Rico is receiving services from the public welfare program. Intensified efforts to combat poverty of this group could be achieved through an improved public welfare program. Provisions of H.R. 12080 could get at the grass roots of many of the problems faced by these families, and constructive financial assistance from the federal government to implement these provisions in Puerto Rico could be a great stride in our conquest over poverty.

Puerto Rico is at present reviewing and evaluating its total government welfare program to reorient properly its efforts to accelerate general progress and combat the substandard levels which is still prevalent in a substantial sector of its population. In this renovated effort, the public welfare program will attempt to find more effective ways to get at the roots of the basic problem causing dependency and maladjustment in these families, to rehabilitate in the shortest possible time all families having members with such possibilities, to strengthen family life and to provide special services to children during their early years, so that many of the social, emotional, and economic problems that affect them during their childhood and that pave the way for the sort of life they will live as adults, may be eliminated to the greatest extent possible.

Public welfare in Puerto Rico aims at being a more effective weapon in this fight against poverty. To do so, it must incorporate into its regular programs additional types of preventive and rehabilitative services that will enrich the lives of children and families, that will bring to the reach of the aged and the disabled the opportunities to preserve and restore their health, and to participate to their full capacity in normal family and community life. To those unskilled, uneducated, and untrained, we must provide the opportunity to get basic education, vocational training, counseling, job finding and placement so that every unemployed or under-employed person could be incorporated into the main-stream of our progress and be given the opportunity to participate in this process to the fullest of his potentials.

Basic to these new approaches in the public welfare program in Puerto Rico is the needed improvement of assistance standards, since very inadequate payments are a serious block to any rehabilitation effort.

In the field of medical assistance for the impoverished and the needy, Puerto Rico has been planning greatly-needed improvements, on the reasonable assumption of continued federal assistance. The very threat of social security changes this year caused a halt in the implementation of these plans.

At this point in which the developed countries of the world are strongly convinced that poverty, ignorance, disease and despair will not be wiped out from the world unless those having resources make a concerted effort to help those who have not, I urged this Committee and the Congress of the United States to provide a greater impetus to Puerto Rico's public welfare program and to preserve its medical assistance program so that these systems can play their proper roles in the war against human, social and economic ills.

Finally, I should like to present for the record the official position of the Government of Puerto Rico, contained in the written statement signed by the Under Secretary of Health, Dr. Francisco Berio.

(The above referred to follows:)

STATEMENT ON BILL H.R. 12080, RESPECTFULLY SUBMITTED TO FINANCE COMMITTEE, U.S. SENATE, BY DEPARTMENT OF HEALTH OF THE COMMONWEALTH OF PUERTO RICO

The Government of Puerto Rico appreciates the action taken by the House of Representatives of the U.S. Congress in raising the dollar limit for Federal financial participation in public assistance from $9.8 millions to $24 millions by 1072. We are deeply concerned, however, by the fact that the matching formula was not changed. Modest yearly increases in the matching formula by the Federal Government have been requested along with the increase in the Federal appropriation. We respectfully request that the bill be amended so that the matching formula is increased gradually from 1968 through 1972.

H.R. 12080 imposes a ceiling of $20 million on our Medical Assistance Program under Title XIX. This provision will affect our health programs adversely. About two thirds of our population have such low income that they can not purchase private medical care. The Commonwealth operates its own medical system to provide services for this group. Setting a ceiling on Federal participation will affect the quality and quantity of the services offered. We hope that the Congress eliminates the ceiling imposed on this program.

The bill requires the establishment of free choice in Puerto Rico by 1972. Considering the high costs of such a system providing health services, the ceiling imposed on the Federal share and the additional amounts that would be required as Commonwealth appropriations, we urge that a study on the feasibility of the implementation of free choice of physicians and hospitals be carried out before such a provision is included in the Law.

The CHAIRMAN. The next witness will be Mr. Thomas Jenkins, president of the American Association of Homes for the Aging.

STATEMENT OF THOMAS M. JENKINS, PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. JENKINS. I am going to summarize.

The CHAIRMAN. Thank you very much.

Mr. JENKINS. Mr. Chairman and Senator Hartke, I am Thomas M. Jenkins of San Francisco, president of the American Association of Homes for the Aging, and I would ask at this time that the testimony which has been presented in writing with some corrections which we will add be made part of the record.

The CHAIRMAN. That will be done.

Mr. JENKINS. Our association is a national membership organization of voluntary nonprofit voluntary and governmental homes. We have been concerned with the problems of medicare legislation and have supported such legislation since our inception.

One of the major accents of our organization has been the principle of continuity of care and comprehensiveness of care.

We would like to stress that the legislation which you are considering at this time is of vital importance to the residents of homes that we represent.

In connection with that concept of quality and continuity of care, I would like to comment briefly on two general areas of concern. The first is the question of a realistic reimbursement formula. Reverend Haeger this morning, of the ANHA, used some rather dramatic language in which he stated that you were in effect legislating our nonprofit homes out of existence, and I would suggest to you that that is strongly possible under the present reimbursement formula.

We are simply unable, unless there is a more realistic approach to the question of costs, to be able to continue to meet our commitments to amortize debt, to pay mortgages.

Senator Hartke this morning mentioned briefly, or perhaps it was Senator Anderson, talked about the question of Federal payments for capital in the case of hospitals and not in the case of nursing homes. I would suggest to you that even in that area of hospital capitalization, that perhaps less than 12 percent of such capitals funds in the United States is obtained from Hill-Burton or matching funds, and that more and more it is necessary to go to private capital in order to build our institutions both in the hospital and in the nursing home and in the home for aging field, and we must have some means by which we meet the mortgage payments. There are over 100,000 voluntary institutions in the country asking for your philanthropic dollar. As long as that continues, then we must have a means by which a more realistic formula for reimbursement costs will permit us to meet our mortgages.

Another area of comment—I will again be brief. That is on the question of spell of illness. I think that the American Nursing Home Association quite accurately depicted the problems we have in that field, and we would ask your serious consideration or reconsideration of the definition of "spell of illness."

At this time I have received, as president of the American Association of Homes for the Aging, numerous letters from the institutions we represent throughout the country, in which they tell us simply that they are now dropping out of the program for extended care facilities, because the benefits to the people who were in our facilities have ended. I suggest to you that the reason is that this is the home of the people we represent, and that there is no rational basis for saying for our people that they are different because they live in the facility than the person down the street who is entitled to regenerate benefits. Therefore, we ask seriously that you consider the type of amendments suggested by ANHA, and also by the American Hospital Association, I understand, which would relate to the medical diagnosis of the patient rather than the question of where they live at a particular time.

Let me move then very briefly to some of the specifics in the legislation which you have before you. We have supported and do favor the social security increases as included in your amendments. We support the changes in the optional medical insurance—part B—program of medicare, which will allow provision for diagnostic X-rays, and podiatry.

We suggest an amendment or addition to your amendments with reference to physical therapy. I am sure that the committee is aware that at present the provisions in sec. 133 provide that physiotherapy furnished to an outpatient in his home or in a nursing home will be funded.

We suggest because there is a difference between the qualification of nursing home and extended care facility that you add the words "extended care facility." This is an area where many of the people in our homes would lose benefits because of the failure to add that phrase "extended care facility."

As to two other matters, we support the principles under what you now call 294, the Moss amendments. We think that the provision setting minimum standards for nursing institutions under title 19 is appropriate. We would suggest, however, that the present provisions in the act as to time are not realistic, and we feel that it will take some period of time, as suggested this morning by ANHA, for standards to be set up and that perhaps a more reasonable time such as 4 years would be in keeping with the intent of the legislation.

We would also advise you that we support the amendment known as the Kennedy amendment or 298. Here perhaps we might be different in our testimony than some of the others, and I might personally be different. I think that this is the beginning of an attempt which will set up some professional standards for those who are administrators in the health field, and I should think that the field itself would welcome it.

I am not sure that administrators of the homes that I represent would be inclined to agree with that statement. I do feel, however, that there must come a time when standards are set, and when there are some minimums which the Federal Government, by the kind of legislation you are considering here, must establish.

I would support the additions made this morning by ANHA, where they suggest that there be a period of time, a study, the setting of criteria, the establishment of curriculum throughout the country for a determination as to what actually a nursing home administrator should be. Nonetheless, we still say to you that with those additional safeguards, there is a need that nursing home administrators have minimum standards throughout the country, and we firmly support that proposal.

In closing, Mr. Chairman, may I say that we have as an association actively participated in developing standards of care. We are part of, and have great respect for the Joint Commission on Accreditation of Hospitals, whose accreditation program for extended care facilities fully meets the requirements for certification under Public Law 89-97, in our opinion.

Since the law provides authority for the Secretary of Health, Education, and Welfare to grant recognition of JCAH accreditation, we would recommend that you actively consider requiring such recognition.

We also continue to express our concern about the voluminous paperwork generated by medicare. It is our position that simplified methods of reimbursement under title 18 can be worked out without jeopardizing the medicare program, without opening the door to unethical practices. We would suggest in connection with that that safeguards in the utilization program be more actively considered. We would, therefore, commend the provision in the amendments for experimental methods for reimbursement and suggest a reexamination of the per diem allowances under certain circumstances as an experiment might be in order.

Thank you very much, Mr. Senator and Mr. Chairman.

The CHAIRMAN. Thank you very much, sir.

PREPARED STATEMENT OF THOMAS M. JENKINS, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

I am Thomas M. Jenkins, President of the American Association of Homes for the Aging. The American Association of Homes for the Aging is the national membership organization of nonprofit voluntary and governmental Homes for the Aged. It provides its members with a means of identifying and solving problems of mutual concern and thus protects and advances the interests of the individuals they serve. The Association has sprung from a genuine need for exchange of experience, technical assistance, help with staff training and education, and representation on the national scene so that Homes for the Aged can more effectively serve the growing number of older men and women in need of residential care.

Founded in 1961 with a grant from the Ford Foundation, the Association, sponsored by The National Council on the Aging, is made up of nonprofit institutions caring predominantly for the aged and meeting licensure standards of their own community or operating under community sanction where licensure does not exist. Membership may also be granted to organizations other than Homes and to individuals who share the aims and goals of the Association.

We appear in support of the Social Security Amendments of 1967 and in support of the amendments S1661, introduced by Senator Frank E. Moss, and S1662 introduced by Senator Edward M. Kennedy, and to present our views on particular aspects pertinent to our major concerns.

The American Association of Homes for the Aging has endorsed the Medicare legislation since its introduction into the Congress of the United States, and has also expressed the concerns of its members in testimony before the Ways and Means Committee of the United States House of Representatives as recently as March 10, 1967.

The Association and its members deeply appreciate the many progressive steps which have been taken on behalf of their clients as well as all of the aging people in our nation. It also appreciates the cordial and cooperative relationship which it has enjoyed with appropriate members of the Department of Health, Education and Welfare since the legislation was passed, and it looks forward to a continuing cooperative partnership with government in all areas of Medicare and welfare concerns.

The Association's primary concern has been the well-being of the aging of our country and places special emphasis on the well-being of the patients and residents served by nonprofit Homes. We recognize that a broad approach to the health and welfare needs of the many millions of aging in the United States may at times conflict with the well-being and needs of those whom the system intends to serve. The Association is hopeful that it can contribute its knowledge and skills in solving these conflicts and, cooperatively with government, help make the program all that Congress and those who administer it certainly intend it to be.

One of the major accents of the Association has been the principle of comprehensive care and the continuity of care of the older people. The Association has again endorsed this principle in its testimony concerning HR5710, and representatives of the Association have on various occasions stated their views concerning the significance of this principle, perhaps more vital to those in institutions serving the aging than in some other sectors of the health field.

In its concern to provide high quality care the Association has also adopted the broad principle that the providers of this care should be adequately and fairly reimbursed for the services which they have rendered.

These principles have many concrete applications, some of which remain the deep concern of the Association and the voluntary and governmental homes it represents.

The Association believes that the reimbursement formula of Title XIII should deal not merely with the out-of-pocket expenses for caring for patients, but should also include a provision for realistic depreciation costs on an economic replacement basis. It further affirms the principle that the amortization of facilities should be included as a part of reimbursable costs. In essence, the Association fully endorses the principle that reimbursement formulas should be based on the realistic financial needs of institutions. It does this with the deep conviction that unless these financial needs are met, the voluntary health system of the nation, including Extended Care Facilities and long-term care institutions, will be jeopardized.

The Association further believes that a reimbursement formula which discriminates against the voluntary health system and more fully reimburses the for-profit sector of the health system is inequitable and not in the best public interest.

H.R. 12080 (SOCIAL SECURITY AMENDMENTS OF 1967)

We favor the increases in Social Security benefits as included in these amendments. Moreover, we support the changes in the optional medical insurance

(Part B) program of Medicare which will allow provision for diagnostic X-rays (Section 131) and Podiatry (Section 127).

In regard to physical therapy, we welcome, as well, the addition to the Part B program which covers physical therapy furnished to an outpatient in his own home or in a nursing home. We would urge an *addition* to this section (133) so that these services would be covered where they are furnished under the supervision of a hospital *or an extended care facility.*

One of the implications of the basic principles for which the American Association of Homes for the Aging stands is that the aging individual residing in an institution has the same right to regenerate his benefits under Title XVIII as the individual who does not happen to have or need the services of a well-qualified institution. Essentially, this right has not as yet been recognized by law. The continuing question of the regeneration of benefits in a nonprofit home for the aging still proves a troubling one. While attempts are being made to regenerate Title XVIII benefits in a distinctly residential area of a home, it is our conviction that aging people in long-term care institutions or in many long-term care sections of institutions should also, as a matter of equity, be permitted the regeneration of benefits in these areas, even if they also are normally designated as ECF sections of homes.

We note the attempt in these amendments to provide an additional 30 days of care during a spell of illness. This attempt to provide more benefits does not go to the core of the problem. At present the older person who *resides* in an institution which provides a variety of health care and residential facilities, and has used up his presently authorized 90 days of inpatient hospital care and presently authorized 100 days of extended care facility benefits, cannot start a new spell of illness and become entitled to further care unless he moves his residence or is moved for at least 60 days to an institution or a part of an institution which does not provide skilled nursing care to anyone.

Thus, he loses his Medicare benefits if he resides in this kind of long-term care facility. If we do not provide a means for the many thousands of elderly patients to regenerate spells of illness beyond the first we are seriously denying them their human rights and, moreover, are creating profoundly serious problems for County and State Departments of Public Welfare and Health.

We are seriously concerned with this disenfranchisement of older people who are in the need of and now being provided residential and nursing care in the same institution. Medicare benefits should not only apply to the extended care facility participating under the control of a hospital. Many nonprofit Homes throughout this country have fought for, have developed high standards, and have supported the Medicare legislation, in principle and in fact, and are now discovering many serious impediments.

RECOMMENDATION

We recommend a more equitable means of terminating the spell of illness. We suggest the full use of medical diagnosis and utilization review procedures (provided for in the Medicare legislation) as a means of determining the older person's need for extended care and/or skilled nursing care. This could be an effective and feasible way of terminating a spell of illness and still assure the older person, his family, fiscal intermediaries, the community and the government that the older person is getting appropriate care and is receiving his deserved benefits under Social Security.

We wish to support the principles underlying Bill S1661, introduced by Senator Moss of Utah, amending the Social Security Act, as an attempt to provide high quality care for older people. These concerns would benefit the entire field of long term care and would not place unreasonable requirements in the way of this care. In giving clear authority to set minimum standards for institutions providing skilled nursing care to Title XIX patients we must point out that clear direction and realistic support of these measures need to be given by the Department of Health, Education, and Welfare, if these standards are to develop realistically and in fact. To be consistent with the original intent of Congress, which intended Title XIX as a program whereby the states would provide programs of care, we would suggest that steps need to be taken by the Department of Health, Education, and Welfare to aid states in developing these minimum standards. In addition we would suggest a reasonable time to be established (possibly 4 years) by which time states would be expected to meet minimum Federal standards. Moreover, we welcome the provision of reimbursement of "reasonable cost of care" to Title XIX as provided under Title XVIII.

The Association believes that a strengthening of the Utilization Review program, to guarantee that possible abuses of Title XVIII monies do not occur, will help prevent unethical use of Title XVIII funds.

We believe that these measures will create significant safeguards, permitting equity to be granted to the institutionalized aging, who have a right to reimbursement for hospital and ECF care, whether they are receiving Title XIX funds or whether they still retain their own financial resources. It is especially this latter group which deserves the full attention of the Federal Government in their search to provide equitable care under the Medicare provisions.

It is the firm conviction of the Association that adequate reimbursement for care on all levels, including the "social care" homes or parts of homes, from both the Federal and the State government, will tend to keep the costs of reimbursement on the lowest possible level, since it will help to eliminate the practice of placing residents and patients in unnecessarily high levels of care.

The Association has consistently maintained this position. In its representations to Congressional committees and to appropriate members of the Department of Health, Education, and Welfare, it has affirmed its adherence to the principle that Title XVIII and XIX should be fully meshed with each other and should supplement each other. It has pointed up the difficulties Homes in various states have experienced when the Title XIX reimbursement payments have been inadequate, and the Association has further underscored the fact that many patients under Old Age Assistance or Title XIX benefits often need more intensive care than do many post-hospital cases in Extended Care Facilities.

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In its concern for high quality care, the Association has repeatedly expressed itself on questions of standards and supported Federal and state efforts to raise the standards of health care in Extended Care Facilities and long-term care institutions. It has also supported and cooperated with a variety of governmental agencies in providing the vital programs and training necessary to improve this quality of care and to raise national standards.

Therefore, we support the amendment introduced by Senator Kennedy (Bill S1662) as an important step toward developing minimum standards. We would suggest, however, that the timing provided in this bill is somewhat unrealistic and will present real difficulties for many of the states to take the necessary steps to meet its provisions. We recommend full support of all attempts to encourage necessary curriculum development, assistance as well as direction, and an adequate provision of time (possibly 5 years after enactment) to enable states to take the necessary steps to meet the requirements of this bill.

We would offer the assistance of our Association in developing the necessary standards and guidelines for this licensure program.

STANDARDS

This Association has participated actively in developing standards of care for the older people in our country. The Joint Commission on Accreditation of Hospitals' accreditation program for extended care facilities fully meets the requirements for certification under Public Law 89–97. Since the Law provides authority for the Secretary of Health, Education, and Welfare to grant recognition of the JCAH Accreditation program, we would recommend such recognition.

The Association also continues to express its concern about the voluminous paper work generated by Medicare. It is the position of the Association that simplified methods of obtaining reimbursement for Title XVIII patients can be worked out without jeopardizing the Medicare program and without opening the door to unethical practices. We would commend provisions in these amendments for experimental methods for reimbursement and would suggest that a re-examination of *per diem* allowances be in order.

The Association looks forward to a further discussion of some of these issues in an effort to resolve them and again expresses its appreciation and hope that the cordial relationship between the Social Security Administration staff and others concerned with the Medicare program and the Association will continue to deepen and increase in mutual understanding of problems as well as their eventual solution.

The CHAIRMAN. Next, we will hear from Mr. August F. Hook, president of the Hook Drugs Co., of Indianapolis, in behalf of the National Association of Chain Drugstores, Inc.

Senator HARTKE. I would like to point out this witness is a resident of my home State and owns a series of drugstores in my home State and I am glad to see him here today.

The CHAIRMAN. Senator Hartke is very hard working and is a highly regarded member of this committee. We are mighty proud to have your Senator as a part of our committee. He doesn't always agree we me, but he is a great advocate of what he believes in.

STATEMENT OF AUGUST F. HOOK, PRESIDENT, HOOK DRUGS, INC., AND PRESIDENT OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC., ACCOMPANIED BY ROBERT J. BOLGER, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF CHAIN DRUG STORES; AND JOHN R. McHUGH, CHAIRMAN OF THE ASSOCIATION'S TASK FORCE ON FEDERAL HEALTH PROGRAMS AND DIRECTOR OF PROFESSIONAL SERVICES, PEOPLES DRUG STORES, INC., WASHINGTON, D.C.

Mr. HOOK. Mr. Chairman, my name is August F. Hook and I am here in my capacity as president of the National Association of Chain Drug Stores. I am a registered pharmacist in Indiana, a graduate of the Purdue University College of Pharmacy and serve as president of Hook Drugs, Inc.

I have with me Mr. Robert J. Bolger, executive vice president of the National Association of Chain Drug Stores and Mr. John R. McHugh, chairman of the association's task force on Federal health programs and director of professional services of People's Drug Stores, Inc., based here in Washington, D.C.

The National Association of Chain Drug Stores is an association which was founded in 1933 to represent the Nation's operators of multiple-retail outlets for dispensing drugs and a wide variety of nondrug products. The association's 160 member companies operate more than 5,700 drugstores in the 50 States and Puerto Rico, and have 100,000 employees, 15,000 of whom are pharmacists. Estimated sales volume of chain drugstores during 1967 will exceed $5 billion. Although chains operate only 24.8 percent of the retail drugstores, they account for 48.3 percent of sales.

As the spokesman for the Nation's chain drugstores, we are very grateful for the opportunity to appear before this committee to comment on the proposed legislation and to give you our suggestions and observations based on our extensive experience in the drug-dispensing field.

Our members strive to bring to the public the widest selection of top-quality drugs at the lowest possible cost to the customer. Chain drugstores are able to dispense drugs to the public at lower than ordinary prices because our customers share in the economy we effect through volume buying, volume selling, and efficient operation. Chain drugstores have traditionally kept drug prices low because of the volume of nondrug merchandise we also sell.

As taxpayers and pharmacists we are concerned about the practical applications of the method of reimbursement.

The present language in section 2005(a)(1) with respect to reasonable charge for drug products could have the effect of raising prescription prices by drugstores not now using a professional fee method of pricing to a level where the usual or customary charge becomes the same as the professional fee. The result would be to raise the price of drugs to the general public.

For example, if a pharmacist needs a gross profit of 40 percent based on selling price, he must charge $1 for an item which costs him 60 cents and $10 for an item which costs him $6. Handling the 60-cent item is generally not profitable for him, but because handling the $6 item is profitable, he is able to offset what he might lose on the lower cost item.

However, if a pharmacist uses cost plus a $2 professional fee, his charge on a 60-cent item would be $2.60, instead of $1; and his charge on a $6 item would be $8, instead of $10.

The language in section 2005(a)(1) would require the pharmacist to charge on each item either the "actual or accounting basis cost plus professional fee" or his "usual or customary charge," whichever is lower.

In the illustration given, the pharmacist using the markup system, would be compelled to charge $1 on the 60-cent item, while the pharmacist using the fee system would be allowed to charge $2.60 on the same item. In other words, the customer would pay more than two-and-a-half times as much.

Since the legislation would impose a ceiling on the higher priced item, the pharmacist would not be permitted to charge his "usual or customary charge" on that item, but would be forced to charge his "usual or customary charge" on the lower priced item.

As a practical business matter, the pharmacist would have to raise his "usual or customary charge" on the lower priced items or accept an inadequate return on those prescriptions.

It is estimated that approximately 85 percent of the prescriptions we fill are for less than $5. So you can see that the net effects of this bill as it is presently written would be to raise rather than lower drug prices. We do not believe that this is the intent of this legislation.

Mixing the two systems would work an undue hardship on the practicing pharmacist who for competitive reasons cannot increase his charges on his low-priced prescriptions which represent the bulk of the prescriptions which he dispenses.

Obviously then, mixing the two systems would be inequitable. If the professional fee established by the Secretary of Health, Education, and Welfare is correct, then it should be applied to the lower priced items, as well as the higher priced items.

We recommend that the language in the bill be amended to reflect this. It is my understanding, our people have been in contact with your staff regarding an amendment which would partially satisfy our objection.

While a majority of our members could support the professional fee method of pricing prescriptions, many cannot employ this system at this time because of competitive reasons.

Now, we would like to turn to another point. There are several terms used in this bill which are subject to varying interpretations. We recommend, therefore, that a new section be incorporated into the bill containing specific definitions of the terms used. We feel that this would help to clarify the intent of Congress and facilitate compliance.

For example, section 2005(a)(1)(A) refers to the "actual or accounting basis cost."

By "actual" cost, we assume the bill means the cost of putting the item on the shelf of one of our chain drugstore units, which would include warehousing, handling, and distribution costs.

It is unclear what is meant by "accounting basis cost."

At the present time, it seems impossible to review every drugstore invoice to determine acquisition cost. Even if this information were available to us, acquisition cost would vary, with respect to each individual chain drugstore unit, and also to every other pharmacy as well.

With respect to acquisition cost, we recommend that since the American Druggist Blue Book and the Drug Topics Red Book are available to every drugstore in this country, the wholesale price to the retailer listed therein be used as the main source for determining acquisition costs. Granted there are variances. Discounts are available to both chains and independents when they buy direct or in large quantities. But, with the blue or red books as a source for determining acquisition costs, you have an accepted pricing compendium listing every available prescription or OTC product. The Government would have less administrative cost in determining acquisition costs by using this method.

Since NACDS represents small, medium, and large drug chains which utilize various methods of pricing prescriptions, we urge that every effort be taken to adopt a method of reimbursement which will best benefit the public, the Government, and pharmacy.

There is another factor which would increase the cost of drugs. One reason drugstores are able to sell drugs at such a low cost is that the sale is on a cash basis. If, however, the drugstore is forced to await reimbursement from the Government, the costs of this tieup in capital will have to somehow be reflected in the cost of the drugs. It would be preferable, therefore, that the customer be required to seek reimbursement, rather than the pharmacist.

However, if pharmacists are required to seek reimbursement, we strongly urge that, regardless of the system adopted, a simplified plan for reimbursement be established because burdensome redtape results in increased cost to the public.

Turning to section 2005(b), the National Association of Chain Drug Stores is most anxious to cooperate with the Secretary of Health, Education, and Welfare to insure that the public is properly served in this vitally important phase of the health care field. We believe we can be helpful in developing the mechanisms and procedures for implementing Federal health programs involving the dispensing of drugs. NACDS should especially be consulted when the levels of reimbursement are being formulated as proposed in this legislation. Chain drugstores dispense more than 120 million prescriptions per year and employ more than 20,000 pharmacists. NACDS is the spokesman for these pharmacists. Since we have no State affiliates, NACDS acts on the local and national levels to keep its members abreast of all developments affecting chain drugstores.

With regard to the bill in general, we submit that this may not be the most appropriate time to act on this legislation. Since HEW foresees numerous problems which would result from this legislation and because the task force on prescription drugs has not yet completed its study or made its report, we recommend that a decision on S. 2299 be deferred until these findings are available.

We are grateful for this opportunity to appear before this committee to comment on the proposed legislation and to give you our suggestions and observations based on our extensive experience in the drug-dispensing field.

Senator HARTKE. Thank you, Mr. Hook. We are glad to have you here. I do not have any questions. I think I understand what you are talking about. We appreciate your waiting so long.

Mr. HOOK. I know that; yes, sir.

Senator HARTKE. Thank you, gentlemen.

Gentlemen, we have a problem here. As you know, we have gone on here until it is now close to 5 until 2. We can do one of two things. We can adjourn these hearings and start them back up at 5 o'clock this afternoon, or if the rest of you witnesses think you can complete your testimony, I am willing to stay until 2 o'clock.

Now, Raymond E. King, Carl Rachlin, Dr. Elizabeth Wickenden, and Mrs. Allen, if you all want to try to squeeze it in within the next 7 minutes, I will be glad to permit you all to take until 2. If you want to come on back, you may at your convenience.

Mr. King, how long will you take?

Mr. KING. Mr. Chairman, I think I can do it in 2 or 3 minutes.

Senator HARTKE. How about Carl Rachlin? Dr. Wickenden—where is Dr. Wickenden? She is not here either. And Mrs. Allen.

Mrs. ALLEN. Mine is very short.

Senator HARTKE. Can you do it in 2 or 3 minutes?

Mrs. ALLEN. About three and a half minutes.

Senator HARTKE. I will stay in 6 minutes if you people can complete it. Otherwise, we are going to adjourn at 2 o'clock sharp in the middle of a sentence or in the middle of a paragraph, and we will come back at 3 so you can make up your minds. If you want to have a nice weekend you can accommodate yourselves. The entire statements will appear as though they were read in full.

Mr. King, I am perfectly willing to come back at 3 o'clock.

Mr. KING. Whatever you wish, Mr. Chairman.

Senator HARTKE. I would just as soon go ahead now but this is up to you.

STATEMENT OF RAYMOND E. KING, JR., CHAIRMAN, NALU COMMITTEE ON SOCIAL SECURITY, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. KING. I am Raymond King, chairman of the Social Security Committee of the National Association of Life Underwriters. I will present for the record if I may my complete statement.

Senator HARTKE. Yes; it will be inserted.

Mr. KING. Let me say just briefly that we approve of the social security program as a means of providing basic economic protection against economic want and need, but believe that overexpansion of benefits beyond basic needs violates the purposes of the program, since additional supplemental retirement benefits should be provided by the private sector of the economy.

Here on my right is a chart comparing the additional cash benefits available at the maximum level for social security beneficiaries under the terms of the administration's proposal, with retirement benefits provided for the equivalent premium by private insurers. This chart illustrates that private retirement benefits substantially in excess of retirement benefits provided under social security are available from commercial insurers. Our prepared statement explains the chart in detail.

We would also like to draw your attention to our proposal for an independent and comprehensive study of the entire social security program, including benefits, costs, and financing. We believe that this study should include an appropriate analysis of the role of private retirement benefits and their relation to public retirement programs. We would earnestly encourage your consideration of a blue ribbon independent comprehensive study of the social security program.

Thank you very much.

Senator HARTKE. Mr. King, let me say I assure you I personally will go over this entire matter in depth and will look into it. I am inclined to be very sympathetic with your last suggestion. I think that one of the real problems in Government is the fact that there is no really comprehensive legislative oversight, that is to look over and see what you have done and reexamine it in the light of what you are trying to do.

Mr. KING. We think that is very definitely true.

Senator HARTKE. Frequently, what happens in the Government is we do something and after we have done it, we continue it ad infinitum without ever looking back to see whether it is serving the original purpose for which it was intended, or even the purpose which it may have been good for at the time, and times and conditions change and it does require additional thought and approaches, so I want to thank you. I really think it is a good suggestion.

Mr. KING. Thank you for your consideration. We feel that it perhaps deserves consideration. Thank you, sir.

(Mr. King's prepared statement follows:)

PREPARED STATEMENT OF RAYMOND E. KING, JR., NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

I am Raymond E. King, Jr., CLU of Charlotte, North Carolina, and I am appearing before your Committee today as the Chairman of the Committee on Social Security of The National Association of Life Underwriters and also as Secretary of the Association's Board of Trustees. For your information, our organization is a trade association composed of 937 state and local life underwriter associations representing a membership of about 103,000 life insurance agents, general agents and managers residing and doing business in virtually every locality in the United States.

We appreciate this opportunity to present our views with respect to certain of the proposed revisions in the Social Security system.

I. H.R. 12080

Prior to commenting on any specific recommendations contained in H.R. 12080, I should like to summarize our basic position with regard to the Social Security program and its objectives and purposes.

We believe that the Social Security program was designed to provide a basic floor of protection against economic want and need, financed by earmarked taxes imposed upon employers, employees and self-employed individuals and by earnings on the Social Security trust funds. It was intended that upon this basic floor, each covered person, by individual and employer initiative, would plan and build additional economic security for himself and his family by means of private savings, investments, insurance, pension programs and the like.

As thus originally conceived and designed, the Social Security program is socially and economically desirable; but to insure its continued existence, it is essential that the program be soundly maintained. Overexpansion of the program must be avoided, since such overexpansion would substantially increase the tremendous financial burden already facing present and future Social Security taxpayers, and pose a threat to the safety and continued existence of the program itself.

Apropos of the foregoing, every further expansion of existing Social Security benefits, or the addition of new types of benefits, would lessen the traditional incentive of Americans to provide economic security for themselves and their families through voluntary, private programs. In addition, the increased Social Security taxes necessary to finance each such expansion would reduce the financial ability of Americans to undertake and carry out such voluntary, private programs.

We believe that the House of Representatives, in rejecting several Administration proposals contained in H.R. 5710, recognized the soundness of these foregoing basic principles which have guided the development of the Social Security system since its inception. In particular, we are pleased that the House rejected the Administration's proposal to increase the taxable earnings base in three steps to $10,800.

We support a reasonable increase in cash benefits to maintain the purchasing power of these benefits in the face of recent cost-of-living increases and the lessened value of the dollar. While we are concerned over the rising cost of living and the inflationary trend of the economy, we recognize that it would be unfair to place the burden of the devalued dollar on retired and other individuals who must live on fixed incomes.

However, we are concerned that expansion of benefits beyond basic needs lessens the ability of millions of covered individuals to make private provision for their retirement needs. As we noted above, we believe that Social Security should provide a basic floor of economic protection, but that covered individuals should retain the responsibility of building additional protection for themselves and their families through their own means and initiative. Every increase in Social Security taxes lessens an individual's ability to provide for his own needs.

In this connection, we prepared a study for the House Ways and Means Committee at its request comparing the additional cash benefits available at the maximum level for Social Security beneficiaries, under the terms of the Administration's proposal, with retirement benefits provided for the equivalent premium by private insurers. This study is attached to our statement as Exhibit #1.

We believe this comparison illustrates the need to contain over expansion of benefits and limit any current benefit increase to that warranted by the rise in the cost of living. Since private retirement benefits substantially in excess of retirement benefits provided under Social Security are available from commercial insurers, it is highly undesirable and unwise to increase cash benefits to a level where they discourage individuals from providing themselves with supplemental retirement protection.

If Social Security fulfills its primary function of providing covered individuals with basic economic protection at retirement, or in the event of disability, it has fulfilled its obligation. However, when benefits are expanded beyond this economic floor, Social Security competes unfairly with private benefits to the disadvantage of the individual.

In reference to the method of financing benefits, H.R. 5710 recommended as a partial method that the taxable earnings base be increased in three steps from the current $6,600 to $10,800 by 1974. This increased base would raise the ultimate maximum benefit payable to a worker from $168 a month under the present law to $288 a month under the $10,800 base. H.R. 12080 would raise the wage base in one step to $7,600 in 1968. This would increase the maximum benefit in the future to $212.

We believe that it is undesirable to finance the Social Security program by increasing the earnings base beyond the average earned income of covered workers. First of all, this would have the effect of providing increased benefits to individuals with above-average earnings who are least in need of such benefits. At the same time, because of the weighted nature of the benefit formula in favor of lower income groups, individuals with above-average earnings would be required to bear an unduly disproportionate share of the financing of the program.

or, to put it another way, would be required to increase the substantial "subsidy" that they are already paying to the system.

Furthermore, increased benefits to individuals with above-average earnings, as we indicated earlier, impairs the incentive of these individuals to provide themselves with adequate supplemental retirement benefits. There is absolutely no justification for increasing the benefits of these persons, since they have been provided with an adequate floor of protection.

If additional revenue is needed to support a cost-of-living increase in benefits or any additional liberalization of the program, we believe that such additional revenue should come from increased Social Security tax rates, rather than from any further increase in the taxable earnings base beyond the current level of $6,600. We feel this will serve to equalize the burden of financing the system among all covered individuals.

In further reference to the method of financing Social Security benefits, we are pleased that H.R. 12080 essentially recognizes and adheres to the sound and vital concept of payroll tax financing.

We wish to go on record as stating our complete opposition to the use of general revenues to finance any benefits provided under the Social Security Program other than those provided on a basis of real and provable need. Financing of the program by means of earmarked taxes paid by employers, employees, and self-employed individuals which are neither excessive nor inadequate, is essential to provide not only necessary control over both the types and levels of Social Security benefits but also a greater measure of assurance that scheduled benefits will in fact be paid. Control of the system would be seriously weakened if general revenues were ever used to finance the benefits to any significant degree since the source of the financing would tend to get lost in the over-all Federal budget and the true cost of the system would be greatly obscured.

H.R. 12080 rejects the Administration's proposal to extend Medicare protection to persons who are under 65 but getting Social Security benefits because they are severely disabled. We believe it would be inappropriate and unwise to substantially extend and expand the Medicare program at this time in light of the limited and uncertain cost experience under the existing program since its enactment and implementation. We believe, therefore, that the House acted wisely in postponing any basic changes in this program until the actual cost of the Medicare program can be more precisely determined and the need for this coverage substantiated.

H.R. 12080 also includes provisions limiting federal payments for state-administered medical assistance programs (Medicaid). Under the proposal, beginning July 1, 1968, the federal government wouldn't contribute for Medicaid for anyone earning more than 150 percent of the annual income standard set by a state for welfare-aid eligibility. The ceiling would drop to 140 percent in 1969, and to 133⅓ percent in 1970. We support this proposal as an effort to prevent undue and excessive utilization by the states of this program.

This concludes our specific comments with regard to H.R. 12080. In summary, we agree that the burden of increased cost-of-living should not be borne by individuals on fixed income, and we would, therefore, support a reasonable cost-of-living increase in cash benefits. But we hope that undue expansion of the program beyond a reasonable floor of protection and creation of new or additional coverage without full preliminary study of all relevant factors will be avoided. In particular, we would hope that expansion of the program, without adequate recognition of the role of the private sector and the availability of private retirement benefits, would be avoided.

II. INDEPENDENT REVIEW AND STUDY OF THE SOCIAL SECURITY SYSTEM

Social Security has gradually grown and expanded from its modest beginnings in 1937 to the point where it encompasses almost the entire working population and provides benefits never envisioned at its inception. Over the years, volumes of literature—the fruits of years of study and research—have appraised all aspects of the System. The volumes of testimony presented Congress alone is ample evidence of the thought which has gone into the study of the various roles of Social Security in assuring the basic needs of individuals. However, no comprehensive and overall appraisal of the Social Security system as it currently exists or as to its future projections is presently available.

You are aware, more than we, of the complexities of the system and the difficulty in assessing the factors involved in appraising such proposals as those involved in H.R. 5710 and H.R. 12080. We suggest, therefore, that a careful study and review of the System and all its aspects is needed at this time.

Our Association is gravely concerned over the implications involved in several proposals to expand Social Security, as our testimony today indicates. We are fearful that the original objectives of the program and its basic role are being lost sight of and that short range tampering with isolated aspects of Social Security might undermine the total structure.

In view of these factors, we believe a comprehensive independent study of the Social Security program, its benefits, costs and financing should be undertaken by independent authorities representing all segments of the economy.

We would hope that appropriate analysis of the role of private retirement benefits would be included as part of any such study. The Administration, in a report on "Public Policy and Private Pension Programs" issued by the President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs, and Congress, in conducting hearings on private pension plans (Joint Economic Committee) and extending private pension coverage (Senate Special Committee on Aging), have initiated what we believe will be a long-range and comprehensive study of the role of the private pension system in providing adequate supplemental retirement income. The role of the private sector and its present and future impact on retirement programs should be thoroughly studied prior to an expansion of the public role beyond reasonable boundaries. We hope, therefore, the Congress will consider the very real relationship between private and public benefits and refrain from expanding Social Security to unreasonable limits that might impede the growth of private pension plans and other retirement programs.

We hope the Committee will consider this relationship in evaluating the proposals contained in H.R. 5710 and H.R. 12080 and in considering the need for further study of the respective roles of both systems in providing adequate retirement protection for the workers of this Nation.

In testifying before the Joint Economic Committee last year, Commissioner Robert M. Ball of the Social Security Administration noted that "private plans cannot reasonably be considered separately from the public program . . ." Similarly, we do not believe that the public program can be considered separately from the private program. Commissioner Ball further stated:

"Private pension plans in recent times have taken on more of a general public purpose and tend now to be justified on the ground that they make an important contribution to the Security of a large number of workers—providing for them in combination with Social Security a much higher level of living in retirement that would probably be reasonable to expect from even a substantially liberalized Social Security program standing alone. There is little doubt that private initiative will continue to foster plans supplementary to the broad base of the public program and it is important that they be shaped in the public interest."

The report of the President's Committee concluded that private pension plans "should continue as a major element in the Nation's total retirement security program." It added that "public policy should continue to provide appropriate incentives to private plan growth, and by improving the basic soundness and equitable character of such plans, set a firmer foundation for their future development."

We further believe that our comparative study of Social Security and private retirement benefits underscores the need for a complete and comprehensive study and reappraisal of the relationship of public and private retirement programs. We believe this study illustrates the superiority of private programs and the need to construct public programs that will expand rather than contract the growth and development of private benefits.

We further contend that a thorough examination of the Social Security program would serve to properly focus the attention of Congress on the objectives and purposes of the System and, in so doing, remove inequities and restore a better balance between contributions and benefits.

In conclusion, we believe that comprehensive and independent analysis of the future of Social Security, the impact of recent amendments on the program, and the relation of private and public benefits is necessary to evaluate the effect of further liberalizations. We, therefore, hope that your Committee will exercise extreme caution in reviewing the 1967 proposals for changes in the Social Security program and will initiate a study to provide a firmer basis for projecting the future of Social Security and its relation to the private sector.

EXHIBIT #1

The Committee on Ways and Means asked our Association to prepare a comparison of the additional cash benefits available at the maximum benefit level for Social Security beneficiaries under the terms of H.R. 5710, with retirement benefits provided for the equivalent premium by private insurers.

We recognize that any comparison of relative benefits available under Social Security and under contracts with private insurance companies is exceedingly difficult in view of the essential differences between public and private retirement programs. However, we believe the following illustration will show the comparative retirement benefits available under the two systems.

In 1974, under the provisions of H.R. 5710, Social Security would entitle an individual to receive at retirement a maximum monthly cash benefit of $288, an increase of $120 a month over the maximum retirement benefit he would be eligible to receive under current law in 1974.

Under the terms of H.R. 5710, OASDI benefits (excluding hospitalization) would be financed at a tax rate of five percent each on employers and employees on a $10,800 taxable earnings base, resulting in a maximum combined employer-employee annual tax of $1,080.00. This would represent an increase of $439.80 over the scheduled tax of $640.20 that would be paid in 1974 under current law.

According to Robert J. Myers, Chief Actuary of the Social Security Administration, 28.3 percent of the OASDI tax represents the contribution for disability benefits an individual is entitled to receive prior to his attaining age 65, and benefits his survivors would be entitled to receive if he dies prior to attaining age 65. Therefore, 71.7 percent of the OASDI tax represents the amount contributed for retirement and survivorship benefits for individuals who have reached age 65.

Applying this percentage (71.7%) to the $439.80 tax increase contemplated by H.R. 5710, the combined employer-employee annual tax necessary to entitle an individual to additional monthly maximum retirement benefits of $120 at age 65 would be approximately $315. A retired individual and his wife would be entitled to additional benefits of $126 per month, and the individual's widow would be entitled to additional survivorship benefits of $99 per month.

The chart which follows this statement illustrates the amounts of benefits available under annual premium retirement annuities that could be purchased with the foregoing additional combined employer-employee contribution of $315 scheduled in 1974, if an insurance premium corresponding thereto were paid from ages 21 and 25 up to age 65.

It should be noted that Social Security benefits are subject to the retirement earnings test which eliminates benefits for certain individuals whereas the private retirement annuity is payable automatically when an individual reaches age 65. Also, whereas the private retirement annuity does not provide death benefits after age 65, the cash value of the annuity or the premium paid, whichever is greater, is paid to an individual's survivors if he dies prior to attaining age 65 or to himself if he should surrender the annuity prior to retirement. This benefit is not available to Social Security beneficiaries.

MONTHLY RETIREMENT BENEFITS AVAILABLE FROM REPRESENTATIVE COMMERCIAL INSURERS FOR $315 PER ANNUM COMPARED WITH INCREASES IN MONTHLY SOCIAL SECURITY BENEFITS PROVIDED BY A LIKE TAX INCREASE

Age at issue	Guaranteed cash at 65, commercial insurer	Dividends estimated at age 65	Total cash estimated at age 65[1]	Individual benefits		Individual and survivor benefits				
				Social security	Commercial insurer, estimated retirement annuity	Social security (while husband and wife live)	Commercial insurer (estimated retirement annuity while husband and wife live	Social security		Commercial insurer (survivor benefit for either husband or wife)
								While husband lives	While wife lives	
Age 21:										
Company A	$22,225	$14,311	$36,536	$120	$278	$126	$244	$120	$99	$161
Company B	24,826	9,982	34,808		272		237			158
Company C	22,591	12,561	35,152		257		225			150
Age 25:										
Company A	19,059	10,760	29,819	120	227	$126	198	120	99	131
Company B	21,145	7,521	28,666		224		195			130
Company C	19,291	9,412	28,703		209		184			122

[1] Dividends cannot be guaranteed.

Senator **Hartke.** All right. Now then, we have Mrs. Allen. How are you, Mrs. Allen?

STATEMENT OF MRS. DeLESLIE ALLEN, PRESIDENT, NATIONAL FEDERATION OF SETTLEMENTS AND NEIGHBORHOOD CENTERS, NEW YORK CITY

Mrs. **Allen.** Fine, thank you, sir.

I am Mrs. Allen of Rochester, N.Y., and a volunteer and president of the National Federation of Settlements and Neighborhood Centers.

Our testimony, which is in your hands——

Senator **Hartke.** This will all be included in full.

Mrs. **Allen.** It is very specific concerning provisions of H.R. 12080, that we support. It is also specific in constructive proposals we make to alternates of provisions that seem unusually progressive. Therefore, I will make my remarks supporting my testimony much more general and I plan to make them quite short.

As you know, we represent affiliates who have neighborhood centers in 399 low-income areas in 94 cities in 30 States. Our testimony is based on a very intimate knowledge of the kinds of things that affect the lives of these people. We welcome the opportunity to speak on this bill on behalf of the well-being of our neighborhoods, and our deep concern about these issues was shown when we devoted a full afternoon at our national board meeting in January to a discussion of public welfare.

Our member agencies testified at all six of the regional hearings conducted by the advisory council on public welfare, of which I was one of the 12 members.

We are all, legislator and citizen taxpayer alike, concerned about the fact that in this most affluent Nation in the world, some 8 million persons are dependent on precariously low level of assistance, and that an additional 26 million are living below the income level which the Government itself defines as constituting poverty in this country.

I believe that we all share the same concern that those who are physically and mentally able should be given the tools and the resources that will help them to become self-sufficient and contributing members to our economy rather than existing on handouts.

However, when one small segment of the population is separated out as in the House bill and new and unnecessary sanctions are imposed upon individuals and a financial penalty is imposed on States holding the family caseload at the January 1967 level, we are taking a step toward becoming not a health Government but an oppressive Government.

Each time the Government takes on new program responsibilities there must be equivalent protections for the rights of those affected by the programs, and this is why the advisory council on public welfare report in emphasizing the rights and guarantees to the citizen in his most vulnerable situation follows the highest traditions of American democracy.

The advisory council also pointed out that the lack of social services for families, children, young people and individuals isolated by age or disability is itself a major factor in perpetuation of such social evils as crime and juvenile delinquency, mental illness, illegitimacy, many generations of dependency, slum environments, and the widely deplored climate of unrest, alienation, and discouragement among the many groups of the population.

The National Federation of Settlements speaks from the everyday personal knowledge and experience of these member agencies in 94 cities, who know and work with many of the individuals most affected, and these may be Mexican Americans or Puerto Ricans, Chinese, Japanese, or Negroes. We also know what can happen when someone is given the encouragement and supporting services to work toward becoming self-sufficient, and I personally have seen women who were on welfare in AFDC get the kind of training in sewing in my own community where there is a large clothing industry, where they were able to, with the support of the clothing industry and the Department of Labor in that town, and with the support of our own settlement house, go off welfare and become self-sufficient. But it took the supporting services of all the elements in the community.

I need not tell you what happens as a result of alienation and discouragement, because I think we have all seen it across the country this summer, and I leave it to you to judge which in the long run is the more costly in terms of dollars, and damaging to the economy of our Nation.

Therefore, we do approve the increase in social security benefits, the increase in the earnings exemption. We favor as changes an increase in the minimum benefits to $100 a month or $150 for a couple, extended coverage to agricultural workers and disabled widows, as proposed by the administration.

We favor changes in the medicare-medicaid programs, extending medicare to those under 65 drawing disability benefits, including prescription drugs and eye examinations and benefits, setting the income ceiling on coverage on 50 percent of the State public assistance level of needs proposed by the administration, making no change in the present requirement of the five basic services.

In regard to public welfare, we approve making AFDC-UP permanent but without new restrictions. Constructive features such as family planning, day-care extension, skilled counseling, extension of child welfare services to all children, but with the birth bill provisions.

We favor as changes the elimination of the punitive and coercive measures, elimination of the freeze on AFDC payments to States, inclusion of the administration proposals that States be required to meet their own minimum standards, and we also approve the provisions of social work education.

We thank you.

Senator HARTKE. Mrs. Allen, thank you for a very fine statement, especially for your consideration of the fact that the payments should be increased to at least $100 and $150 for a couple on minimum payment, with people having the opportunity to eliminate the earnings test.

Do you have any organizations in my State of Indiana?

Mrs. ALLEN. Yes, we have, in Indianapolis. We have a couple of settlement houses there, neighborhood centers.

Senator HARTKE. I want to thank you for a very fine statement and for your consideration.

Mrs. ALLEN. Thank you, Senator.

(Mrs. Allen's prepared statement follows:)

Prepared Statement of Mrs. DeLeslie Allen, National Federation of Settlements and Neighborhood Centers, New York, N.Y.

I am Mrs. DeLeslie Allen of Rochester, New York, a volunteer and President of the National Federation of Settlements and Neighborhood Centers, 232 Madison Avenue, New York. Our Federation is composed of 262 affiliates who conduct neighborhood center programs in 399 low-income areas in 94 cities in 30 states. Our testimony is based on an intimate knowledge of those whose lives are affected by the proposed legislation, and it is based on the official position of the Federation, adopted at its annual meeting in May, 1966.

We welcome an opportunity to speak on a bill so basic to the well-being of neighborhoods. Our deep concern about these issues was shown when we devoted a full afternoon of our National Board meeting in January of 1967 to a discussion of public welfare. Our member agencies testified at all six regional hearings conducted by the Advisory Council on Public Welfare, of which I was a member.

Many of the provisions of H.R. 12080 are constructive and in line with the goals that we have advocated. But other provisions seem unusually regressive. We shall comment specifically on several sections of this very complex bill.

SOCIAL SECURITY

At its annual membership meeting in 1966 the National Federation of Settlements declared that its basic goal was a "federal program insuring an adequate minimum income to all individuals and families." It believes that our affluent industrial society can provide this base, whether through social security, some form of guaranteed minimum income, or a combination of measures.

The OASDI program is obviously of basic importance, for it sets a floor of security which can assure a minimum standard of protection for American families whose income is interrupted. This program can lift millions out of poverty. It has the great advantage of being self-respecting. As Helen Hall pointed out when she testified for the National Federation on the Insurance Benefits Act of 1961 and the Hospital Insurance Act of 1963, "insurance is universally preferred to being on welfare." There is no humiliating means test. People feel it is theirs by right, or through having contributed. Because social insurance is universally accepted and universally preferred, the National Federation supports all feasible extensions in coverage and increases in benefits.

In this context, the National Federation approves the 12% increase in benefits provided in the Bill, but considers it too modest since it barely reflects the increased cost of living. We are most concerned with those below the poverty line, however, who are affected by the provisions of *minimum payments*. Again the Bill provides for a slight increase, but not enough to enable most beneficiaries to reach the acknowledged poverty floor of $1540 for individuals (and $1860 for aged couples). Certainly this country should be able to provide its retired citizens with a minimum benefit of $100 a month ($150 for a couple). This was originally proposed by the Administration as a special minimum benefit for those with 25 years of covered employment. Establishing *this* minimum would make a substantial and direct attack on the problem of poverty.

We wish to call attention to the August 21 warning issued by Senator Randolph's Subcommittee on Employment and Retirement Incomes. The benefit of any increases will be lost if other payments such as OAA and Veterans benefits are correspondingly reduced. Some safeguards should be written in to prevent this happening, as has whose income is interrupted through no fault of their own.

MEDICARE

Our National Federation has pressed for a comprehensive medical care program ever since 1935. We believe that quality health care can and must be provided for all citizens. Obviously we favor every step toward more inclusive coverage. This is an area where the United States has lagged at least three decades behind other industrialized nations.

We support the extension of medicare to those under 65 who are now drawing *disability benefits*, an administration proposal which was not included in the House Bill. This obviously low-income group probably will not enter the labor force and is most in need of health services. We also favor the inclusion of his dependents and survivors since his family is obviously in the same need as the prime beneficiary.

We are for the inclusion of prescription drugs and eye examinations, items which are basic to comprehensive care, and prohibitively expensive for many who need them desperately.

MEDICAID

We believe that the medicaid program has been an important step in extending quality health care to those in need. It has already made an enormous difference in the lives of hundreds of our neighbors. We heard from many of them when they volunteered to "witness for medicaid" at an informal hearing conducted by New York City's United Neighborhood Houses last April. These neighborhood people told congressmen and administrators what they liked—and didn't like—in the medicaid program. Mrs. Bertha Jackson is one who told how medicaid makes all the difference in keeping a low-income family afloat and independent and in conserving our human resources. Mrs. Jackson said "We have two small children and you know what happens.

"Out of the clear blue sky you have to figure $10 for penicillin injection and then you have to figure out three stitches, that's $10. And that's something on the regular weekly budget. You always keep figuring where is the money going to come from to pay for these unexpected bills.

"Just before we were able to get our Medicaid cards my husband had an operation which was $125 and then I had to go to the dentist and he told us that it would cost $250 for some work on my teeth. And that was just—well that was just the end, because that was the end of the bank account we had. We were really finished—flat out. So we got our Medicaid card and right after that I had to go to the hospital for three weeks and it took care of a three week stay. Since that time I've had other medical attention which involved an x-ray which would have run us $65, and my little boy had to have some extensive dental work on his teeth which is going to be taken care of."

This kind of marginal family illustrates why we thought that the ceiling which the Administration proposed was too low—50% above the public assistance program. We are seriously opposed to the even lower ceiling set in H.R. 12080, or 33⅓% above what the state is actually *paying* for public assistance, a figure often far below the state's own declared level of need. This limitation would affect 13 states which already have higher standards. We deplore it as a backward step.

We also oppose any change in the present requirement of *five basic services*. Any health program worthy of the name should certainly include in-patient and out-patient hospital care, laboratory and x-ray work, skilled nursing service, and physician's services. The proposal in H.R. 12080 to substitute a choice of 7 out of 14 services seems particularly regressive, and could result in a state program which has no real significance in advancing health care.

PUBLIC WELFARE

The National Federation has always been concerned about public welfare. We believe that they way in which we help those who are unfortunate or dependent is a reflection upon the very quality of a society. We were aware of the shortcomings of our welfare program, and therefore welcomed the 1962 Amendments, and testified for them. We approved the measures which would treat individuals with respect, give them choice and hope, and restore them to independence. These measures included work-training, expanded day care, homemaking service, family planning information, competent individual counseling, and elimination of out-dated residence requirements. Some of these same constructive programs are included in H.R. 12080, but in what a different context! The general theme is one of getting tough with welfare recipients, attempting to meet the problem of higher welfare rolls by forcing everyone over 16 into work or training, and stopping the birth of illegitimate children by punitive measures. Programs such as day care are absolutely sound when they provide employable mothers with an opportunity to work at a period when it will not hurt their family. Many mothers could work, and want to work. But day care is unacceptable as an adjunct to a forced-work program, a concept which completely reverses our belief that bringing up children is a perfectly honorable full-time occupation.

We are for the expansion of day care for families of all economic levels, coupled with establishment of federal standards, and recognizing that such expansion will require facilities and qualified personnel. To make it a crash program coupled with work-training for mothers is to force children to pay the penalty of inadequate care.

We deplore the whole series of threatening and punitive measures in this Bill, measures which open the administration of welfare to many personal judgments and abuses. Threats to cut adults off from the family payment if they do not take a job which is deemed suitable, threats to take away children if the home is judged unsound—probably because of illegitimacies, tying the welfare department closely to the courts in determining paternity and locating absent fathers—these harassments will demoralize those who already feel unwanted and cast out, and will further aggravate the tensions in our city slums.

Because we work with marginal, low-income families, we have no illusions about how hard it is to help them. Frequently they are newcomers to the crushing, impersonal city. They have few resources and are easily overwhelmed by a series of unfortunate circumstances. But they are not without courage and hope. We know from experience that they can become independent. They need patient and dignified help, not punishment and coercion. Here are just two stories of families who belong to a neighborhood center in Brooklyn. The director writes:

"Mrs. Diaz was helpless. She came to us for help with Hector's truancy when her husband had just deserted her and their five children. The older children could never stay in school for even a week at a time, and always for reasons: there were no shoes or clothes; the welfare check had not come on time; they had to be at home watching the babies while Mrs. Diaz sat weary hours in the welfare office, or in the various agencies to which we hopefully referred her for additional aid. Often those agencies would phone us to ask why Mrs. Diaz had not arrived for an appointment, and we would find her at home, paralyzed by her inability to organize herself or her children or her home.

"Look at them now. Mrs. Diaz has a job. In her spare time she learns to type. She even attends an occasional concert or a play when we have tickets. She has become a one-woman recruiter for Medicaid, making appointments for neighbors who seek her advice. Two of her boys are in our work-study program, and Hector developed enough skill to take on small repair jobs in the community. The children attend school regularly.

"What happened? We kept looking for the key which we finally found: a job for Mrs. Diaz *in the community*, so that she can be close to her children. Her job involves helping others and gives her confidence in herself as a human being. And we were there—trying to help as long as she and her family needed us."

Another story from the same center:

"At age 16 Debbie had already known a lifetime of grief: a broken family, and years in the hospital with rheumatic fever which left her with a serious heart condition. Soon she was also pregnant and unwed. This increased her mother's rejection. The family of Jose, the baby's father, didn't know she existed. Jose had a poor job, and the little he had earned was needed by his parents. Debbie got nothing.

"Now married to Jose, she is the mother of two. Jose had qualified for a better job and knows his responsibility is to his own young family. This dramatic change did not take place overnight.

"For three years Debbie was a member of our Teen-Age mother's club. They met with a psychiatric social worker and as they talked they began to learn how to be mothers, how to budget for and manage a wide array of family problems. Debbie and Jose had special counseling and assistance so they could continue as a worthwhile and responsible family."

We know hundreds of neighbors like these. We know they can respond to help, offered in a spirit of respect. Harsh, bureaucratic rules, reflecting punitive, judgmental attitudes, will drive them further and further from a sense of belonging to the human race.

Making AFDC-UP permanent is a very progressive step, aimed at keeping families intact rather than driving fathers out of the home. However, we think that H.R. 12080 places undue restrictions on eligibility, which for example would cut out an estimated 50% of those now included in New York City. Cutting out fathers who are receiving any unemployment insurance no matter how small, cutting out the lowest grades of returned servicemen, cutting out those who have not recently been in the labor force, or who cannot meet strict requirements on work or training, limits the concept of the program. It can damage rather than support fathers whose self-esteem is already low.

The most cruel feature of the Bill, however, is the *freezing of the broken family caseload* at the January, 1967 ratio. This arbitrary restriction takes no account of changing economic conditions in a state. It will not change individual behavior. Since the economically poor state whose ratio goes up has the alternatives of raising eligibility requirements or reducing the level of payments, it is helpless children who would be paying the costs. It is unthinkable for an advanced society to take out its moral confusions and its economical frustrations on children yet unborn.

We regret the absence of the original Administration proposal that states be *required to meet full need* as determined by their own standards. This was a major recommendation of the Advisory Council and seemed to us a minimum expectation.

Once minimum need is established, it has been extraordinarily callous to accept any lesser percentage in policy or in fact. We know human beings who are kept in abject misery in states as wealthy as Ohio, and this is a matter of personal shame. We ask for restoration of the Administration proposal, with its enabling funds for a transitional period.

We question the establishment of a massive *work program* under the Welfare Administration. We are in complete accord with the Urban Coalition's call for one million jobs, and were present at its Emergency Convocation. We think that this effort demands private and public cooperation, and that the government must become the "employer of last resort." We are in favor of various measures which have been introduced to help assure full employment. But a comprehensive manpower program belongs under the Department of Labor, where it can be related to long-range economic trends, automation, meaningful job training, and adequate safeguards.

CHILD WELFARE

In regard to the child welfare provisions of H.R. 12080, we favor the extension of services to all children in need—urban as well as rural, AFDC as well as non-ADC. However, in carrying out this principle we favor the Burke bill, which made federal matching funds available for all child welfare services.

SOCIAL WORK EDUCATION

The National Federation is gratified to note that H.R. 12080 recognizes the manpower crisis in social welfare, and provides for constructive measures to meet the shortage.

In summary, we approve—
- the increase in social security benefits;
- the increase in earnings exemption.

We favor as changes—
- increase in minimum benefits to $100 a month ($150 for a couple);
- extended coverage to agricultural workers and disabled widows as proposed by the Administration.

We favor as changes in the Medicare-Medicaid provisions:
- extending medicare to those under 65 drawing disability benefits;
- including prescription drugs and eye examinations as benefits;
- setting the income ceiling on coverage at 50% of the state's public assistance level of need, as proposed by the Administration;
- making no change in the present requirement of five basic services.

In regard to public welfare, we approve—
- making AFDC–UP permanent, but without new restrictions;
- constructive features such as family planning, day care extension, skilled counseling, extension of child welfare services to all children, but with the Burke bill provisions.

We favor as changes—
- elimination of the punitive and coercive measures;
- elimination of the freeze on AFDC payments to states;
- inclusion of the Administration proposal that states be required to meet their own minimum standards.

We approve the provisions for social work education.

Senator HARTKE. I understand that Mr. Rachlin has come back. I said I was going to adjourn these hearings a while ago and I asked consideration while you were out of the room. If you want to summarize your statement very quickly, otherwise, you are going to have to come back at a later time. How long will it take you?

Mr. RACHLIN. Five to seven minutes.

Senator HARTKE. I have given these other people 3 minutes.

Mr. RACHLIN. All right.

Senator HARTKE. If you will be through in 3 minutes I will be glad to include your whole statement in the record. I am not being arbitrary. You can come back if you want to, but it is up to you.

STATEMENT OF CARL RACHLIN, LEGAL DIRECTOR, SCHOLARSHIP, EDUCATION, AND DEFENSE FUND FOR RACIAL EQUALITY, INC., NEW YORK, N.Y.

Mr. RACHLIN. I will be very brief, Senator.

I am grateful to be here. In the welter of words going around I wonder if the feeling is mutual but I hope what I say will make the feeling mutual.

What I would like to add to the written statement I have prepared, which I understand will be a part of the record——

Senator HARTKE. Most certainly.

Mr. RACHLIN. We are all of us, whatever our motivations, interested in ending the welfare system the best way we can. And we are also, of course, interested in creating family stability.

It is our view, however, that H.R. 12080 does quite the opposite of what it hopes or pretends to do. I don't think that anyone seriously can think that family stability will be provided by H.R. 12080 and I would like just briefly to say why I think that is so, and emphasize that point.

Historically, in the United States we have made it almost impossible for the Negro male to work, and to some extent this has been modified by recent laws that have been passed, but it is still highly inadequate.

In addition, we have written our welfare laws to make it certain that if the Negro male remains part of the family, his family in almost all cases, cannot receive welfare assistance because then there is an employable male in the house.

Now what this bill does, Senator, is further carry the destruction of the Negro family one step beyond what I have just said, because now we are saying not only can the father not be there, but that the mother, in order to continue to receive any assistance at all, must leave the house: That is she has no alternative as to whether she will or will not work or will or will not remain and take care of her children. She must accept whatever employment or training will be provided or risk losing assistance for her children.

We say that with the mother out of the house, having already forced the father out of the house, what will be left of the family stability? We think mothers ought to be given an opportunity to decide for themselves. Some may feel that it is better if they work, others may feel better if they stay in their homes. This should be the mother's decision. We think that that is the significant thing that H.R. 12080 is very weak on.

Very briefly, further, we cannot both demand stability and morality from our people receiving assistance, and then take legislative steps that assure the opposite of this. We insure immorality by preventing a stable family, by preventing the male from remaining in the house, and we are now insuring instability by making certain the mother gets out.

What effect this will have on our urban centers no one can tell, but we think that it is inflammatory, and perhaps dangerous.

One or two comments about the proposals themselves even within their own context. Requiring mothers to take training when there are no standards set forth in the bill is dangerous. It is no secret that certain States in the United States would be very happy if they can get the mothers out of their homes and make them go back to the point where they were housemaids and private laundresses. There is nothing in the standards set forth in that bill which would require the development of any useful skill. In other words, what I suggest is the bill ought to have a provision that nobody would be required to work at less than the national minimum wage, that nobody will be required to take training at an unskilled trade, because that makes the bill a mockery.

I think if you are going to get people trained, let's train them at some kind of a skill, not at being something that is a symbol of degradation and slavery in the older tradition of the United States.

Thirdly, we ought to make certain in the bill that there is no violation of the National Labor Relations Act. The States must not be permitted to send people out of work in situations which will be possible violations of the National Labor Relations Act. There might be strike situations or things where there are proceedings pending in the National Labor Relations Act. There should be protection in lockouts and strikes.

Another suggestion we would like to make is that no State be allowed to send anybody to an employer who is in violation of the Civil Rights Act of 1965, particularly title 7, the employment section, that people should not be allowed to go to and be forced into a segregated, discriminatory employment situation. Every employer must certify his willingness to comply with the Civil Rights Act, regardless of size, when people are sent to him under this law.

We think that those things are the very minimum standards that ought to be in a bill; this bill makes no pretense of any standards whatsoever; they could be sent out to be housemaids, which would violate I assume the intentions of many of the people who voted for the bill.

I would like to emphasize one other thing in closing to keep within my time schedule, Senator, with regard to the earnings exemption. It is historic in the United States that we give all kinds of inducements to people to do things. We give businessmen a variety of inducements to produce on cost-plus contracts, and I don't criticize this. We induce them to enter into various types of relationships for and on behalf of the Government. We induce builders, by tax saving devices, to construct urban centers and urban development all over the United States. We induce farmers by all kinds of devices not to produce or to produce certain types of crops. At the same time we force welfare mothers into work situations without attempting in any reasonable way to offer the same kinds of inducements to welfare mothers that we offer to businessmen, builders and farmers.

For example, if instead of trying to force by punitive means mothers into work situations, we were to offer them the same kind of inducements in employment for mothers that we offer to businessmen, I think we would achieve a much better result for both the taxpayer and for those who are very anxious to involve welfare people in this mainstream of American life. If we would permit them to keep reasonably substantial amounts of their employment on a graduated scale until their total income from both welfare assistance and employment equals what everybody agrees is the national minimum poverty standard, we would then be doing a very useful thing. In the long run we would bring these people into employment and in the long run save taxpayers' money. Then by a gradual reduction of assistance get people to a point where they are encouraged and in fact become self-sustaining.

I trust I have kept within my time.

Senator HARTKE. I might say you took about 7 minutes but that is all right.

Mr. RACHLIN. That is not bad for me, considering that I am a lawyer I consider that is pretty good.

Senator HARTKE. I am a lawyer too.

Mr. RACHLIN. I was going to if you had given me the full time——

Senator HARTKE. You can have the full time if you want to wait.

Mr. RACHLIN. I don't want to wait.

Senator HARTKE. You are like me.

Mr. RACHLIN. I want to give this in this part of the record. I was going to have with my clients, Dr. George Wylie, who I understand was not permitted into the room, and I would like to advise the committee that his organization has submitted a statement with appendices to the committee, and I respectfully urge that that statement be made a part of the committee record.

Senator HARTKE. It will be made a part of the record as requested.

(A prepared statement of George A. Wiley, director, Poverty Rights Action Center Headquarters, National Welfare Rights Organization follows:)

TESTIMONY OF DR. GEORGE A. WILEY, DIRECTOR POVERTY/RIGHTS ACTION CENTER HEADQUARTERS, NATIONAL WELFARE RIGHTS ORGANIZATION

Mr. Chairman: You have before you amendments to the public assistance section of the Social Security Act which could be fatal to our country. H.R. 12080 is a throwback to the 17th Century "poor laws" at a time when our country must find 20th Century solutions to the complex problems of race and poverty which threaten to tear our nation asunder.

I believe current deficiencies in welfare programs to be one of the root causes of the urban crisis we face in our country today. I believe the national organization of welfare mothers which is ardently working to redress grievances and pursue change through peaceful and legal channels to be one of the brighest hopes of an otherwise dismal landscape.

It is abundantly clear that neither the American public nor the Congress has much understanding of the far reaching implications of the complex set of public welfare proposals in H.R. 12080. There would seem to be great wisdom in the proposal made by the officers of the National Welfare Right Organization, that the Committee delay any action on these welfare proposals until there can be public hearings held in key cities across the country to permit a full hearing of the problems of the current welfare system and the dangers of the regressive proposals of H.R. 12080.

A few supporting facts will be cited here.

The present welfare system assists only about 1 family in four that is in poverty. This is because grant year levels are universally pegged far below the poverty standard. Most states have very restrictive eligibility standards and needy persons are not told of their rights to public assistance. *The increases in the welfare rolls in recent years reflect the fact that increasing numbers of people (particularly needy children) are being assisted by the program. The increases in the welfare rolls should therefore be lauded, not scorned.*

Under the provisions of H.R. 12080 the House freezes the number of A.F.D.C. absent parent cases at the January 1, 1967 level. This would deny Federal welfare aid to over a quarter of a million children on the day it goes into effect. Aid would be denied not because these children do not need it but because the Congress would have decided that there are too many needy children in this country to provide with food, clothing, and shelter. We would make this economic move in spite of the fact that *welfare costs are less than 1¢ on the dollar of personal income in this country* and as proportion of personal income, *have been decreasing over the past fifteen years.*

ILLEGITIMACY AND FAMILY BREAKUP

The House Ways and Means Committee apparently was alarmed by the "spiraling welfare rolls" and attributed "a very large share of the program growth to family break up and illegitimacy."

The Committee is wrong in this assessment. The illegitimacy rate among welfare recipients has been constant at about 18% of the children over the past 1! years. The number of poor female headed households, "broken families", has been roughly constant since 1959 at about 1.9 million families, in spite of considerable population growth during that period. The number of children on welfare has grown by 50% between 1959 and 1965 and the cost of the AFDC program has increased by 80% during that period. *Growth in the AFDC rolls in the face of decreasing population of poor people can only reflect the fact that the program is reaching more needy persons.* This is due to three factors:

1. The shift in population of poor people from Southern states where welfare policies are particularly restrictive and punitive to Northern states where welfare relief is more accessible. This factor also explains the fact that welfare costs are going up faster than the number of welfare recipients: payment levels are higher in Northern states than in Southern states.
2. The liberalization in welfare policies under 1962 amendments.
3. The Welfare Rights Movement and the poverty program have increasingly alerted poor people as to their rights and entitlements in welfare.

From 1959–1965 the number of children receiving welfare increased by about 1 million children. The 1959 AFDC level represented 13% of all poor children, and in 1965 23% of poor children received AFDC, reflecting the increase in the efficiency of the program.

Federal share of welfare costs

The Federal Government has been paying a steadily *decreasing* share of the welfare costs and AFDC costs. In 1959 the Federal Government paid approximately 60% of the AFDC bill; by 1965 this had dropped to 55%. This has meant a greatly increased tax burden on the state and local governments which are less able to afford this burden. While the total AFDC costs increased by 80%, federal share has increased only 67%. The state and local government share has increased by 101%.

The net result of the freeze on AFDC levels will require states to take one or more of the following courses of action:

1. Cut some children off AFDC.
2. Arbitrarily deny assistance to some eligible new applicants.
3. Keep AFDC rolls down by repressive enforcement of old and new eligibility barriers.
4. Assume the full financial burden themselves of providing for many eligible AFDC children.

FORCED WORK FOR MOTHERS

In the majority of our states, aid to families with dependent children (AFDC) *requires* jobless men to desert their families if they want public assistance for their children and now H.R. 12080 wants to drive women out of the home as well.

AFDC mothers are some of the hardest working women in our society. On the average they raise three or four children apiece under the most trying circumstances and with very few resources provided to them by society. For the government to try to force them into the job market when there are not enough jobs for the men in the ghetto, is to add insult to absurdity.

ELIGIBILITY REQUIREMENTS

The bill adds to the already tangled maze of eligibility requirements a myriad of new requirements and restrictions which will be used to deny benefits to needy children and add to the misery of the lot of millions of destitute families. We document some of these problems in the analysis of the bill which is appended. Others are cited by Professor Edward Sparer in his testimony presented on September 21, 1967. Appended also are a brief history of the welfare organization the proposals for the 90th Congress developed by the National Welfare Rights Organization, a copy of the booklet on the Poverty Line, which contains graphs and charts related to our benefit level proposals, a memorandum which shows how we arrive at the estimate that a quarter of a million children will be denied aid when the bill goes into effect, and a set of bar graphs on the U.S. poverty profile which illustrate the fact that only about ½ of the persons in poverty in this country who are probably eligible for welfare actually receive any aid at all, that only ¼ of those below the economy poverty line (the one popularly referred to as the poverty line) receive public assistance and only 1/6 of those below the low income poverty line receive public assistance.

Senator **Hartke**. Let me say to you, sir, I think the one problem here that people are looking at is the fact that they see this mounting cost, and this is what the House saw, this mounting cost of welfare. There is no question about it, they are looking for an answer. I appreciate the fact that you have come here with some positive suggestions.

Mr. **Rachlin**. Thank you, sir.

(Mr. Rachlin's prepared statement follows:)

PREPARED STATEMENT OF CARL RACHLIN, LEGAL DIRECTOR, SCHOLARSHIP, EDUCATION AND DEFENSE FUND FOR RACIAL EQUALITY, INC.

I am Carl Rachlin, Legal Director of the Scholarship, Education and Defense Fund For Racial Equality, commonly called SEDFRE, located at 150 Nassau Street in the City and State of New York. SEDFRE is a national organization. One of SEDFRE's programs involves scholarships to youngsters who have shown leadership in the development of their communities. In five years we have helped more than 100 go on to colleges and universities, 32 have now graduated and become teachers and social workers. We are also actively assisting numerous communities develop leadership and help train leaders to meet the problems that are to be faced by very small communities. The legal service program is designed to assist people who ask for help in the areas of equal protection, poverty and discrimination. As part of our work we have spent a major effort answering the call for assistance from literally hundreds and hundreds of persons of who require help in the fields of social problems and administration.

Our help has taken various forms. We have also sponsored a Welfare Rights program in Newark, New Jersey. This has involved the preparation of a manual on the welfare regulations and the training of clients on their legal rights. On the national level, I am general counsel to the Poverty Rights Action Center, with headquarters here in the District of Columbia. PRAO is a coordinating organization of welfare clients and their organization throughout the United States. PRAO recently sponsored the convocation of the National Welfare Rights Organization held a few weeks ago in this city. In these various capacities, it has been my duty to acquaint myself with the laws, and the administration of welfare assistance; and most importantly, I have acquainted myself with the needs of welfare clients.

People receiving assistance in various parts of the United States call us for advice and help with regard to the problems of welfare administration and assistance to clients. In New York City for example, we are counsel to the City-wide Coordinating Committee of Welfare Groups which in the large city of New York represents many, many thousands of welfare clients throughout the New York City area. In addition to this, many non-profit organizations in the child welfare area and neighborhood houses request advice, and often, assistance for clients who require help. With this experience in mind we approach the proposed 1967 amendment to the Social Security Act as passed in HR 12080, and try to apply that experience to the proposals.

Had it been the design of those who sponsored H.R. 12080 to reduce the number of welfare clients, to reduce taxes, to make more productive persons who receive welfare assistance, to me, based upon our experience H.R. 12080 will not meet that design almost on its face. No one can seriously desire the permanent continuance of the welfare system. Would that we were sufficiently wise to develop the means to make all people independent, to be able to take care of themselves and their families. As strong and economically potent as American society is, it has not learned yet the means to bring into the main orbit of American life the many millions who live still at a shameful level far beneath the standard which most of us consider minimal poverty standards; and the welfare system which we here today discuss, to the best of my knowledge, now here brings the recipients up to the poverty level.

While there may be a few chiselers, and a few people who do not have the right to the statutory benefits provided by the federal/state programs, despite the hullabaloo from time to time, relatively few have been shown to be in that category. I have had the sad experience to visit welfare homes and I can tell you, gentlemen, welfare clients do not live in luxury—there are more cockroaches and rats than people in the apartments in which welfare clients live.

Although cockroaches eat very little and rats only children, they do not add to the decor, provide no luxuries known to man and they merely reduce the living standards of the clients. Welfare clients need our help, our wisdom, a reasonable amount of assistance; they do not need punishment.

That some of the amendments to the existing law proposed by H.R. 12080 appear to be punitive. Others have alluded to this previously and require no special comment from me. From my experience, punitive results cannot either assist clients to become productive members of society, or reduce the tax load of the organized citizens of this country. In our past history we have been successful in bringing about a substantial destruction of the Negro family in the United States by substantially preventing the Negro male from working except at the most menial jobs. Only recently has there been any change in this pattern, and that change, insufficient. We have made him an unimportant figure in his family, unlike his white counterpart, who is, or at least should be the symbol of character, strength and justice. We have reduced him to an extra mouth to feed. In writing our welfare laws however, we have decided that even that was too important a role for him to play in society. Our welfare laws dictate that if his family is not to starve, in most communities, he must not be present in the home even though he cannot find work. Our welfare laws have thus brought about the result of Mother remaining with the children in the house in order to maintain some obviously incomplete, semblance of a home. Our welfare laws have never been written with a view to assisting those in need and supplementing income when necessary, but in reality have created a substantial amount of instability in many American homes, which we as a nation, state we abhor.

Seemingly, in order to complete the job of disintegration! H.R. 12080 now places the Mother regardless of her feelings or desires about remaining at home or trying to keep some element of stability present, or the needs of her children, to submit to compulsory training and to a work program. If she does not, her family may suffer economic distress. Under these alternatives, the Mother is placed in the dilemma either to work and not be home to take care of her children or not to work and risk the loss of financial assistance. I wonder how many of us would enjoy the prospect of that dilemma, in which we apparently wish to place the welfare client, work and neglect your children; refuse and starve them.

But punitive as it is, even this is not sufficient for its sponsors. In the legislation no standards exist which would guarantee decent employment training to the mothers. What would happen to a mother if she refused to be a laundress or a maid in a household. Undoubtedly every community has need for these symbols of degradation and slavery. Nothing in H.R. 12080 in any way apparently gives the client the right to play some part in the decision-making process as to the kind of training to be made available to her.

It would seem to me, furthermore that before an program of this kind should be undertaken on a serious basis, we ought to know a lot more than we do know about the effects upon a family of doing this. Without in any way denigrating child care programs, we ought in addition, to be studying more fundamentally how best to involve people, more than we have, in the day to day living of American life, before we take such major steps as requiring children day after day after day to be without father or mother.

We cannot both worry about the instability of American Society, the breakup of American homes and then take steps to ensure it. While it is pure speculation what will happen when more children are without parental care of any kind, nevertheless we cannot be blind that this may well be an additional concern when trouble erupts, as it has in American cities.

In so many aspects of our way of life we offer major inducements to business men with cost-plus contracts to farmers in a variety of agricultural programs, to builders of our cities with tax-saving plans, and yet despite the seeming success of those programs in the areas of their concern, we still don't seem to be willing to apply that success to this area. While welfare clients under the various statutes, if the persons qualify, receive financial assistance from different levels of government, no less so do business men and farmers. Yet our attitude toward the welfare client, of course, is quite different, instead of a punitive program, which is the basis of H.R. 12080. Were we to institute a true incentive program, so that there might be real inducements, and no fear of economic catastrophe, the results would probably be more to our liking, whether our main concern is involving more people in the American way of life or saving tax money, or both. I therefore would suggest that we use the poverty line as a basis for an inducement. Welfare recipients should be able to keep substantial parts of their assistance until their earnings from employment plus their welfare assistance brought them above the minimum poverty line, then assistance should be scaled down gradually as the welfare recipient earned more money herself and her family. The incentives in H.R. 12080 are absurdly low and, of course, can have no meaningful effect on the needs of clients.

No one of course will quarrel with the idea that all people particularly the young generation, should be given the tools to be economically, socially independent and secure. How this can be done under the punitive approach set forth in H.R. 12080 is hard to visualize. While there are provisions of the bill attempting to induce communities to adopt the various programs requiring welfare clients to engage in work training, no such inducements are offered to the clients themselves in any understandable way. The client is confronted with punitive results, not inducements.

One of the other effects of such a program as set forth in H.R. 12080, if it succeeds, is to throw many welfare clients into the arms of private charity which is not equipped for such problems, or into city and state programs outside the scope of the federal categorical programs. As a lawyer one of the saddest things I have seen is the way the client is treated in non-federally aided programs in New York. Up to the present time, unlike those situations arising under federally supported programs, a client, who is the beneficiary of a state or city program solely, doesn't have an administrative appeal from a decision adverse to his interest. While this may be changed in New York in the near future, up to the present this is the law thus when clients are shifted from federal to state programs, because of the punitive effects of H.R. 12080, they are thrown into a situation where their rights to due process are even less clear, their lives more insecure. But even worse than this, some states have no such programs at all, and starvation may be the only alternative people in such situations face.

Another aspect of the bill that is of concern to us, relates to the limitation of future Aid to families with Dependent Children in proportion to the number in a state receiving aid in 1967. As an attorney who has spent some time in this area the number of people who are entitled to assistance and who do not receive such assistance, either because they have not been aware of their statutory right to receive assistance or because they have been improperly kept off the rolls by one of the state welfare departments, is very substantial. The provisions of H.R. 12080 thus deny persons, who for any reason have either not previously applied for assistance or were improperly kept from receiving assistance from applying for aid, and receiving such assistance in the future. By these provisions we are encouraging the states to act with unnecessary rigor in keeping the proportion down and denying assistance to people who would otherwise be eligible. A failure to apply in the past, whatever reason, in effect, precludes the application in the future. If the purpose of the law is to aid people who can prove statutory qualifications then only hardship can be caused to people who normally have no other resources of any kind. I wonder how often an examination of other federal programs, where non-welfare recipients are involved, have such arbitrary cutoffs taken place. This is not a statute of limitations which says that unless you enforce an old right by a certain date you are barred. But here one is in effect barred from applying for a present, not past, right, if one has not applied by a certain date.

In substance we are told one cannot apply next year if you have not applied prior to 1967. This is harsh. If we are lucky, it will not cause conduct to be regretted in the urban centers. Or it will be a reduction in times of rising costs, of amounts of assistance to families.

In many areas of the United States only a small percentage of the dollar amounts of the states own minimum standards are in fact given to welfare clients. It is with regret that we note that H.R. 12080 fails to require states to meet their own standards and not merely a percentage of those standards. It is of little comfort to a family to know of the paper rights to which they may be entitled in their state. Such paper rights can't even be used to cover the inside of the childrens shoes needed to go to school, and not able to be bought because only a percentage of the paper rights is in reality available. We would hope and recommend that this Committee in its report to be issued will propose that states give 100% of their own standards. Better yet, that this committee will recommend minimum poverty standards which states may not go below.

Insofar as the program toward needy children of unemployed fathers is concerned there too the provisions are unnecessarily harsh and encourage the breakup of the family. The circumstances under which people may qualify for this program are now so limited that the only thing the unemployed father can do is to disappear. What the consequences are of such disappearance no imagination is required. The absence of the father from the home invites difficulty. We should merely require proof of need and not family disintegration in order to receive help from our governments.

We feel that it is important in addition to rejecting the punitive measures of H.R. 12080 that a major legislative study be instituted to understand better child assistance programs all over the United States. It is important that more and more people be involved and participate more and more in the daily life of our country. This can only be done by knowledge on our part as to the nature of the problems and the best ways to help people. We will also understand what are fair and reasonable inducements pointing the way to a better and more equitable life for all. Whether our objectives are as I hope, a greater participation in American life for all persons, or merely a saving of tax dollars, the results can be nothing less than advantageous.

STATEMENT OF CAROL RUTH SILVER, CALIFORNIA RURAL LEGAL ASSISTANCE

(This statement is limited to selected portions of the public assistance amendments, sec. 201 et seq. of the bill, and Sec. 245.)

Summary

I. Federal standards are not enforced at the local level, and section 245 of H.R. 12080 appears an insufficient remedy: A further amendment is therefore suggested.

II. The effort to hold down the number of AFDC cases and replace them with retraining for self-sufficiency is commendable, but great danger is seen in sections 208 and 204 of H.R. 12080: Amendments are therefore suggested.

A. The work-training programs are ineffectual because State and Federal standards are not met.

B. The ceiling on AFDC cases conflicts with basic values of the Social Security Act and with constitutional principles of equal protection.

C. The method proposed for computing the welfare ceiling will lead to great inequities between citizens of States and counties which have in the past had adequate and those which have had inadequate intake procedures for welfare.

III. The prohibition on supplemental AFDC benefits for persons receiving unemployment benefits creates a disincentive to accepting employment marginally meeting minimum basic need.

IV. The deletions of apparently redundant language from the work-training statute could create dangerous negative implications of legislative intent and restoration is therefore suggested.

Report

I. FEDERAL STANDARDS ARE NOT ENFORCED AT THE LOCAL LEVEL, AND SECTION 245 OF H.R. 12080 APPEARS AN INSUFFICIENT REMEDY: A FURTHER AMENDMENT IS THEREFORE SUGGESTED

Miss **Silver.** The most pervasive problem in the administration of the Social Security Act today is the fact that Federal standards, laid down by the Social Security Act, are not being enforced at the local county administration level by either the State or the Department of Health, Education, and Welfare. Exemplifying the problem of nonenforcement is the situation in Sutter County, Calif. See attached "Report on Sutter County Welfare Department Abuses," hereby incorporated and made a part of this statement as if fully set out herein.

This report demonstrates how a county welfare department does, and can with impunity, consistently refuse to comply with State and Federal law and regulations.

(The report referred to above was made a part of the official files of the committee.)

Particularly prominent in the Sutter County report are abuses of the Federal requirement that application for aid to families with dependent children be made available to all eligible persons. The Sutter County Welfare Department has ignored and continues to ignore the dual requirement of section 402 of the Social Security Act (42 U.S.C. 602):

> A state plan * * * must * * * (9) provide * * * that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall be furnished with reasonable promptness to all eligible individuals.

See particularly section 1A of the Sutter County report and appendices referred to therein, for description of the devices used by the Sutter County Welfare Department to accomplish this, and parts II and III for a description of the inaction of Federal and State officials. A substantial number of administrative appeals won on this issue has still failed to change the policy of the county welfare department—see the end of appendix A, which shows that the most recent administrative appeals filed on the same issue. Thus it is clear that the "fair hearing" requirement of section 402 of the Social Security Act (42 U.S.C. 602, is insufficient both because it is not Federal and because it is concerned only with individuals. It provides no remedy where a local welfare department violates Federal and State law and regulations wholesale.

Section 245 of H.R. 12080 is a commendable step toward making more flexible the enforcement provisions available to HEW. Merely giving HEW additional power to police State requirements will not be sufficient, however. It is necessary that local persons directly in contact with the actual operations of the welfare programs have access to a meaningful Federal procedure for invoking the notice and hearing provision provided in section 404 of the Social Security Act (42 U.S.C. 604). I therefore would suggest an amendment to require an investigation and a determination of the merits by the Secretary with regard to all substantial complaints. The text of the amendment suggested is as follows:

Add to H.R. 12080 at page 176, following line 3, the following:

"Sections 4, 404(a), 1004, and 1404 of the Social Security Act are each amended by adding at the end thereof a new paragraph as follows:

" 'The Secretary shall give notice as provided in this section within thirty days after (i) his determination that reasonable cause exists to believe that a State program may be subject to payment stoppage pursuant to this section, or (ii) after receipt of either:

"'(A) twenty-five complaints (or one complaint with 25 complainants) from persons, organizations, or agencies, in an individual or representative capacity, that the State or any subdivision or agency or program thereof has failed to conform to Federal law or regulations; or

"'(B) certification by a Regional Administrator of the Department of Health, Education, and Welfare that a State, or any subdivision or agency or program thereof, within this region has failed in some particular regard to conform to Federal law or regulations.'"

II. THE EFFORT TO HOLD DOWN THE NUMBER OF AFDC CASES AND REPLACE THEM WITH RETRAINING FOR SELF-SUFFICIENCY IS COMMENDABLE, BUT GREAT DANGER IS SEEN IN SECTIONS 208 AND 204 OF H.R. 12080: AMENDMENTS ARE THEREFORE SUGGESTED

A. The work-training programs are ineffectual because State and Federal standards are not met

The most controversial amendment suggested in H.R. 12080 is of course section 208, amending section 403 of the Social Security Act (42 U.S.C. 403), the ceiling on AFDC cases. The purpose of the proposed amendments is excellent—to channel Federal welfare expenditure in such a manner as to promote programs to restore the welfare recipient to economic self-sufficiency. Nor are the work-training programs inherently unworkable. But section 208 is based on two fatally erroneous assumptions—that work-training programs will be administered in good faith compliance with Federal and State laws designed to promote their effective operation and that if so administered they will result in substantial numbers of persons now receiving welfare becoming employable and employed.

The almost universal failure of the work-training programs now extant may be traced in large part to the fact that Federal and State laws and regulations setting minimum standards of acceptability have been studiously ignored. The counties (or other local political subdivisions which administer the welfare programs), intending either to punish welfare recipients or to get a return for their share of the cost of welfare payments, have extensively used work-training labor under the "work experience" pseudonym for jobs that would otherwise be performed by regular, paid, county workers. In some counties work-training labor has been "donated" wholesale to powerful private individuals. The "training" component of such programs is usually, of course, minimal.

A few examples may suffice. In Sutter, Imperial, and Yuba, rural counties in the State of California, the "training" provided welfare recipients consists exclusively of work in building and ground maintenance, carrying slops in hospitals, country road work and other tasks which displace regular workers without training welfare recipients in any usable skill. See the report on Sutter County welfare department abuses, previously incorporated into this testimony, particularly Part IB. CRLA is familiar with no work-training program in California which does not assign welfare recipients to such jobs (although some counties do in addition have limited classroom training programs, primarily in basic English).

In Madera County, Calif., work-trainees are traditionally assigned to prune vines on the property of a certain agri-business proprietor who is paid $5 per hour to "teach" vine pruning—despite the fact that most of these welfare recipients are Mexican-American farm laborers who have been pruning vines all their lives. In Tulare County, Calif., welfare recipients doing county jobs are not provided with necessary protective clothing, clothing which would have had to have been supplied to county employees doing the same labor. In some areas, welfare recipients on work-training work side-by-side with prison gangs—except when the guards take the prisoners in because of rain; the welfare work-"trainees" are not permitted to retire because of the inclement weather.

Greatly needed is some kind of comprehensive check on performance of work-training programs. Even assuming that Federal and State standards for work-training programs are complied with, there is no indication at the present time that the work-training concept has had—or can have—any impact on the welfare rolls by creating or increasing both the employability and the employment of present or potential recipients. There is, in fact, substantial evidence, as noted by one HEW consultant, that only on-the-job training for jobs predetermined to be actually available can have any meaningful impact on the problem and that in fact that current programs—even if legally conducted—are useless.

An amendment is therefore suggested to H.R. 12080 to require that, as an addition to the report required by Public Law 87-543, there be conducted by HEW an evaluation of the current work-training concepts and recommendations for modification, continuation or expansion of those aspects of the program found, in fact, to have been successful in promoting employment of persons initially classed as unemployable. The text of the amendment suggested is as follows:

Add to H.R. 12080 at page 136, following line 3, the following:

"(h) The Secretary shall submit to the President, for transmission to the Congress prior to January 1, 1969, a full report of the administration of the provisions of Section 409 of the Social Security Act with particular emphasis on the kinds of training and the kinds of work experience which have been made available under these programs, the number of persons who have obtained gainful employment as a result of such enrollment, any effects attributable to these programs upon the incidence of dependency on public assistance, and any other matters which the Secretary may designate.

"(i) Section 409 of the Social Security Act, as set forth in Section (a) of this Section, is further amended by renumbering the present provisions as (a) and adding a section (b) as follows:

" 'The Secretary shall compile yearly statistics showing the number of persons enrolled in community work and training programs, the nature of the training and work experience involved in said programs, and the number of persons who have obtained gainful employment as a result of such enrollment.' "

B. The ceiling on AFDC cases conflicts with basic values of the Social Security Act and with constitutional principles of equal protection

The original purpose of the Social Security Act, stated in section 401 (42 U.S.C 601), is the proper care of dependent children. The purpose is to care for the innocent child not to either rehabilitate his parents, admittedly a worthwhile purpose, or to punish them. All dependent children are to be aided without discriminatory denial of aid or the right to apply for aid (section 402(a)(9) of the Social Security Act (42 U.S.C. 602(a)(9)), quoted above in part I-A of this statement in connection with abuses by the Sutter County Welfare Department). This section extends the right to apply for assistance to all dependent children and the right to receive aid to all eligible children.

In enacting the welfare ceiling, Congress would be saying that all children up to the immutable number of *x*-hundred may receive aid. Their needs shall be met because they are needy children deprived of parental support. Child number *x*-hundred plus 1, however, will not receive aid because he happened to have been born too late, or made application too late, or was overlooked in the making out of an application—or for some other reason irrelevant to his need and to the purpose of the Social Security Act.

Quite apart from that purpose, and from attendant considerations of fairness and equity, the proposed welfare ceiling constitutes a constitutionally prohibited invidious discrimination. The ceiling is applicable only to AFDC and AFDC-U—it has no analogy in the laws applicable to OAS, AB, ATD, and so forth. Whatever ostensible reason may be invented to justify this distinction, the real reason is that AFDC and AFDC-U recipients are members of one of the most despised minority group in the country today, and that programs for their aid are among the most controversial items considered by Congress. Denunciations of "the dole," allegations that welfare recipients are deadbeats—lazy, worthless, immoral and irresponsible—are directed at AFDC and AFDC-U programs and recipients. In part, at least, this reflects class differentiation. OAS, ATD, and AB recipients often have middle or even upper-class backgrounds and often possess vocal political support. AFDC and AFDC-U recipients on the other hand are largely of lower-class background and rarely if ever possess and political representation. Even within H.R. 12080 this discriminatory attitude is perpetuated—the new homeowner repair provision, section 209 of H.R. 12080, does not apply to AFDC recipients. Neither does the provision for minimum payments under California law in cases of reduction in Federal participation. And see the Sutter County report, particularly part I-A and appendices B. & C., incorporated herein, describing the obstacles placed in the path of persons wishing to apply for AFDC; no such pattern exists with regard to the aged, blind, or disabled.

The constitutional guarantee of equal protection is not limited to prohibition of discriminations by race; it applies whenever "the existence of a distinct class is demonstrated, and it is further shown that the laws, as written or as applied, single out that class for different treatment * * *." *Hernandez* v. *State of Texas*, 347 U.S. 475, 478 (1954). Distinctions based on economic or social status are as much forbidden as distinctions based upon race or color, *Harper* v. *Virginia Board of*

Elections, 383 U.S. 663, 668 (1966). Legislative distinctions which otherwise might be valid must be invalidated where their "immediate objective" is surreptitious but invidious discrimination against a defined class, *Reitman* v. *Mulkey*, 87 S. Ct. 1627 (1967).

It is therefore urged that section 208 of H.R. 12080 be deleted in its entirety.

C. The method proposed for computing the welfare ceiling will lead to great inequities between citizens of States and counties which have in the past had adequate and those which have had inadequate intake procedures for welfare

The method proposed for computing the ceiling on AFDC welfare cases in section 208 of H.R. 12080 assumes that present AFDC rolls accurately reflect the number of persons eligible for welfare. Such is not the case.

Even from county to county within the State of California, the percentage of eligible persons who are in fact on the welfare rolls will vary greatly with such factors as language barriers and inhospitable attitudes at the intake level of welfare. See the incorporated "Report on Sutter County Welfare Abuses: Section IA," according to the determination of California State Department of Social Welfare referee in an administrative appeal the practice in Sutter County is merely to give agricultural surplus commodities (at no cost to the county) in all immediate need cases rather than taking an application for AFDC and granting immediate aid under the categorical program (saving the county its 16 percent of the costs of AFDC). Unless the applicant is specifically aware of the AFDC program, no information is given, no application taken, and unless the applicant obtains information or sophistication he may never be permitted to make an application. As the referee found:

> Mr. Fuentes [pseudonym] worked during January, February, and until March 7, 1967, when he was layed off. He then became ill and the family became delinquent in their financial obligations and were *entirely without funds on March 24, 1967, when they went to the County Welfare Department* to request emergency and immediate aid. . . . The general relief *intake worker to whom the couple had been referred by the receptionist did not consider or discuss the possibility of referring them for an A.F.D.C. application*. . . . (Emphasis added)

The statistics which appear at the end of the 1966 State department of social welfare report on Sutter County, appendix E to "Report on Sutter County" at pages 25 and 26, show that although there were a total of 3,363 families considered to be under the poverty level in the county at that time, only 44 percent, 1,487 cases (a family on AFDC is considered one case) were receiving public assistance. From this example it is easy to see why welfare rolls in any given geographical area at any given time may be an inaccurate reflection of actual need for welfare in the area. A State with a majority of counties like Sutter will thus be substantially disadvantaged by the freezing of welfare rolls at any given date over a State in which policing of local departments has been more stringent.

It is suggested that any limitation on AFDC families be tied to the percentage of persons whose income, according to U.S. census figures, places them below the poverty line. The following amendment to section 208 of H.R. 12080 is therefore suggested:

Delete on page 141 from and including line 9 to and including line 13, and substitute the following:

"which such quarter falls as the number of families with median income under such sum as shall be determined by the Secretary for each State bears to the total population of such State as shown from time to time by the figures of the U.S. Bureau of the Census."

III. THE PROHIBITION ON SUPPLEMENTAL AFDC BENEFITS FOR PERSONS RECEIVING UNEMPLOYMENT BENEFITS CREATES A DISINCENTIVE TO ACCEPTING EMPLOYMENT MARGINALLY MEETING MINIMUM BASIC NEED

Section 203 of H.R. 12080, amending inter alia section 407 (b) (ii) (D) (v) of the Social Security Act (42 U.S.C. 607(b)(ii)(D)(v) requires that no dependent child may receive AFDC–U when the child's father is receiving unemployment compensation.

The amount of unemployment compensation received by an individual is determined by the level of wages paid to the employee previous to his unemployment. The amount of public assistance received by a family is determined by the minimum basic nondeferrable need of the recipient. Thus the father of a family of dependent children, who, by obtaining a marginal job (i.e. a job which pays low wages and/or is seasonal or likely to be automated out of existence), can meet the needs of his family by welfare standards, would on unemployment compensation be reduced to receiving substantially less than the minimum basic nondeferrable need of the family. In the example given a premium would be placed on not obtaining marginal work such that the family's minimum basic nondeferrable need, as assessed by the welfare department, is barely met, since the loss of such a job would require the exhaustion of unemployment benefits, at substantially below minimum basic need, before welfare eligibility would revive. Public assistance as a supplement to unemployment insurance benefits, social security benefits, workmen's compensation, and other such standard benefits, is established on the basis that if the income from such benefits meets the minimum basic nondeferrable need of the family, no welfare eligibility exists; if such benefits do not meet the need of the family, then welfare eligibility is established.

The following amendment is therefore suggested to H.R. 12080:

Delete from and including the comma in line 19 to and including line 22, and place a period at the end of the parenthesis in line 19.

IV. THE DELETIONS OF APPARENTLY REDUNDANT LANGUAGE FROM THE WORK-TRAINING STATUTE COULD CREATE DANGEROUS NEGATIVE IMPLICATIONS OF LEGISLATIVE INTENT AND RESTORATION IS THEREFORE SUGGESTED

Section 204 of H.R. 12080 is not a complete revamping of the predecessor statute establishing work-training programs, section 409 of the Social Security Act (42 U.S.C. 609), but rather appears to intend to make substantial but consistent changes in the program. In so doing, certain language apparently has appeared redundant to the drafters of the statute and has been omitted, particularly the italicized passages of the following sections of the present statute:

Section 409(a)(1)(C):

"[A State plan shall include provision that—]

(C) such work is performed on projects which serve a useful public purpose, do not result *either* in displacement of regular workers *or in the performance by such relatives of work that would otherwise be performed by employees of public or private agencies, institutions, or organizations. . . .*"

Section 409(a)(2)(4):

[The State plan shall include provisions for entering into agreements with the Public Employment offices, including:]

(4) provision for assuring appropriate arrangements for the care and protection of the child during the absence from the home of any such relative performing work under such program *in order to assure that such absence and work will not be inimical to the welfare of the child; . . . .*

Section 409(a)(2)(6):

[The State plan shall include provisions for entering into agreements with the Public Employment offices, including:]

(6) *such other provisions as the Secretary finds necessary to assure that the operation of such program will not interfere with achievement of the objectives set forth in section 601 of this title. [Section 401 of the Social Security Act]*"

In amended subsection 409(a)(1)(C), the retention of the language "do not result in displacement of regular workers" shows a clear intent that unemployed parents who are welfare work-training trainees should not take the jobs of persons, including themselves, who would or might otherwise be employed. If the language of the original statute be considered not redundant, "displacement" might be distinguished from performing work "that would otherwise be performed by employees." In the one case the evil prevented is the firing of regular employees so that work trainees could take their jobs. In the other it is use of work trainees to fill new positions which would otherwise be open to the labor market. Restriction in both cases is necessary to assure that work-training programs do not create new welfare recipients while supposedly retraining the present recipients. Again Sutter County provides a prime example of why both situations need be remedied against. An administrative hearing officer found that a Sutter County work trainee had been assigned to do work in the city of Live Oaks city park—work which he had performed as a salaried employee in a supervisorial position in another community. See appendix B to report on Sutter County at page 11. Thus this work trainee received welfare on condition of work "training" when he should otherwise have had an opportunity to become an employee of the city. Since the Federal Government pays a large part of the Sutter County welfare budget, this constituted an unintended fiscal subsidy to the Live Oak City Parks Department.

It is strongly suggested that displacement of unfilled jobs from the labor market is as dangerous and is as subject to abuse by budget-conscious public administrators as the displacement of persons already employed, and that lest any possible negative implication be drawn from the deletion in section 409(a)(1)(C) of the act of the language referred to above, the language be restored.

The other two deletions noted, of part of section 409(a)(2)(4) and all of section 409(a)(2)(6), of the Social Security Act both relate to the general purposes of the public assistance program for aid to families with dependent children as detailed in section 401 and 402 of the act. Although the deletion of such general language may be considered a mere removal of redundant material, it is upon such innocent acts that vigorous litigating attorneys will affix a negative implication pernicious to the real intent of the legislature. It is therefore suggested that these sections be restored.

STATEMENT OF ROBERT M. GETTINGS, ASSISTANT FOR GOVERNMENTAL AFFAIRS, ON BEHALF OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN

The National Association for Retarded Children maintains a continuing interest in the full range of Federal actvities benefiting mentally retarded children and adults regardless of their age, race, socioeconomic status, religion, or degree of disability. As a result, there are a number of aspects of the Social Security Amendments of 1967, as passed by the House, which are of concern to us.

The mentally retarded will be affected by several general provisions of the bill (H.R. 12080) such as across the board increases in social security benefits and increases in the amount a person may earn while receiving benefits. However, since the committee will hear considerable testimony on the general provisions affecting broad segments of the population, we will concentrate on those items which seem particularly important for retarded members of our society.

Social Security

1. MEDICARE COVERAGE FOR THE DISABLED

The House passed measure eliminates entirely the President's proposed extension of medicare protection to disabled beneficiaries under 65 years of age. Instead, the Secretary of Health, Education, and Welfare would be required to establish an advisory council to study the problems and costs involved in including the disabled under the health insurance program. The report of the House Ways and Means Committee indicates that the main reason for elimination was the receipt of up-to-date cost figures which indicate that the original administration data significantly underestimated the cost of extending medicare to the disabled.

Under President Johnson's proposal, approximately 1.5 million additional citizens would be eligible for hospital and medical insurance coverage; this group would include approximately 200,000 permanently and totally disabled adults who are receiving childhood disability benefits—an estimated 180,000 of these beneficiaries are mentally retarded.

Disabled Americans are frequently trapped in the vise of increased health care needs and sharply decreased income.

They share with the aged the difficulty of obtaining adequate private health insurance.

These problems are compounded in the case of adult-child social security beneficiaries since, in most cases, they never will have an opportunity to earn an income and the expenses of health care will stretch over their entire lifetime.

Proposals to extend health and medical insurance coverage to the disabled are not new. This suggestion has been under study since 1960 and the 1965 Advisory Council on Social Security definitely advocated extending protection to the disabled. We urge this committee to consider the right of disabled Americans to adequate health care and accept President Johnson's proposal to extend medicare protection to this needy group of citizens.

2. THE DEFINITION OF DISABILITY

The House Ways and Means Committee expressed concern over several recent court decisions reversing departmental determinations of eligibility for disability payments. In these cases, HEW found that the individual was not absolutely disabled but only disabled relative to the local job market. In an effort to correct this situation, H.R. 12080 revises the definition of disability to provide that if the client can do appropriate work which is significantly available in any part of the economy he will not be considered disabled. This language has two drawbacks from the point of view of the retarded. First, a retarded individual may be able to live and work in the community if he is residing with his family but not if he must venture forth on his own without proper social shelter. Second, the definition of feasibility for purposes of vocational rehabilitation depends on the availability of suitable work opportunities locally or at least within the State. The House language would tend to hinder proper coordination between welfare and rehabilitation programs immediately after these two activities had been combined for administrative purposes in the new social and rehabilitation service. We respectfully suggest that this committee include clarifying language in its report to insure that the new House definition of disability does not work to the disadvantage of retarded citizens.

AID TO FAMILIES WITH DEPENDENT CHILDREN

1. INDIVIDUAL PLANNING

Section 201 of H.R. 12080 would require States to include in their AFDC programs provision for making individual plans for members of AFDC families so as to maximize their potential for employment and independence. Such individual planning might tend to improve services to retarded members of the family since the retarded individual has atypical needs.

2. CHILD ABUSE REPORTING

H.R. 12080 would require the States to make provision for reporting cases of child abuse and neglect in AFDC families. Since brain damage can be one of the many horrifying results of child abuse, we endorse this additional effort to control the battered child syndrome.

3. DAY CARE SERVICE

The States would be required to provide in their AFDC plan provision for day care services. Although the basic purpose of these services is to permit AFDC mothers to become gainfully employed, we hope that the States will be encouraged to support specialized day care programs for mentally retarded and other handicapped children from AFDC homes. In its report on H.R. 12080, this committee should take note of the right of handicapped children from AFDC families to have access to the specialized day care services they require.

4. PURCHASE OF SERVICES

The House passed measure would offer States greater latitude in purchasing certain "child welfare" and "family services" which heretofore had to be provided by State agency employees.

This provision might be particularly helpful in cases where the dependent child or relative is mentally retarded and needs a special type of service which the AFDC agency is not qualified to render.

5. FOSTER CARE

After July 1, 1969, States will be required to include provision for foster home care in their AFDC plan; the Federal Government would match grants of up to an average of $100 per month per child providing a court determination of need is obtained and the child is otherwise eligible for AFDC. This provision may help to eliminate some of the economic barriers to proper placement of needy retarded children in specialized foster home care programs.

CHILD WELFARE

1. FORMULA GRANTS

Beginning in fiscal year 1969, authorizations for child welfare formula grants to the States would be nearly doubled ($55 million for fiscal year 1968 under the present law to $100 million for 1969 under H.R. 12080). The House committee indicates that the major portion of this increase should be used to provide improved foster care for children. In its report the committee takes cognizance of the fact that some children who are not candidates for adoption need foster home care such as "* * * the most deprived young children, the handicapped * * *" (House Rept. 544, p. 114). NARC endorses the effort to improve foster home care and other aspects of child welfare services including parent counseling, homemaker services, day care, small group care, protective services, and institutional preadmission and aftercare services. All of these services have been used to benefit retarded children but are currently available on too small a scale.

2. RESEARCH AND DEMONSTRATION GRANTS

The authority to support research and demonstration projects in child welfare would be amended to add contract authority and broaden the purpose of the program to include dissemination of findings and multiple demonstration of new and innovative services.

As one example of a successful demonstration project which should be "disseminated and included into a program on a broad scale," the House committee mentioned the use of homemaker services in families with severely physically and mentally handicapped infants. As stated above, we support the extention of homemaker services and other child welfare activities.

MEDICAID

1. ELEMENTS OF SERVICE

Under the current provisions of title XIX, States participating in the medicaid program must provide five types of services including inpatient hospital services and skilled nursing home care for persons over 21 years of age. H.R. 12080 gives the States the additional option of choosing any seven of the 14 services specified in the act so that skilled nursing home care could be excluded. This provision would slightly weaken the leverage on including care for more severely retarded adults under medicaid programs. A significant number of retarded adults are already receiving care in nursing homes in those States which have adopted medicaid programs.

2. SCREENING AND DIAGNOSIS

After July 1, 1969, States which include skilled nursing home services for persons over 21 in their title XIX plan will have to provide "periodic screening and diagnosis" of eligible children "* * * to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions * * *" as the Secretary may specify. This provision should help institute more effective screening, diagnostic, and treatment programs for mentally retarded youngsters.

CHILD HEALTH

1. EARLY IDENTIFICATION OF HEALTH DEFECTS OF CHILDREN

H.R. 12080 would require the States to make more vigorous efforts to screen and treat children with disabling conditions through their crippled children's program. The planning-programing-budgeting analysis conducted by the staff of HEW graphically illustrates the economic and social advances of early identification and treatment of handicapping conditions. We heartily endorse this emphasis on locating and treating mental retardation and other disabling handicaps early in the child's life.

2. GRANTS FOR STAFFING UNIVERSITY AFFILIATED FACILITIES FOR THE RETARDED

The House bill extends and somewhat expands the authority for grants to "public or nonprofit institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps." The Secretary is to give priority to "programs providing training at the undergraduate level." We hope this latter statement means that priority will be given to training programs which include undergraduate as well as graduate training. Certainly, our experience thus far verifies the wisdom of a multilevel, multidisciplinary approach to training in the field of mental retardation. The committee should clarify this point in the legislative history of the bill.

3. DEFINITION OF CRIPPLED CHILD

The bill includes a revised definition of the term "crippled child"—that is, "an individual under the age of 21 who has an organic disease, defect, or condition which may hinder the achievement of normal growth and development." According to the House report, the purpose of this new definition is to avoid any overlapping in funding with the community mental health program. However, we hope that this committee will view the definition in a broader context—that is, as a positive protection against denial of service to any child who met this definition. In the past, a number of States have dragged their feet on extending crippled children services to mentally handicapped children.

This committee faces a challenging task in amending and extending the massive social security and public assistance programs authorized under this omnibus bill. We understand the difficulty which you face and thank you for the opportunity to present our views on one small, but to us important, aspect of your work.

STATEMENT OF ELIZABETH WICKENDEN, TECHNICAL CONSULTANT ON PUBLIC SOCIAL POLICY, NATIONAL SOCIAL WELFARE ASSEMBLY

Miss WICKENDEN. My name is Elizabeth Wickenden and I have been asked to present the views of the National Social Welfare Assembly, national planning, and coordinating organization in the social welfare field, on needed improvements in the social insurance and public welfare provisions of the Social Security Act. My remarks will be necessarily brief, both by the committee's wish and because many of the assembly's affiliated organizations have submitted excellent detailed analyses of the particular provisions lying within their fields of special competence and experience. The brevity of my testimony should not, however, obscure the grave alarm felt by both citizen and professional leaders within our organization regarding the drastic reversal of welfare policy incorporated in H.R. 12080, title II and their disappointment that limited, if long overdue, improvements in social security benefit levels should be linked to such unacceptable changes in the public welfare program. We sincerely hope that the Senate Finance Committee will recommend to the Senate a bill which is more adequate on the social insurance side and carries forward the long-standing progressive policies of the Congress in moving toward a more acceptable underpinning program of welfare benefits and services. We further hope that the House of Representatives after more careful consideration of the full implications of title II of H.R. 12080 will be willing to accept a different approach to welfare policy.

GENERAL RECOMMENDATION

We find the provisions of H.R. 12080 inadequate with respect to social insurance benefits, especially as they affect those individual beneficiaries most vulnerable to the threat of poverty, and catastrophic with respect to public welfare philosophy and practices. Since there was virtually no opportunity for interested citizen groups to express themselves on these unprecedented welfare changes prior to their adoption by the House of Representatives, we urge this committee to substitute for H.R. 12080 the original administration proposals incorporated in both titles of H.R. 5710 and build improvements into those.

POLICY REVERSAL

Before making specific recommendations with respect to needed improvements in H.R. 5710 I would like to comment briefly on the rationale which seems to underlie the basic shift in welfare policy incorporated in H.R. 12080. It is easy to understand that mounting welfare rolls, especially among young families with children, create anxiety in the public at large which is naturally reflected by their representatives in Congress. Public assistance caseloads constitute one of the most sensitive barometers for measuring the failure of our society on other fronts and no one is easy about evidence of social dislocation. On the other hand it is unthinkable that a country which prides itself on being in the vanguard of social progress and concern for human dignity would revert to a welfare policy which was already outmoded and discredited over 600 years ago. Such a great leap backward could only discredit us at home and abroad.

This long-discarded philosophy is based on a comforting assumption (comforting, I mean, to the consciences of those who are prospering) that the poverty and helplessness of others is a penalty imposed on them for their own shiftlessness and willful misbehavior. Under this philosophy even deserted mothers and children become not the victims of unacceptable hardship but the prime agents of a condition visited upon them in retribution. Public aid, by mitigating that "punishment," thus becomes a party to their malefactions. Under this upside-down philosophy it becomes the function of public welfare not to alleviate hardship but to reinforce it by conditioning public aid on coercive requirements which may well further threaten the healthy development of children and impair the mother's constitutional rights and freedoms. A few years ago the New York community of Newburgh made a similar nationally publicized effort and we all applauded the firm action of the New York Board of Social Welfare, subsequently upheld by the court, in repudiating this action. It would indeed be a tragedy if this were now to become established Federal policy.

The principal, but not the only, coercive sanction imposed by H.R. 12080 on a mother dependent on public assistance for the support of her children is that she should "submit" herself to a test of her willingness to work outside the home, either in regular employment or on a welfare-operated "work and training" project. Failure to do so without "good cause," recognized as such by her local welfare worker, could mean suspension, grant reduction, the humiliation of "voucher relief," payment of her grant to a third party, or the thinly veiled threat of court action looking to child removal. When the Social Security Act was passed in 1935 it was assumed that the rearing of small children was itself socially useful "work" and that children deprived of a father's support should not be doubly deprived by the enforced absence of their mothers. It was assumed that any mother, whatever her economic or marital condition—whether she was backed up by a helpful supportive husband or was the sole reliance of her children—should have some choice in deciding whether she could safely manage the double burdens carried by all working mothers.

Many women—blessed with unusual energy, talent, a favorable home situation, and adequate substitute care—manage this very well. But they do so by their own choice not under duress. This bill seems to imply a double standard of judgment. Men who would not wish their own wives to work outside the homes lest their children's development suffer seem to see in enforced work for other mothers an easy answer to the "welfare problem." The fact that it is not simply an economic problem is clearly reflected in the cost estimates on page 117 of the House committee report which show projected expenditures for day care and other compensatory benefits in fiscal year 1972 amounting to almost six times the projected savings in AFDC reductions. It seems rather that the public welfare agency and its already overburdened workers are to serve as judge, jury, and policeman in deciding which mothers are "worthy" to be supported at home and which must be goaded, deprived, humiliated, and threatened off the welfare rolls. Such a policy would hardly be worthy of a nation whose constitution promises due process, equal treatment under the law, and freedom from involuntary servitude to all its people.

ASSEMBLY POSITION STATEMENT

The recommendations and position of the assembly derive from its official position statement on public welfare, adopted at its membership meeting on December 13, 1961 after extended committee and membership study, review and revision. This statement is as pertinent today as it was then and I, therefore, request permission to insert it in the committee hearing record at this point. Since its adoption this official statement of general policy has served as the basis for appraising relevant current proposals for changes in social insurance and welfare policies. With respect to the bills before this committee a meeting was held on August 28th of this year at which over 50 interested organizations were represented. It is on the basis of discussion at this meeting that the assembly finds the provisions of H.R. 12080 unacceptable and urges you to return to the provisions incorporated in H.R. 5710 with the following amendments.

SOCIAL INSURANCE

It is a basic premise of the assembly position that the best way to deal with poverty and need is to take advance steps to prevent its occurrence. One of our strongest and most widely accepted mechanisms for this purpose is the social insurance system under which working people receive a part of the return on their labor in the form of deferred benefits and protections against the risks of a modern industrial society. The social insurance system is our most successful welfare institution from all points of view. But it needs to keep pace with the fantastic growth in productivty of our economy with its resulting increase in national income. Only this week the Commerce Department reported that personal income in the first 8 months of 1967 was up $43 billion from the comparable 1966 period. (See Wall Street Journal, Sept. 19, 1967 p. 2.) But the people who have retired, the disabled, the widowed and orphaned are not receiving the benefit—let alone a fair share—of this increase. This is especially true of those whose low earnings record entitles them to such low social insurance benefits that they fall below the Federal Government's own definition of the poverty line.

We therefore strongly urge the Senate Finance Committee to restore at least the 20 percent average benefit increases, with a minimum level set at $70 a month for an individual and $105 for a couple, proposed in H.R. 5710. We would, however, urge the Senate to go further than this bill in providing adequate retirement and survivors benefits more nearly commensurate with our current national income level. We further urge that the general public share in financing the social costs of social insurance through an appropriate general revenue contribution as is done in most other countries of the world.

We also urge the Senate to restore the provisions of H.R. 5710 that would provide medicare coverage for beneficiaries of disability insurance and cash benefits for younger disabled widows. The former is an important step in the prevention of need while the latter is a question of social justice toward one of the most handicapped groups in our whole population.

We sympathize with the desire of the House of Representatives to reduce the number of people who must rely on public assistance for their cash and medical needs (if not with some of the methods proposed for achieving this result) and believe appropriate expansion in the social insurance system is one of the most sensible and acceptable ways to achieve this end. I would also like to add parenthetically, even though most proposals for this purpose are before other committees, that expanded opportunities for work unrelated to assistance eligibility or benefit standards are another major means to the reduction of dependency. To the extent that these are also protected by social insurance coverage there is, of course, a double return.

PUBLIC ASSISTANCE COVERAGE

Another basic premise of the assembly's position statement is the importance of an underpinning public assistance program that can meet such need as still occurs, despite preventive measures) whatever its cause. We do not feel that H.R. 5710 goes far enough in that respect. We would like to see a universal system of federally aided assistance as recommended by the advisory Council on Public Welfare but lacking that we would like to see the provisions for meeting the needs of children of unemployed parents enacted in 1962 made an integral part of the mandated provisions of title IV. We are particularly dismayed by the restrictive definitions of unemployment incorporated in H.R. 12080. These not only are retrogressive from existing policy but present two grave problems which it seems to us were not clearly anticipated by the House. The first is the inequity of applying unemployment insurance concepts, in which benefit entitlement must be related to evidence of attachment to the labor force, to a program in which entitlement is based on need. When the State of Michigan proposed such a policy a few years back, its officials were advised by the Federal Government that this must be considered an "unreasonable classification" under court interpretations of the Constitution. The second inequity is that created by the prohibition against supplementation of earnings for the underemployed. This is especially serious in view of the provision for exempting a part of the earnings of persons already on assistance. In this way a family head who has never previously applied for assistance may well find himself working next to an assistance recipient in a similar family situation with a higher total income. Thus in an effort to solve one problem (incentives to work) the bill creates another.

The question of eligibility limits for medical assistance under title XIX is one on which I would also like to comment. We do not feel the States have yet had sufficient time to gain experience under their own existing laws and standards to justify a Federal restriction such as is imposed in H.R. 5710. It should, however, be noted that this is far less damaging than that contained in H.R. 12080 which could actually have the effect in some States of an eligibility standard for medical indigency lower than that for cash assistance. In many instances medical expenditures made in behalf of persons who are otherwise self-supporting are the best possible investment in the prevention of long-term dependency and should have a high priority as a part of this general effort.

I would also like to draw the attention of the committee to recent court decisions which challenge the constitutionality of durational residence requirements for public assistance. It would be highly gratifying if the Congress would remove this question from the court calendar by imposing on all categories the prohibition against residence requirements now contained in title XIX.

LEVEL OF ASSISTANCE BENEFITS

The assembly favors the provisions in H.R. 5710 which would require the States to meet in full its own level of budgeted need as prevailing in January 1967 with a requirement for subsequent updating. We believe, however, that these requirements are not sufficient without Federal minimum standards and a financing formula which would assist low-income States to reach that standard. Without such Federal standards and financing the provisions of H.R. 5710 would tend to penalize those States with high budgetary standards and benefit those who have never given official recognition to actual current living costs.

We also wish to express our concern about the provisions in H.R. 12080 which would eliminate the requirement of title XIX that States provide five basic health services as a condition of Federal participation. Again that is a move away from the goal of a nationwide program with minimal standards applicable to all.

CHILD WELFARE AND OTHER SOCIAL SERVICES

The National Social Welfare Assembly position statement gives strong support to the importance of extending publicly financed social services to all who need, want, and can benefit by them. Such services include but go far beyond the traditional functions performed by professional social workers. They include services for the protection of children and incapacitated adults; day care and other services to supplement a mother's care; homemaker services for the motherless home and the handicapped; family planning advice and referral; general informational and referral services; legal services to help straighten out family or debt problems and protect the rights of low-income families and children; and many more. In all instances such services not only strengthen the individual and family in their immediate situation but also serve as a means of preventing future trouble, whether that "trouble" take the form of juvenile delinquency and other antisocial behavior, mental or family breakdown, or long-range dependency.

But the very effectiveness of such services would be destroyed and their good faith discredited if, as under H.R. 12080, their purpose was seen solely in terms of removing otherwise eligible persons from the assistance rolls. No one is ever persuaded to change his way of thinking or behaving under duress; the outward pretense of compliance may be there but beneath the surface resentment at the affront to human dignity boils and gathers steam. It is impossible to give real help to people under these circumstances and that is why so many organizations have had reluctantly to oppose the provisions of H.R. 12080 which provide additional financing, under this coercive umbrella, to the very programs they have long advocated.

In returning to H.R. 5710 the committee could avoid this dilemma. Since, however, the House recognizes in its projected cost estimates for services the desirability and practicability of increased expenditures for these purposes, it would seem quite logical to increase the amounts authorized for this purpose. It would be especially desirable to increase the authorization for child welfare and day care under title V of the Social Security Act and provide for 75 percent Federal matching as proposed in the Burke-Pell bill.

SOCIAL WORK TRAINING

We wish also once again to reiterate our support for Federal provisions to stimulate training that will increase the national supply of social workers and related auxiliary personnel without which the public welfare program cannot function effectively. This action is long overdue and we strongly urge you to take immediate steps to overcome this bottleneck to effective progress.

STATEMENT OF WALTER J. SHEERIN, REPRESENTING THE NEW YORK CITY CENTRAL LABOR COUNCIL, AFL-CIO, AND THE NEW YORK LABOR-MANAGEMENT COUNCIL OF HEALTH AND WELFARE PLANS, INC.

Mr. SHEERIN. I am Walter J. Sheerin, executive director of the New York Labor-Management Council of Health and Welfare Plans, Inc., speaking in behalf of the New York City Central Labor Council AFL-CIO with a membership of 1,200,000, and the New York Labor-Management Council of Health and Welfare Plans, Inc., with a membership of 160,000.

I am here today to testify to the dire need of retired workers in New York City for increased income and also to the fact that our working members support our requests. We support the President's proposals for increased social security benefits as the first step toward a 50-percent increae.

The concern of the 89th Congress and the present Congress for our Nation's millions of older people has been evident. Unfortunately, however, no relief in added income came last year and so our elderly Americans have continued to suffer privations and hardship till this date.

We in the labor movement have long been aware, from our own experience, of the inadequacy of social security benefits.

For instance, the income of 5,600 retired hotel workers in New York City amounts to an average of $90 a month from social security, plus an average of $30 a month pension. This total of $120 is inadequate, especially in New York City.

Almost 900,000 people in our city are 65 and older and the overwhelming majority have no income other than social security payments.

Even the 15-percent increase in this bill would give them only an additional $13 monthly.

Such an income comes nowhere near the estimate of the Community Council of New York City, based on 1965 prices, that an elderly man or woman needs a minimum of $190 a month to live decently.

If social security benefits were raised by 50 percent, the average retiree would still receive less than $1,500 annually, and couples only about $2,600. This does not meet the minimum standard of the U.S. Department of Labor of $3,000 for a couple.

Social security payments today certainly fail to realize the intent of the law as set forth in 1935: That our social security system maintain for senior citizens an American standard of living. With almost three-fifths of all old-age beneficiaries in the United States living on an income at the poverty level—how can anyone question the responsibility of Congress and the Nation to fulfill that promise?

That our ever richer society can afford it, surely cannot be questioned. But the method of financing is another matter. In our view the time is approaching when a further tax on payrolls would be unfair. We must turn to general revenues. Almost every Social Security Advisory Council has recommended this method, which is common practice in many foreign nations. Besides precedent exists here in our country; Congress provided funds from general revenues to pay doctors' bills under medicare. The savings in welfare costs that result from the social security system add to the justification for a government contribution. Americans dislike the stigma of being a pauper on public assistance. Sufficient income benefits should be provided as a matter of right.

Even though savings from welfare costs would contribute substantially, it is not only a matter of money. Not in the wealthiest country in the world. It is a matter of dignity and self respect.

However if Congress does not now provide government revenues for this purpose, it still ought to be possible to raise benefits in excess of 20 percent and thereby advance toward the goal of 50 percent or an American standard of living. We favor also, a cost of living provision to maintain income level up to date.

We urge that beneficiaries at the lowest level of benefits receive the highest priority in increases, and that widows be paid their husbands' level of benefits.

We support the administration's request for higher allowable earnings for those few retired elderly who can find employment.

MEDICARE

All social security beneficiaries should be covered by the health insurance program and the disabled deserve priority.

The deductible and coinsurance features of medicare have proven to be an obstacle. They deter the elderly from obtaining needed medical care and should be eliminated.

DRUGS

Most of the aged, have chronic ailments that do not require hospitalization, but require continuous use of expensive drugs. This financial burden is borne by the aged. Medicare should round out its program by filling this great need of providing drug prescription coverage.

MEDICAID

We urge that no changes be made in the medical assistance program that will reduce the present Federal formula. We support the New York State program. It has been in existence before title 19 became law and we consider the income requirements realistic.

HOSPITAL AND MEDICAL COSTS

It has been said, that House leaders want to wait to get a true picture of what medicare is costing, before it approves further benefits.

We say set up controls, protect the public now, from uncontrolled skyrocketing hospital charges, doctors' fees, and expensive drugs, if you want to obtain a true picture of health care costs, but please do not forsake our elderly citizens in their hour of great need.

Health care costs have been spiraling for several years. This began when health insurance became so widespread and popular. Even at these hearings Congress was told by Blue Cross to expect a sharp rise in hospital costs this year. In 1929 this Nation spent $9 billion on health care. This year we will spend $40 billion. And by 1975 we will be spending over $70 billion.

It is plainly not a coincidence that hospital and medical costs have risen along with insurance coverage. In 1965 the New York Labor-Management Council of Health & Welfare Plans, Inc., published a report of a study which showed that surgeons' fees increased as insurance benefit payments increased; so that the worker, who was insured, did not receive the benefit which was intended.

President Johnson ordered an investigation of the cause of rising medical fees and hospital charges in August 1966 when there were widespread claims throughout the Nation that they were being raised to take advantage of medicare.

We knew it was happening in New York. The Department of Health, Education, and Welfare, which conducted the inquiry, confirmed in its report to the President, that in 1966 hospital charges and medical fees were raised almost double the increase of previous years. Medicare became effective in 1966. Any gain made by the public through the passage of title 18 (medicare) was eaten up by the doctors and hospitals.

The raising of medical fees, hospital charges, and drugs has also affected people not covered by medicare. Health care services are the most vital need of humanity. Other services essential to the public, such as utilities, are controlled by legislation and governmental agencies. Yet there is no protection of the public's interest in respect to uncontrolled health care costs, which have risen beyond the ability of the average citizen to pay. It has become a national crisis.

In a letter to the President, February 15, the New York Labor-Management Council of Health & Welfare Plans, Inc., urged him to act now, to set up controls of the costs of health care services and drugs. We repeated this request to the Ways and Means Committee on March 23, 1967. We again urge Congress today to act now on this very urgent national problem.

STATEMENT OF SIMON N. WHITNEY, CONSULTANT, U.S. ECONOMICS CORP.

Mr. Whitney. I am professor of economics at the University College of Arts and Science, New York University, and also consultant to the U.S. Economics Corp., a firm which has been retained by the Pharmaceutical Manufacturers Association to conduct studies of the prescription drug industry. My statement is presented on behalf of this firm and its client.

The radical change in our economic and medical policies proposed in S. 17 and S. 2299 seems to me to require, as with new drugs today, that the benefits be clear and any "side effects" not serious. It should offer both efficacy and safety, but I shall argue that both are dubious. First, the money savings will be less than expected, and perhaps nil; second, the amendments carry an indirect, long term, threat to the improvement of the Nation's health.

As a preliminary, I must concede that I am not medically qualified to comment on whether the physician's traditional right to prescribe should be replaced, when Government reimbursement is involved or otherwise, by decisions of a single national formulary committee. I have observed that there are many experts on both sides of this issue. Insofar as the bills are designed primarily to save money in Government purchasing, an economist does have something to say; and the first half of my statement will discuss whether drug price control will really do this.

Large savings have been predicted from having prescriptions written in generic names. We should not forget, though that only a minority are now written in brand names for which the generic could be substituted—the great majority are for single-source drugs, for generics themselves, or for standard items where brands carry little weight. Nor should we overlook that higher margins on some drugs produced by a manufacturer are needed to carry the costs of less profitable, or wholly unprofitable, items, not to mention the losses in unsuccessful research. No general conclusions can be derived from a few high-margin drugs. One must look at the total profits of a company, indeed at those of the industry as a whole rather than of the most profitable companies.

The earnings tabulations published by the First National City Bank of New York isolated the drug manufacturing industry for the first time in 1950. For 1950, the average of 1950–66, and 1966, respectively, earnings on net worth were 21.9, 19.5, and 21.0 percent for drugs; and 17.1, 12.7, and 14.1 percent for all manufacturing.[1] The official Federal Trade Commission-Securities and Exchange Commission ratios are not as appropriate, since they did not isolate drugs until 1956

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[1] "Monthly Economic Letter," April issues.

and since they include small firms not conducting research or selling by brand name. It happens that in 1966 they showed a four-quarter average for the drug industry at 20.3 percent, and for all manufacturing at 13.5 percent, of net worth. Thus the latest annual profit figures for all manufacturing are approximately two-thirds as high as those for drugs, whichever source is used.

There is nothing shocking about this ratio. Soft drink companies happened to earn 22.3 percent in 1966; steel, 9.3 percent, or only two-thirds of the average; meatpacking, only 5.5 percent. No one is shocked at these figures either. The conclusion I draw is that any proposal to bring drug profits down to so-called normal levels cannot go further than a one-third reduction. If investors are told that they must expect less than the average returns of all manufacturing, only philanthropists will be interested in the drug industry, and it will wither away.

The drug profit margin on sales in 1966 was 10.8 percent, both in the City Bank and FTC-SEC series, so that equalizing profits on net worth with all manufacturing would mean reducing drug manufacturers' selling prices by one-third of 10.8 percent, or by 3.6 percent. What would this amount to? Consumers are estimated to have spent $3.05 billion on prescriptions at community pharmacies in 1966, and manufacturers received $1.4 billion of this.[2] A 3.6 percent cut in the $1.4 billion would reduce it by $50.4 million. A $3.05 prescription would then cost $3. Even less would in fact be saved: the industry reinvested 46 percent of its 1966 profits in expansion,[3] and this would have to be replaced from somewhere.

I shall pass over certain debating points quickly. Price cuts, it is true, would impinge on profits before instead of after corporate income taxes and might thus equal 10 cents instead of 5. But nothing is gained if the Government's tax loss must then be made good by some one else, or if the Government loses in tax receipts what it gains in reimbursement of prescription charges.

Again, the drug companies have far larger sales than $1.4 billion. They sell to hospitals and governments; sell proprietary and veterinary drugs, fine chemicals, and many other products; and sell abroad. But if we concentrate a 33-percent reduction in their total profits into the one area of sales for community pharmacies, in order to get more than a $50 million reduction in this area, managements will soon shift resources, either voluntarily or under stockholder pressure, into the other areas permitted to have better profit margins.

These proposals affect only a minority of ethical drug users, to be sure, mainly though not exclusively older persons. If a $50 million saving in Government reimbursement for prescriptions is made here, the American taxpayer will save about 1 cent in every $40 he now pays out each year. Perhaps it is politically realistic to suspect that these benefits, such as they are, may eventually be demanded by all consumers. No matter how narrowly or broadly the controls on drug prices are applied, either profits must be driven below the manufacturing average and capital thus warned to move out of ethical drugs, or the total price reduction on sales to community pharmacies, at 1966 profit ratios, will be limited to $50 million.

It seems clear that the percentage of consumer prices accounted for by industry profits has been much exaggerated. Those who have

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[2] Department of Commerce; Pharmaceutical Manufacturers Association.
[3] FTC-SEC, Quarterly Financial Report for Manufacturing Corporations.

claimed large prospective savings have had to rely either on vague generalities or on unrepresentative selected examples of high-margin drugs. The unchallenged arithmetic of the industry as a whole will not support their views.

I digress on one unexplored possibility. If marketing costs could be reduced along with prices, the drug industry might theoretically make as much money as before. Manufacturers might well be pleased to reduce competitive marketing costs if their rivals would do the same; but it cannot be done by private agreement. In any case, promotional costs of an industry offering such a high percentage of new products are bound to be high. Also detail men are expensive, but questionnaires to physicians have consistently shown that their discussions of the new drugs are welcomed by most, though not of course accepted in every particular.[4] The chairman of the British Committee on Safety of Drugs is one of those who argue that mass marketing techniques are essential to new drug acceptance. If any one can prove the contrary and show how innovation and profits can be maintained while reducing marketing costs and prices, it will be a service to the public and to the companies as well. So far it has not been shown.

Although I am resting my argument, that the money savings from these proposals will be small, primarily on the foregoing evidence relating to the ratio of profits to sales, I want to list four more reasons for this view.

1. The proposal is that, as soon as a patent expires, purchases be made on a generic name basis. This will deny the originator of the drug the opportunity which firms in other industries possess, to continue to make profits through a respected trademark on which consumers rely for quality. Since no further compensation for the original costs and risks of research and promotion will be made, we can expect prices to be set higher during the patent period. The firms will try to amortize their investment sooner, and, if this effort fails, the stimulus to research will be inevitably reduced.

2. As the demand for generic drugs is sharply increased under these proposals, they will respond like any other product: their prices will rise. One problem here is which generic prices to choose. Dr. Richard Burack's "The Handbook of Prescription Drugs" lists price ranges (from p. 84) of 92 cents to $1.90, $1.10 to $2.10, $11.05 to $19.75, $7.95 to $15.70, $2.50 to $5.75, and so on. Assuming that the Secretary of Health, Education, and Welfare excludes the lowest and highest prices because they "vary significantly" (S. 2299), the lowest will probably be raised quickly; but one wonders whether the higher priced generic drug suppliers will be able to reduce their prices and still continue in business. To the added costs of generic drugs from rising prices may be added the costs of quality control, estimated by the HEW staff for this committee at $25 million a year (plus $14.6 million in other administrative costs and at least $300 million for clinical testing in the first 6 years). It appears that the expected monetary savings will soon shrink and perhaps vanish.

3. Pharmacists' fees are to be "reasonable"—a deceptively reassuring word which in practice has sometimes led right into litigation. The guidepost of return on investment, used for public utilities, will have

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[4] Raymond A. Bauer and Lawrence H. Wertzel. "Doctor's Choice: The Physician and His Sources of Information About Drugs," Journal of Marketing Research, February 1966, pp. 40-47.

no application here. Perhaps the Secretary will find himself picking some rounded figure per prescription, or at least one divisible by 25 cents. Perhaps he will make the most "reasonable" judgment as to what the income of pharmacies, in other words the standard of living of their owners, should be. Supporters of this program agree that something must be done for pharmacists to win their approval, and an increase from $1.50 to $2 or more per prescription, as has been suggested, would add about $125 million to the annual cost of drugs for those over 65. The Secretary will also have problems in setting consistent fees for unit pharmacies and chains, big city and smalltown operations, those in high and low volume city locations, pure pharmacies and drug department stores, and those with more low-priced and more high-priced prescriptions to dispense because of their classes of customers. The continuing administrative costs, especially as wages and other pharmacists' costs keep rising over the years and compelling changes in fees, will not be small. Let us hope evasions prove so few that law enforcement machinery will not be needed in addition.

4. The latest report of the Department of Health, Education, and Welfare shows the average person over 65 spending $41 a year on 11 prescriptions.[5] Each purchase will have to be checked against maximum allowable price, as will the details of any $25 annual deductible if one is added. It is an undisputed principle of all insurance that administrative costs eat up the benefits where the individual risks which are insured are small. This will surely apply where the average insured person, 73 years old, must report 11 payments averaging around $3 each at maximum allowable cost. It is no overall economy if drug companies lay off employes for lack of profits, and government agencies or pharmacies hire them to check forms.

I have used enough space on the illusion that money can be transferred from profits to consumers or the Government by legislation without serious leakages. I turn now to my second, and more important, topic. Only a few tens of millions are involved, one way or the other, if we set up administrative machinery to try to bring the prices of ethical drugs to supposedly more "reasonable" levels. If there is potential danger to the flow of new effective drugs, however, hundreds of millions, or more, in the ultimate money value of relief from illness may be lost. To show this danger, I shall rely on the most basic of economic principles, supported by the relevant statistics.

The science of economics begins, perhaps, with the truths that work is necessary to produce goods, and saving, constructively employed, is necessary for progress. These lead straight to the proposition that, if an economy relies on voluntary action rather than orders and penalties dictated from above, it must find adequate personal motives for work, saving, and investment. The guiding principle which it has in fact found for investment is this: where consumer demand is greatest, profits are greatest provided operations are efficient, and these profits in turn attract capital to the place where consumers need it. Profit rate differences thus serve a vital economic function. Adam Smith called this the "invisible hand." Our high standard of living is irrefutable evidence that capital's search for profit has benefited consumers; and countries which condemn the profit motive are glad to draw on the surpluses which it produces.

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[5] "Cost and Acquisition of Prescribed and Nonprescribed Medicines," October 1966.

Let us apply this to pharmaceutical manufacturing. Quite simply, its products are too important to the public welfare for us to withdraw the incentives which have so multiplied our other goods and services. This central economic principle, taught in all the universities with which I have been acquainted, seems to have been forgotten by those who are denouncing drug industry profits as unreasonable on the implicit assumption that there is one reasonable level for all profits. But it is the differences in profit rates on which the economic system thrives.

The number of drug manufacturers large enough for their earnings to be tabulated by the First National City Bank increased from 10 in 1950 to 39 in 1966. Stockholders' investment, reported in the same source, expanded 640 percent, compared with 208 percent, or one-third as much, for all manufacturing. Investment increased 150 percent, for example, in steel, and just 50 percent in meatpacking. The economic process—rising consumer demand, high profits, attraction of capital to make what consumers want—has worked in drugs as predicted, brilliantly.

It has been confirmed by the rapid rise in physical volume of production. Consumer purchases of ethical plus proprietary drugs—of which an increasing proportion, now about three-quarters, has been ethical—expanded by 189 percent, or 5.5 percent annually, from 1946 to 1966 compared with only 105 percent, or 3.7 percent annually, for all other consumer expenditures (using Department of Commerce dollar estimates adjusted for price changes).

Another result has been a rocketing of research and development expenditures—from $50 million in 1951 to an estimated $400 million in 1966.[6] Recently 98 percent of this war financed by industry, as against less than half for American industry as a whole. Of the many hundreds of new drugs introduced, critics say that only a few dozen have constituted real breakthroughs. So be it: we all know what the few dozen have accomplished; without them there would be no insistent demands for drug price control like those before us. The industry has sprung into world leadership, recognized by foreign spokesmen and in foreign purchases which have been rising 10 percent a year to ever new records.

It is these achievements that we imperil if we remove the so-called excess profits which, in fact, have furnished their driving force. For a mere 6 cents in dividends per dollar of sales in 1966, or a cent and a third in dividends for each dollar in total medical care costs,[7] the industry has done its essential job—not one of basic biological rerearch, but one of discovery and bringing to use of new medicines. Critics say it has offered too many small changes; if so, it is at least better than too few. Its investors are probably as human as others: strike off 2 pennies in dividends per dollar of sales, thus reducing their return to the average, and their enthusiasm will wane. If the public expects to find satisfaction in making the drug industry earn less profit, it should be warned that an inevitable accompaniment will be less investment of capital in the search for cures of our dread diseases.

It is implicit in my argument that drug prices on the whole are not "too high." I shall reivew briefly five rationalizations for this charge which is so often made.

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[6] Pharmaceutical Manufacturers Association.

[7] Moreover, a large part of these dividends are not derived from the sale of medical care products.

1. Those who say high profits prove that prices are excessive overlook the economic function of profits as already summarized. They also forget that, in a free market, earnings vary with risks. When an industry's ratio of research and development expenditures to sales is several times that of the average manufacturing industry, and when half the prescriptions filled in 1966 are for drugs not known in 1956,[8] there is obviously a high built-in risk factor. Furthermore, if one looks at research expenditure itself as a form of investment—and it is one in the real sense of an added preliminary outlay of investors' funds which a non-research based industry does not have, prior to any production or sales at all—most of the higher rate of drug earnings on net worth is accounted for. Referring to my previous discussion of differential profits and their effects on movements of capital, it appears that a moderately higher rate of real profits, after allowing for risks, exerts the necessary capital attraction.

Some critics, using good economic theory but not acquainted with all the facts here, say that a temporary high profit is understandable, but that entry of new capital ought soon to bring it down to normal unless there are artificial barriers to entry. In this industry, capital has entered. It is the continued high consumer demand, revived by the industry whenever it develops a new effective drug, which has sustained its earnings.

2. To many people, drug prices are an obvious example of rising costs of medical care. This is an error. Secretary Gardner pointed out recently that drugs are not a "key element" in the rise of health care costs. The Bureau of Labor Statistics indexes for wholesale and retail ethical drug prices have been declining since 1960. Principally because older drugs, whose prices are thus declining on average, are replaced in prescriptions by new and more effective drugs, the cost of a dispensed prescription has been rising.[9] The 36 percent increase from 1954 to 1966 in the American Druggist index, partly offset by this greater effectiveness in newer prescriptions, is far less than the 57-percent increase in cost of all medical care services.

The decisive point, however, is that the percentage of ethical plus proprietary drugs in total medical care expenditures as estimated by the Department of Commerce has been declining: from 15.3 percent in 1954 to 13.8 percent in 1955. In 1939 it had been 18.3 percent. Community pharmacy prescriptions are now less than 10 percent of all medical care costs, as are also total manufacturers' sales of ethical drugs to all outlets. Increasing use of effective drugs has, in fact, relieved the dependence of patients on other forms of medical care whose costs have been rising much faster.

3. When *is* a price too high? Is $15 too much for a pair of theater tickets, $200 for a television set, $2,500 for a car? A moment's thought reveals that a price is "reasonable" if it causes goods or services to change hands because buyers value them at more than the price, probably because this purchase replaces some other and greater expense or yields some unique satisfaction. If a physician thinks $25 in drugs will have one chance in three of keeping a patient from losing a week's pay, or spending 2 nights in a hospital, the price is in fact low. I observed that the American Public Health Associa-

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[8] Pharmaceutical Manufacturers Association.
[9] This is the explanation recently given by the Commissioner of Labor Statistics.

tion, in its March 13 submittal to the House Ways and Means Committee advocating generic drugs, emphasized the value of today's drugs which "in many cases, will obviate the need for more costly rehospitalization."

The view often met with that prices ought to be set according to costs is not approved in any economic textbook I have seen, simply because it would cause the economic system to stagnate. Not only would producers lose their incentives, but consumers could not give the signals, by bidding more or bidding less, as to what products they prefer.

4. Are prices all right for most people, but too high for the medically indigent? Certainly, and so are doctors' fees, good housing, even good food. We do not legislate the market prices of all these downward so that the indigent can afford to pay: we have special programs for them instead. For the small percentage of old persons who must spend hundreds of dollars a year on drugs, rather than the $40 or so average, insurance can reasonably be written or other help given as deemed by the Congress appropriate.

5. There are many to whom the higher prices of brand name drugs than of generic name drugs is proof positive that the former are excessive. But they must cover the risks of research, testing and promotion. I, at least, have seen no earnings data for non-research based companies. I have no knowledge as to whether these are less than the 10 percent of sales or 20 percent of capital which have been characteristic of successful research-based firms, or whether they are in line with the risks of their particular type of operation. Before the committee takes a position, it would be desirable to have such information developed.

The danger of experimenting with price controls which might imperil the incentives of the research-based pharmaceutical industry, in the hope of eating our cake and having it too, can be illustrated by an interesting set of figures. In the years from 1959 through 1966 new chemical entities marketed by this industry (according to the DeHaen survey) per $100 million of research and development spending Nos. 32, 22, 17, 11, 6, 6, 7, and 3, respectively. Although they should advance again to 6 or 7 as the industry adapts itself to the Food and Drug Administration's present requirements, it is clear that research is already less productive. Its costs and delays have been increasing. Price ceilings such as are now proposed will certainly be another deterrent, when present trends make stimulants seem more in order. Lower costs of existing drugs might be obtained at too high a price in terms of the loss of drugs yet to be discovered. There could also be a cost in terms of mortality of presently operating nonresearch companies if the larger corporations were to respond by reducing their research, testing and promotion, concentrate on achieving the economies of mass production in existing products, and take over more of their market.

Estimates of the economic value of longer life and better health resulting from modern drugs run into the billions. The so-called excess profits of the industry, perhaps $262 million in 1966 (one-third of the FTC–SEC total of $787 million earnings of drug companies), shrink into insignificance compared to these or to the annual health care bill of more than $31 billion—and all the more so when one recalls that these earnings were derived from sales of $7.8 billion including nondrug products and exports and that nearly half of them were not paid in dividends but reinvested for expansion.

The American ethical drug industry is the world leader, just as is the American economy, and because the same free enterprise principles are being applied in both. Defenders of S. 17 and S. 2299 have seen the immediate differences in prices quoted to wholesalers or pharmacists, though little has been published on the exact prices paid by consumers. But they have not faced up to the most fundamental issues.

Thank you.

STATEMENT OF KENNETH A. ROBERTS, ON BEHALF OF THE COLLEGE OF AMERICAN PATHOLOGISTS

Mr. ROBERTS. The College of American Pathologists is a professional society of physicians representing approximately 5,000 doctors of medicine practicing the medical specialty of pathology in hospitals and medical schools, clinics, government, research, and private offices throughout the country. This statement is being presented to you today on behalf of these physicians, presenting their views on those aspects of H.R. 12080 which provide that the full reasonable charges for pathology and radiology services furnished by physicians to hospital inpatients will be paid under the medical insurance program (pt. B) and the provisions of this bill which would consolidate all coverage of outpatient hospital services under the medical insurance program.

With the risk of taking many of you once again over a quite familiar path, we beg your indulgence while we briefly review the legislative history of the provisions relating to the reimbursement for the provision of pathology service to medicare beneficiaries.

In both H.R. 1 and S. 1, 89th Congress, the professional services of pathologists, radiologists, anesthesiologists, and physiatrists were specifically included in definitions of "inpatient hospital service" and "outpatient hospital service." In passing H.R. 6675, 89th Congress, the House Ways and Means Committee removed this adverse discrimination against these doctors by treating physicians' professional services in these specialties in exactly the same way as other doctors' services were covered under part B of title XVIII.

Speaking quite frankly, pathologists would have preferred to have the total payment for their professional services placed in the voluntary insurance portion of title XVIII, and then for the pathologist to reimburse hospitals for the space, equipment, supplies, personnel, etc., furnished by the institution. We genuinely believed then, and are of the current conviction, that this would have provided the maximum physician control over the medical services rendered to each patient.

However, the Congress chose in enacting Public Law 89-97, 89th Congress, to provide that the costs involved in the operation of the departments of pathology, radiology, anesthesiology, and physiatry be reimbursable along with other hospital costs under part A of title XVIII. The services of all physicians, including pathologists and other so-called hospital-based specialists, would all be paid under the same part B of the law. This House Ways and Means Committee was particularly clear on this point in its report to the House on H.R. 6675. [H.R. Rep. No. 213, 89th Cong. 1st Sess. 24 (1965)]:

> Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. *Like other physicians' services, the services of* radiologists, anesthesiologists, *pathologists,* and other physicians employed by the hospital or working through the hospital *would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan.* However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan. (Emphasis supplied.)

Unfortunately the administrative implementation of Public Law 89–97 has not chosen to follow what we believe to be the clear mandate of the Congress. Beginning in January 1966, with the publication by the Secretary of the Department of Health, Education, and Welfare of a series of eight principles entitled "Reimbursement Under Medicare for Service of Hospital-Based Physicians"; continuing in June 1966, with proposed rulemaking relating to the principles of reimbursement of hospital-based physicians; and ending with the publication on October 18, 1966, of part 405, Subpart D: Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians, the Department of HEW, despite repeated objections from the college, the AMA, and others, has interjected into the regulations an illusory principle which provides, in essence, that the only physicians' services reimbursable under part B are identifiable services requiring performance by a physician in person on behalf of a specific individual patient.

This administrative principle as applicable to pathologists, excludes from payment under part B, a large portion of the pathologists' professional practice of medicine. All of the time of a physician practicing pathology spent in setting standards, establishing controls, and otherwise supervising the clinical laboratory for which he is individually and directly responsible must be remunerated through the hospital under part A of the law. This is true even though HEW admits that this service requires a pathologist's "professional expertise." In practical effect, this administrative requirement effectively prevents the hospital-based pathologist, except in those instances where he personally has reviewed the specimen or file of the individual, from separating his physician's fees from hospital charges and billing the patient or his carrier for such medical fees. This, we submit, was not the desire of the Congress and has caused a disruption of existing patterns between doctors and hospitals and has been in large part responsible for the administrative quagmire which originally caused HEW to propose the enactment of a new part C in H.R. 5710.

The pathologists of this country, as represented by the college, are currently being forced to practice their profession and to negotiate their relationships with hospitals within a regulatory framework promulgated by the Department of Health, Education, and Welfare which has resulted in a situation varying from mild confusion in some areas to utter chaos in others. This situation cries for correction.

The changes proposed in section 131 of H.R. 12080 will, in large measure, correct the administrative deficiencies in Public Law 89–97 which we find in the law in action. To many, including the college, it seems unnecessarily drastic to urge legislative correction of administrative error. However, the Department of HEW informs us that in their view of the law an administrative correction of the confused situation in which we are all embroiled is impossible. The college has exhausted its administrative remedies and, therefore, short of involved and protracted litigation, finds itself in a situation where the only alternative appears to lie in legislative action.

If this view of the administration is correct, then the college would urge the principles embodied in H.R. 12080 be recommended by this committee to the Senate for its adoption.

In making such a recommendation we have some serious misgivings. The elimination of deductible and coinsurance requirements for hospital inpatients cannot help but cause greater utilization and result in higher costs for the program.

On the other hand, approval of the provisions of H.R. 12080 relating to pathology services would tend to allow pathologists complete freedom at the local level to work out their agreements with hospitals unfettered by an artificial administrative requirement which refuses to pay them as doctors unless they personally lay their hands on the patient or the specimen. Furthermore, unlike the present situation, the part A fiscal intermediary would need play no role in determining the mode or reasonableness of physicians' arrangements with hospitals. In addition, the outpatient services in hospitals would be subject to a uniform deductible and in parity with similar services performed in physicians' private offices. This latter change could not help but to eliminate much patient confusion and more correctly classifies outpatient diagnostic services as physician services paid under part B of title XVIII.

Accordingly, the College of American Pathologists, urges that this committee give serious and thoughtful consideration to those sections of H.R. 12080 which would provide payment in full under part B for the reasonable charges for pathology services furnished to hospital inpatients and those provisions consolidating all coverage of outpatient hospital services under the medical insurance program. It would appear to us that from the standpoint of the current law as it is being applied by the administration, this concept has considerable merit and would substantially alleviate much patient confusion regarding medicare and its benefits, in addition to its salutary effect on the freedom of pathologists to practice their profession with a minimum of unnecessary artificial administrative regulation.

The College of American Pathologists is deeply grateful for the opportunity you have afforded us to submit this statement for the record on these most important proposed legislative changes.

Senator HARTKE. These hearings are now adjourned until Tuesday morning at 10 o'clock, when we will hear the distinguished Secretary of Health, Education, and Welfare, Mr. Gardner.

(Whereupon, at 2:15 p.m., the committee adjourned until Tuesday, September 26, 1967, at 10 a.m.)

SOCIAL SECURITY AMENDMENTS OF 1967

TUESDAY, SEPTEMBER 26, 1967

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

The committee met, pursuant to recess, at 10:05 a.m., in room 221, New Senate Office Building, Senator Russell B. Long, chairman, presiding.

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

The CHAIRMAN. The hearing will come to order.

This morning we hopefully begin the final phase of hearings on the Social Security Amendments of 1967. The Secretary of Health, Education, and Welfare, the Honorable John Gardner, and his staff, have returned to answer whatever questions still remain in the minds of the members of the committee regarding this important legislation.

After we have concluded this hearing we intend to move into closed sessions next week to begin a markup of this bill.

I understand Senator Talmadge wanted to be recognized.

Senator TALMADGE. Mr. Chairman, I thank the Chair for his courtesy. I have notified Secretary Gardner on September 20 that I intended to ask him some questions about the Memorial Hospital at Bainbridge, Ga. This hospital filed its application on February 28, 1967, with the Department of Health, Education, and Welfare in order to participate in the Medicare program. To this date its application has neither been rejected nor accepted. I am thoroughly familiar with the facts in this case and cannot understand why the Department has refused to certify this hospital to participate in the Medicare program. It is for that reason, Mr. Chairman, that I invited Mr. Lee Thomas, administrator for the hospital, to be present today so that he could assist me in trying to determine why the Department has continued to refuse to grant certification while all of the information that has been made available to the Department would have normally been sufficient to make the hospital eligible to participate in this program.

If it meets with the Chair's approval and the Secretary's approval, I would like to ask Mr. Thomas to come up and sit by the Secretary and outline briefly what steps they have taken to date to be certified and then we will ask the Secretary to explain to the committee why they haven't been certified.

The CHAIRMAN. Mr. Secretary, if you have no objection, I would just ask that the witness sit over there in Senator Ribicoff's chair since he is not here and explain his problem. You came here to answer the questions of the committee, and I don't think it appropriate that anyone other than committee members should ask questions of the

Secretary at this session. But Senator Talmadge certainly has a right to have any advisers he likes and if it is all right it is all right with me.

Secretary GARDNER. It is perfectly all right with me.

The CHAIRMAN. Would you please take that microphone at the end?

Senator TALMADGE. This is Mr. Lee Thomas, administrator of the Memoral Hospital at Bainbridgde, Ga. Will you state briefly what you and your authority have done to comply with the Medicare program?

STATEMENT OF LEE THOMAS, ADMINISTRATOR OF MEMORIAL HOSPITAL, BAINBRIDGE, GA.

Mr. THOMAS. Thank you, Mr. Chairman, and members of the committee. On the 19th of January, our hospital authority in a special called session decided to participate in the medicare program. We knew at the time that there would be certain things that we would have to do to meet the guidelines as laid down by the Department of Health, Education, and Welfare. We have subsequently tried to meet every one of these guidelines.

To begin with we knocked out a partition in our dining room in order that we could desegregate our dining facilities in the employees dining facilities. We met with all of the employees in the hospital in small groups and explained to them that it was the intent of the hospital authority to comply with these guidelines that were laid down by the Department.

We subsequently made an application in February to the Department. At the time we advertised in the newspaper and on the radio that we intended to comply. We posted notices of admission policies in the hospital admitting offices, and we actually stopped assigning patients to any specified areas of the hospital. We are competely desegregated in our facilities.

On June 12, we were inspected by a Mr. Carter from the Department. At this inspection, and he spent 4 hours in our hospital inspecting us, went into all of the areas of the hospital, and he made some suggestions which we have subsequently incorporated in implementing our program of hospital care. Among these were that the waiting room which had been previously used by colored patients be locked. That door has been locked, and there is a sign on the door that it is for employees and doctors only.

We have sent letters, which he gave us copies to send, to all of the Negro physicians in our community, there being only two. A copy of this letter has been sent to these physicians explaining our situation, that we intend to comply with the guidelines of HEW and we have not heard any blessed thing from any one of these letters.

He suggested that we notify all of our employees in writing again that we intended to comply. This we have done and we have copies of this which Senator Talmadge has. We posted notice of our admission policy in our admitting rooms and all over the hospital. We completed numerous forms showing the patient assignment of previous weeks prior to this visit, and since then we have completed several other of these forms.

On August 16 we received a letter from Mrs. Rose Brock, of the Department, alleging that our patient assignment to rooms showed discrimination in certain areas of the hospital. Subsequent to this we sent additional information showing patient assignment for approximately 6 weeks prior to this letter. If these papers that we sent are studied they completely refute this allegation that we are discriminating in assignment of rooms to these patients, or patients to these rooms.

I have since talked with her on the telephone and she has alleged to me over the telephone that our physicians are putting their colored patients into the colored hospital. We have a hospital owned and operated by a Negro doctor. This is not so. We have letters from each of these doctors, Senator Talmadge has these in his files, showing that they do not admit patients to any hospital except our facility.

We have a small number of Negro patients in our hospital percentagewise. The percentage of white and colored population in Decatur County is approximately 45 to 55. Because of the other hospital which uses the Negro doctor and his hospital facilities, it is impossible for us to come up with any sort of percentages that will approximate this ratio of colored and white patients in our community. I think our figures show that our Negro patients amount to 18 or 20 percent in this neighborhood of our patient load.

There were three practicing midwives licensed by the State of Georgia to deliver babies, and I have a letter from the State health department of our local public health office showing the number of Negro births that these three practicing midwives delivered, and these are factors that contribute to the low occupancy of the colored patients in our hospital.

We have asked that they inspect our hospital again. We think we are in compliance with what they have asked us to do, and if it is not, we would appreciate them telling us what we can do to bring our hospital into compliance.

Senator TALMADGE. Thank you very much, Mr. Thomas.

Mr. Secretary, I would like to have your response as to why this hospital hasn't been certified?

STATEMENT OF HON. JOHN W. GARDNER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY WILBUR J. COHEN, UNDER SECRETARY; RALPH HUITT, ASSISTANT SECRETARY FOR LEGISLATION; MISS MARY SWITZER, ADMINISTRATOR OF SOCIAL AND REHABILITATION SERVICE; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; DR. FRANCIS LAND, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE; AND CHARLES HAWKINS, LEGISLATIVE REFERENCE OFFICER, SOCIAL AND REHABILITATION SERVICE

Secretary GARDNER. Senator, I believe that we have here an honest difference of opinion as to the degree of desegregation or integration in this hospital. We have been operating on the same facts as they have, and it is clearly a difference of interpretation as to what has been accomplished to date on the basis of the June 12 site visit and on the basis of the material which was sent us in the mail. We are sending another person down this week to review the case again, and we will attempt to arrive at some judgment. It is very possible that if the difference in interpretation continues we will have to go to a hearing and then the case will be resolved before an independent hearing examiner.

I would simply stress that the people making these judgments are people who have cleared very large numbers of hospitals throughout the South; they are operating on the basis of a great deal of comparative information, and they are not without standards of judgment on this. Nevertheless, your case may be sound, and I would not want to express an opinion personally at this time because if there is a hearing, I will have to make a decision then on the basis of the hearing evidence.

Senator TALMADGE. Mr. Secretary, I appreciate your sending someone down to make an inspection.

Now, Mrs. Brock told Mr. Schramm of my staff that unfortunately they didn't have anyone they could send down to make an inspection.

I have the census occupancy here from July 10 to August 22, 1967, and one prior thereto, and it shows both white and Negro occupancy in the east wing, in the south wing, in corridor 7, the west wing, corridor 8, the west wing and for the period involved, and I ask unanimous consent, Mr. Chairman, that these census occupancies be inserted in the record at this point.

The CHAIRMAN. That will be done.

(Data referred to above follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE.
Washington, D.C., August 16, 1967.

Mr. LEE M. THOMAS,
Administrator, Memorial Hospital,
Bainbridge, Ga.

DEAR MR. THOMAS: We appreciate the cooperation you have shown in our program to determine the status of your hospital relative to Title VI of the Civil Rights Act of 1964.

Information obtained from our staff's evaluation visit to your hospital and/or information we have received from you has been reviewed and indicates that, despite corrective steps already taken by you, that certain phases of your hospital's operation are in violation of Title VI of the Civil Rights Act and this Departments implementing Regulation:

> "Discrimination on the basis of race in the assignment of patients to the East, South and Corridors #7 and #8 of the West Wing resulting in virtually segregated sections of the hospital."

Unless you can demonstrate within the next ten days, by submittal of a census report and any other information, your intent to comply with the law, we will be compelled to conclude that compliance cannot be secured by voluntary means and we would then recommend to our Office of General Counsel that proceedings be initiated which might lead to a denial of all pending applications for federal financial assistance and a termination of all direct and indirect federal financial assistance now in force.

We therefore urge you to submit the necessary information and inform us immediately of any other steps you plan to take to come into compliance. Please address any response in writing to Chief, Hospital Compliance Branch, OBHO, Room 5416, HEWS, Washington, D.C. 20201.

Sincerely yours,

ROSE E. BROCK,
Chief, Hospital Compliance Branch, OEHO.

AUGUST 24, 1967.

MRS. ROSE E. BROCK,
Chief, Hospital Compliance Branch, Department of Health, Education, and Welfare, Public Health Service, Washington, D.C.

DEAR MRS. BROOK: We acknowledge receipt of your letter dated August 16, 1967, advising that your investigation indicated:

> "Discrimination on the basis of race in the assignment of patients to the East, South and Corridors #7 and #8 of the West Wing resulting in virtually segregated sections of the hospital".

We feel an analysis of the enclosed report of room occupancy in the East, South and Corridors #7 and #8 of the West Wing, covering the period 7-10 thru 8-22-67, indicates no racial discrimination in patient assignment. On the contrary we believe, in view of the relative small number of Negro patients, it demonstrates accomplishment, by the hospital, of elimination of any pattern of segregation which may have previously existed.

We are, and it is our intent to continue making a sincere and strenuous effort to comply with the law and your Department's implementing Regulations as we understand them.

Should this information not be sufficient to approve our application, of February 28, 1967, for Medicare participation, we would appreciate a visit within 10 days by your representative to specifically inform us what further steps are required to obtain approval.

We believe that the people of Southwest Georgia are deserving of the benefits of this program and solicit your aide in making them available.

Very truly yours,

LEE M. THOMAS,
Administrator Memorial Hospital.

MEMORIAL HOSPITAL, BAINBRIDGE, GA.—WING OCCUPANCY BY RACE, July 10–Aug. 22, 1967

Date	East wing		South wing		Corridor No. 7,[1] west wing		Corridor No. 8,[2] west wing	
	White	Negro	White	Negro	White	Negro	White	Negro
July 10	7	3	7	0	3	1	0	0
11	6	3	7	2	2	1	0	0
12	7	3	7	0	2	1	0	0
13	6	4	7	1	0	2	0	0
14	5	4	9	1	0	2	0	0
15	3	2	7	1	1	2	1	0
16	8	2	8	1	2	1	1	1
17	9	2	9	2	3	2	1	1
18	7	2	9	2	3	2	1	1
19	10	1	9	3	4	2	1	1
20	11	1	8	3	5	1	1	0
21	9	1	9	4	4	1	1	1
22	9	1	10	1	3	1	1	1
23	8	2	9	1	4	1	1	1
24	10	2	8	0	4	2	1	1
25	12	2	15	0	2	2	2	3
26	12	2	16	0	2	2	3	3
27	10	1	16	0	3	1	3	2
28	9	2	15	0	3	1	5	3
29	9	2	13	0	1	0	4	1
30	9	2	12	0	1	0	4	2
31	8	2	11	0	0	0	3	3
Aug. 1	11	1	11	0	1	0	2	5
2	11	1	11	0	1	0	1	4
3	12	1	9	0	2	0	1	4
4	11	1	10	0	4	0	1	3
5	11	1	11	0	3	0	1	3
6	9	1	11	0	2	0	1	3
7	10	1	9	1	1	1	2	3
8	10	1	7	2	1	1	2	2
9	10	1	9	1	0	1	1	2
10	11	1	11	1	1	0	1	2
11	14	0	12	1	2	0	1	3
12	15	0	12	1	3	0	0	2
13	14	1	10	2	3	0	0	3
14	13	1	12	2	4	0	0	3
15	14	1	16	2	4	0	0	3
16	11	1	12	1	5	1	0	2
17	10	1	10	1	3	1	1	3
18	8	1	9	1	3	0	1	4
19	7	1	8	1	1	1	1	3
20	8	1	6	1	2	2	1	3
21	9	1	6	1	1	2	2	3
22	13	1	8	1	2	3	4	2

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[1] Maternity only.

[2] The only 4 bedrooms available for medical cases are on this corridor.

DAILY CENSUS REPORT

June 1, 1967

[N—Negro; W—white; M—male; F—female]

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Clinton, David (WM)
N-4A	Maddox, James Grant (WM)
B	
N-5A	
B	
N-6	
N-7	Day, William (WM)
N-8	Smith, Michel (WM)
N-9	
N-10	
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Ulmer, Carol Lee (WF)
B	
E-15	Smith, Sarah (WF)
E-16A	Strickland, Evey Ree (WF), dismissed
B	
E-17A	Barber, Roy (WM)
B	Musgrove, Roland (WM)
E-18	Wright, Sarah (WF)
E-19	Tipton, Myrtle (WF)
E-20	Horn, Roland (WM)
E-21	Chambless, Miriam (WF), dismissed; Strickland, Ruth (WF)
E-22	Desvergers, Clifford (WF)
E-23	Herrington, J. R., dismissed; Glisson, Anthony (WM)
E-24	Byrd, James Robert (WM), dismissed
E-25	Drake, Linton (WM)
S-26A	Dennis, Lucy (NF)
B	
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Pitisci, Joseph (WM)
S-30	Johnson, Norman (WM)

MEDICAL WING ONLY—continued

S-31	Griffin, Ottonese (WF)
S-32A	Daughtry, Annie (WF)
B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Ira (WM)
B	Gibbons, Jessie (WF)
S-35	Cameron, Hazel (WF)
S-36	Martin, Susie (WF)
S-37	Shepard, Brownie (WF)
S-38	Jones, Fannie (WF)
S-39	Widener, Mae Dee (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jackson, Cleotha (NF)
B	Braswell, Perry Lee (WF)
C	
D	
W-48A	McKay, John (NM), dismissed
B	Reed, Jay C. (NM)
C	
D	
W-49A	Smart, Willie Mae (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Kelly, Frances (WF), dismissed
B	
W-56A	
B	
W-57	Grimes, Linda (WF)
W-58	

NURSERY

Grimes, Baby Girl (WF)
Smart, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 2, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Clinton, David (WM)
N-4A	Maddox, James Grant (WM), dismissed
B	Kilgore, Wilma (WF)
N-5A	
B	
N-6	
N-7	Day, William (WM)
N-8	Smith, Mike (WM)
N-9	
N-10	
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Ulmer, Carol Lee (WF)
B	
E-15	Smith, Sarah (WF)
E-16A	
B	
E-17A	Barber, Roy (WM)
B	Musgrove, Roland (WM)
E-18	Wright, Sarah (WF)
E-19	Tipton, Myrtle (WF), dismissed
E-20	Horn, Roland (WM)
E-21	Strickland, Ruth (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	
E-25	Drake, Linton (WM)
S-26A	Dennie, Lucy (NF)
B	
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Pitisci, Joseph (WM)
S-30	Johnson, Norman (WM)
S-31	Griffin, Ottonese (WF)
S-32A	Daughtry, Annie (WF), dismissed

MEDICAL WING ONLY—continued

B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Jessie (WF)
B	Gibbons, Ira (WM)
S-35	Cameron, Hazel (WF)
S-36	Martin, Susie (WF)
S-37	Shepard, Brownie (WF)
S-38	Jones, Fannie (WF)
S-39	Widener, Mae Dee (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jackson, Clothea (NF)
B	Braswell, Perry Lee (WF)
C	
D	
W-48A	Reed, Jay C. (NM)
B	Dollar, Johnny N. (WM)
C	
D	
W-49A	Smart, Willie Mae (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Clark, Ossie Lee (NF)
B	
W-56A	
B	
W-57	Grimes, Linda (WF)
W-58	Bailey, Priscilla (WF)

NURSERY

Grimes, Baby Girl (WF)
Smart, Baby Girl (NF)
Clark, Baby Girl (NF)
Clark, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 3, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Clinton, David (WM) dismissed
N-4A	Kilgore, Wilma (WF)
B	
N-5A	
B	
N-6	
N-7	Day, William (WM) dismissed
N-8	Smith, Mike (WM)
N-9	Hatton, Abbie (WF)
N-10	
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Ulmer, Carol Lee (WF) dismissed
B	
E-15	Smith, Sarah (WF)
E-16A	
B	
E-17A	Barber, Roy (WM)
B	Musgrove, Roland (WM)
E-18	Wright, Sarah (WF)
E-19	Drinkwater, Lidia (WF)
E-20	Horn, Roland (WM), dismissed
E-21	Strickland, Ruth (WF), dismissed
E-22	DesVergers, Clifford (WM)
E-23	Glisson, Anthony (WM)
E-24	
E-25	Drake, Linton (WM)
S-26A	Dennis, Lucy (NF)
B	
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Pitisci, Joseph (WM)
S-30	Johnson, Norman (WM)
S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	Gibbons, Jessie (WF)
B	Gibbons, Ira (WM)
S-35	Cameron, Hazel (WF)
S-36	Martin, Susie (WF), dismissed
S-37	Shepard, Brownie (WF)
S-33	Jones, Fannie (WF)
S-39	Widener, Mae Dee (WF), dismissed
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jackson, Cleotha (NF)
B	Braswell, Perry Lee (WF)
C	
D	
W-48A	Reed, Jay C. (NM)
B	Dollar, Johnny N. (WM)
C	
D	
W-49A	Smart, Willie Mae (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Clark, Ossie Lee (NF)
B	
W-56A	Sirmons, Jeanette (WF)
B	
W-57	Grimes, Linda (WF)
W-58	Bailey, Priscilla (WF)

NURSERY

Grimes, Baby Girl (WF)
Smart, Baby Girl (NF)
Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Bailey, Baby Girl (WF)
Sirmons, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 4, 1967

SURGICAL WING ONLY

N-1A	Perry, John D. (NM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Owens, Bill (WM)
N-4A	Kilgore, Wilma (WF), dismissed
B	
N-5A	Williams, Juanita (WF)
B	
N-6	
N-7	
N-8	Smith, Mike (WM)
N-9	Hatton, Abbie (WF), dismissed
N-10	Bridges, Mavis (WF)
N-11	Green, Mary (WF)

MEDICAL WING ONLY

E-14A	
B	
E-15	Smith, Sarah (WF)
E-16A	Newsome, Nellie Mae (WF)
B	
E-17A	Barber, Roy (WM), dismissed
B	Musgrove, Roland (WM)
E-18	Wright, Sarah (WF)
E-19	Drinkwater, Lydia (WF)
E-20	Godwin, Allen Thomas (WM)
E-21	Powell, Rose (WF)
E-22	Des Vergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Barr, Mary Alice (WF)
E-25	Ingram, C. H. (WM)
S-26A	Dennis, Lucy (NF)
B	Cole, Agnes (NF), moved to W-47
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Pitisci, Joseph (WM)
S-30	Johnson, Norman (WM)
S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Jessie (WF)
B	Gibbons, Ira (WM)
S-35	Cameron, Hazel (WF)
S-36	
S-37	Shepard, Brownie (WF)
S-38	Jones, Fannie (WF)
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	

MEDICAL WING ONLY—continued

W-47A	Jackson, Cleotha (NF)
B	Braswell, Parry Lee (WF)
C	Cole, Agnes (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Close, Randolph (NM)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Clark, Ossie Lee (NF)
B	Canidate, Johnny Mae (NF)
W-56A	Sirmons, Jeanette (WF)
B	
W-57	
W-58	Bailey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Girl (NF)
Bailey, Baby Girl (WF)
Sirmons, Baby Girl (WF)
Canidate, Baby Boy (NM)

SURGICAL WING ONLY

N-1A	Perry, John D. (NM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Owens, Bill (WM)
N-4A	Cummings, Diane (WF)
B	
N-5A	Williams, Juanita (WF)
B	
N-6	Jepson, Carol Lee (WF)
N-7	
N-8	Smith, Mike (WM)
N-9	
N-10	Bridges, Mavis (WF)
N-11	Green, Mary (WF)

MEDICAL WING ONLY

E-14A	Peavy, Lloyd (WM)
B	
E-15	Smith, Sarah (WF)
E-16A	Newsome, Nellie (WF)
B	
E-17A	Musgrove, Roland (WM)
D	

DAILY CENSUS REPORT—Continued

June 4, 9167—Continued

MEDICAL WING ONLY—continued

E-18	Wright, Sarah (WF)
E-19	Drinkwater, Lydia (WF)
E-20	Godwin, Allen (WM)
E-21	Powell, Rose (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Barr, Mary Alice (WF)
E-25	Ingram, Charles Henry (WM)
S-26A	Dennis, Lucy (NF)
B	
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Pitisci, Joseph (WM)
S-30	Johnson, Norman (WM)
S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Jessie (WF), dismissed
B	Gibbons, Ira (WM)
S-35	Cameron, Hazel (WF)
S-36	Edmond, Charles (WM)
S-37	Shepard, Brownie (WF)
S-38	Joes, Fannie (WF)
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	

MEDICAL WING ONLY—continued

W-47A	Jackson, Cleotha (NF)
B	Braswell, Parry Lee (NF), dismissed
C	Cole, Agnes (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Close, Randolph (NM)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Clark, Ossie Lee (NF), dismissed
B	Candidate, Johnny Mae (NF)
W-56A	Sirmons, Jeanette (WF)
B	
W-57	
W-58	Bailey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Girl (NF)
Bailey, Baby Girl (WF)
Sirmons, Baby Girl (WF)
Canidate, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 6, 1967

SURGICAL WING ONLY

N-1A	Perry, John (NM)
B	Musgrive, Eddie (WM)
C	
D	
N-2A	
B	
C	
D	
N-3	Owens, Bill (WM)
N-4A	Cummings, Diane (WF)
B	
N-5A	Williams, Juanita (WF)
B	
N-6	Jepson, Carol Lee (WF)
N-7	
N-8	Smith, Mike (WM)
N-9	
N-10	Bridges, Mavis (WF), moved to S-39
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Smith, Sarah (WF)
E-16A	Newsome, Nellie Mae (WF)
B	Cloud, Eva (WF)
E-17A	Musgrove, Roland (WM)
B	
E-18	Wright, Sarah (WF)
E-19	Drinkwater, Lydai, (WF)
E-20	Godwin, Allen (WM)
E-21	Powell, Rose (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Barr, Mary Alice (WF)
E-25	Ingram, Charles (WM)
S-26A	Dennis, Lucy (NF)
B	Burney, Peddie Mae (NF)
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)

DAILY CENSUS REPORT—Continued

June 6, 1967—Continued

MEDICAL WING ONLY—continued

S-29	Pitisci, Joseph (WM) dismissed
S-30	Johnson, Norman (WM), expired
S-31	Griffin, Ottonese (WF)
S-32-A	
B	
S-33	Johnson, Joseph (WM)
S-34A	Gibbons, Ira (WM)
B	
S-35	Cameron, Hazel (WF)
S-36	Edmonds, Charles (WM)
S-37	Shepard, Brownie (WF), dismissed
S-38	Jones, Fannie (WF)
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jackson, Cleotha (NF)
B	Bell, Paulette (NF)
C	Cole, Agnes (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Close, Randolph (NM)
C	

MEDICAL WING ONLY—continued

D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Canidate, Johnny Mae (NF)
B	
W-56A	Sirmons, Jeanette (WF), dismissed
B	
W-57	Hinson, Judy D. (WF)
W-58	Bailey, Priscilla (WF), dismissed

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Bailey Baby Girl (WF), dismissed
Sirmons, Baby Girl (WF), dismissed
Canidate, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 7, 1967

SURGICAL WING ONLY

N-1 A	Perry, John (NM)
B	Musgrove, Eddie (WM)
C	
D	
N-2 A	
B	
C	
D	
N-3	Owens, Bill (WM)
N-4 A	Cummings, Diane (WF), dismissed
B	
N-5 A	Williams, Juanita (WF)
B	Griffin, Marthine (WF)
N-6	Jepson, Carol Lee (WF)
N-7	Barber Susan (WF)
N-8	
N-9	
N-10	
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Smith, Sarah (WF)
E-16A	Newsome Nellie (WF), dismissed
B	Cloud, Eva (WF)
E-17A	Musgrove, Roland (WM)
B	
E-18	Wright, Sarah (WF)
E-19	Drinkwater, Lydia (WF), expired
E-20	Godwin, Allen (WM)
E-21	Powell, Rose (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Barr, Mary Alice (WF)
E-25	Ingram, Charles (WM)
S-26A	Dennis, Lucy (NF)
B	Burney, Peddie Mae (NF)
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Hall, Ellie H. (WF)
S-30	Johnson, Norman (WM) expired

MEDICAL WING ONLY—continued

S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Ira (WM)
B	
S-35	Cameron, Hazel (WF)
S-36	Edmonds, Charles (WM)
S-37	Spooner, Mable (WF)
S-38	Jones, Fannie (WF)
S-39,	Bridges, Myrvis (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Bell, Paulette (NF)
B	Cole, Agnes (NF)
C	Jones, Mendell (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Close, Randolph (NM)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Canidate, Johnny Mae (NF)
B	
W-56A	
B	
W-57	Hinson, Judy (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Canidate, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 8, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	Perry, John (NM)
C	
D	
N-2A	
B	
C	
D	
N-3	Owens, Bill (WM)
N-4A	Bailey, Betty Jo (WF)
B	
N-5A	Williams, Juanita (WF)
B	
N-6	
N-7	Barber, Susan Lee (WF)
N-8	
N-9	
N-10	
N-11	Greene, Mary (WF)

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Smith, Sarah (WF)
E-16A	Brinson, Jason (WM)
B	
E-17A	Musgrove, Roland (WM)
B	Rathel, Samuel (WM)
E-18	Wright, Sarah (WF)
E-19	Williams, Gloria (WF)
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rose (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Peterson, Eugen J. (WM)
E-25	Ingram, Charles (WM)
S-26A	Dennis, Lucy (NF), dismissed
B	Burney, Peddie Mae (NF)
S-27A	Granthum, Mattie (WF)
B	
S-28	Donley, Claudia (WF)
S-29	Hall, Ellie H. (WF)
S-30	
S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	Gibbons, Ira (WM), dismissed

MEDICAL WING ONLY—continued

B	
S-35	Cameron, Hazel (WF)
S-36	Edmonds, Charles (WM)
S-37	Spooner, Mable (WF), dismissed
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Bell, Paulette (NF)
B	Cole, Agnes (NF)
C	Jones, Mendell (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Close, Randolph (NM)
C	Jones, Willie (NM)
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Canidate, Johnny (NF), dismissed
B	
W-56A	
B	
W-57	Hinson, Judy (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Canidate, Baby Boy (NM), dismissed

DAILY CENSUS REPORT—Continued

June 9, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Owens, Bill (WM), dismissed
N-4A	Bailey, Betty Jo (WF), dismissed
B	
N-5A	Williams, Juanita (WF)
B	Granthum, Mattie (WF)
N-6	
N-7	Barber, Susan Lee (WF)
N-8	
N-9	
N-10	
N-11	Greene, Mary L. (WF), dismissed

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Smith, Sarah (WF)
E-16A	Brinson, Jason (WM)
B	
E-17A	Musgrove, Roland (WM)
B	Rathel, Samuel (WM), dismissed
E-18	Wright, Sarah (WF)
E-19	Williams, Gloria (WF), dismissed
E-20	Youman, Eugenia, (WF)
E-21	Powell, Rosa (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM)
E-24	Peterson, Eugene J. (WM)
E-25	Ingram, Charles (WM)
S-26A	Burney, Peddie (NF)
B	
S-27A	
B	
S-28	Donley, Claudia (WF)
S-29	Hall, Ellie H. (WF), dismissed
S-30	

MEDICAL WING ONLY—continued

S-31	Griffin, Ottonese (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	Cameron, Hazel (WF)
S-36	Edmonds, Charles (WM)
S-37	
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Bell, Paulette (NF)
B	Cole, Agnes (NF)
C	Jones, Mendell (NF)
D	
W-48A	Dollar, Johnny N. (WM)
B	Jones, Willie (NM)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	
B	
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 10, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Bailey, Betty (WF), dismissed
B	Battle, John (NM)
N-5A	Williams, Juanita (WF)
B	Granthum, Mattie (WF)
N-6	
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Smith, Sarah (WF), dismissed
E-16A	Brinson, Jason (WM)
B	
E-17A	Musgrove, Roland (WM), dismissed
B	
E-18	Wright, Sarah (WF), dismissed
E-19	Flowers, Ada (WF)
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	DesVergers, Clifford (WF)
E-23	Glisson, Anthony (WM), dismissed
E-24	Peterson, Eugene J. (WM), dismissed
E-25	Ingram, Charles (WM)
S-26A	
B	
S-27A	
B	Rowell, Maude (WF)
S-28	Donley, Claudia (WF)
S-29	
S-30	Griffin, Wilbur (WM)
S-31	Griffin, Ottomose (WF)
S-32A	

MEDICAL WING ONLY—continued

B	
S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	Cameron, Hazel (WF)
S-36	Edmonds, Charles (WM), dismissed
S-37	
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Bell, Paulette (NF)
B	Cole, Agnes (NF)
C	Jones, Mendell (NF)
D	
W-48A	Dollar, Johnny (WM)
B	Jones, Willie (NM)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Iglus, Eloise (NF)
B	
W-56A	Hall, Mary (WF)
B	
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM)
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 11, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Maxwell, Linda (WF)
N-4A	Battle, John (NM)
B	
N-5A	Williams, Juanita (WF)
B	Granthum, Mattie (WF)
N-6	Merit, Don (WM)
N-7	Tharpe, Richard (WM)
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	Austin, Howard (WM)

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	
E-16A	Brinson, Jason (WM)
B	
E-17A	
B	
E-18	Flowers, Ada (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	DesVergers, Clifford (WF) dismissed
E-23	
E-24	
E-25	Ingram, Charles
S-26A	
B	
S-27A	Granthum, Mattie (WF), moved to N-5
B	Rowell, Maude (WF)
S-28	Donley, Claudia (WF)
S-29	
S-30	Griffin, Wilbur (WM), dismissed
S-31	Griffin, Ottomose (WF)
S-32A	
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	Cameron, Hazel (WF), dismissed
S-36	Jones, Fannie (WF)
S-37	Bridges, Myrvis (WF)
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jones, Mendell (NF)
C	
D	
W-48A	Dollar, Johnny (WM)
B	Jones, Willie (WM)
C	
D	
W-49A	Middleton, Edith (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Iglus, Eloise (NF)
B	
W-56A	Hall, Mary J. (WF)
B	Maxwell, Clara (WF)
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Iglus, Baby Girl (NF)
Hall, Baby Boy (WM)
Maxwell, Baby Boy (WM)
Middleton, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 12, 1967

[N—Negro; W—White; M—male; F—female]

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Maxwell, Linda (WF); Julian (WM), dismissed
N-4A	Battle, John (NM)
B	Dowdell, Elmore (NM)
N-5A	Williams, Juanita (WF), dismissed
B	Granthum, Mattie (WF)
N-6	Merritt, Don (WM)
N-7	Tharpe, Richard (WM)
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	Austin, Howard (WM)

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	
E-16A	Brinson, Jason (WM)
B	
E-17A	
B	
E-18	Flowers, Ada (WF), dismissed
E-19	Wimberly, Clara (WF)
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	
E-23	
E-24	
E-25	Ingram, Charles (WM)
S-26A	
B	
S-27A	
B	Rowell, Maude (WF)
S-28	Donley, Claudia (WF)
S-29	
S-30	
S-31	Griffin, Ottomose (WF)
S-32A	
B	
S-33	Johnston, Joseph

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	
S-41	
S-42	
S43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jones, Mendell (NF)
C	Cunningham, Lillian (NF)
D	Osbourne, Ather M. (NF)
W-48A	Dollar, Johnny (WM)
B	Jones, Willie (NM)
C	
D	
W-49A	Middleton, Edith (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Iglus, Eloise (NF), dismissed
B	
W-56A	Hall, Mary J. (WF)
B	Maxwell, Clara (WF)
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Iglus, Baby Girl (NF), dismissed
Hall, Baby Boy (WM)
Maxwell, Baby Boy (WM)
Middleton, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 13, 1967

[N—Negro; W—white; M—male; F—female]

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Battle, John (NM)
B	Dowdell, Elmore (NM)
N-5A	Granthum, Mattie (WF)
B	
N-6	
N-7	Tharpe, Richard (WM)
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	Austin, Howard (WM), dismissed

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	Harrell, Paul (WM)
E-15	
E-16A	Brinson, Jason (WM), dismissed
B	
E-17A	
B	
E-18	
E-19	Wimberly, Clara (WF), moved to S-40
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Ingram, Charles (WM)
S-26A	
B	
S-27A	Rowell, Maude (WF)
B	Smith, Bertha (WF)
S-28	Donley, Claudia (WF), dismissed
S-29	
S-30	
S-31	Griffin, Ottomose (WF)
S-32A	
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jones, Mendell (NF), dismissed; Jeffery, Artie (NF)
C	Osbourne, Ather (NF)
D	Cunningham, Lillian (NF)
W-48A	Dollar, Johnny (WM)
B	Jones, Willie (NM)
C	
D	
W-49A	Middleton, Edith (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Kelly, Sybil (WF)
B	
W-56A	Hall, Mary (WF)
B	Maxwell, Clara (WF)
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Clark, Baby Boy (NM)
Iglus, Baby Girl (NF)
Hall, Baby Boy (NM)
Maxwell, Baby Boy (WM)
Middleton, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 14, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM)
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (WM)
B	
N-5A	Granthum, Mattie (WF)
B	
N-6	
N-7	Tharpe, Richard (WM)
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	Harrell, Paul (WM)
E-15	
E-16A	
B	
E-17A	
B	
E-18	
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Ingram, Charles (WM)
S-26A	
B	
S-27A	Rowell, Maude (WF)
B	Smith, Bertha (WF)
S-28	
S-29	Cook, Michael (WM)
S-30	
S-31	Griffin, Ottomose (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	

MEDICAL WING ONLY—continued

S-37	
S-38	Jones, Fannie (WF)
S-39	Bridges, Myrvis (WF)
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jeffery, Artie (NF)
C	Osbourne, Ather M. (NF)
D	Cunningham, Lillial (NF), dismissed
W-48A	Dollar, Johnny, expired
B	Jones, Willie, dismissed
C	
D	
W-49A	Middleton, Edith
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Kelly, Sybil
B	Meeks, Gail
W-56A	Hall, Mary, dismissed
B	Maxwell, Clara, dismissed
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM)
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Hall, Baby Boy (NM), dismissed
Maxwell, Baby Boy (NM), dismissed
Middleton, Baby Girl (NF)
Meeks, Baby Girl (WF)
Kelly, Baby Boy (WM)

DAILY CENSUS REPORT—Continued

June 15, 1967

SURGICAL WING ONLY

N-1A	Musgrove, Eddie (WM), dismissed.
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (NM)
B	
N-5A	Granthum, Mattie (WF)
B	
N-6	
N-7	Tharpe, Richard (WM)
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	

MEDICAL WING ONLY

E-14	Beavey, Lloyd (WM)
B	Harrell, Paul (WM)
E-15	
E-16A	Faircloth, Benny W. (WM)
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Ingram, Charles (WM)
S-26A	
B	
S-27A	Rowell, Maude (WF)
B	Smith, Bertha (WF)
S-28	
S-29	
S-30	
S-31	Griffin, Ottomose (WF)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

MEDICAL WING ONLY—continued

S-35	
S-36	
S-37	
S-38	Jones, Fannie, dismissed
S-39	Bridges, Myrnis, dismissed
S-40	Wimberly, Clara
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jeffery, Artie (NF)
C	Osbourne, Ather (NF)
D	
W-48A	Dollar, Johnny (WM), expired
B	
C	
D	
W-49A	Middleton, Edith (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Kelly, Sybil (WF)
B	Meeks, Gail (WF)
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM)
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF)
Meeks, Baby Girl (WF)
Kelly, Baby Boy (WM)

DAILY CENSUS REPORT—Continued

June 16, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	Dowdell, Elmore (NM)
N-4A	
B	
N-5A	Granthum, Mattie (WF)
B	
N-6	
N-7	
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	Harrell, Paul (WM)
E-15	
E-16A	Faircloth, Bonnie Wayne (WM)
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Ingram, Charles (WM)
S-26A	Little, Thomas J. (NM)
B	
S-27A	Powell, Maude (WF), dismissed
B	Smith, Bertha (WF), dismissed
S-28	
S-29	Cook, Michael (WM), dismissed
S-30	
S-31	
S-32A	
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF)
S-39	
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Cole, Agnes (NF)
B	Jeffery, Artie (NF)
C	Osbourne, Ather (NF)
D	
W-48A	Middleton, Edith (NF)
B	Calloway, Barbara (NF)
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Kelly, Sybil (WF), dismissed
B	Meeks, Gail (WF)
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM)
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF)
Meeks, Baby Girl (WF)
Kelly, Baby Boy (WM), dismissed
Calloway, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 17, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (NM)
B	
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie (WF), dismissed.
N-6	Cato, Jimmy (WM), dismissed.
N-7	
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	Harrell, Paul (WM) dismissed.
E-15	Simpson, Helen (WF) dismissed.
E-16A	Faircloth, Benny W. (WM)
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Dobke, Glenn (WM)
E-24	
E-25	Ingram, Charles (WM)
S-26A	Little, Thomas J. (NM)
B	
S-27A	Blanchard, Tom (WM)
B	
S-28	
S-29	
S-30	
S-31	Griffin, Ottomose (WF)
S-32A	
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF)
S-39	
S-40	Wimberley, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-46A	Cole, Agnes (NF), dismissed, Laster, Hammie (NF)
B	Jeffery, Artie (NF)
C	Osbourne, Ather Mae (NF)
D	Brown, Mittie (WF)
W-48A	Gossett, James (WM)
B	
C	
D	
W-49A	Middleton, Edith (NF)
B	Calloway, Barbara Ann (NF)
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Meeks, Gail (WF)
B	
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM)
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF)
Meeks, Baby Girl (WF)
Calloway, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 18, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (NM)
B	
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie L. (WF)
N-6	Cato, Jimmy (WM)
N-7	
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF)
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Simpson, Helen (WF)
E-16A	
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Dobke, Glenn (WM)
E-24	
E-25	Ingram, Charles (WM), dismissed
S-26A	Little, Thomas J. (NM)
B	
S-27A	Blanchard, Tom (WM)
B	
S-28	
S-29	
S-30	
S-31	Griffin, Ottomose (WF), expired
S-32A	
B	
S-33	Johnston, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF)
S-39	
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jeffery, Artie (NF)
B	Osbourne, Ather M. (NF)
C	Brown, Mittie (WF)
D	Laston, Hannie (NF)
W-48A	Gossett, Henry (WM)
B	
C	
D	
W-49A	Middleton, Edith (NF)
B	Calloway, Barbara
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Meeks, Gail (WF), dismissed
B	
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Boy (NM), dismissed
Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF)
Meeks, Baby Girl (WF), dismissed
Calloway, Baby Boy (NM)

Daily Census Report—Continued

June 19, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (NM)
B	King, Jerry (NM)
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie Lee (WM)
N-6	Cato, Jimmy G. (WM)
N-7	
N-8	Gunn, Mattie (WF)
N-9	
N-10	Adams, Rebecca (WF), dismissed
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Simpson, Helen (WF)
E-16A	
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Doebke, Glen (WM)
E-24	
E-25	
S-26A	Little, Thomas James (NM)
B	
S-27A	Blanchard, Tom, Jr. (WM) dismissed
B	
S-28	Brady, Mittie (WF)
S-29	
S-30	
S-31	
S-32A	
B	
S-33	Johnston, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	Jones, Fannie (WF), dismissed
S-39	
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jeffrey, Artie (NF)
B	Osbourne, Ather Mae (NF)
C	Brown, Mittie (WF)
D	Laston, Hannie (NF)
W-48A	Gossett, James Henry (WM)
B	
C	
D	
W-49A	Middleton, Edith (NF)
B	Calloway, Barbara Ann (NF)
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	
B	
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF)
Calloway, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 20, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourne, Ather Mae (NF)
B	
C	
D	
N-3	
N-4A	Dowdell, Elmore (NM), dismissed
B	King, Jerry (NM)
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie Lee (WF)
N-6	Cato, Jimmy Gene (WM), dismissed
N-7	
N-8	Gunn, Mattie (WF), dismissed
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Simpson, Helen (WF)
E-16A	
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	Funderburke, B. D. (WM)
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Doebke, Glen (WM)
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas James (NM)
B	
S-27A	King, Linda Ruth (WF)
B	
S-28	Brady, Mittie (WF)
S-29	Kerce, Cathy (WF)
S-30	Haire, Ollie (WF)
S-31	
S-32A	
B	
S-33	Johnson, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	
S-39	
S-40	Wimberly, Clara (WF)
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Jeffery, Artie (NF)
B	Brown, Mittie (WF)
C	Laston, Hannie (NF)
D	
W-48A	Gossett, James Henry (WM), dismissed
B	
C	
D	
W-49A	Middleton, Edith (NF), dismissed
B	Callaway, Barbara Ann (NF), dismissed
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Batchelor, Jo Ann (WF)
B	
W-56A	
B	
W-57	
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Middleton, Baby Girl (NF), dismissed
Callaway, Baby Boy (NM), dismissed
Batchelor, Baby Girl (NF)

DAILY CENSUS REPORT—Continued

June 21, 1967

SURGICAL WING ONLY

N-1 A	
B	
C	
D	
N-2 A	Osbourne, Ather (NF)
B	
C	
D	
N-3	Benton, Rosa (NF)
N-4 A	King, Jerry (NF)
B	
N-5 A	Granthum, Mattie (WF)
B	Heath, Jessie Lee (WF)
N-6	
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Simpson, Helen (WF)
E-16A	
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	Funderburke, Bickett David (WM)
E-20	Youmans, Eugenia (WF)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Doebke, Glen (WM)
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas James (NM)
B	
S-27A	King, Linda Ruth (WF)
B	
S-28	Brady, Mittie (WF)
S-29	Kerce, Mary Cathy (WF)
S-30	Haire, Ollie (WF)
S-31	
S-32A	
B	
S-33	Johnston, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	
S-39	
S-40	Wimberly, Clara (WF), dismissed
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Laston, Hannie (NF)
C	Jeffery, Artie (NF), dismissed
D	Williams, Ophelia (NF)
W-48A	
B	
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Batchelor, JoAnn (WF)
B	
W-56A	
B	
W-57	Johnson, Ellie (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 22, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	OsBourne, Ather Mae (NF)
B	
C	
D	
N-3	Benton, Rosa Mae (NF)
N-4A	King, Jerry (NF), dismissed
B	
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie Lee (WF)
N-6	Griffin, Irene (WF)
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM)
B	
E-15	Simpson, Helen (WF)
E-16A	
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	Funderburke, David Bickett (WM)
E-20	Youmans, Eugenia (WF), dismissed
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Doebke, Glen (WM), dismissed
E-24	Brown, Steve Randall (WM)
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas (NM)
B	
S-27A	King, Linda Ruth (WF)
B	
S-28	Brady, Mittie (WF)
S-29	Kerce, Mary Kathy (WF)
S-30	Haire, Ollie (WF)
S-31	Howard, Eugene, Jr. (WM)
S-32A	
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hannie (NF)
C	Williams, Ophelia (NF)
D	
W-48A	
B	
C	
D	
W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Batchelor, JoAnn (WF)
B	Haire, Sandra (WF)
W-56A	Walker, Allie Mae (NF), dismissed
B	
W-57	Johnson, Ellie (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)
Johnson, Baby Girl (WF)
Haire, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 23, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourn, Ather Mae (NF)
B	
C	
D	
N-3	Benton, Rosa Mae (NF)
N-4A	
B	
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie Ruth (WF)
N-6	Griffin, Irene (WF)
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Peavey, Lloyd (WM), dismissed
B	
E-15	Simpson, Helen (WF)
E-16A	Holt, Millie Jones (WF)
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	Funderburke, David Bickett (WM)
E-20	
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	King, Linda Ruth (WF)
B	
S-28	Brady, Mittie (WF)
S-29	Kerce, Mary Kathy (WF)
S-30	Haire, Ollie (WF), dismissed
S-31	Howard, Eugene, Jr. (WM)
S-32A	
B	
S-33	Johnston, Joseph (WM)

MEDICAL WING ONLY—continued

S-34A	
B	
S-35	
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	Williams, Ophelia (WF)
D	
W-48A	
B	
C	
D	
W-49A	Mitchell, Emma (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	
W-55A	Batchelor, JoAnn (WF)
B	Haire, Sandra (WF)
W-56A	Goodman, Zelinda (WF)
B	
W-57	Johnson, Ellie (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)
Haire, Baby Girl (WF)
Johnson, Baby Girl (WF)
Mitchell, Baby Boy (NM)
Goodman, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 24, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourn, Ather Mae (NF)
B	
C	
D	
N-3	Benton, Rosa Mae (NF)
N-4A	
B	
N-5A	Granthum, Mattie (WF)
B	Heath, Jessie Ruth (WF)
N-6	Griffin, Irene (WF)
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	
B	
E-15	Simpson, Helen (WF)
E-16A	Holt, Millie Jones, dismissed
B	
E-17A	
B	
E-18	Dollar, Zudie (WF)
E-19	Funderburke, David Bickett (WM)
E-20	
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	King, Linda Ruth (WF)
B	Alday, Pearley (WF)
S-28	Brady, Mittie (WF)
S-29	Kerce, Mary Kathy (WF)
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene, Jr.
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

MEDICAL WING ONLY—continued

S-35	
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	Williams, Ophelia
D	
W-48A	
B	
C	
D	
W-49A	Mitchell, Emma (NF)
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	Sykes, Marion (WF)
W-55A	Batchelor, Joann (WF)
B	Haire, Sandra (WF)
W-56A	Goodman, Zelinda (WF)
B	
W-57	Johnson, Ellie (WF)
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)
Haire, Baby Girl (WF)
Johnson, Baby Girl (WF)
Mitchell, Baby Boy (NM)
Goodman, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 25, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourne, Ather Mae (NF)
B	
C	
D	
N-3	Benton, Roas Mae (NF)
N-4A	Thompson, Annie (NF)
B	
N-5A	Granthum, Mattie (WF), dismissed
B	Heath, Jessie Lee (WF)
N-6	Griffin, Irene (WF)
N-7	
N-8	
N-9	
N-10	
N-11	

MEDICAL WING ONLY

E-14A	Banks, Sarah (WF)
B	
E-15	Simpson, Helen (WF)
E-16A	Musgrove, Roland (WM)
B	Hathaway, Ronnie (WM)
E-17A	
B	
E-18	Dollar, Zudie (WF), dismissed
E-19	Funderburke, David (WM)
E-20	Shaw, Venon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	King, Linda (WF), moved to S-32; Harrell, Cornelia (WF)
B	
S-28	Brady, Mittie (WF)
S-29	Kerce, Mary Kathy (WF)
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene, Jr.
S-32A	King, Linda (WF)
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

MEDICAL WING ONLY—continued

S-35	
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	Williams, Ophelia (NF), dismissed
D	
W-48A	
B	
C	
D	
W-49A	Mitchell, Emma (NF)
B	Washington, Lillie (NF)
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

OBSTETRICAL WING ONLY

W-54	Sykes, Marion (WF)
W-55A	Batchelor, Joann (WF)
B	Haire, Sandra (WF)
W-56A	Goodman, Zelinda (WF)
B	Alley, Barbara (WF)
W-57	Johnson, Ellie (WF), dismissed
W-58	McVey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)
Haire, Baby Girl (WF)
Johnson, Baby Girl (WF), dismissed
Mitchell, Baby Boy (NM)
Alley, Baby Boy (WM), expired
McVey, Baby Girl (WF)
Washington, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 26, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourn, Ather Mae (NF)
B	Thompson, Annie (NF)
C	Laster, Katie Mae (NF)
D	
N-3	Benton, Rosa Mae (NF)
N-4A	Thompson, Annie (NF), transferred to N-2
B	Hathaway, Ronnie (WM)
N-5A	Heath, Jessie Lee (WF)
B	
N-6	King, Linda (WF)
N-7	
N-8	Olivent, Dorothy (WF)
N-9	
N-10	
N-11	
S-35	Chastain, Albert (WM)
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	McMillan, Myra Frances (NF)
D	
W-48A	Mack, Jesse (NM)
B	
C	
D	
W-49A	Mitchell, Emma (NF)
B	Washington, Lillie Ruth (NF)
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	

MEDICAL WING ONLY

E-14A	Banks, Sarah Viola (NF)
B	
E-15	Simpson, Helen (WF)
E-16A	Musgrove, Roland (WM)
B	Hathaway, Ronnie (WM), transferred to N-4
E-17A	
B	
E-18	
E-19	Funderburke, David (WM)
E-20	Shaw, Vernon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	
E-24	
E-25	Wingate, Myrtle (WF)
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	Alday, Pearly (WF)
B	Harrell, Cornelia (WF)
S-28	Sullivan, Jeanette (WF)
S-29	Kerce, Mary Cathy (WF)
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene, Jr. (WM)
S-32A	King, Linda (WF), moved to to N-6
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

OBSTETRICAL WING ONLY

W-54	Sykes, Marion (WF), dismissed
W-55A	Batchelor, Joann (WF)
B	Haire, Sandra (WF)
W-56A	Goodman, Zelinda (WF)
B	Alley, Barbara (WF)
W-57	Youmans, Karen (WF)
W-58	McVey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF)
Haire, Baby Girl (WF)
Mitchell, Baby Boy (NM)
Goodman, Baby Girl (WM)
McVey, Baby Girl (WF)
Washington, Baby Girl (NF)
Youmans, Baby Girl (WF)

DAILY CENSUS REPORT—Continued

June 27, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Osbourne, Ather (NF), dismissed
B	Thompson, Annie Louise (NF)
C	Laster, Katie Mae (NF)
D	
N-3	Benton, Rosa Mae (NF)
N-4A	Hathaway, Ronnie Keith (WM), dismissed
B	
N-5A	Heath, Jessie Lee
B	
N-6	King, Linda Ruth (WF)
N-7	Boyette, Myra Faye (WF)
N-8	Olivent, Dorothy (WF)
N-9	
N-10	
N-11	Smith, Emma Lee (NF)

MEDICAL WING ONLY

E-14A	Banks, Sarah (NF)
B	
E-15	Simpson, Helen (WF), dismissed
E-16A	Musgrove, Roland (WM)
B	Scott, Clinton (WM)
E-17A	
B	
E-18	Zeigler, PollyAnn (WF)
E-19	Funderburke, David (WM)
E-20	Shaw, Vernon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Godwin, Charles (WM)
E-24	
E-25	Wingate, Myrtle (WF), dismissed; Sanders, Leslie (WM)
S-26A	Little, Thomas, (NM)
B	Moon, Royce (WM)
S-27A	Alday, Pearly (WF)
B	Harrell, Cornelia (WF)
S-28	Sullivan, Jeanette (WF)
S-29	Kerce, Mary (WF)
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene (WM)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

MEDICAL WING ONLY—continued

S-35	Chastain, Albert (WM)
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	McMillan, Myra Frances (NF)
D	
W-48A	Mack, Jessie (NM)
B	Lumpkin, Ralph (NM)
C	
D	

OBSTETRICAL WING ONLY

W-49A	Mitchell, Emma (NF)
B	Washington, Lillie (NF)
W-50A	Middleton, Vivian (NF)
B	
W-51A	
B	
W-52	
W-53A	
B	
W-54	
W-55A	Batchelor, Joann (WF), dismissed
B	Hatton, Judy (WF)
W-56A	Alley, Barbara Carol (WF)
B	
W-57	Youmans, Karen (WF)
W-58	McVey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Batchelor, Baby Girl (WF), dismissed
Mitchell, Baby Boy (NM), dismissed
McVey, Baby Girl (WF)
Washington, Baby Boy (NM)
Youmans, Baby Girl (WF)
Hatton, Baby Girl (WF)
Middleton, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 28, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Thompson, Annie Louise (NF)
B	Laster, Katie Mae (NF)
C	
D	
N-3	Benton, Rosa (NF)
N-4A	Cooper, Patty Ann (WF)
B	Cooper, William (WM)
N-5A	Heath, Jessie Lee (WF)
B	
N-6	King, Linda (WF), dismissed
N-7	Boyette, Myra Faye (WF)
N-8	Olivent, Dorothy (WF)
N-9	
N-10	
N-11	Smith, Emma Lee (NF)

MEDICAL WING ONLY

E-14A	Banks, Sarah (NF)
B	
E-15	
E-16A	Musgrove, Roland (WM)
B	Scott, Clinton (WM)
E-17A	
B	
E-18	Zeigler, Pollyann (WF), dismissed
E-19	Funderburke, David (WM), dismissed; McDuffie, Joe (WM)
E-20	Shaw, Vernon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Godwin, Charles (WM)
E-24	
E-25	Sanders, Leslie (WM)
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	Alday, Pearly (WF)
B	Harrell, Cornelia (WF)
S-28	Sullivan, Jeanette (WF)
S-29	Kerce, Mary Cathy (WF)
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene (WM)
S-32A	
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

MEDICAL WING ONLY—continued

S-35	Chastain, Albert (WM)
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hammie (NF)
C	McMillan, Myra Frances (NF)
D	
W-48A	Mack, Jessie (NM)
B	Lumpkin, Ralph (NM)
C	Williams, George (NM)
D	Dodson, Dock (NM)

OBSTETRICAL WING ONLY

W-49A	
B	
W-50A	
B	
W-51A	
B	
W-52	
W-53A	
B	
W-54	
W-55A	Hatton, Judy (WF)
B	
W-56A	Alley, Barnata (WF), dismissed
B	
W-57	Youmans, Karen (WF)
W-58	McVey, Priscilla (WF)

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
McVey, Baby Girl (WF)
Washington, Baby Boy (NM)
Youmans, Baby Girl (WF)
Hatton, Baby Girl (WF)
Middleton, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 29, 1967

SURGICAL WING ONLY

N-1A	
B	
C	
D	
N-2A	Laster, Katie Mae (NF)
B	
C	
D	
N-3	Benton, Rosa Mae (NF)
N-4A	Cooper, Patty Ann (WF)
B	Cooper, William Maxwell (WM)
N-5A	Heath, Jessie Lee (WF)
B	
N-6	Nelson, Ivory Nell (NF)
N-7	Boyett, Myra Faye (WF), dismissed
N-8	Olivent, Dorothy (WF)
N-9	
N-10	Anderson, Jerry (WM)
N-11	Smith, Emma Lee (WF)

MEDICAL WING ONLY

E-14A	Banks, Sarah (NF)
B	
E-15	Merkeson, Elsie (WF)
E-16A	Musgrove, Roland (WM)
B	Scott, Clinton (WM)
E-17A	
B	
E-18	Poitivent, Jimmy (WM)
E-19	McDuffie, Joe (WM)
E-20	Shaw, Vernon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF)
E-23	Godwin, Charles (WM)
E-24	
E-25	Sanders, Leslie (WM), dismissed
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM)
S-27A	Alday, Pearly (WF)
B	Harrell, Cornelia (WF)
S-28	Sullivan, Jeanette (WF); Wall, Alvin (WM)
S-29	
S-30	Smith, Sarah (WF)
S-31	Howard, Eugene (WM)
S-32A	Duncan, Archie (WM)
B	
S-33	Johnston, Joseph (WM)
S-34A	
B	

SURGICAL WING ONLY—continued

S-35	Chastain, Albert (WM), dismissed
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Laston, Hannie (NF)
C	McMillan, Frances (NF)
D	Jeffery, Artie (NF)
W-48A	Mack, Jessie (NM)
B	Lumpkin, Ralph (NM)
C	Williams, George (NM)
D	Gadson, Dock (NM)

OBSTETRICAL WING ONLY

W-49A	Washington, Lillie (NF), dismissed
B	
W-50A	Middleton, Vivian (NF)
B	
W-51A	
B	
W-52	
W-53A	
B	
W-54	
W-55A	Hatton, Judy (WF)
B	
W-56A	
B	
W-57	Youmans, Karen (WF)
W-58	McVey, Priscilla (WF), dismissed

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
McVey, Baby Girl (WF)
Washington, Baby Boy (NM), dismissed
Youmans, Baby Girl (WF)
Hatton, Baby Girl (WF)
Middleton, Baby Boy (NM)

DAILY CENSUS REPORT—Continued

June 30, 1967

SURGICAL WING ONLY

N-1A	Hinton, Robert (WM)
B	
C	
D	
N-2A	Laster, Katie Mae (NF)
B	
C	
D	
N-3	Benton, Rosa (NF)
N-4A	Cooper, Patty Ann (WF), dismissed
B	Cooper, William Maxwell (WM), dismissed
N-5A	Heath, Jessie (WF).
B	
N-6	Nelson, Ivory Nell (NF)
N-7	
N-8	Olivent, Dorothy (WF)
N-9	
N-10	Anderson, Jerry Floyd (WM)
N-11	Smith, Emma Lee (NF)

MEDICAL WING ONLY

E-14A	Banks, Sarah (NF)
B	
E-15	Merkison, Elsie Mae (WF)
E-16A	Musgrove, Roland (WM)
B	
E-17A	
B	
E-18	Poitivent, Jimmy (WM)
E-19	McDuffie, Joe (WM)
E-20	Shaw, Vernon (WM)
E-21	Powell, Rosa (WF)
E-22	Balkcom, Mamie (WF), dismissed
E-23	
E-24	
E-25	
S-26A	Little, Thomas (NM)
B	Moon, Royce (WM), dismissed
S-27A	Alday, Pearly (WF)
B	Harrell, Cornelia (WF)
S-28	Wall, Alvin (WM)
S-29	Rentz, Rossie (WF)
S-30	Smith, Sarah (WF)
S-31	
S-32A	Duncan, Archie (WM)
B	

MEDICAL WING ONLY—continued

S-33	Johnston, Joseph (WM)
S-34A	
B	
S-35	
S-36	
S-37	
S-38	
S-39	
S-40	
S-41	
S-42	
S-43	
S-44	
S-45	
S-46	
W-47A	Brown, Mittie (WF)
B	Latson, Hannie (NF)
C	McMillan, Frances (NF)
D	Jeffery, Artie (NF)
W-48A	Mack, Jessie (NM)
B	Lumpkin, Ralph (NM)
C	Williams, George (NM)
D	Gadson, Dock (NM)

OBSTETRICAL WING ONLY

W-49A	
B	
W-50A	Middleton, Vivian (NF), dismissed
B	
W-51A	
B	
W-52	
W-53A	
B	
W-54	
W-55A	Hatton, Judy (WF), dismissed
B	
W-56A	
B	
W-57	Youmans, Karen (WF), dismissed
W-58	

NURSERY

Clark, Baby Girl (NF)
Iglus, Baby Girl (NF)
Youmans, Baby Girl (WF), dismissed
Hatton, Baby Girl (WF), dismissed
Middleton, Baby Boy (NM), dismissed

Senator TALMADGE. I thank the distinguished Secretary and I would appreciate it if you could expedite the approval of that hospital because it is handicapping unfortunate people in that area who are entitled to the benefits of medicare and now can't receive it because this hospital is not certified. It is a nonprofit hospital, operated by the county, built by the proceeds of the Hill-Burton Act, and if it can be expedited I would be grateful.

Secretary GARDNER. Senator, I have asked my people to resolve this within the next 30 days.

Senator TALMADGE. Thank you.

The CHAIRMAN. Mr. Secretary, in connection with Senator Talmadge's statement, are your people still insisting that before a hospital can be certified for medicare they have to put an ad in the newspaper saying they are fully integrated? Is that still a requirement for the hospital to be certified?

Secretary GARDNER. It is supposed to give public notice; yes.

Senator TALMADGE. Will the chairman yield at that point? The hospital not only ran an ad in the newspaper, but also went on the radio to make certain everyone got the message.

The CHAIRMAN. It seems patently ridiculous to me. If a hospital is not discriminating in any fashion it seems to me this thing of irritating people by making them run an ad in the newspaper is unnecessary.

I notice—we have had a parallel situation in Louisiana. That big hospital in Shreveport is one of the few in the State that seeks to do business with the Federal Government. One of the big problems there is that historically there was one waiting room for Negroes and one for whites, but now they have a big sign on both of them saying absolutely no discrimination based on race, color, or creed, and this is open to everybody. But notwithstanding that, the whites tend to go back to the waiting room where the whites have traditionally gone, and the Negroes tend to go to the other. I recall that that has caused a great deal of consternation in one place just because people by force of habit tend to use the waiting room they are accustomed to. For the life of me, I have never been able to understand why you have to deny all people in the area hospital treatment because people just by force of habit tend to prefer to sit among their own. I think you are aware of the fact we have had problems with that. How we can do more than just go and tell Negroes they can't sit with other Negroes is more than I can understand, but that would seem to me to be kind of a denial of their right, too, wouldn't it—telling a Negro he can't sit beside another Negro? He would be denied that right.

Secretary GARDNER. That is correct.

The CHAIRMAN. Let's see, Mr. Secretary. I am planning to offer an amendment which we looked at last year, and Mr. Cohen is quite familiar with it, with regard to foster care. The House was more liberal than the Department was on the foster care provision, but even then there is only a relatively small percentage, maybe it is 50,000 out of a quarter of a million foster care children that could be helped under the House provision. Is the Department just adamantly opposed to extending this foster care assistance to additional groups; for example, families that have a number of foster children that they are looking after or institutions that care for foster children?

Mr. COHEN. In the House committee, Senator, we supported very vigorously measures to improve the Federal financing of foster care. There were, however, two or three arguable issues in which the House committee did not take action. I don't know which ones you refer to, but the main area in the 1962 amendments which has been an arguable issue in foster care, is the one which provides that there have to be court determinations before there is Federal sharing. Is that the one you are referring to?

There are a number of parties, particularly county officials, especially in California, who came before the House committee and argued that we should pay the Federal share of foster care for a child that had been on aid to dependent children irrespective of whether the removal of the child from his home was based on a court determination or whether it was just an administrative determination by the State welfare agency.

The decision, after much discussion in executive session, was that the child's interests were better protected if there was a court decision and a judge making the determination that the child should be taken away from its parents and placed in a foster home, and so the bill before you today, while liberalized in a number of respects, still retains the provision about court determinations.

Now, it is correct that if you eliminated the court determination provision very likely there would be many more cases in which the Federal Government would pay for foster care, and all I can say on that issue is that there are some very strong supporters but there are some very strong opponents to it on the grounds that if a child is taken away from its parents in foster care it should be based on a judicial determination by a judge.

The CHAIRMAN. Well, of course, one of the principal purposes of foster care in many cases is to arrive at a result where the children eventually will be restored to their parents and in a case of that sort it would seem to me that the court decision might not be necessary. It might be better just to go ahead and provide them care on a foster home basis and then put them back in the home with their parents when they can be restored as early as they can.

Mr. COHEN. I am not quite clear myself, and I think it is a matter which the Department intends to go into, why it is that a child couldn't be referred to the court for a judicial determination before it is taken away from its parents. If there is some impediment there that we discover in our further study, we will come back and make a recommendation to the committee.

The CHAIRMAN. Now the words "community work and training programs" are used in both the House and the administration bills and I would like to ask if this envisages a program that is in all instances training programs or does it envisage programs that could be work programs for individuals for whom further training did not appear to be feasible—where we might make better use of that person's capabilities by putting him to work. In other words, what would your view be if we seek to more or less subsidize a person to do some work that would otherwise go undone rather than simply train them for a job that doesn't exist?

Secretary GARDNER. The present conception is that this program always has a training ingredient in it or almost always, and if it is solely work it is contrary in the sense that this is not a WPA or an employment of last resort, so to speak. Its conception is that these people will be trained, trained while working, to eventually enter the job market, and be employed as other people are employed. In other words, the idea is that this is a temporary measure of rehabilitation and that they will move on, and because of that there is always the conception of training in it.

The CHAIRMAN. I hope the Department is not trying to make the decision on this basic economic security idea or this guaranteed annual wage for unemployed people type thought—that you are going to provide income to people even if they don't choose to work and where work can be available.

Now, I know that labor would like to guarantee a minimum wage to everybody in the whole country with no exceptions whatever. But it would seem to me that when we are trying to provide assistance for those who have no income other than a Government handout, that we ought to be thinking in terms of finding work for them. It is not for us to pass on the job that is available to them whether it is a minimum wage job or not. If it is a job that pays more than a person would make simply living on a welfare check, we ought to encourage people to take those jobs even to the extent, I would think, of saying to State and local governments and perhaps others that we would subsidize them to get them off the public welfare and onto some constructive endeavor. I don't hope to do it all overnight. I know you can't do it all in 1 day or 1 year or 2 years, but can't we work toward trying to put these people to work?

It seems to me that even if you only increase their income by $80 or $90 a month at least that is that much that they are earning to live better. People who are doing something, or learning how to do something, constructive are just a lot better citizens and their children will grow up to be better citizens than people sitting around the house all day.

Secretary GARDNER. Mr. Chairman, the fact is, as you know, that in most parts of the country jobs are available——

The CHAIRMAN. You say they are or are not?

Secretary GARDNER. They are available if people are trained and motivated to take on these jobs. The big task in tackling hard-core unemployment in these parts of the country where jobs are available, and this is in the overwhelming majority of areas, is to enable people to become employable, to get them to the point where they can enter the job market and get the kind of jobs that are available. This the community work-training program seems to me to do extremely well.

The CHAIRMAN. Well now, if Congress wants a work program for public assistance recipients, would the administration bill be a proper vehicle toward this end?

Secretary GARDNER. Well, I would say that it should hew to the original conception of a work-training program, and not just a work program. That is a program that is designed to equip people better to enter the general job market and go on their own rather than simply some kind of program to keep them busy and keep them active. In other words, it seems to me that rehabilitation ought to be at the heart of the thing.

The CHAIRMAN. Mr. Secretary, there were just a lot of things that were done under the old WPA programs which some people scoffed at at the time that have subsequently proved to be very worth while things. I recall visiting with the sheriff of Cameron Parish after Hurricane Audrey hit Cameron Parish. I believe that hurricane killed almost half the population of that parish. About half the people who survived managed to get to the parish courthouse that was built there by the WPA, and if I do say it that thing was made to withstand a hurricane. The sheriff of that parish told me that he had been one to ridicule that project as just a foolish waste of money when it was done.

It saved his life as well as his deputies and practically everyone in that area. That was the only place of refuge that people could go to and be secure. It must have saved 500 or 600 lives.

Now, one really can't look upon that as a matter of waste. That was something that really was needed and it proved itself when that hurricane hit. It seems to me there are just a lot of things that the State and local government could do and they could put some of these people to work very constructively if we could work out the proper arrangement where rather than just give people the money we would subsidize them to work with someone who could provide them with jobs.

We will consider it in executive session, but I hope that you and the administration might help to work out something along that line.

Now, what do you think would happen to an unemployed father who took the labor training course, but after 3 months there was no job for him? What provision of the administration bill would allow him to participate in a work program?

As I understand it as of now there is nothing in the bill that would do that. You trained him to do something and you still don't have a job for him.

Secretary GARDNER. In the States that have aid to families with dependent children of unemployed parents he would have some recourse, and in the other States not.

The CHAIRMAN. Now, how many States are there who refuse welfare to people who have jobs available to them, but who refuse to take those jobs?

Mr. COHEN. Senator, in my recollection all of these 22 jurisdictions that have aid to the children of unemployed parents have that provision in it. Other States that don't have aid where the parent is unemployed have various provisions, but in the 22 that actually pay cash assistance where the father is unemployed, they refuse assistance to a father who turns down an appropriate job without good cause.

The CHAIRMAN. I understand the poverty amendments on the bill that is on the floor right now propose day care programs with up to 90 percent Federal matching for children of low income, from low-income families whose parents are taking training or seeking unemployment. How will this fit in with the day care provision in the House bill for the AFDC children?

Mr. COHEN. I don't know that I can asnwer the question quite definitively. I have discussed it with Senator Javits several times. In our bill the day-care provisions under public assistance are for people who are actually on aid to dependent children. However, some of the money in child welfare services may be used for day care for persons who either have recently received aid to dependent children or to help other low-income mothers, at the determination of the State.

The way I would view the amendment in the poverty bill, if it were enacted, so as to have a rational relationship to the two provisions in our bill, is that those funds shoud be used for low-income people who are, by and large, not on aid to dependent children or who are not persons who recently came off of aid to dependent children, but who are low-income people who are not being helped by the State standard of need.

I think we would have to work out something like that to avoid duplication, and I think it could be worked out. I don't see any difficulties in working it out if it is passed, but I thing a rational relationship should be worked out.

The CHAIRMAN. I would hope that it could be worked out so we don't have a conflict between two agencies in handling the program that one would take priority over the other.

Mr. COHEN. Our two programs that we have, Senator, are State based; in other words, the aid to dependent children program and the child welfare services program which uses money for day care is really a Federal grant to the States for those purposes. So that the primary factor in how it was used under our two programs would be the State policy consistent with whatever the Congress said in the Federal law.

But the Ways and Means Committee in the House-passed bill put in a provision that these two units in the State must now be in the same organizational location for the very reason that we are now talking about. Since there were two sources of money for those who are on aid to dependent children and those who were recently off and are not on, the Ways and Means Committee quite properly, in my opinion, said if you had one organizational unit in the State you would be sure there would be proper coordination and allocation of those funds.

Now I am not sure whether the OEO amendment flows through the States or is a Federal program, and that would have to be worked out, but I see no problem in our arriving at a conclusion with Mr. Shriver to be sure there is no duplication.

The CHAIRMAN. Well, the Federal program provided by the OEO bill has 90-percent Federal matching. I should think that that would tend to displace the ADC program here when, or AFDC when, you have a 90-percent matching program. The States would tend to shift over to claim the 90-percent money rather than the money in the welfare bill.

Mr. COHEN. We asked the Ways and Means Committee to put 90-percent financing in at least for the first year or 2 on the grounds that this would stimulate the States to more rapidly put the day care programs into operation on a voluntary basis so that the program could be effective.

As I recall, after much discussion the committee did put in something like 85 percent for the first year and a half, and then 75 percent thereafter. But I would agree with your observation that if the Federal financing is different in the two programs State money is going to go to the program in which they get the greatest amount of Federal matching and I would think, therefore, whatever the final figure is in either this bill or the other bill they ought to be made consistent.

The Chairman. I understand the House has put about two and a half billion dollars in the poverty program beyond what the administration requested. Now is this part of what was added by the—that is the Senate committee has done this. Is this particular thing one of the things that the Senate committee has done in addition to what the administration requested?

Mr. Cohen. In my opinion, yes, sir; but I wasn't aware that it was $90 million.

The Chairman. Ninety percent.

Mr. Cohen. Yes; but I think it is, Senator Javits told me it was $35 million. I think that is the correct figure for that unit, is it not? Yes, Mr. Hawkins tells me that is correct, that is what Senator Javits told me. I think he was the sponsor of the amendment and at that point, I hadn't seen it. When Senator Javits talked with me, I urged him to put an amendment to modify the amendment in such way that the funds could be in some way combined with this program so there wouldn't be any overlap and there wouldn't be any difference in Federal money. I don't know whether they did that.

The Chairman. Does this administration support that which is presently in the committee bill on the floor in that regard?

Mr. Cohen. I think you are asking us the question whether we support the $35 million for the day care that is in that program; is that what you are asking?

The Chairman. Yes.

Mr. Cohen. I told Senator Javits this. I would prefer that whatever extra money the Congress wanted to put in for day care be put in the bill before your committee so there would be one place, one program, one Federal matching requirement for that program. I think that is the more desirable coordinated consistent way, Senator.

The Chairman. I think it makes sense, too. You are well aware, Mr. Cohen, because you have worked on it and Secretary Gardner, I am sure, has some familiarity with it that we have a terrible situation to straighten out in Louisiana because you have several agencies handling money on this end and they have several different agencies handling money on their end. It is mainly their mess rather than yours, but as between them, the bureaucratic tangle has been such that the State doesn't begin to get the matching that it was supposed to have. So it would be just a lot better if we build on the program that we have rather than set some whole new program up that either overlaps or is in conflict with some Federal program.

This committee is being urged to consider a tax bill that initially was to raise about $5 billion tax. In this bill out there on the floor now, there are two and a half billion of add-ons by the Senate committee.

There is half your tax increase right there on a new program, and I will say that the committee that has to worry about raising the money to pay for it thinks a long time before they put $2½ billion extra on something—a lot longer, I suppose, than the committee that hasn't got to raise the money. You are aware of the fact that an increase in social security is much more popular before you talk about paying for it than it is after you say "are you for these benefits if it means that we have to increase your tax." There are a lot of people who would be for it before the tax increase is mentioned who suddenly cool to it when they talk about the increase in tax.

You are aware of the resistance that is growing in that area, are you not, that where the tax has to be added to the benefit resistance buildup.

Mr. COHEN. Yes; although I have to give vent to my own prejudice and say that I think there are lots of people who are aware of the tax increase, yet are willing to pay that tax if it means more benefits.

I recognize there are limits. But I do think that is one of the advantages of the social security program—that you tie the benefits and taxes together and you discuss them, as you always have in this committee, at the same time.

Senator WILLIAMS. And they should always be made the same effective date.

Mr. COHEN. No; I don't agree with that.

Senator WILLIAMS. I thought you were getting religion. [Laughter.]

Mr. COHEN. You would have to talk with me on Sunday, I guess, about that.

The CHAIRMAN. Senator Anderson.

Senator ANDERSON. I have no questions.

The CHAIRMAN. Senator Williams.

Senator WILLIAMS. Mr. Secretary, to get the record straight, as the chairman has mentioned, I think it is, two and a half or 2.8 billion that was added to the poverty bill that is now before the Senate. Do I understand correctly that the administration is strongly opposed to that addition by the Senate?

Secretary GARDNER. Yes, sir; that is my understanding.

Senator WILLIAMS. And they are opposed to it in any form? They want it stricken from the bill; is that correct?

Secretary GARDNER. That is correct.

Senator WILLIAMS. A report has been furnished to this committee, that you are experiencing considerable difficulty now in the administration of the medicare program in that in certain areas that it resulted in excessive payments to doctors. I think this was particularly true in the California area which was called to our attention.

Secretary GARDNER. Medicaid, title XIX.

Senator WILLIAMS. Yes. I understand you have done considerable research in this particular field?

Secretary GARDNER. You mean have we looked into the California incident?

Senator WILLIAMS. Yes. Not only California, but as it may be prevailing in other areas?

Secretary GARDNER. Yes, sir.

Senator WILLIAMS. Could you give us a report?

Secretary GARDNER. Well, we have not been able to get as much information as we had wanted on the California episode. But the data that we have led us to believe that the situation probably does involve excessive payments. But the facts are not clear. For example, we do not have data and data were not published which would permit us to know what the level of overhead was for some of these payments that a doctor is receiving over $100,000 as was reported, and we were not able to find out how many people he employed in his clinic, how large a payroll he had, how much of this was net to him at the end of the year. Again we were not able to find out the extent to which some of these payments were to clinics rather than individuals.

Senator WILLIAMS. Well, have you pursued some of these investigations on an individual case basis and made an effort to get that information?

Secretary GARDNER. We intend to. We intend to.

Senator WILLIAMS. You haven't done it as yet?

Secretary GARDNER. We have not done it as yet. May I say that the data we have so far from California indicate that they have done a very impressive job of checking and the system is working in the sense that if there are faulty practices the State is going to find out about them. This whole thing was brought to public view by a very well working system of data gathering on medicaid programs.

Senator WILLIAMS. That is my understanding. Was it not called to your attention likewise or was it just called to the attention of the State? Didn't your department have any knowledge of this situation or suspicion that it may be existing and haven't you done something about it, too?

Secretary GARDNER. No, sir. These programs are administered through the States, and it is not only the existing practice but it is the desirable practice that they should develop their own system of checking and administering these programs.

Senator WILLIAMS. Well, I know the program is designed as much as possible for State administration. But there is Federal money involved, a substantial percentage of it is Federal money and as the Senator from Georgia pointed out you do go into these areas and when certain questions are raised you make a rather intensive study and determination.

Now, are you not equally interested in the money factor as well to see that that is being properly spent? Don't you think that the agency itself should go into this, not just leave it to the States?

Secretary GARDNER. I believe this very strongly, Senator, and we will get at it through at least two channels: First, the normal auditing procedures, and second, sample studies which we will carry on.

I would like to have Dr. Land comment on that. Could you come up? Dr. Land administers title XIX and he can tell you about it.

Dr. LAND. Would you like for me to comment, sir, on the investigation——

Senator WILLIAMS. Yes.

Dr. LAND (continuing). Of the administrative procedure. I was recently in California, and they have a very well established system of where the alleged abuses occur they are reported and investigated very thoroughly. We will continue surveillance and close contact with the Office of Health Care Services in California and will at a later time have a more complete report.

Senator WILLIAMS. Will you make that report available to this committee when you get it?

Dr. LAND. Yes, sir.

Secretary GARDNER. Yes.

Senator WILLIAMS. Do you have any indication that this may, too same practice may be prevailing in other States or is that the only State that is involved?

Dr. LAND. That is the only State so far.

Senator WILLIAMS. You have no indication that it is more widespread?

Dr. LAND. No, sir.

Senator WILLIAMS. Do you have authority to really audit these accounts as you mentioned?

Dr. LAND. Yes.

Senator WILLIAMS. Your Department does have the authority?

Dr. LAND. Yes, sir.

Senator WILLIAMS. Do you think it would be well for the committee to ask the General Accounting Office likewise to check into this or do you think you could give us a report that would be thorough enough?

Secretary GARDNER. Well, it is always appropriate for you to ask the General Accounting Office if you feel that it is needed. But our job is to proceed on our own in this field of auditing and we intend to do a very thorough job.

Senator WILLIAMS. I noticed that several GAO reports have been somewhat critical of your agency for not pursuing these audits as they thought you should have done. Do you think that that can be corrected and we get a more careful auditing on the part of your Department?

Secretary GARDNER. I am convinced we can do a far better job.

Two years ago when I first joined the organization we brought together all of the audit units from various parts of the Department. We had, at that time, eight agencies, and we had eight audit units and we have put them together into a single unit. We have set up training courses and we have a far more efficent system today than we have ever had before.

Senator WILLIAMS. It is my understanding that under section 1872 of the Social Security Act you were to submit a report on the medicare program by June 30. Was that correct and if so is that report ready?

Secretary GARDNER. I will ask Robert Ball to comment.

Mr. BALL. Senator, I don't believe there is a specific date for that report. I think the law refers to it in terms of an annual report.

Senator WILLIAMS. Yes.

Mr. BALL. And we plan to make that report during the course of this year, but I don't believe there is a June 30 deadline.

Senator WILLIAMS. Well, June 30 is not the deadline. It says the Secretary shall make a continuing study of the operations and administration of the insurance program under parts A and B and shall transmit to the Congress annually a report concerning the operation of such program.

How long has this program been in effect?

Mr. BALL. This program——

Senator WILLIAMS. Medicare?

Mr. BALL. Started in operation June of 1966.

Senator WILLIAMS. 1966?

Mr. BALL. I mean July of 1966, July of 1966. It seems longer. [Laughter.]

Senator WILLIAMS. July of 1966?

Mr. BALL. July 1966.

Senator WILLIAMS. Well, July 1966 and your year would be up in July and I understood you had told the House that you were expecting that report would be ready by June 30, but if not when is that report going to be here?

Mr. BALL. Mr. Cohen just indicated to me that his plan was to include it in the regular annual report of the Department, which is submitted before the close of the year.

Senator WILLIAMS. Well, don't you think that in view of the fact that you are making rather extensive recommendations here for changes in the act itself it would be well if we had the benefit of that report since it is a new program rather than to study it after we made the changes? In other words, how could you decide that we needed all these changes in the program, that it is not working without them and, at the same time, tell us you haven't completed the report?

Mr. BALL. Well, Senator, as far as the basic data that would be necessary for a good report on the operation of the program—that has been accumulating over time and has up until this point really not been sufficient to form a basis for a comprehensive report. But our recommendations in the area of medicare really reflect that fact. We are not asking for any big substantive changes. We are suggesting, really, only the extension of the program as it now exists to a new group, the disabled, and then there are some rather obvious administrative difficulties that have arisen that lead to the kind of administrative changes that are in the bill, they didn't have to wait for data to emerge. They emerged from day-to-day problems in running the program.

Senator WILLIAMS. Is it your contention that there is no major change as far as title XIX is concerned?

Mr. BALL. I am sorry, Senator, I was only speaking of title 18.

Senator WILLIAMS. You were only speaking of A and B?

It has been called to my attention that in the reimbursement of the hospitals of their costs that there has been a question raised in that many of the hospitals operate with volunteers. It has been called to my attention that the Department in computing the cost to the hospital and reimbursing them, that you are allowing them for such costs on the basis they might have been incurred not on the basis of what was paid. I will cite an example as it was called to my attention: They will have these volunteer nurses who are working on a purely voluntary basis contributing their services, not accepting any payment whatever. But in computing the costs to reimburse this hospital the Department is assigning, we will say, $3,000 to her services of this lady who is not being paid and then reimbursing the hospital as though it were paid. Is that correct?

Mr. BALL. This situation arises, as you know, primarily among certain religious orders, where the individual is performing in all respects the services of a nurse, and yet may not receive a specific——

Senator WILLIAMS. But it goes far beyond that, does it not? It may have started with that. But it goes far beyond that to practically volunteer workers.

Mr. BALL. No, Senator, we have carefully drawn the line to omit from payment volunteer service that is of a type not usually supplied by a paid worker such as the Candy Stripers, or Gray Ladies, who perform services that are not ordinarily paid for.

Senator **WILLIAMS**. Well, can a hospital use Red Cross volunteers for switchboard activities and then collect for it when it is strictly volunteers?

Mr. **BALL**. No, I don't believe so, Senator. Perhaps it would be useful to have in the record at this point the full statement of the policy on this, plus the clarification of the principles, which was issued fairly recently, partly around a misunderstanding which had arisen in connection with Red Cross workers. I believe that has now been straightened out, so there isn't that situation.

Senator **ANDERSON**. Do you offer it for the record? Would you like to have the information put in the record?

Mr. **BALL**. Yes.

(The following material was received by the committee.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 22, 1967.

BUREAU OF HEALTH INSURANCE INTERMEDIARY LETTER NO. 262

Subject: Clarification of Principles of Reimbursement for Provider Costs 1-7, Value of Services of Nonpaid Workers (Reg. Sec. 405.424).

The principle covering the value of services of nonpaid workers has been the subject of possible misinterpretation with respect to the types of services which may be included in a provider's allowable reimbursable costs. The guidelines listed below are intended to clarify and provide more detailed instructions for implementing principle 1-7; they are not changes or modifications to that principle.

Principle 1-7 is effective July 1, 1966. A provider may claim as an allowable cost the value of services of nonpaid workers beginning with its first cost reporting period *provided* the conditions of principle 1-7 and *all* the criteria of the guidelines listed below are met. Because the publication of this principle in regulation form was delayed, however, providers and the organization of nonpaid workers may meet the requirement of a written agreement as follows. The written agreement required by principle 1-7 may be made retroactive to cover the first cost reporting period, if *all* the other requirements of principle 1-7 and these guidelines are met during the cost reporting period although not formalized by a written agreement. Before the imputed value of these services may be allowed, however, there must be a written agreement on file. Where appropriate, providers may submit revised cost statements to include the value of these services.

The guidelines are as follows:

1. *Services of nonpaid workers must be performed in positions customarily held by full-time employees*

The services of a nonpaid worker must be performed by an individual on a regular, scheduled basis in a full-time position. This requirement would exclude nonpaid workers who perform services on an intermittent and/or infrequent basis.

Moreover, the services of the nonpaid worker must be comparable to the services of a paid worker in a full-time position in the provider's organization.

Where the provider has no similar full-time positions, comparison may be made to similar positions of other providers in the area of similar size, scope of services and utilization. In all cases, the test is whether the institution would have had to employ another person in the event that the nonpaid worker had not rendered his services.

2. *Services of nonpaid workers must be performed in positions necessary to enable the provider to carry out the functions of normal patient care and operation of the institution*

Services must be related directly to patient care or in administrative positions essential to the provision of that care. Where the provider would not ordinarily be required to engaged others to perform the services of the nonpaid worker in order to properly care for the patient or properly operate the facility, the value of the nonpaid worker would not be allowed as an element of cost. Services not directly related to patient care or in administrative positions not essential to the provision of that care, such as donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen, cafeteria or gift shop, would not be reimbursable.

3. The amount allowed in reimbursable costs for the services of nonpaid workers cannot exceed those paid by the provider for similar services

The amount recognized in reimbursable costs for the services of nonpaid workers cannot exceed the amount which would have been allowed for paid employees of the provider who performed similar services; or, where the services of a nonpaid worker are performed in a position unlike any other full-time position in the provider's organization, the amount allowed in reimbursable costs cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services and utilization. The value of similar services necessarily includes actual salaries paid plus maintenance, perquisites, and fringe benefits. (Examples: Maintenance—Room and board; Perquisites—Free uniforms and laundry; Fringe benefits—Vacations, holidays, sick leave and discounts below cost on hospital bills and drugs.)

4. Nonpaid workers must be subject to the same direction and control by the provider as applicable to any other employee of the provider

Nonpaid workers must observe all rules, regulations, and codes of conduct required of regular paid workers by the provider.

5. Nonpaid workers must be members of organizations having tax exempt status under the U.S. Internal Revenue Code. These organizations must have arrangements with providers for the performance of the services of such nonpaid workers

Nonpaid workers must be members of an organization of nonpaid workers that has arrangements with the provider for the performance of services by nonpaid workers. Membership in the organization must be substantiated by adequate documentation in the files of the organization of nonpaid workers. The requirement of "under arrangements" requires a written contract between the organization of nonpaid workers and the provider (see provision above for establishing effective date of contract), stipulating the types and duration of specific services to be performed by the nonpaid workers identified to full-time positions. Also, the amount includable in reimbursable costs cannot exceed the amount required under the terms of the contract for the period during which the contract is in effect; i.e., the amount includable in reimbursable costs will be limited to those services covered during the contract period.

The organization of nonpaid workers must obtain a tax exempt status from the U.S. Internal Revenue Service. This requirement will become effective six months from the date of issuance of this letter in consideration of those organizations that may not have met this requirement previously.

6. Services of nonpaid workers must be performed without direct remuneration from the provider and the organization to such individuals

Reimbursable costs cannot include any imputed value (i.e., any expenses not actually incurred) for the services of a worker who has received any direct remuneration (salaries, wages) from the provider or from the organization of nonpaid workers. Where a worker receives direct remuneration from either organization, he cannot be considered a nonpaid worker under the definition of this principle.

See 3 above for computation of allowable amount.

7. The qualifications of nonpaid workers must be comparable to the qualifications of paid employees performing identical services

The qualifications of nonpaid workers must be comparable to the qualifications of paid employees performing identical services. Where services of nonpaid workers are performed in a position unlike any other full-time position established by the provider, the qualifications must be equivalent to the qualifications for similar services of other providers in the area of similar size, scope of services and utilization.

8. A provider must maintain proper records for the reimbursable services performed by nonpaid workers, identified as a legal obligation for operating expenses.

A provider must maintain proper records for the reimbursable services performed by nonpaid workers, identified to establish full-time positions and to the rates of pay in a manner equivalent to the identification of the payroll record for a paid employee of the provider. Also, the provider's files must contain a copy of the contract between the organization of nonpaid workers and the provider.

The amount developed, under the terms of the contract between the organization of nonpaid workers and the provider, for services rendered to the provider by the nonpaid workers, must be entered in the provider's accounts.

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Senator WILLIAMS. Does the legislative history of the Medicare Act provide a base for reimbursing these institutions for these costs and if so, under what section?

Mr. BALL. Senator, there was a great deal of discussion, particularly in the Ways and Means Committee, relating to what principles of reimbursement were to be followed by the Government under the cost-reimbursement principle. The testimony was frequently repeated by the Government witnesses, and gone into by the committee, that by and large the accepted principles of reimbursement developed by the American Hospital Association and applied by Blue Cross and other organizations would be followed.

It is my understanding that the principles that we are following in relation to unpaid workers do follow those general principles of the American Hospital Association that were in effect at the time of the discussion. Those principles were made part of the record, I remember, in the Ways and Means Committee and were discussed.

Senator WILLIAMS. These payments are being made based upon regulations issued by the Department, is that correct?

Mr. BALL. Yes, sir.

Senator WILLIAMS. Under what section of the law are these regulations based?

Mr. BALL. It is the cost-reimbursement section. I would have to look up the number for you, sir.

Senator WILLIAMS. Will you furnish that for the record if you don't have it right here?

(The following material was received by the committee:)

REASONABLE COST

SEC. 1861. (v) (1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services: except that in any case to which paragraph (2) or (3) applies, the amount of the payment, determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. 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. 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 to 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 produced by the methods of determining costs proves to be either inadequate or excessive. (Title XVIII of Public Law 89-97.)

Mr. BALL. Yes, Senator.

I believe the committee report discussed the payment of volunteer——

Senator WILLIAMS. Could you discuss to what extent institutions have been reimbursed for services of these unpaid workers during the first year of experience with medicare?

If you don't have that report, could you furnish for the record a breakdown of the payments that have been made for that type of volunteer workers?

I understand these are more or less phantom costs or——

Mr. BALL. Yes, Senator; we will furnish it.

(Pursuant to the above discussion, the following information was received by the committee:)

We have discussed with Blue Cross plans the reported attempt of some few hospitals to collect for Red Cross volunteers. The informed opinion of nine large Blue Cross plans engaged in medicare hospital reimbursement which were contacted is that the plans have allowed no reimbursement for unpaid services except that provided by members of religious orders. No other volunteer services, to their knowledge, meet the medicare requirements for reimbursement.

We estimate that roughly $30 million, about one percent of the medicare program's payments to hospitals for the first twelve months of operation, were for the services of unpaid members of religious orders.

Data on the value of voluntary unpaid services reimbursed will be available from audited hospital cost reports as the audits are completed. However, such data are not available centrally at this time because fiscal intermediaries are just now in the process of receiving final reports and conducting audits. The details requested must be secured from auditors' work sheets and we are asking for a preliminary report based on a sample of cases.

Secretary GARDNER. Does this include the religious?

Senator WILLIAMS. It includes all of them, whether they are religious or not so we can have a determination. I think the committee should have such a report of all reimbursements for costs which were not actually incurred, just assumed, and on the basis of what they would have paid if they had paid. It is recognized there was no payment made and they were reimbursed accordingly.

Mr. BALL. Senator, as far as furnishing quickly reliable figures on the total problem of allowing for the costs of unpaid workers, including the regular nurses in religious hospitals, we would really have to wait until we have the audited cost reports from the hospitals. We now have only a small percentage.

Senator WILLIAMS. Don't you have any information at all as to what you have paid thus far?

Mr. BALL. Yes; but I just would like you to understand what we have paid has generally been on the basis of an estimate for the hospital, and then there is an audit and settlement at the end of the year, and there will be changes as a result of these. We could make some estimates.

Senator **ANDERSON.** I wonder, Senator Williams, if you wouldn't want the division between religious organizations and Red Cross set forth clearly?

Senator **WILLIAMS.** Yes; I would just like to have an itemized breakdown whether they are religious organizations, Red Cross, or just ordinary volunteers, because it was my understanding that this practice is spreading. Surely you must have some information available now——

Mr. **BALL.** Yes.

Senator **WILLIAMS** (continuing). As to how much you have spent in cases A, B, C, D, and E, on reimbursements on this particular type of cost. Do you not have such records?

Mr. **BALL.** Yes, we do, Senator, but it just won't be final because they are not audited.

Senator **WILLIAMS.** I realize that. They wouldn't be final.

But you could furnish a preliminary report so we could have it available during our consideration of this bill, could you not?

Mr. **BALL.** Yes, Senator, and the point Senator Anderson made, just for clarification of the record, is very important. The misunderstanding and difference of opinion that arose about reimbursements of voluntary workers I think was confined to the fairly narrow area of people who were doing the kind of work that was not ordinarily paid for. I don't believe there was a significant difference of opinion about the approach that was used to reimburse for individuals performing regular nurse duties. It was in this area of the Red Cross volunteers, and that sort of thing, that a problem arose. Would it be satisfactory to you—we could do a much better job—if we could confine the material to that issue?

Senator **WILLIAMS.** No; that wouldn't do at all. I recognize that this concern which is being expressed to us as a committee may very well be the result of a misunderstanding, and I think in order to get the true picture we need like to have this report all-inclusive. Because the only way to straighten it out would be to see exactly what is happening in practice as you are administering this program, so I would like to have the all-inclusive report to the extent that you have made any payments at all up to this point.

Mr. **BALL.** All right, Senator.

Senator **WILLIAMS.** I think we can understand it better.

Mr. **BALL.** We will furnish it.

Senator **WILLIAMS.** All right.

I just have one further question at this point. Perhaps you don't have it today, but, Mr. Myers, you have furnished to the committee, and it was upon my request, a comparison of the value of benefits and the contributions under H.R. 12080. Now this comparison that you gave was on the basis of 12080. Perhaps you don't have this information here available, but I would like for you to furnish it to us.

During the first days of hearings, Commissioner Ball gave benefits that a young worker going into the labor force now would get, certain increased benefits, as a result of raising the contributions to the

$10,800 level. It was pointed out that he would not reap the full benefit of these maximum payments until after he had worked in the labor force for a period of around 40 years, or 2006.

What I would like to have is a computation at today's prevailing rates of interest, how much this individual worker and, of course, the employer would pay a like amount, would contribute over that 40-year period in return for those benefits. Do you have that available? If not, would you furnish it for the record. I have your answer here on the $7,600 maximum, but, you know, the administration proposal goes to $10,800.

Mr. MYERS. Senator Williams, I do not have those figures here, but I can readily calculate them, and I will furnish them promptly to you for the record.

Senator WILLIAMS. At this point, that will be perfectly all right.

(Data referred to above follows:)

OCTOBER 2, 1967.

MEMORANDUM

From: Robert J. Myers.
Subject: Comparison of Value of Benefits and Contributions Under H.R. 5710 for a Young New Entrant.

Request has been made for a comparison of the accumulated value of the employee contributions as of age 65 and the present value of the benefits at the same point for a young new entrant under H.R. 5710. As has been pointed out elsewhere, comparisons of this type are not very valid, since the results thereof can differ widely, depending upon the assumptions made.

I was given the assumptions that the individual would enter the program at age 18 (alternatively at age 21) in 1974, when the maximum OASDI contribution rate and earnings base become effective. In my opinion, these assumptions are not realistic or "typical". It was further hypothesized that the individual would survive to age 65 and would have earnings at the maximum creditable amount in every year. A 3¾% interest rate has been used and mortality has been assumed to be that of the U.S. Life Tables for Total Males and Females for 1959–61.

Under these assumptions, the total present value of the monthly benefits for a man at age 65 with a wife the same age is $51,860 (regardless of whether the individual enters employment at age 18 or at age 21). The accumulated amount of the employee contributions is $59,480 if the individual begins working at age 21, and $68,080 if he begins working at age 18.

It should be noted that this method of computation does not allow for the survivor and disability protection that the individual had before age 65. Nor is there considered the fact that Social Security benefits are likely to be increased in the future as the general level of earnings rises (and, accordingly, as contribution income increases).

ROBERT J. MYERS.

Senator WILLIAMS. Now, one other question. Mr. Secretary, the testimony of the gentleman that was representing Mr. Reuther made several recommendations here as to increasing benefits under social security. They recommended a guaranted minimum monthly benefit of $100 for a worker retiring at the age of 65, $100 for a disabled worker, and $150 for an elderly couple both at the age of 65 or over. Now my question is, Does the administration endorse those proposals as presented by AFL–CIO?

Secretary GARDNER. Mr. Chairman, we submitted a letter on this subject. We stick to the administration proposals. We would like to see these proposals of Mr. Reuther's studied very carefully. They deserve the most serious attention, and we would propose that they be placed before the Advisory Council at a later date. But at this point we stand with the proposals put forward by the administration.

Senator **Williams**. And you would oppose these recommendations?

Secretary **Gardner**. Yes, sir.

Senator **Anderson**. Before Senator Carlson starts I was interested in the comments you made about medicare and the costs of it. You sort of casually made some suggestions that the bill did not make very important changes. It changes the tax rate and changes the wage base, doesn't it? It raises about a billion dollars a year. Isn't that pretty substantial?

Secretary **Gardner**. This is the action taken by the Ways and Means Committee.

Mr. **Ball**. Yes, Senator; those are certainly substantial changes in the program. Perhaps I didn't speak clearly enough. I meant we, the administration, were not making substantial changes in the content of the benefit package of the medicare program. On the other hand, the financing changes that were put in the House bill are certainly significant changes; yes, sir.

Senator **Anderson**. The medicare provision is not a billion dollars out of balance, is it? Does it take a whole billion dollars to make them solvent?

Mr. **Ball**. I believe Mr. Myers' estimate is that in the first year the costs were around 7 percent above what he had originally estimated, which, of course, would be nowhere near a billion dollars.

Senator **Anderson**. Thank you.

Senator Carlson?

Senator **Carlson**. Mr. Secretary, I want to discuss briefly one section of the House bill, section 131, which is found on page 58 of the House bill and it deals with the radiological or pathological services furnished by certain persons to hospital inpatients. We have a real problem on this in this particular fashion, particularly out in the rural areas where we have many small hospitals. Under this proposal a person who enters a hospital has no problem with this $50 deductible or 20 percent coinsurance for the medicare patient. But many of these people who need these services which are physician's services either in an office or nursing home or some place, if they do not go to the hospital they do not receive the benefits of these payments.

Now, that makes a real problem out in the rural areas, and I happen to know personally of some of these smaller hospitals. If we have to put all these patients in a hospital in order to take advantage of a radiologist services and not be charged with it we won't have any hospitals. Do you have any suggestions on that?

Secretary **Gardner**. I would like to have Commissioner Ball comment on it.

Mr. **Ball**. Senator, we did go into this particular point at considerable length with the Ways and Means Committee, and both we and the committee came to the conclusion that the House provision really does not have in it any significant incentive for hospitalization. Individuals would typically be treated quite similarly whether they received their radiology services outside or inside the hospital.

Now, I know some of the radiologists have felt that is not so. But let me explain why we and the committee came to that conclusion. If you receive your radiology services outside the hospital, then there is a $50 deductible and a 20-percent coinsurance, which applies not just to radiology services, but to all your physician services—everything that is covered under the supplementary medical plan during the course of that year.

Now, it would be almost impossible for an individual to need significant radiology services, which are specialist-type services, if he also was not incurring other kinds of medical expenses. He would ordinarily have gone first to a general practitionery or an internist, who would have ordered the radiology services.

So quite typically the $50 deductible which applies to services outside the hospital would be met without regard to the radiology services, so that ordinarily he would be paying only the coinsurance of 20 percent for radiology services outside the hospital.

Now, if he goes into the hospital, on the other hand, he always has to pay at least $40. Now it is true that there is no deductible or coinsurance specifically applied to the radiology services, but to be an inpatient in the hospital it is necessary for him, as you know, to pay the $40 deductible.

Senator CARLSON. But once in a hospital he is qualified?

Mr. BALL. Yes. The mathematics, I think, works something like this: The 20-percent coinsurance for radiology services outside the hospital would exceed the $40 you have to pay if you go in the hospital when those radiology service charges exceed $200, because 20 percent of the $200 would result in the same patient liability as the $40 deductible that he has to pay for going into the hospital. So we came to the conclusion, and the committee agreed, that an incentive to go into a hospital for radiololgy services, as against getting such services outside, would usually occur only when the total charges for radiology services exceeded $200—which is a very rare situation, and when it exists hospitalization may well be justified. So we felt really on analysis that the way the House bill is set up does not provide an incentive for hospitalization. Although I agree that on the surface it looks as if it were an advantage to be hospitalized for radiological services.

Senator CARLSON. All I can say is that some of these things that you write into legislation look all right and work out all right as you discuss them around the table here, but when you get out into the country where the people actually are living and you have a large number of small hospitals and the person feels they need the service of a radiologist and he says, "Well, the only way I can get it and get benefits of medicare I have to go to the hospital," and these small hospitals just don't have room out in the rural areas, and I can mention names, and that is just one of the problems. I just wonder if we should permit them to get payments outside regardless of admission to the hospital, in a physician's office or some other place, what additional cost, if any, would you think would be involved?

Mr. BALL. You mean if you allowed——

Senator CARLSON. Let them take advantage of it, right?

Mr. BALL. Let them take it outside without any deductible or coinsurance at all?

Senator CARLSON. That is right, just as if they would go to the hospital as they would like to do.

Mr. BALL. I think Mr. Myers can be thinking of a cost estimate on that, Senator, but let me say right away it doesn't make it comparable, because to go into the hospital you have to pay $40.

Senator CARLSON. That is right.

Mr. BALL. You are saying give radiologists' services at physician's offices without any deductible?

Senator CARLSON. He will have some charges if he goes to a physician's office, no doubt about that, but he also will need a radiologist.

Mr. BALL. The purpose would be to take the one service of radiology and remove from it any deductible and coinsurance when performed outside the hospital? Bob, do you have any idea of how much it would cost?

Senator CARLSON. Could you not, Mr. Ball, still have a deductible under part B, the $50 deductible, and still take advantage of it?

Mr. BALL. Yes, I really think a more comparable position to the treatment in hospital would be to have the $50 deductible apply and, if one wanted to remove anything, remove the coinsurance. I think that would be a more——

Senator CARLSON. Mr. Ball, as we get into executive session I want to explore this further and see if we can't work out something.

Mr. BALL. We will give it further thought.

Senator CARLSON. I wish you would give it further study.

I have one more question, Mr. Chairman. When Senator Scott testified on his bills, on Senate 1954, which I and Senator Dirksen and others coesponsored, which provides for temporary emergency payments in cases where social security payments have been denied, his proposal seemed to have a great deal of merit. However, I wonder how it would fit in with your machine processing system. Can you handle it that way?

Mr. BALL. Well, Senator, if anything along that line were to be done, and frankly we don't really feel that it is a necessary change, we would have several suggestions to make of a detailed nature, because, for instance, the whole new application process, we think, would really cause more problems than it would help. Our intention and practice is to identify the older cases and without anybody making an application to put them into a special speedup process.

Senator CARLSON. Well, I assume that, of course, these are a very limited or minimum number of cases.

Mr. BALL. Yes.

Senator CARLSON. But on the other hand the individuals it affects, it is very important to him.

Mr. BALL. Right.

I really believe, Senator, that a preferable way is for us to have procedures for specially identifying every delayed case, which we have largely accomplished now, and for us to take the initiative, without the individual having to apply for special procedures.

Now, it might be useful if we were to be given clear authority to start a payment on the basis of lesser evidence than we might want for a final determination. One thing that I am sure you realize happens: When an individual files an application with us, that starts the running of a time period, but he doesn't in some instances have evidence readily available that shows eligibility, and maybe for some reason he may not pursue it too hard. Nevertheless, if there is a real hardship in the situation, perhaps it ought to be clear in the law that we could go ahead and make the payment, even though we would later want to fully verify the case for a continuing payment.

Senator CARLSON. Well, this bill that is pending does provide for special procedures to avoid these undue delays in payments, these monthly benefits.

Mr. BALL. Yes.

Senator CARLSON. And if you have other suggestions we would sure like to have them because I think when we get into executive session we are going to go into a discussion of some of these problems.

Mr. BALL. We will see you have that, sir.

Senator CARLSON. And if you can write them or if you can do it administratively what we want it would be helpful, but we also want to take care of some of these people who are writing us saying they have been delayed and it creates problems for us and it creates problems for the individual.

Mr. BALL. Yes, Senator, and, of course, we have exactly the same objective.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. At this time I have one question. The reimbursement of hospitals and medicare facilities is based on language such as the reasonable cost for such services, is that correct?

Mr. BALL. Yes, Senator.

Senator CURTIS. Would the Department object to changing the term to "reasonable charge?"

Mr. BALL. Yes, Senator.

We have given a lot of consideration to that, but it seems to us that typically the hospital situation, unlike the physician situation, is such that it is very difficult to determine whether the charge that they make is a reasonable one, by reference to what may be customarily charged and what is prevailing as it is in part B. You know we follow the "reasonable charge" reimbursement approach in part B, where it is possible to look at what any one physician charges and compare it with what other doctors in the same area charge for the same services.

But when it comes to a hospital, there is a great variety in the level of services they provide, and their different charge levels may reflect many differences in the level of the service being furnished or they may not feel that if you base hospital reimbursement on "reasonable charges" you would really have to make a cost determination anyway. It would be necessary to find out whether a hospital's charges were reasonably related to costs, and then decide how much of a markup on the costs was reasonable to get to a charge. In our judgment "reasonable charge" is a way of getting to a cost-plus arrangement.

Senator CURTIS. Well, but reasonable cost sort of rewards inefficiency.

Mr. BALL. Senator, it is not that we necessarily feel that reasonable cost is the best possible reimbursement formula. As you know, the House bill contains a provision for experimentation and demonstration of alternative approaches—approaches that might provide better incentives for economy and efficiency related to and consistent with the maintenance of quality. We very much would like to have the authority that is proposed in the House bill to conduct these experiments. I think there are a variety of things one could do that might improve on the cost formula.

Senator CURTIS. I have in mind one nonprofit organization which I have been familiar with for a number of years. It is church related. It has become quite expert in managing homes for the elderly and, as a result, has a great many qualified extended care facilities, and they say that their managers in years past just worried them to death because their expenses were so high, have put them in good stead now and in other institutions where they had a manager who got the cost way down and still maintained quality services has reduced their payments from the Government.

Mr. BALL. Well, Senator, I do think there is a good deal of room for experimentation with the reimbursement formula. We wouldn't be prepared at this time to make a recommendation to change it fundamentally, but we would like the authority to try out different things and then come back to you with a recommendation based on those experiments.

Senator CURTIS. Isn't the objective such that the Government should not pay an unreasonable charge; isn't that right?

Mr. BALL. Yes, Senator, if you can define what that is.

Senator CURTIS. The objective is to have good service and not an unreasonable charge.

Mr. BALL. Yes, plus your idea of actual incentives for improvement in the delivery of quality services on a more efficient and more economical basis. We would like to have more incentives if we can determine effective ones.

Senator CURTIS. That is all.

Senator ANDERSON. Any further questions?

Senator WILLIAMS. I have three questions.

Mr. Myers, in August, you told the committee that sometime prior to October 1 we would know whether or not an increase would be needed on Part B of the medicare program. Assuming no change is made in part B what rate would be required?

Then my next question will be for the rate assuming we make the changes that are provided for in the House bill, the third question would be, assuming we make the changes in part B as recommended by the administration. What would the rates be in each of the respective areas?

Mr. MYERS. Senator Williams, as you realize, the law provides that the rate will be promulgated by the Secretary of Health, Education, and Welfare on or before October 1 of this year.

Now, to the best of my knowledge the Secretary has not—he is here and, of course, he can speak for himself—yet promulgated the rate. I have made certain studies on this matter from the available data, as I indicated to you in my previous testimony. Much data have become available since I testified previously. Of course, I suppose that, as any other actuary or statistician, the more data I had the more satisfied I would be to determine a premium rate. As a matter of fact, we are still getting in considerable data for the last 6 months of 1966, which were the first 6 months of operation of the program. In fact, in August 1967, about 5 percent more data came in for that past period, so that we still don't have final data.

However, realizing that a rate determination by law had to be made by October 1, I have made certain studies, and I have made a recommendation on it.

Senator WILLIAMS. What was that recommendation based upon?

the assumption there is no change made either by adoption of the House bill or the administration's recommendation?

Secretary **Gardner**. Senator, we would really prefer not to state a figure at a time when we are still debating among ourselves several figures. It seems to me that it would be irresponsible of us to name a figure when we are still going back and forth on a range of figures and have not yet formed our final judgment.

Senator **Anderson**. You are only 4 days away, aren't you?

Senator **Williams**. Yes, 4 days, on October 1 and, Mr. Secretary, you have made substantial recommendations to this committee. How could either you make the recommendations or we consider them intelligently if we don't have any idea as to what this cost is going to be?

Would you give us the best figure that you have available or will have available 4 days from now?

Secretary **Gardner**. If you——

Senator **Williams**. Under the existing law.

Secretary **Gardner**. If you feel that 4 days is too long, could you give us 24 hours?

Senator **Williams**. Yes.

Secretary **Gardner**. We have been counting for some time on the date indicated in the legislation.

Senator **Williams**. Yes, but I think we should have the new rates, and——

Senator **Anderson**. We will give you 4 days.

Senator **Williams**. Sure, we won't be going into executive session until next week, but I think we should have this information at that time. I would like the figures both as they would relate to the existing law, assuming no change is made whatever. Then relate those figures to the House passed bill, assuming no changes.

Secretary **Gardner**. Yes.

Senator **Williams**. And then I want the rate related to your recommendations, assuming we accept all of your recommendations in the administrations bill.

Secretary **Gardner**. Fine, we will present those, sir.

The Secretary of Health, Education, and Welfare,
Washington, D.C., September 27, 1967.

Hon. Russell B. Long,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: I am writing in response to the request made by Senate Finance Committee members at the hearings yesterday on the Social Security Amendments of 1967, H.R. 12080. The Committee asked for our best estimate on the cost of the Supplementary Medical Insurance plan to date and our best estimates concerning a proper rate for the program for 1968 and 1969.

As I indicated at the hearings, because of the time lag in the submission and processing of bills in this program, we do not yet have complete figures for the 6 months of 1966 and have only very incomplete data for the first 8 months of 1968.

We do, of course, have up-to-date figures of cash expenditures under the program, but these figures taken alone, would be misleading because they do not take into account liabilities of the program arising from the natural delay in benefit payments until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians and enrollees in completing the claim forms, and the time required by the carriers to adjudicate and pay claims. There was a balance of $426 million in the Supplementary Medical Insurance Trust Fund at the end of July but there are also many outstanding liabilities. On the basis of claims paid (a cash basis), the average monthly per capita expenditures of the program, including administrative costs, for the six months of 1966 were $1.93 and in 1967, for the seven months through July, $5.71. As indicated, however, these figures need to be adjusted for the estimated increase in liability that took place during the period.

Figures on an accrual basis (the proper basis for rate determination) for the six months of 1966 are, of course, much more complete than for 1967. On the basis of the 1966 accrual figures we now estimate that the $3 premium rate for that period was about 15 cents too low. It is the best estimate of our experts that the liability of the system for the entire year and a half period of 1966 and 1967 will be about 8% higher than is provided for by the $3 premium plus the matching government contribution. In other words, we expect that the $3 premium for the entire 1966–67 period will be low by about 25 cents. About 15 cents is accounted for by the fact that physicians' fees have been rising at a faster rate during this period than was assumed in setting the premium; about 10 cents arises from the fact that there has apparently been a somewhat greater utilization of services under the program than had been anticipated. These estimates are based upon incomplete data for past periods and upon projection for the period September through December and may be somewhat more or less when the final accounts are in.

In estimating the cost of the program for 1968 and 1969, we cannot, of course, project the same per capita costs as for the past period. To be reasonably certain that the rate is properly set it is necessary to assume further increases in physicians' fees and in utilization.

Based upon our estimates of the cost for the present program over the two years of 1968 and 1969, we now anticipate the need for an increase of about 50 cents in the premium rate in addition to what we estimate was needed for 1966 and 1967. The 50 cents would be matched, of course, by an equal amount from the government. This figure allows for approximately a 3% annual increase in utilization and a 5% annual increase in physicians' fees in each of the years 1968 and 1969.

As you know, H.R. 13026 as reported out by the House Ways and Means Committee yesterday would make it unnecessary for us to proceed with the announcement of a rate for 1968 and 1969 based upon present law, but rather would postpone a setting of the premium rate until the end of December. The Committee believed it would be best to postpone the setting of the rate until a time when our information would be more complete and when the changes in the program now under consideration by Congress could also be taken into account.

Members of the Senate Finance Committee have asked, nevertheless, what rate I would promulgate if it were necessary to proceed by October 1, as required by present law. My answer is that I would promulgate a rate of $3.80 for the two-year period of 1968 and 1969, 25 cents of the increase being based upon our evaluation, as yet incomplete, of the extent to which we believe the premium rate was below the actual cost for 1966–67 and 55 cents being the estimated additional cost to be expected in 1968–69 arising from an estimated increase in utilization and in physicians' fees and an allowance for a contingency margin.

Under H.R. 13026 it would not be necessary to promulgate a premium rate until the end of December, at which time we would have better information concerning the liabilities of the program for the 1966–67 period and, therefore, a better basis for estimating 1968 and 1969 costs. Thus, any rate promulgated at that time may or may not be entirely consistent with the figures supplied in this letter. Moreover, of course, the rate promulgated in December would cover any additional benefits included in social security legislation as finally enacted. As you know, we estimate that the additional benefits included in H.R. 12080 as it passed the House would call for a premium rate increase of about 20 cents per month.

I would also like to make clear in response to a further request for information at the hearing yesterday that the Administration does not propose any changes in the provisions of H.R. 12080 which would change the cost of the Supplementary Medical Insurance program.

Sincerely,

JOHN W. GARDNER,
Secretary.

Senator WILLIAMS. The administration has submitted a series of recommendations under H.R. 12080, altogether about 75 or 80 amendments to H.R. 12080.

Do you have any more amendments to the bill which you expect to submit to us in executive session or do you stand by the amendments as submitted?

Secretary GARDNER. I would like Under Secretary Cohen to comment on that.

Mr. COHEN. As matters stand right this minute, Senator, we do not have any more amendments to offer. However, individual Senators have been consulting with me about amendments that they wish to offer and in some cases, I have indicated our willingness to either go along with the amendment or work out some modification of the amendment. It may, therefore, be possible either before or during the executive session that as a result of both what has been said in the public hearings and the consultations we will support a number of other amendments.

Senator WILLIAMS. I understand that. I was asking primarily from the administration's standpoint so we would have the record straight before we close these hearings.

Mr. COHEN. As far as we are concerned we stand on the record that we have submitted. But I must say quite frankly a number of Senators have made some very good suggestions for clarification and modification, and I am sure we would want to support many of those.

Senator WILLIAMS. I understand that.

Last year you requested this committee to delay consideration of Senator Moss's nursing home bill pending the report of your task force on nursing homes.

Now, to date we have not received that report. But wasn't that nursing home report submitted to the White House last December?

Mr. COHEN. Yes, a report was submitted to the White House on nursing home care at that time.

Senator WILLIAMS. Has that been made public, and if not, why not?

Mr. COHEN. Well, as far as I know it was not made public because it was a report to the President, and I can't tell you why he didn't make it public.

Senator WILLIAMS. Will it be made available to our committee? The point is that the Congress was asked to withhold action on this bill which would require a task force report on the basis that your report was being assembled. Now, if the report being assembled was available to the White House only and would not be available to Congress why should we have waited? Will we get access to that report?

Secretary GARDNER. Senator, we will have to check that and let you know. We will do that promptly.

(Pursuant to the above discussion the following letter was received for the record:)

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., October 5, 1967.

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

DEAR SENATOR LONG: During the testimony before the Senate Committee on Finance, Senator Williams asked Secretary Gardner about the Special Task Force Report relating to nursing homes. The report was submitted to the White

House. It has not been released. Only the White House can release the Report. On the basis of the report President Johnson recommended in his special message on Health and Education of February 28, 1967, the establishment of a National Advisory Commission on Health Facilities "to study our needs for the total system of health facilities."

We have been in touch with Senator Moss' staff and the staff of the Senate Committee on Finance with regard to our views on Senator Moss' nursing home bill.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

Senator WILLIAMS. Well, in the event that the report is not available to us would you recommend that the committee proceed with a proposal similar to what Senator Moss made and require a report by a certain time?

Secretary GARDNER. I will ask Mr. Cohen to talk to that.

Mr. COHEN. Senator, the Moss bill and other aspects of the entire nursing home situation were discussed rather extensively in the executive session of the House Ways and Means Committee and we are fully prepared to discuss the details of the Moss bill or any other bills that relate to nursing homes, not only merely on the basis of that report, which did not touch on many of the aspects in the Moss bill, but on subsequent studies of ours.

Senator WILLIAMS. I was not interested in discussing the Moss bill because I can read that myself, but I am interested in the report itself to see just how this program is working. Surely this report is not top secret.

Now, do you have a report within your own agency that you could make available to the committee in connection with this program?

Secretary GARDNER. We have a great deal of material on nursing homes and studies that we have made in the period since the Moss bill came up, and we will be very glad to put this material together for you and present it.

Senator WILLIAMS. But you are not sure whether we could get a copy of this particular report to which I refer, is that correct?

Secretary GARDNER. I am not sure.

Senator WILLIAMS. You will let us know on that?

Secretary GARDNER. Yes, sir.

Senator WILLIAMS. How many task force and advisory committees does HEW have operating today? [Laughter.]

Secretary GARDNER. I don't think there is any count of them.

Senator WILLIAMS. Would you recommend that we have one more task force to survey how many task forces there are, how many reports are available that we haven't had a chance to read? Seriously, aren't we getting bogged down with committees and task force reports that are never being read by Congress, and maybe never submitted to you? I am serious; aren't we getting bogged down running around in circles?

Now, how many task forces do you have operating now in HEW?

Secretary GARDNER. I don't really know, Senator, and I really am not terribly interested in knowing. In our Department we have now five separate agencies, with many bureaus and divisions—and as far as I am concerned any bureau chief is free to appoint a small task force to examine a subject and I would not ask him to clear that through me. If it is a major central problem relating to pending legislation, of course, it would come to me, and we have a good many of those, but I would assume this is simply another form of getting outside advice.

I very strongly encourage our people to reach out to the best minds they can reach out to. I don't want to impede or centralize or control that process.

Senator WILLIAMS. Would you furnish for us at this point in the record how many task forces we do have in operation and how many and so forth. Yesterday in a discussion with the Chairman of the Civil Service Commission, Mr. Macy likewise expressed concern at the overexpansion of these task force consultants and experts throughout the Government. His statistics, if I recall correctly, indicated that we had spent in a 6-month period around $21 million in addition to the expense allowance on these experts and consultants. I am wondering if it isn't about time we get an expert or two to analyze what these experts are telling us.

(Pursuant to the above discussion, the following information was received for the record:)

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., October 5, 1967.

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

DEAR SENATOR LONG: During the testimony before the Senate Committee on Finance Senator Williams asked Secretary Gardner about how many task forces we have in operation.

Attached is a list of those task forces which the Secretary has established under his general responsibilities. I have excluded task forces or study groups dealing solely with the administration or management of programs. The list includes only those groups whose purpose is substantive consideration of programs.

We have quite a number of advisory councils which are specifically required to be established by law. If you wish to have the names of these Councils I shall be glad to provide them.

If there is any additional information you wish, please let me know. We shall be glad to supply it.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

SUBJECTS CURRENTLY UNDER STUDY BY DEPARTMENTAL TASK FORCES, COMMITTEES, OR SIMILAR GROUPS

Alcoholism
Traffic Safety
Prescription Drugs
Family Planning
Science Communication
Health, Education, and Welfare Manpower
Day Care
Employment of Public Assistance Recipients
Education of Deprived Children
Health Services for the Poor
Health Facilities
Kidney Disease
Student Aid for College Students
Exits from Poverty
Air Pollution
Occupational Training
New Careers
Dyslexia (Reading Problems)

Secretary GARDNER. Well, I think you will find, Senator, that as with all other human ventures, they vary tremendously in effectiveness, but if you look at the best of them, I would say that the Health Insurance Benefits Advisory Council was in itself worth all the $21 million, because they put together the medicare program, and they put together a very, very complex mix of public and private, and hospitals, professions and governmental activities, and this was a lay group, this was an advisory group. I have no doubt that they are in that total that was indicated to you. Our Advisory Council on Public Welfare was of immense use. Now, there is no doubt we have some useless ones too, but I think they are a small price to pay for the fine help that we get.

Senator WILLIAMS. I don't question but what there is merit to a lot of these, but I am just raising the question.

This particular task force that was prepared and which you asked us not to act on until it was ready was that prepared with the intention that it would be available to the White House only or was being prepared so that it would be available to us in Congress?

Secretary GARDNER. I will have to tell you the truth that I do not know. I didn't know the background of the formation of the task force and I do not know the circumstances.

Senator WILLIAMS. Yes, but you will report this within the next day or so?

Senator ANDERSON. Thank you very much, Mr. Secretary and you have given us some very fine testimony and we appreciate it a whole lot.

Secretary GARDNER. Thank you very much.

(There follows, questions raised by the committee, and submitted to the Department of Health, Education, and Welfare, for their response:)

Q. Why does title XIX prohibit the use of deductibles toward the cost of in-hospital care?

A. This prohibition was developed in the Committee on Ways and Means at the same time concepts of deductibles and payment of hospitals on the basis of reasonable costs were being included in the Medicare Program. Apparently it was felt that if hospitals were to be paid reasonable costs they should be assured that the payments would cover such costs. The Report of the Committee on Ways and Means accompanying the bill (House Report No. 213, 89th Congress, First Session) states:

"No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward the bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan."

Q. Don't you think greater use of deductibles and copayment would help cut title XIX costs of benefits for people who are at the top of the eligibility limits for assistance?

A. Most States have, apparently, concluded that it is desirable to set limitations on income low enough that these cover only maintenance costs. If such limitations are set, it cannot be assumed that individuals or families have appreciable resources to use for the payment of deductibles or coinsurance. As noted under Question 1, deductibles and cost sharing are prohibited with respect to inpatient hospital services and for other services must be related to income. This is a complex provision to administer.

Under existing law, even though deductibles are not imposed within the income eligibility limits, there is in effect a 100 percent deductible for income in excess of the eligibility limit. Thus, a lower eligibility ceiling tends to restrict the number of eligibles and to deal with only the "catastrophic costs" of families with more income. While at any given eligibility level, deductibles and coinsurance would reduce costs, the reduction would not be as great as the effect of the somewhat lower level.

Senator ANDERSON. Dr. Lash, we are very happy to have you here and you may proceed with your testimony.

STATEMENT OF DR. TRUDE W. LASH, EXECUTIVE DIRECTOR, CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK

Dr. LASH. Thank you very much, Mr. Chairman. I am Dr. Trude W. Lash, and I am executive director of Citizens' Committee for Children of New York. I am also a member of the council against poverty of New York City, and the chairman of its education committee.

I mention these affiliations because some of the direct knowledge I wish to report to you as a member of the council and though also being a member on hearing panels in the various poverty areas and ghetto communities in New York City.

I wish to thank you for hearing me, letting me come again after last week's adjourned hearing.

So much has been said about H.R. 12080 that very little can be added, and I will not read the statement which I have presented to you.

I shall simply talk about a few issues which I believe can usefully be further explored.

Senator ANDERSON. Thank you. We will have your paper printed in full.

Dr. LASH. Thank you.

We agree of course, with the purposes of the House Ways and Means Committee amendments, that "family life needs to be strengthened" * * * "that self-support must be encouraged" and "that the incidence of illegitimacy must be reduced and above all children must be protected from neglect and abuse."

We believe the present situation is a national tragedy, particularly in view of the fact that we have reached the highest national income and the lowest unemployment levels at this time.

We do not believe, however, that the amendments suggested by the House would deal effectively with this situation. Since we are mostly interested in children, and since we do not wish to leave to our own children and grandchildren an unbearable load which we believe this way of dealing with what we call a national tragedy would indeed present to them, we are audacious enough to bring to you some alternative suggestions.

First, let me tell you that in New York City there is an enormous amount of unemployment in the ghetto areas. whenever there is a halfway decent job available, the emplyoment offices are swamped. A few weeks ago a group of young people sat in for a whole week because they wanted jobs and when none were available they refused to leave. In New York this happens quite often, Mr. Chairman.

When the summer program of the Neighborhood Youth Corps ended, 23,000 out-of-school young people were dumped on the streets.

We say that the unemployment rate in our ghetto areas is between 15 and 20 percent. That is so. However, only two out of five young males work, and for adult males the figure is three out of five. The employment figures are swollen by women who work because their men have no jobs.

Just yesterday our committee began to investigate what happens to some of the children of women who work. We found, for instance, that women who make between $60 and $70 a week pay up to $20 a week for a baby to be cared for by totally unsuited persons. One person was found obviously not very sober and listening to TV and not caring for the children in her apartment at all.

That does not mean that we believe that women, mothers, should never work. We believe they should have the right to work and we were always opposed to the pressures which were being brought on ADC mothers in earlier times not to work but always to stay home with their children. We believe that their children should be cared for, while they work.

However, we have day-care facilities (after many years of trying to increase the program), for approximately 7,000 children in all of New York City with approximately the same number of children on the waiting lists because there are no facilities. Their mothers want to work. They cannot work because there is no program for their children.

In general, however, we firmly believe that the work training program must be first directed to males. We must deal with the enormous unemployment of our young untrained males, school dropouts, dropouts of vocational high schools, which are not very successful in training young people for jobs. We believe the training has to be directed at jobs and that at the end of the training there has to be a job.

New York City is full of training programs: The Nelson-Scheuer program is just getting started; MDTA and OEO have training programs. Most of the ones we have had up until now have simply ended with people being trained and not getting jobs after being trained. This has added enormously to unrest and bitterness.

Senator CURTIS. Mr. Chairman, may I ask why that is?

Dr. LASH. Well, these programs were started very fast, and they were formulated along the lines on which training programs, particularly vocational training programs, are often formulated. You know we still teach young people in vocational high schools things that no reasonable employer has ever dreamt of using for the last 20 years.

Senator CURTIS. Were they State programs or Federal programs?

Dr. LASH. They were programs prepared on the local level, mostly with Federal funds, sir.

To prepare a comprehensive training program is a very difficult and extremely important business and should not be done by the welfare department. People get stigmatized if they get their jobs as welfare recipients. Its training programs should be under the Labor Department. There can be different programs—I am very much in favor of the Nelson-Scheuer bill—but all the training programs have to be clearly interrelated, and have to be clearly related to jobs. We believe that males should receive first priority, because by leaving them out—as H.R. 12080 does—we are further degrading the image of the male. The degradation of the male is one of the reasons why there are so many women now without males in the households. Males leave because they cannot stand the idea of sitting around while their wives bring in the money or they leave because they are afraid their wives will lose the welfare payments.

Therefore, it seems to me a national training-job program is of vital importance particularly for the ghetto areas, the Bedford-Stuyvesants, east Harlems, central Harlems, and south Brooklyns and others in other cities, but not under the welfare department and not as a program to force mothers, particularly mothers of young children, out of their homes.

This we believe would end only in disaster and certainly would not help us in trying to pull the millions of children who are now on ADC rolls into the mainstream of life.

We do not believe that humiliating mothers ever helps children.

Now, obviously we do need welfare reforms. I served on the committee which proposed the amendments that were enacted in 1962. I am afraid we were not very realistic in believing that our proposals would reduce the welfare rolls. They did no such thing. The rolls have been growing ever since, and it seems to me—and it has seemed to me increasingly over the last few years that one of the big mistakes was that we thought by offering social services we could deal with abject poverty. It now seems obvious that it is an insult to offer services and not money enough to eat at the same time.

But we believe, as we indicate in our statement, that the recommendations of the Advisory Council on Welfare are realistic. However, we must see welfare in a much wider context. I have seen in my education work with the young people in ghetto areas that without much better educational opportunities problems in these areas cannot be solved.

We also believe that we have to experiment with other income maintenance methods.

Last week Senator Javits mentioned children's allowances. I would like to add that the Citizens' Committee for Children, with a grant of the Ford Foundation, is organizing a conference, which will be held in Airlie House in October, to explore the feasibility of a children's allowance in this country.

As Senator Javits pointed out, every other industrialized nation has such an allowance, some minimal, some more considerable, like France, for instance. We do not know whether in this country this kind of thing would be feasible or acceptable. But we believe that it is an important enough issue to have experts look at it from every point of view. We hope that after the conference we shall be able to present to you our recommendations.

I would now like to discuss only one issue having to do with medicaid. I listened with the greatest of interest to the questions that Senator Curtis asked about "reasonable cost." You will find in our statement some charts about the rise in hospital costs since July 1966, the date medicare began and the interim rate for this coming year. Interim rates and provided for next year because it is expected that costs will be much higher than projected now.

If you cut medicaid eligibility the way the House proposes then you make absolutely sure that those people who are not welfare clients but medically indigent will be completely and totally unable to buy health services.

In New York City, for instance, the House proposed eligibility for medicaid would mean a top of $3,900 for a family of four. Such a family would have to pay for a clinic visit, which used to be free, up to $20. If a doctor other than a resident or an intern is involved in the visit, the patient would also have to pay a doctor's fee.

If such a person had to check in at a hospital, in a ward of St. Vincent's, for instance, he would have to pay $76.26 a day plus doctor costs beyond the care that interns and residents provide. Long Island Jewish, it would cost $94 a day; Montefiore, $87; Cancer Memorial, $93.60 a day. Now imagine a family with two children living on $3,900 a year and being faced by these prices. Remember there is no longer any free doctor's care in New York City; everything has to be paid for now. Imagine what would happen to the children of such a family, if the Senate were to agree with the cut in medicaid eligibility in the House bill, which, Mr. Chairman, I hope and am confident will not happen.

Senator ANDERSON. Thank you very much.

Senator Curtis?

Senator CURTIS. I realize that New York State has considerable population. But do you regard New York as typical of the national situation?

Dr. LASH. No, sir; I do not. But I talk about New York because I really know the situation in New York, very well, and I hesitate to talk about other States I do not know from my experience.

Senator CURTIS. I think their cost items are much higher.

Dr. LASH. Yes, of course.

Senator CURTIS. I was rather shocked that you said that there is no such thing as free medicine in New York. In my State I just do not think anybody is turned down because they do not have the ready cash for medical attention.

Dr. LASH. It may be, sir, that is true upstate, where general practitioners will not ask questions. We used to have doctors serving in city hospitals and voluntary hospitals without charge. But that is not so any more, and now all doctors are paid. Of course, the residents and interns get only nominal salaries. Under medicaid, a general practitioner is paid $35, according to State rules, for a 3-hour stretch in a clinic and specialists receive $50 for a 3-hour session in a clinic. These are not high doctors' fees but these fees get added to what the hospital charges for the clinic visit.

Senator CURTIS. Here is something else that I think must have consideration in connection with medicaid. Are not a high portion of the people of New York who are employed and have some income in a position where they can secure hospital and medical insurance at group rates?

Dr. LASH. Yes, they are, sir. Many people have Blue Cross or HIP, the health insurance program, through which the city employees are insured. But there are large numbers, particularly among the borderline cases, who carry no such insurance programs. I think that could be shown, although I do not have the figures here.

Senate CURTIS. Of course, to meet these costs for New York State which is going to be derived from a Federal tax, the tax is going to fall on many citizens over the country who make less than $6,000 and who pay their own medical bills.

Dr. LASH. Yes, I see the problem.

Senator CURTIS. And they pay their own medical bills, and many of them carry hospital, some medical, so they are not public charges if they have a rather sizable illness.

Dr. LASH. Of course, I was talking about the group who are not now public charges, who are called medically indigent for purposes of medicaid, and those are the ones that struggle extremely hard to stay self-supporting.

Senator CURTIS. New Yorkers established this system prior to the enactment of medicaid.

Dr. LASH. Yes, New York State established a system of publicly supported medical care prior to medicaid, but New York under medicaid, as you know, the eligibility became higher.

It is possible, Senator, that New York State will have to bear a greater share of the medicaid burden than it does now. I think Senator Javits was pleading with the committee that the State be allowed to make its own decisions, I would plead that we not be forced to limit medicaid as this bill proposes.

Senator CURTIS. You would not be forced, you could go ahead as high as you want to, it would be just a limit as to how much the Federal Government would pay.

Dr. LASH. Yes, I understand that the Federal Government under H.R. 12080 would share the cost of medicaid for families of four with an income up to $3,900 which would mean that New York would have to pay enormous additional sums or cut the program as I think Commissioner Wyman pointed out in his testimony.

Senator CURTIS. How many individuals have been taken out of New York City to be trained by the Job Corps elsewhere?

Dr. LASH. I am not sure about the exact number, but I think it is below 3,000.

Senator CURTIS. So the Job Corps has not made much of a dent in training the people who need training in New York City?

Dr. LASH. No, sir; it has not, and those who know the situation best have questioned the removal of the young people from the community.

Senator CURTIS. I am very interested in that remark, because I question the wisdom of it as you have expressed there. It is because of those who go, perhaps a much, much smaller number return and never add anything to the poverty stricken area from which they were taken.

Dr. LASH. Also a good many come back because they are homesick. It is very difficult for children who may never have been even 20 blocks away from their homes suddenly to be taken to a place where it is quiet and there are birds and everything is scary and where there is no reassuring noise at all.

Senator CURTIS. Is it not also true that a well organized and productive training program in a slum area sets an example for the whole area and provides a worthwhile activity there that makes a contribution?

Dr. LASH. I completely agree; particularly under the present circumstances after the summer's difficulties, this would be so.

Senator CURTIS. Now, in reference to your statement concerning the ADC freeze——

Dr. LASH. Yes.

Senator CURTIS (continuing). Particularly on page 3, about six lines from the bottom you say:

> However, the directions to states in H.R. 12080—seen together with the baby freeze—add up not to family planning but to enforced birth control.

Enforced birth control for whom?

Dr. LASH. For the ADC mothers.

Senator CURTIS. Both married and unmarried.

Dr. LASH. Yes.

Senator CURTIS. Well, the freeze does not apply to a situation where the husband is deceased or disabled, does it?

Dr. LASH. No.

Senator CURTIS. Then would the freeze not apply only in those cases where there was no man in the house?

Dr. LASH. Yes, Senator.

Senator CURTIS. Well now, then to read on, it says:

> No matter what the records say, the proposed action comes through loud and clear. It makes a travesty of "family planning" which should mean the right to plan the size of one's family, not merely the prevention of childbirth.

Now, what right does a woman have to engage in family planning in itself, accepting the term to mean bringing a family into being, if there is no man in the home?

Dr. LASH. I take it, Senator, you are not asking about the moral right.

Senator CURTIS. Well, you have used the words here: "It makes a travesty of family planning" which should mean the right.

Dr. LASH. Yes?

Senator CURTIS. Now moral, legal, or anything else, what right does a woman without a husband living with her, what right is violated if she is not allowed to go on in family planning, and by family planning I assume it means bringing a family into being.

Dr. LASH. Maybe we expressed in a way that could be misunderstood what we mean by saying "making a travesty of family planning." What we were saying here is, what the bill is talking about, is birth control and not family planning.

And we go on to say that you cannot enforce birth control by either starving the mother or taking her children away from her, that all studies have shown that this cannot be done. But I would like to say, Senator, I have seen things that can be done.

Senator CURTIS. What are they?

Dr. LASH. Let me tell you of one program that is now going on in New York City. It is very brief.

Senator CURTIS. That is all right.

Dr. LASH. Youth In Action, which is an antipoverty program in Brooklyn, has just opened its eighth 20-week course for young mothers and one for young fathers. There are 141 young mothers in the course, most of them not married, some married. The fathers' course is the biggest one yet because usually one does not get the fathers to come around very easily. There are 30 fathers in the fathers' course. The mothers are being trained in homemaking, cooking, and how to care for themselves and their children, provide health care and so on. The fathers are being given training for jobs.

The program has now been in operation for over 2 years and since that time among all the women who have taken the course there have been only two pregnancies. Now, I think it is terrible for women to put children in the world for whom they know they probably cannot care. But I think that was not what we were discussing. It seems to me that what we need to find out is what we have to do to change this situation.

Senator CURTIS. Now, you trained in that New York project how many people?

Dr. LASH. The first courses were much smaller. I think around 600 women were trained.

Senator CURTIS. But that still in a place the size of New York does not attack the problem.

Dr. LASH. Senator, it attacks the problem more I think than it has been attacked in other places.

We are also doing something else. This too is very small and started much too late. We have just begun programs for teenage mothers, schoolchildren, who get thrown out of school because they are pregnant. We have a very large number of those children, any age up from 12. The mnimum guess is that there are at least 2,500 a year.

Senator CURTIS. In New York State?

Dr. LASH. In New York City.

Senator CURTIS. In New York City.

Dr. LASH. Yes, sir. Up to now they were simply thrown out of school and many went on to have more and more children. Now we are beginning in the various neighborhoods to get hold of these youngsters; to work with them and try to teach them, what it means to give birth to a young life, to teach them health care, give them training. Too small? Yes, too small.

Senator CURTIS. Coming back to your statement, the understanding I get is that you contend that H.R. 12080 will bring about enforced birth control.

Dr. LASH. We said it will try enforced birth control but we also say it will not work.

Senator CURTIS. Well, you missed your guess in 1962.

Dr. LASH. I might miss it again, but I know much more now than I did then.

Senator CURTIS. Are you opposed to enforced birth control for the unmarried women?

Dr. LASH. Yes; I would be, I would be opposed unless this were a law that would be applicable to all young unmarried girls. I might even be opposed then.

Senator CURTIS. No, I mean restricting it to those who by their past conduct put them in a class where if they did not have it the number of public charges would increase.

Dr. LASH. Yes, I would be opposed to singling out women on public welfare for a rule of this sort. I would not see how this could be done without enacting a law, and I would be opposed to such a law. I believe that this would simply increase the difficulties of trying to shrink the welfare rolls and of trying to get people self-sufficient so that we do not have generations of welfare recipients.

Senator CURTIS. Well, now, I do not want to take so much time but——

Dr. LASH. My time is yours, Senator.

Senator CURTIS. But I am aware that there are many people on various types of welfare who have never had an opportunity and who are perhaps well-intentioned and who are definitely well-intentioned, in other words, they are not—they have not chosen it.

On the other hand, I think as we look back 20 or 25 years the number of people who are on there who could do better if they wanted to is increasing. What do you recommend to curtail not only AFDC cases but all cases where they just lack the moral fiber to do what they could right in their own surroundings and with the education and training that they have had?

Dr. LASH. The real problem, of course, is the AFDC caseload because it takes up between 75 and 80 percent of the whole welfare rolls.

Senator CURTIS. Yes.

Dr. LASH. And by far the largest number of AFDC clients are children. I believe that for them it is most important that we spend much more in educating them.

It seems to me, Senator, that if we start with a really very large national job training program for males first, we will effect changes in the situation. I also believe that if we concentrate on the adolescents who are now school dropouts by the thousands and have a crash training and job program for them, that will help.

I do not mean to say that one has to approve of the present situation at all. I simply believe that it does not pay to act out of anger or because something is going on that one wishes were not.

When one group in Harlem was last counted, it was found that 50 percent of them had come from the South where I take it they had left because they were starving. I talked with some women who wanted to work to feed their children and the question was what would they be able to do. They could not read, they had not had a chance to learn. That hardly was New York's fault. There are no panaceas, it seems to me.

Senator CURTIS. I am not looking for a panacea, and I am not putting everyone in that category, but I do think we have a segment of recipients who are not doing as well as they could do——

Dr. LASH. I agree.

Senator CURTIS (continuing). With the training they have already had.

Dr. LASH. Yes, sir; and the segment of employable welfare recipients on relief seems to be growing. There always have been 2 or 3 percent, now this has risen to 4 percent. I firmly believe it is growing because we never really have been providing jobs with a living wage and the kind of training that would lead not just to the job no one else wants, the kinds of jobs that in New York City are called "nigger" jobs, but to jobs that have dignity and decent salaries connected with them.

Senator CURTIS. There is one thing in the House bill with which I do not agree.

Dr. LASH. In our chart?

Senator CURTIS. No; in the House bill.

Dr. LASH. In the House bill. I thought you said hospital.

Senator CURTIS. It refers to illegitimate births.

Dr. LASH. Yes, sir.

Senator CURTIS. So far as I know that is not in the Federal law.

Dr. LASH. No.

Senator CURTIS. It is in the House bill, and I do not think that any child should be so stigmatized; do you?

Dr. LASH. No.

Senator CURTIS. Do you know what some of the other countries have done?

Dr. LASH. Yes; I know about some of the European countries.

Senator CURTIS. What countries have had the most success in requiring people to perform useful service who have been content merely to be welfare recipients?

Dr. LASH. I do not think that any country has the same problems, sir, because no country has made this tremendous progress and left some behind, I think. So that the problem is not the same. It is not the same in Italy where it might be the same but many of their unskilled workers have always gone to other countries to work, for instance to Germany and Switzerland and lately even to France, so that the groups of people who might have to be on welfare simply leave the country.

Senator CURTIS. Are you familiar with what Sweden has done?

Dr. LASH. Sweden has a labor shortage. Sweden has done more with free services than with money payments. It does not have problems with welfare but it looks as though at this moment the young people in Sweden are not very motivated. There is not the surge ahead that one thought might happen in a country where no one is left out.

In our country the danger is that those who were left out will afterward attack the ones who are in.

Senator CURTIS. Of course nobody knows of those who are left out, whether they are left out by their choice. I do not imply that all of them are, but some of them are.

Dr. LASH. Yes, I am sure.

Senator Curtis. And that is the group that worries me.

Dr. LASH. Yes, but the question is who are they. I have seen men who simply do not have the attitude that would ever mean they would hold down a job. But not among many of the young people are of that kind, and I am scared that unless they get offered a real chance and promises are kept that more and more will join, those leaders who are leading them into trouble.

Senator CURTIS. Well, we thank you for your presentation here and your entire statement will be put in the record.

Dr. LASH. Thank you very much.

STATEMENT BY DR. TRUDE W. LASH, EXECUTIVE DIRECTOR, CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK

Gentlemen, I am Trude W. Lash, representing the Citizens' Committee for Children of New York, a coalition of lay and professional workers from all fields concerned with children which the New York Times has called "a fierce watchdog for children."

For more than 20 years we have worked for better health, education and welfare services for our most vulnerable children and their families, through fact-finding, public education, community action, participation in policy-making and monitoring of service programs. Our studies and reports which are intended as agenda for community discussion and debate have attracted attention nationally, since our members are people of recognized competence. I wish to offer as illustration of the kind of report we publish: "Life at the Bottom," a recent welfare documentary.

We are grateful for the opportunity afforded us to discuss the Social Security Amendments proposed in H.R. 12080. While commenting briefly on Title I, the social insurance portion of the amendments, we wish to concentrate on Title II, the Public Welfare Amendments enacted by the House on public assistance, medical assistance and child welfare.

We fully support the goals expressed by the House Ways and Means Committee: "to break the cycle of dependency . . . strengthen family life . . . encourage self-support by providing training and jobs . . . reduce the incidence of illegitimacy . . . protect children from neglect and abuse . . ."

But we know that they cannot be achieved by the measures proposed in Title II, part 1, of H.R. 12080 (Public Assistance Amendments).

Studies have shown that the assumptions about illegitimacy, on which the proposals of H.R. 12080 are based, are erroneous.

It has also been shown that punitive and coercive policies only perpetuate the poverty cycle.

The House bill would fragment manpower programs in a wasteful, self-defeating way.

The demands upon the states are unreasonable and would force them into financial strait jackets or into pushing welfare payments below starvation levels.

The positive measures such as increased federal reimbursement for social services, improved child welfare financing, emergency assistance, day care aid, work incentive through partial exemption of earned income and help for social work education are so enmeshed in regressive measures that we prefer to give them up and to hope for future legislation rather than suffer the entire package.

We, therefore, hope you will pass Title I, after raising the House-proposed ceilings on both taxable income and social security benefits.

But we urge you to drop Title II entirely.

More specifically:

THE AFDC FREEZE. (SECTION 208)

It is unthinkable that in 1967 Congress would consider limitation of the number of children for whom federal payments would be made. Yes, public assistance is expensive and will become more expensive. Nevertheless, the American people will not mandate child starvation. Already inadequate AFDC grants cannot be divided among more children. Already hard-pushed states cannot take on additional financial burdens. Few states, even today, are granting cash payments up to their own stated minimum. Their only choice, if the "freeze" were adopted and the "open ended" federal support discontinued, would be to use coercion to get mothers off the public assistance rolls, no matter what happens to them or their children.

There is no evidence at all that "the freeze" will decrease illegitimacy or dependency. There is clear evidence that it will increase starvation, disease, school failure, resentment and social instability.

We believe family planning programs should be available to all, as a matter of choice. States have been slow in developing such programs, and federal aid and encouragement are needed and welcome. (See p. 17 for our recommendations on Medicaid services.) However, the directions to states in H.R. 12080—seen together with the baby freeze—add up not to family planning but to enforced birth control. No matter what the words say, the proposed action comes through loud and clear. It makes a travesty of "family planning" which should mean the right to plan the size of one's family, not merely the prevention of childbirth.

The House bill further proposes to decrease illegitimacy by threatening the removal of a child from the home in cases of multiple illegitimacy. This might indeed discourage relief application by some mothers. However, HEW surveys have shown that ⅘ of all out-of-wedlock children are not receiving Public Assistance even now! These figures are almost more tragic than those of out-of-wedlock children on the relief rolls. One dreads to imagine what is happening to some of those children. Quite apart from humane consideration for mother and child, the cost of foster care and residential treatment, the dreadful cost of national ill health are so forbidding that none of the measures proposed should survive realistic analysis.

Birth control by Congressional edict imposed on one group of women in our society, would be naked discrimination—if it could be done. But there is no way of enforcing it.

Moreover, the proposal is apparently based on the assumption that the same mothers stay on AFDC and that the rolls grow because they keep on having children. These are not the facts. There are, of course, some families who stay on Public Assistance for generations. But, according to HEW figures, about 45,000 new families come on the rolls each month, and about 41,000 leave.

There has been—over the last 20 years—and is continuing to be a large influx of rural families into the cities. The agricultural revolution has driven hundreds of thousands of our rural poor off the farms. The whole sad story of what has happened to the superfluous farm workers—especially the Negro families—was told with his usual grasp of the essentials by William V. Shannon in the New York Times of September 18, 1967.

COMMUNITY WORK AND TRAINING PROGRAMS (SECTION 204)

We have long urged that AFDC mothers be given the choice of caring for their children themselves or working either part-time or full-time while being provided with group day care, family day care, or homemaker services. It is also appropriate that AFDC mothers be allowed financial incentive to work through earning exemptions until they become self-supporting (Sect. 202), though we support the Administration proposals for higher exemptions. But to compel mothers to work is the surest way of destroying whatever family ties may exist. It would break up the home of young children—as a matter of public policy.

The most destructive aspect of this work-training proposal, however, is the fact that it would drive women into the work force while the men remain untrained and unemployed. Unwilling to face the humiliation of not being the "provider" and thereby the acknowledged head of the household, they leave home, particularly in those states where their presence might threaten AFDC payments for their children. Doing further damage to the status of the male will not strengthen family life.

It would be a safe guess that the majority of fathers have not worked 6 out of the last 13 quarters, that few have more than a casual relationship to work and are therefore excluded from the AFDC program. Chief among the reasons for this situation is lack of education and training—due to lack of opportunity. The job market for untrained worker is tight. The urban ghettos are full of healthy, untrained and unemployed males who want to work. Thousands line up every time a city job-opening is announced.

When the summer Neighborhood Youth Corps in New York ended this program recently, over 23,000 out-of-school youths were thrown on the streets, and many in these groups are the absent fathers of AFDC children.

"Increased efforts to enforce the laws against desertion and non-support," will not only be costly but will result in driving unemployed fathers further underground and further away from sources of training and work.

Only a major new training and job program that give absolute priority to the unemployed male can provide a solution.

Such a community work and training program should not be forced upon the states as a welfare measure. If we equate trainees with welfare recipients we isolate them further from their fellow-citizens. Work and training programs must be comprehensive and unstigmatised.

It will be some time before a truly effective training and job program can be developed—and the jobs must be found first. The MDTA program, the OEO manpower program, the Nelson-Scheuer programs are still in the trial and error stage—all of them struggling to define training programs for jobs that have a way of eluding their graduates. The new proposals would mandate another layer and simply add to the confusion and duplication.

The Administration recommended, quite appropriately, that community work and training be transferred to the Department of Labor so that resources can be coordinated and training and jobs provided speedily and effectively.

It should be added here that even if jobs were available for all those mothers who want to work, they would not now be able to find the day care or family day care services they would need for their children in order to be able to go to work. The cost of these programs is only one factor; the shortage of trained staff in another; but the lack of space in crowded ghetto areas may be the biggest obstacle of all. In New York City after 20 years of effort, only 7,000 children can be accommodated in our Day Care Centers and the same number of children are usually to be found on waiting lists.

With adequate financing and mobilization of all the creative genius and innovation at our command, it may be possible to develop an effective day care program, but not tomorrow or next year.

PROTECTIVE OR VENDOR PAYMENTS (SECTION 207)

Voucher relief was carefully safeguarded and limited in the present law at the urgent advice of local and state public welfare officials who realized the destructive potential of such payments but also knew from bitter experience that lack of funds and sometimes community exasperation and anger might force their use, unless the law was clear for all to see. Does anyone who has had experience with the education of children, who knows how carefully the sense of responsibility has to be nurtured, how many setbacks there are—does anyone really believe that taking away the right to decide, humiliating a person in the eyes of the community or a mother in the eyes of her children, is the road to independence and self-reliance?

Except in cases of physical danger to children—and then the neglect provisions of the law are available—or in cases of diagnosed mental incompetence, vendor payments should be forbidden.

Finally, our legal advisors tell us that several of the proposed provisions are of doubtful constitutionality: (a) separate policies for children in need because of illegitimacy and desertion; (b) special child neglect rules for relief recipients. Should these provisions be retained, we assume that the courts will rule on constitutionality. What we are certain about today is that they are poor public policy.

THE 1962 AMENDMENTS

We understand the frustration of the House concerning the 1962 amendments which were heralded as a way to cut relief rolls. Instead, relief rolls have been going up and up. Partly, this is due to the fact that implementation of the amendments has been slow and spotty. But the decisive fact is that the promises were not realistic. Our child population is growing. The problem of illegitimacy and family breakup is serious. Abject poverty cannot be solved by social services alone. To offer them without also providing funds for housing, heat and food is an insult. Major new programs are needed to restore health to our cities. The price of solving our most urgent national problems will be large.

RECOMMENDATIONS

While we believe that the proposals of H.R. 12080, Title II will not be effective, we would recommend alternative measures.

The Administration and the Advisory Committee on Public Welfare have singled out for action what we consider to be the key issues:

The below-poverty-level public assistance grants.

The fact that many states do not offer subsistence equal to the minimum budget levels which they themselves set.

The excessive policing, monitoring, harassment and paper work where there is desperate need for simplification, efficiency, speed, protection of rights.

The tendency of the present system to perpetuate dependency and all the problems it was expected to alleviate.

Many of us who have worked to improve the public assistance program had hoped that relief investigations would be objectified and simplified.

We are encouraged by the experiments with affidavit and declaration procedures.

We believe that a minimum federal assistance guarantee which might approach the poverty line would help the states and strengthen families.

We believe enforcement of new directives protecting the constitutional rights and privacy of applicants in the course of the investigatory process would build confidence and decrease dependency.

We believe that increased efficiency would result from flat grant budgeting and computer procedures.

We see progress in Secretary Gardner's administrative separation of the money payment and social service functions on the federal level, an approach which removes improper coercion from social services and recognizes that many people who are not relief recipients require social services.

All these reforms are based on two assumptions:

(1) Adequate support for families while children are developing, as a matter of right and not of stigma, assuring the growth of children who will be self-respecting and eventually self-supporting whatever their parents' problems.

(2) Training and jobs for those able to work; all people needing rehabilitative services should have access to them; people who are not employable (and this means a very large percentage of recipients) should be given adequate support in a way which does not make them second-class citizens.

We believe in government contributions toward the cost of bringing up children, not in perpetuating child poverty.

Every other industrialized country in the world offers some form of family allowances, considering such a contribution to child-rearing a sound social investment.

Our Committee, with the backing of the Ford Foundation, is convening an expert conference, under the chairmanship of Professor Eveline M. Burns of Columbia University, in late October to consider the feasibility and desirability of such a program for the United States. (For your information I present copies of an abstract of Dr. Burns' background paper and of the fact sheet prepared for the conference.)

It is our hope that the family allowance will prove to be a humane and dignified way of saving people—rather than money—and will be seriously considered as a substitute for some of the most regressive House proposals.

Basic to any consideration of welfare reform must be the clear understanding that the Welfare System is only a reflection of our failure to prepare millions of citizens for the world in which they now find themselves. The Welfare System cannot be improved in isolation—without adequate education and health services, the people now on Welfare and those to follow will remain dependent because our changing labor market has no place for them.

In 1967 there can be no question in anybody's mind that our rural and urban poor are not being educated for the jobs that are available today. Will forcing them into employment and off the Public Assistance rolls change this fact?

Nor can anyone believe that poor health is not also a determining factor in one's ability to benefit from education and training. Or that substandard housing is not another major contributing factor.

We urge you to study the data already compiled by the U.S. Public Health Service, the Bureau of Labor Statistics, the Children's Bureau, the Office of Economic Opportunity and many other official and voluntary agencies, spelling out the fact that malnutrition and a host of untreated, debilitating illnesses are to be found among the country's poor—both on and off the welfare rolls. "Health ranks second to education as a cause of sub-employment" according to the Bureau of Labor Statistics. This hardly seems the time to cut back on health services for the indigent and medically indigent; to hobble the developing Medicaid program with restrictions and/or loopholes that will undermine whatever has been accomplished in recent years and signal the end of medical care for millions who are about to receive it for the first time.

A recent study of Job Corps trainees revealed that 50% had never been to a doctor; 70% lived in sub-standard housing; 30% were from homes with at least one parent with a physical or mental defect. Within the first month there was an average gain of 15 lbs. Selective Service rejection-statistics have consistently parallelled these findings.

Unless we are prepared to alleviate the health deficiencies, the educational deficits and the housing and related conditions under which children and their parents struggle to exist, any talk of reducing the AFDC rolls by forcing adolescents and adults into employment, is almost ludicrous.

TITLE II. PART 2 (MEDICAL ASSISTANCE AMENDMENTS)

In 1965 when the Congress enacted Public Law 89-97 millions of people rejoiced. They believed that for the first time, Americans would no longer be deprived of health care solely because they could not afford it. Before that Medicare-Medicaid law was passed, many compromises were made. Some of these, we believe, detracted from the objective of insuring high quality medical care for all under these new programs and may have raised the cost of medical care to even higher levels.

Title XIX (Medicaid) as enacted by the Congress, made it possible for the States to provide programs of medical care not only for those who were receiving categorical public assistance payments (the aged, families with dependent children, the blind, or permanently and totally disabled individuals), but also for the medically needy—" . . . all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient . . . income and resources to meet the costs of necessary medical or remedial care . . ."[1]

We are aware, of course, that providing health care to many millions more people due primarily to Medicare (and less so to Medicaid) has created enormous medical and administrative problems as well as large increases in medical costs. This is because we do not have a health system that can be called a system; we also have an obsolete set-up for delivering medical care services; and all too often, a crippling scarcity of resources and personnel. We are not prepared to say that the existing law is perfect or that in the future a more logical health-care system and financing mechanism should not be enacted. However, the amendments proposed will not lead us towards this goal.

We believe that the concept of medical care set forth in Title XIX of P.L. 89-97 would be vitiated if H.R. 12080 is enacted. We, therefore, urge that the House amendments, outlined below, not be enacted by the Senate, for the following reasons:

LIMITATION ON FEDERAL PARTICIPATION IN MEDICAL ASSISTANCE (SECTION 220)

This proposal to cut back on federal participation seems to us to be a most regressive step. Federal participation in medical assistance would be limited to families whose income falls below 133⅓ percent of the amount a family with no income or resources would receive in AFDC cash payments or 133⅓ times the State per capita income, whichever is lower. The House Committee report itself notes that "AFDC income limits are, generally speaking, the lowest that are used in the categorical assistance programs."[2] This provision would immediately affect fourteen states, including the largest states in the country: California, Connecticut, Delaware, Illinois, Iowa, Kentucky, Maryland, Michigan, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island and Wisconsin.

In New York State, the Commissioner of Welfare has estimated that we would lose in federal reimbursement—

At least $15 million for the first six months.
$40 million for the second year.
$50 million for the third year.

This only represents one-third of the ultimate effect of the State's conforming to the Federal proposal. If New York State actually changed the Medicaid eligibility requirements so that only those who met the Federal requirements were eligible, we would have program reductions of—

At least $45 million the first six months.
$120 million the second year.
$150 million in the third year.

And hundreds of thousands of families who are now entitled to medical care would no longer be entitled to it.

A clear reflection of the inadequacy of medical services in the pre-Public Law 89-97 days, can be found in the age break-down in almost any hospital today. Patients over 65 are filling an ever larger percentage of the beds. These older people simply were not receiving the hospital and other medical services they needed before passage of Medicare. The same is true for all age groups—though the unmet need varies. Many had hoped that through Medicaid we could begin to provide adequate care for the people who need it.

The cost of medical care is rising much faster than the cost of living. The Senate Finance Committee knows how the cost of medical care is sky-rocketing. To cite but a few examples:

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[1] Public Law 89-97, Section 1902(a)(10)(B)(i).
[2] Page 119.

> During the Period of 1956–66,[3] the Consumer Price Index rose 19 percent; cost of medical care rose 42 percent; cost of medical care services rose 50 percent compared to the rise in costs of all services of 33 percent.
>
> During the Year 1966 the Consumer Price Index rose 3.3 percent; the Medical Care Index increased by 6.6 percent. (The largest annual increase in eighteen years.) But all hospital charges increased[4] 16.5 percent; physicians' fees rose 7.8 percent.

The Journal of the American Hospital Association noted in its August 1st, 1967 issue that present indications are that the increases in hospital costs will accelerate. These increases in medical costs apply to all, not just those for whom the government is paying through Medicare and Medicaid. Thus, it is becoming increasingly difficult for almost all families to afford good medical care.

If this amendment is enacted, the Congress would be saying that payment for needed medical care for those under 65 will not be assisted by the federal government unless children and their families are destitute. We find it impossible to reconcile this proposal with your often expressed concern for children.

The screw is further tightened by the fact that the amendment would limit federal participation to 133⅓ percent of the cash payment level, based on the AFDC standard, rather than the income level of eligibility for public assistance. This would actually eliminate the concept of medical assistance for the medically needy in some States which do not pay the recipient more than 75% of need. In his testimony before the House Ways and Means Committee, Under-Secretary of HEW, Wilbur Cohen, cited several examples. In Indiana, for instance, a family of four is eligible to receive cash assistance if their income is below $271.40 per month. However, the highest cash payment the State will furnish is $103. Thus, if the House amendment is enacted, for purposes of Federal matching, a family of four could receive cash assistance if their income is below $271.40 but medical assistance only if their income is below $137. If this is enacted, these families will be caught in a squeeze between the new below-poverty-level eligibility standards and the sky-rocketing cost of all medical care.

What will happen to self-supporting families who suffer a catastrophic illness or whose children need ongoing medical care? Is the Congress saying that the United States will insist that such people be dragged down to the lowest public assistance payment level before they can have help in obtaining medical care?

MAINTENANCE OF STATE EFFORT (SECTION 221)

Under this amendment, states would be permitted to include in their computation of state effort, expenditures for cash grants only (including expenditures for child welfare services), rather than the combined expenditures for money payment and for medical care as in the 1965 Medicaid law. The House Report states that the 1965 amendment was to assure that "... States did not replace existing State expenditures with Federal dollars made available under that legislation." States were required to continue their financial commitment so that Federal funds would be used for new or expanded services. Under the House proposal, a State need not spend one cent more for medical care and would still be eligible to receive 50% or more Federal reimbursement for whatever services it provides under its Medicaid plan. This, in effect, becomes a replacement of State effort for medical care, rather than any maintenance of State effort.

REQUIRED SERVICES UNDER STATE MEDICAL ASSISTANCE PLAN (SECTION 224)

One of the most forward steps in P.L. 89–97 was the provision in Section 1902(a)(13)(A) which required all states (by July 1, 1967) to provide five basic health services for all people covered under the state program—in-patient hospital care, out-patient hospital services, other laboratory and x-ray services, skilled nursing home services and physician services. In addition, nine less

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[3] U.S. Department of Health, Education and Welfare, A Report to the President on Medical Care Prices, by William Gorham, Assistant Secretary, February 1967.

[4] See Appendix for rate comparisons.

essential services (medical care, or any other type of remedial care furnished by licensed practitioners; home health services; private duty nursing services; clinic services; dental services; physical therapy and related services; prescribed drugs, dentures and prosthetic devices and eye-glasses; other diagnostic, screening, preventive and rehabilitative services; in-patient hospital or nursing home services for those over 65 in institutions for tuberculosis or mental disease) were to be optional until 1975, when all must be provided.

Incidentally, we agree with the Planned Parenthood Association that family planning should be included as a required basic service.

The proposed amendment would allow the States to provide any seven of these fourteen services outlined. Thus a State could, for example, exclude physicians' care or hospital services which are obviously basic to any health program. We are certain that this was not the intent.

MODIFICATION OF COMPARABILITY PROVISIONS (SECTION 223)

Under the existing law a state plan for medical assistance must (1) provide benefits of the same amount, scope and duration for all those covered under the different cash-assistance titles and for all those who are medically needy and, (2) determine eligibility under comparable standards for the two groups—the needy and the medically needy.

The proposed amendment would allow states to include benefits under Part B of Title XVIII for those over 65 without requiring similar benefits for the other public assistance categories of those under 65. This amendment clearly discriminates against mothers and children.

Many states in our country still have the most inadequate medical services for mothers and children, in contrast to the aged. Yet under this amendment, if enacted, the Department of HEW could have to approve a state plan which would provide only minimal services to children and their mothers.

The House Ways and Means Committee Report implies that the Child Health programs of Title III of H.R. 12080 amending Title V of the Social Security Act will take up the slack if Title XIX is cut back. We seriously question this assumption. On page 128, the Report notes that—

"In 1966, the infant mortality rate was reduced by 5 percent as compared with 1965, reaching a new low of 23.4 per 1,000 live births. This was the largest reduction in any year since 1950. Significant reductions are taking place particularly in the Nation's large cities which were experiencing some of the highest rates in the country prior to the development of their maternity and infant care projects."

But on page 129, we find that maternity and infant care projects were in operation in only 27 of the 56 counties in the country with the highest infant mortality rates.

And in New York City in 1966 infant mortality rates (provisional) were:

Infant mortality per 1,000 live births

New York City	24.9
Poverty areas:	
Central Harlem	43.3
Fort Greene	40.2
Bedford-Stuyvesant	38.3
East Harlem	32.9
Mott Haven	32.6
Two lowest infant mortality districts:	
Flushing	18.4
Maspeth-Forest Hills	15.1

Obviously the present medical programs are a tiny drop in a large bucket. Medicaid is our only hope at this time if we are to reach all the people who need good medical care the most.

We therefore earnestly hope that the Senate will reject in their entirety the House Medicaid amendments discussed above.

COMPARISON, NEW YORK STATE REIMBURSEMENT RATES TO HOSPITALS—INPATIENT CARE

County & Hospital	Number of beds[1]	1965 66[2] [3] (premedicare)	1967-68[2] [4]	
			Semiprivate[5]	Ward
Erie County:				
Buffalo Columbus	124	$27.45	$42.12	$41.07
Buffalo General[6]	716 727	37.88	49.64	48.37
Niagra County: Lockport Memorial	174 192	30.54	48.60	....
Chemung County: St. Joseph's	275 244	35.55	47.25	
Monroe County:				
Lakeside Memorial	72	32.42	53.49	....
Park Avenue	119	38.35	62.26	....
Strong Memorial[7]	650 631	52.76	84.59	....
Genesee[6]	288 332	39.29	63.48	....
Clinton County: Physicians' Hospital of Plattsburgh, Champlain Valley unit	140	33.73	52.67	51.35
Essex County: Moses-Ludington	75 59	29.03	41.21	40.18
Albany County: ALB. Medical Center[7]	558 688	43.42	58.60	57.14
Otsego County: Aurilia Osborn Fox Memorial	128	33.10	46.82	45.65
Warren County: Glens Falls	345 372	30.52	47.37	46.19
Washington County: Mary McClellan	76	34.91	47.66	46.47
Dutchess County: Northern Dutchess	70	27.68	42.60	41.54
Nassau County:				
Franklin General	204	39.28	56.60	....
Nassau Hospital Association	316 416	39.96	59.84	58.34
Orange County: Elizabeth A. Horton Memorial	259 256	35.09	46.73	45.56
Putnam County: Putnam Community	60 65	33.37	62.14	....
Suffolk County: Smithtown General	147 210	40.79	54.78	53.41
Sullivan County: Monticello	86	29.13	54.36	53.00
Westchester County:				
Grasslands	503 502	41.39	67.28	65.60
St. Joseph's	165 175	42.73	63.09	....
Yonkers General	144 188	36.97	54.48	53.12
New York City:				
Beekman Downtown	200	39.76	61.36	59.83
Booth Memorial	210 250	44.14	66.37	....
Brooklyn Womens	71	43.79	60.74	....
French	240 238	42.09	70.11	68.36
Lenox Hill	562 559	47.53	82.86	80.79
Long Island College[6]	568	45.60	69.12	67.39
Long Island Jewish[6]	268	51.67	94.82	....
Memorial[6]	273	51.67	96.00	93.60
Montefiore[6]	655 656	51.67	90.19	87.94
Peninsula General	182 193	42.90	62.10	....
Richmond Memorial	160	32.64	48.76	47.54
Presbyterian[7]	1,531 1,542	55.29	78.92	76.95
St. Vincent's[6]	805 795	45.56	78.22	76.26
Municipal—General and Cancer		47.84	85.24	....

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[1] When two figures are given, top figure is 1965 and bottom is 1967.

[2] New York State fiscal year, July 1 to June 30.

[3] In 1965–66, New York State computed an average weighted daily patient rate for each region of the State according to size of hospital, type of hospital (whether university medical school hospital or affiliated with a university medical school); 10 percent above this weighted average for each hospital was the maximum per patient-day rate recognized in each region and classification.

[4] Interim rates.

[5] Under titles XVIII and XIX it is required that patients be given semiprivate accommodations when available.

[6] Affiliated with a university medical school.

[7] Part of a university medical school.

New York State reimbursement to hospitals, out-patient care

Hospitals in New York City only:	*July 1, 1967, to June 30, 1968, outpatient rates per visit, emergency or clinic*
Beekman Downtown	$21.25
Booth Memorial	16.57
Brooklyn Womens	2.06
French	12.90
Lenox Hill	11.80
Long Island College	14.30
Long Island Jewish	20.25
Memorial	12.75
Montefiore	26.20
Municipal Hospitals—General and Cancer	10.97
Peninsula General	13.70
Presbyterian	15.22
St. Vincent's	20.30

Range in reimbursement rates to New York City hospitals is from $2.00 to $29.59 per visit. These rates includes the salaries of interns, residents, full-time medical staff on salary at the hospital.

Attending physicians, not on the full-time staff, who work in clinics will be paid on the basis of a three hour session—$50.00 for specialists and $35.00 for general practitioners. Therefore, the amount for physicians' fees to be added will depend on the type of hospital and the number of full-time staff giving care in the outpatient clinics.

In 1965/66 the City of New York only reimbursed hospitals for welfare recipients at the rate of $7.00 per visit for hospitals meeting specific standards and $5.00 per visit for others.

STATE OF NEW YORK,
DEPARTMENT OF HEALTH,
Albany, August 8, 1967.

Dr. T. NORMAN HURD,
Director of the Budget,
State Capitol, Albany, N.Y.

DEAR DR. HURD: In accordance with the provisions of Section 2807 of the Public Health Law, I am certifying to you that the proposed rate schedules for payments for hospital services for the period July 1, 1967 through June 30, 1968 are reasonably related to the cost of providing such service.

In computing the rates listed in the above schedules, the following elements of cost were taken into consideration:

A. Reimbursement for proper expenditures, including but not limited to salaries, wages, supplies and other expenditures for services incurred for the purpose of maintaining necessary activities and services usually provided and required to be provided.

B. An allowance of 5% of the adjusted gross expense in lieu of depreciation on wholy owned real property.

C. Expenditures for research up to a maximum of 5% of the adjusted gross expense for inpatient services but not to exceed the expenditures made.

D. Expenditures from current income for equipment and major repairs and alterations up to a maximum of 3% of the adjusted gross expense but not to exceed the expenditures made.

E. An allowance for development of 2% of adjusted gross expense to voluntary and public hospitals and 1.5% to proprietary hospitals.

F. An addition of 7% of historical cost for propriety hospitals as an allowance for a return on net equity capital. Where data were not available, an addition of 2% of adjusted gross expense for wholly owned property of 1% of adjusted gross expense for rented property was made.

G. An increase was applied to each hospitals' basic rates to adjust to current costs. This increase is equal to 1½ times the lesser of the following: (1) the percent rate of change of each hospital computed by using a three year moving average or (2) 15% above the average percent of change for the area and capacity grouping for inpatient rates, and 20% for outpatient rates.

Sincerely yours,

HOLLIS S. INGRAM, M.D.
Commissioner of Health.

The rates established above are hereby approved.

JOHN J. GORRIGAN,
Acting Director of the Budget.

Senator CURTIS. Mrs. Wayne Coy.

Mrs. Coy, the Senate has been in session some little time now. I want you to know, however, that the absence of committee members does not mean that your statement will go unheeded. Among other things, our staff does a very good job of summarizing and cataloging the testimony so that when we go into executive session and we consider a particular point or policy decision we have before us a summary of what various groups have proposed, so you may proceed.

STATEMENT OF MRS. WAYNE COY, ON BEHALF OF THE FAMILY SERVICE ASSOCIATION OF AMERICA, NEW YORK, N.Y.

Mrs. COY. I know that, Mr. Chairman. I have been in on a great many hearings and I know that the Senate is a busy body, and I can understand that there are many things that demand your attention.

I do appreciate being asked back. I am here as the vice president of the Family Service Association of America. Some of the things in my testimony have a direct bearing on some of the questions you were asking the past witness, so if you will bear with me I would like to sketch our testimony.

Senator CURTIS. All right.

Mrs. COY. I am here representing the board and the professional staff on title II of 12080. Family Service Association of America is a federation of 336 local family service agencies throughout the country, largely supported by local Community Chests and United Funds. The major purpose of the national federation and its accredited member agencies is to prevent family breakdown and achieve family development. Our experience in counseling and assisting, each year, nearly 2 million people from all walks of life, torn by family problems, qualifies us to speak about public policies which we think have destructive impact on social conditions affecting family life.

Added to our long years of experience in this field has been recent experience in cooperation with the war on poverty. In the past 2 years we have worked with many thousands of families in parent education, neighborhood centers, counseling, and other programs designed to help people help themselves out of poverty. We know more clearly than ever that people who struggle for existence, combating hostile forces in the environment on a daily basis, have many strengths, including the ability to learn and to change, and are motivated to provide a better life for their children. Given the tools of education, health, decent housing, usable helping resources, and, most important of all, a feeling of hope, self-worth, and the reliable concern of the community, most families can and do produce adequately functioning members of our society. We are convinced that this strength of the people themselves must be enhanced by all necessary policies and programs, for it provides a potential resource of great value to this country.

In our opinion title II of H.R. 12080 constitutes a most serious threat to strong family life.

The family, more than any other human institution, shapes the personality and character of each individual. It is the source of human love and caring and it is necessary for psychological, social, and emotional maturing. People whose needs are thus met will in all likelihood develop a feeling of usefulness and self-regard and of "belonging," and will be far along the way toward becoming responsible and responsive participants in the solutions of our Nation's complex problems.

Public policy and voluntary effort must be directed to providing conditions in which all families of this Nation have the opportunity to function in this basic fashion. Punitive, repressive, or coercive measures directed toward those families already handicapped by illness, unemployment, broken marriage, inadequate education, or minority status, have always failed in the past and will always, most certainly increase the sense of alienation, worthlessness, and hopelessness which at best perpetuate dependency and at worst result in violence.

Provisions in title II of H.R. 12080 will have the effect of creating more and worse poverty by reducing the number of children eligible for assistance in their own families, by discriminating especially against those children who are dependent on the care of only one parent, and by reducing the amount of Federal money available to share in the support of all dependent children. Meanwhile, the number of children needing assistance will not decrease nor will the amount of money necessary to any family to maintain a minimum standard of living.

The arbitary limitation of Federal matching funds to a maximum AFDC caseload equivalent to the January 1967 ratio of children involved to the total State child population ignores these two facts and withdraws Federal responsibility in a situation beyond the ability to cope of the State or local units where need will be greatest.

With reference to the work-training program authorized in this bill, FSAA holds that such programs are productive only if they increase skills and employability—in occupations where jobs are available—at a living wage. Participation should be encouraged, must be encouraged, but not forced.

Forced labor, especially at anything less than a living wage, is a treadmill leading nowhere, certainly not to self-sufficiency and self-respect. Moreover, forced work for mothers will result in young children being neglected or cared for outside their own families. Most children need a mother's presence and her love. Mothers must have the right of choice as to if and when it is appropriate and desirable for them to work outside the home, giving the care of their children to others. The fact that a mother is unmarried or has been deserted by her husband does not lessen her importance to her children but rather makes her basic function more vital to their well-being, and more difficult. Such mothers and their children need society's help to develop a strong family. All our experience indicates that threats, undeserved punishment, deprivation of rights and resources, curtailment of funds, create only fear, bitterness, and apathy. Individuals burdened with these emotions do not make good workers, are not readily trained in new skills, and most certainly are not able to impart to their children the values and attitudes essential to mental health and productive living.

To eliminate—as does H.R. 12080—the requirement of a minimum wage for people forced to work actually creates a slave labor market, substandard and degrading. All of these results must be abhorrent to all people truly concerned with human dignity and well-being. Breaking the cycle of dependency and crime, as the bill sets out to do, requires, in its application to families in need, the provision of positive measures for full opportunity rather than withdrawal of opportunities through repressive measures.

A youth driven back to school to escape forced labor does not go willingly nor with increased motivation to learn, but rather with rebellion in his heart. Please do not do that to him nor to those of us working patiently to make him want to go and to give him the hope of better opportunity if he does.

Fundamental to all other necessary condtions favorable to the attainment of satisfying and effective family life is the means for maintaining a decent standard of living. Family Service Association of America appeals to the conscience, the sense of justice, and the wisdom of the Senate of the United States to enact legislation which will provide a guarantee against poverty and social deprivation for all people—not just a few, not just those who meet restrictive requirements, not just those who adhere to a prescribed socially acceptable pattern of behavior.

Family Service Association of America therefore strongly urges the Senate to reconsider H.R. 5710 in place of H.R. 12080. H.R. 5710 is free of moral judgments and repressive measures. It should be strengthened in the following ways:

(1) The requirement that adequate assistance levels be reestablished. States should pay the full budgetary need and the Federal Government should be authorized to establish minimum budgetary requirements.

(2) Mandatory inclusion of assistance for needy children of unemployed fathers without requiring their absence from the home.

(3) No new restrictions on eligibility for medical assistance, at least until there has been time to gain better knowledge of need through experience.

(4) Increased authorization for social services, including day care, counseling, homemakers, and family planning.

In the interest of strengthening family life and preventing family breakdown, which is the core of the Family Service movement, we hope that you will make the necessary changes in this legislation.

I have one other thing, two other things, that I would like to emphasize personally, Senator. I have for 25 years been working as a lay person in the social welfare field, and I have worked in every phase of it—education, children, family problems, youth, health, equal opportunity. I am presently on the District's Council on Human Relations as well as chairman of the Public Welfare Advisory Council. and I speak therefore, I hope, with knowledge of both people and problems. I must say that the combination of restrictive regulations in title II of 12080 will be abhorrent not only to AFDC mothers but also to those of us who have worked long, patiently, and constructively toward building strength in the families and hope in the children. Give all of our welfare departments a chance to set up a work training opportunity program, and I hope it is in welfare departments. We have a range of service that we can provide that I think we can utilize other departments within the cities or within the States, and I think this is a very proper place for it to be. But give our welfare departments a chance to set up these programs where participation is voluntary and the aim is self-sufficiency, dignity, and a living wage. This is helping people to stay helped.

As of September 15 in the District of Columbia, after less than 2 years of operation, the Welfare Department has placed in training-related jobs not only at a living wage but likewise with chance of advancement 744 heads of households involving about 2,600 children. They were in training an average of 9 months and started work at an average wage of $75 a week; 864 are still in training. This has been done under title V of the Economic Opportunity Act and with the complete cooperation of the Departments of Health, Education, and Welfare and Labor in the District of Columbia.

Senator CURTIS. It has been done under which act?

Mrs. COY. Title V.

Senator CURTIS. Of what.

Mrs. COY. Economic Opportunity Act. This sort of program needs to be made permanent, and I will tell you why. If these 744 heads of families, from hard-core families, had not been trained, and had not gone on to jobs at a living wage, they presumably would have stayed on public assistance. The average stay on public assistance is, incidentally, not a lifetime; it is three and a half years. They would, therefore, have gotten——

Senator CURTIS. That is the average.

Mrs. COY. That is the average stay.

Senator CURTIS. You arrived at that average by reason of the fact there are a few people who meet misfortune and are on a matter of months and then go off.

Mrs. COY. That is true.

Senator CURTIS. The number that are on, if not for a full lifetime, for a substantial number of years, is still sizable, is it not?

Mrs. COY. No, I would not say it was sizable. Of course, in other categories than AFDC, aid to the aged, the blind, and the disabled, many are on for the rest of their lives. Our AFDC mothers average 3½ years and not many are on for a lifetime, they are much more apt——

Senator CURTIS. AFDC, I can understand that. What causes them to go off is the age of the children.

Mrs. COY. No, they go off for various reasons; they go off when they can. Many of them want a job, they want to be self-supporting; this is the thing I think that is overlooked too often.

Senator CURTIS. No, no; I do not think it is overlooked. I think the thing that is concerning the Congress is that people in the administrative agencies of the Government, the so-called professional welfare workers, have never come in with anything, any direct proposal that I know of to deal with that segment, and I do not know how large it is, who are riding along on various welfare and could do better if they wanted to.

Mrs. Coy. I do not think that core will always be there, Senator.

Senator Curtis. Yes, but I think something ought to be done about it.

Mrs. Coy. Well, we started out a long time ago with the Ten Commandments, and we still find that people do not abide by them. There is always a core of people who cannot be reached. The thing that we strive to do in welfare, the thing we strive to do in Family Service Associations, is to get just as far into that group as we can. I do not think everybody will ever think we will have a 100-percent efficient program.

Senator Curtis. Well, I will state it another way. I think there is a segment of recipients who are being harmed by receiving help.

Mrs. Coy. What would you do otherwise?

Senator Curtis. That is I am wondering——

Mrs. Coy. I should not ask you questions.

Senator Curtis (continuing). Why this entire group of people who have spent their lifetime in social work have not come up with something to deal with that. I am disturbed about that segment, and I do not know how large it is, that would rather be provided for than to provide for themselves.

Mrs. Coy. How large is that? I have no real confidence that this is a sizable segment of them. I think this would have to be proven before I accept it. Too much evidence is on the other side. I think this hardcore of unreachables is estimated out of proportion to its actuality. We find that we can help people. We have had people through the poverty program within the city go into Neighborhood Services that never held a job before, and probably had been on AFDC.

They were very, very happy to go into a kind of neighborhood activity that gave them something constructive to do. We find very few people that resist any desire to help. There are people who are unemployable and will continue to be unemployable for psychological or social reasons.

Senator Curtis. I do not know why any particular segment of our population should be protected from all forms of compulsion. Now people have to pay the bill, they are compelled to. Paying taxes is not voluntary.

Mrs. Coy. Well, I am protected from compulsion.

Senator Curtis. Not from the payment of your taxes.

Mrs. Coy. No, but in lots of ways.

Senator Curtis. What I mean, the flat position that under no circumstances should there be any compulsion with reference to getting someone to do for themselves I think is quite unreasonable. I do not want to speak harshly of the people who are victims of an unfortunate situation and they ought to receive welfare payments. But paper after paper have come in here rejecting in total any compulsion for people to do for themselves. You might be right, but it seems rather strange to me.

Mrs. Coy. I reject compulsion. I think it is unconstitutional for one thing, and I think we should no more impose on people who are in the poverty level and must have welfare assistance, a different set of rules——

Senator Curtis. Do you reject compulsory attendance at school?

Mrs. Coy. This is general across the board. No place in our economy do we tell everybody, including me, that you have to go to work. Compulsion that is across the board and not against a single class or economic group is——

Senator CURTIS. Well, there is a way of forcing most people.

Mrs. COY. This would not be across the board.

Senator CURTIS. I believe the average citizen is compelled to do a lot of things, including he is compelled to pay taxes, he is compelled to go to school. Many of them probably supporting their families because they lived in States where they were compelled to do so.

Mrs. COY. Well, if we want to compel the AFDC mothers to go to work, then we should compel all the mothers to go to work.

Senator CURTIS. I am not particularly defending it.

Mrs. COY. I hope not.

Senator CURTIS. In some instances perhaps, but I do believe that the professional welfare workers are wrong in rejecting any compulsion because there are people in the world that do things that they have to and do not do anything they don't have to.

Mrs. COY. If you could put these women—if you want to force them to work, and you put them to work at a job that has some dignity and at least a living wage, they would be willing to cooperate and would like to work. If you are saying they must work, and the worker puts them on the block and says "Yes, I think you can work so you are going to work," the determination is not being made by the person but by the worker. When you put them to work at something that is menial and pays them not a minimum wage, this is a type of compulsion that is not fair and will not be conducive to any good. You are not going to rescue that mother from dependency in that way.

Senator CURTIS. Well, I do not quite agree with you. I think if there is an unfit mother who is spending her allowance in the taverns and so on, neglecting her children and still drawing welfare——

Mrs. COY. Who is this?

Senator CURTIS. Any mother who is doing that.

Mrs. COY. I do not know one. I just thought maybe you knew one.

Senator CURTIS. I know a few. I still do not want to condemn them as a group. There are still some of those. I think for that person to do any useful work upgrades her and certainly upgrades her children.

Mrs. COY. How does it upgrade the children? I feel unhappy about that.

Senator CURTIS. I feel it is better for any child to know his parent is somewhere performing some useful work rather than sitting on a bar stool. I believe it is, maybe it is heresy, I do not know.

Mrs. COY. I think it works——

Senator CURTIS. I think you are wrong in saying that these people cannot be put to work unless it meets certain standards. People ought to be glad to do any useful work rather than be dependent on somebody else.

Mrs. COY. They would still be dependent on somebody else. If the work they are doing is not paying a living wage, and in addition they will still be away from their family.

Senator CURTIS. Only they would depend on other people to a lesser degree is all. And it probably would give them sufficient training, if they performed one job worthwhile, that they could move up to a better job that did pay them more.

Mrs. Coy. This is a fine kind of job training, this is what I want you to give us a chance to do. We have a waiting list, Mr. Curtis, of people who want on our job, our WTOC, our training opportunity center.

Senator Curtis. Yes. But all worthwhile job training, is it not?

Mrs. Coy. No; not all work is "training."

Senator Curtis. It is not?

Mrs. Coy. No; it is not.

Senator Curtis. You mean to say if somebody performs a necessary worthwhile work that he can earn something by—I think that anybody who performs a worthwhile job, that that is one step in the process of preparing him for another job.

Mrs. Coy. I think a worthwhile job is likewise staying home and taking care of our children and a lot of our AFDC mothers do this. This is a job, too.

Senator Curtis. I have not mentioned that. I have serious questions in my mind on how that matter should be determined as to what mothers should stay home. I am not referring to that. I am not singling those people out, the mothers of small children.

I know that Congresswoman Griffiths said in her statement:

> There is nothing in the bill that will permit or require a child to starve because of the foolishness of his parents. All children will be provided for. But let me put the official proposition in its true light. What he is really saying is that America should offer each person a choice, "Either work or if you don't like that, don't work. The rest of us will provide for you." If every person chose not to work, we could all starve together. It is a form of togetherness that I oppose.

Mrs. Coy. I would not like that either.

Senator Curtis. Well, I think that the people who have spent a lifetime in welfare work should come up with a solution. Clear across the board of our economy most people are subject to compulsion: some of them are compelled to go to Vietnam. They are all compelled to pay taxes. They are all compelled to mow their weeds and remove their garbage.

Mrs. Coy. Nobody tells you when you have to do that.

Senator Curtis. Well, it does not make any difference.

Mrs. Coy. Well, you do that out of a sense of responsibility.

Senator Curtis. This idea that nobody should be compelled to do anything is betraying the people involved.

Mrs. Coy. May I speak to that, please?

Senator Curtis. Yes.

Mrs. Coy. I think there is a much better way than compelling. I think to work with them and get their cooperation and to get their interest in doing something progressive is much better. I think that is exactly what we are trying to do in many of the poverty programs and likewise in our departmental program here. We are trying to get the mother that can work and would like to work and give her the training that she can go out and get a job in which there was some future. We do not see any reason in putting her out to work at $2 or $3 a day which can be done under this bill, when she has to—there would be much more money spent in taking care of her children than there would be money she would earn. This is not work that has any dignity, future, or answer to her problem.

The thing we have done in our work-training program is to have a waiting list of people who want to do it and this is wonderful. The one sure way to dry up that source of cooperation and of feeling of participation is to start to say, "You have to," start to put the compulsion in it, and you will get a reaction. This is a fact of human nature.

I think that if we can be given a chance to work in a caseload of 60 or less with people, AFDC mothers who—many of whom maybe could never work, many of whom have small children and should stay home with their children, many of whom want very badly to work and have a good enough education that they could go on and be trained for something in which there is a future, let us do it on a selected basis.

We have no more desire to encourage women to stay on AFDC rolls until their children are grown, we have no more desire to do that than you do. What we want more than anything is to have a kind of progressive program that gives them some reason to step up and out, and to help them really to stay out, stay helped.

Senator CURTIS. What age would you say should be the borderline for mothers who should not attempt to leave the home to go to work?

Mrs. COY. The age of the children?

Senator CURTIS. Yes.

Mrs. COY. I think that would vary totally with the degree of the problems that she might be having with children.

I know of one AFDC mother who had an asthmatic child and this mother could never really leave that child in anybody else's home nor in any day care facility of any sort because there were problems within the child. If the children are very young and very closely spaced, the mother should stay home, and as for setting an age limit, I think this is the kind of thing that you would have to treat each case separately to find out just exactly what would make sense.

When children are in junior high school and can look after themselves after school, so long as there is someone to check on them, there certainly is no particular reason why a mother has to stay home when the youngest is age 12 or 13. However, if that child is a girl and has ideas, as young girls do, it is probably better that the mother stay right home. If she has any job at all, she should be at home when the child gets home from school, but it varies. I do not think you can put an absolute age.

Senator CURTIS. The staff calls my attention to a provision in the House bill which—12080, section 204, paragraph (E):

> Payments for such work are at rates not less than the minimum rate (if any) provided by or under applicable Federal or State law for the same type of work and not less than the rates prevailing for similar work in the community (except that in the case of work by individuals who under such law are considered learners or handicapped persons, payments may be at special minimum rates established for them or under such law).

Mrs. COY. Would you call these people untrained? Would you put them in a special class?

Senator CURTIS. No. What this really does is just conform to existing law. It says the State and Federal minimum wage laws should prevail.

Mrs. COY. If they are trained and if they are working in classified jobs.

Senator CURTIS. No. The Federal law exempts learning positions, it exempts work for good will and for the handicapped and so on. In other words, it applies the same rules.

Mrs. Coy. Unless you are in a learning position.

Senator Curtis. Well, that is the situation now.

Mrs. Coy. But these people would be apparently in a learning position because they would be doing jobs that cannot go into the labor market and take the place of other labor.

Senator Curtis. I do not think that is what it means. I think that is——

Mrs. Coy. I am glad to know that.

Senator Curtis. I think H.R. 12080 definitely says the work shall be paid the minimum wage.

Mrs. Coy. Do you think we could take all of our AFDC mothers off of assistance as of today and put them in jobs at the minimum wage?

Senator Curtis. Some of them would not——

Mrs. Coy. Could we? I do not think we could.

Senator Curtis. I think that the biggest problem we are confronted with is not resistance to paying people who are the victims of misfortune. I think we are confronted with a problem of people who are not doing the best they could.

I heard last week of a mother who in spite of her arthritis is very proficient at sewing and she is keeping busy, she has built up a business of her own of making jockey shirts. She gets $20 a shirt because they all have to be in different colors and they are handmade.

I think the time has arrived when we have to do something about the people who have no desire to do things for themselves.

My attention is also called to the fact that H.R. 5710, which you support——

Mrs. Coy. The association supports.

Senator Curtis. Yes—has a provision that the States should take off the rolls a mother who refuses work or training if she is determined to be in a position which she could.

Mrs. Coy. I am against that in 5710.

Senator Curtis. That is in 5710.

Mrs. Coy. I am against that also.

Senator Curtis. That is all, unless you have something else to say.

Mrs. Coy. The one thing I would like to say is that I think that this would be declared unconstitutional, this forcing mothers to work. I think that. But I do know that what it would do to people, and I think it would dry up the source of trust and participation and I think it would create hate and fear for everybody, and all the people will recognize that it is a regressive step that is taking us back more than a hundred years in social welfare.

Senator Curtis. You might be interested to know that during the Labor Day recess I visited a hippie village. They did not know who I was.

Mrs. Coy. I do not approve of that, Senator.

Senator Curtis. They did not know who I was, but it was made up of college graduates who contended they had a constitutional right to be poor and a constitutional right not to work. They made that contention because food stamps were shut off to them. The head of it has a master's degree. The other people there were college graduates. They formed this colony and they make the same contention that they had a constitutional right to be poor.

Well, I do not think that those people that I referred to are right. They have a choice, they can go to work or not, but the people who pay for it have some rights too.

Mrs. Coy. If they do not have children, they are not our problem.

Senator Curtis. No, but they are making the same contention that you do.

Mrs. Coy. They are young people.

Senator Curtis. That the people have a constitutional right to resist being compelled to do for themselves if they care to.

Mrs. Coy. Are you going to put them in jail? This is what bothers me.

Senator Curtis. No, there is nothing in the House bill to jail them.

Mrs. Coy. No.

Senator Curtis. Well, we thank you.

Mrs. Coy. Thank you.

Senator Curtis. The committee will adjourn subject to the call of the Chair.

(The Chairman subsequently said:

Lest someone gain the impression that the demonstration staged in this hearing room a few days ago reflects any consensus that welfare mothers who are able to work should be permitted instead to remain idle and continue to draw welfare benefits, let me insert at this point, a number of letters I have received decrying the events which occurred here and supporting the proposition that those who are able to work should work.)

Dear Senator Long: Hurray for you and your stand on this Welfare Program. Even here in Fla. they are the same type of free-loaders and all claim I'm set for life and having a Ball. They can be made to work. They belong to a group of. I.W.W. which stands for "I won't work, I want welfare." It is about time some of you Senators took the stand and told them off. They get $75 a month plus rent gas, electric, free welfare pays. But how many senior citizens on Social Security must get along on a lot less and pay for everything. These recipients don't pay into Medicare and get the best service. I with my S.S. check of $78 must pay all and $3 for Medicare. If you ask me they surely have a Ball and they will fuss and scream if they are told to work. Lots of them have imaginary ailments and keep Drs. and Hospitals busy trying to find out what ails them.

While they can get all this we senior citizens must wait, wait for the increase that was promised us last January. It was supposed to be 20%, even the lousy 12½% can't be brought to a vote. Shame on you Senators who refuse us but come election we'll get more foolish promises. Thank God I've a little for a rainy day: God help me if I had to wait for the increase.

With best wishes and hope you can push the increase for us on Social Security.

Sincerely,

——— ———.

September 22, 1967.

Hon. Russell B. Long,
Senate Office Building,
Washington, D.C.

My Dear Senator: I am delighted that you spoke out so forcibly against these demonstrations which interfere with the orderly process of business. I know you will agree that freedom in America today has been run to the ground. If more Congressmen and public officials would resist this pressure as you have done, we would all be better off.

Thanking you for having the interests of America at heart.

Sincerely,

——— ———.

September 20, 1967.

Senator Long.

Sir: Just a note to say how much I agree with your remarks about welfare sit-ins as quoted by Tom Wicker.

If welfare recipients can afford to go to Washington for a convention—they sure do not need to be on welfare.

——— ———.

September 19, 1967.

Dear Mr. Long: I hope you, among others, can do something about the abuse of welfare recipients!

I know of a woman, getting "Aid to Needy Children"—and not herself employed—taking a 3 weeks' vacation to Hawaii!

I too, was in Hawaii—enroute to Vietnam in the Merchant Marine (S/S African Lake) (MSTS). The woman in case above is 24 years old. I am 51.

——— ———.

Dear Mr. Long: I was just reading about you and Mr. Harris listening to the mothers demanding more welfare. I became so angry I just had to write.

My husband is a brick contractor who has worked hard all his life—he didn't run to the welfare department for help, and he's still working hard. Why? Because he can't find enough men who are willing to work hard, and they are very well paid. They show up on the job whenever they feel like it. It's so much easier to stay at home and let the welfare take care of them.

I say what they need is not more welfare but less! Maybe then, they would go out and work for a living. They say they can't get jobs—there are plenty of jobs for them, they are just too darn lazy to work. Many contractors are moving because they can't get enough laborers, so where are they?

How about these young girls who have so many illegitimate children?

If they had to pay for their keep, maybe they would think twice before getting pregnant.

I think they are just plain spoiled. If you ask me, I think they have a lot of nerve demanding more welfare. Let them go out and work like everyone else.

Everyone I talk to feels the same way, believe me.

——— ———.

Senator Russell Long,
Chairman, Senate Finance Committee,
Washington, D.C.

Dear Senator Long: I cannot urge you too strongly to retain the public and child welfare provisions in the Social Security Amendments of H.R. 12080! I, and several of my colleagues daily see the results of overburdened, harrassed AFDC mothers—inadequate women who are raising inadequate children to further swell the public welfare rolls.

Government spending is past the point of being ludicrous; it is appalling and frightening. If our congressmen can't hold down the ever increasing burden, to whom can we turn?

Sincerely yours,

——— ———.

September 21, 1967.

Dear Senator Long: The working New Yorkers are growing bitter at the welfare situation which is getting way out of hand. That these career welfare clients had the unmitigated gall to travel to Washington using relief money that is supposed to be used for food, etc., and then claim that they were using their *own* money for this purpose is beyond belief. If this doesn't convince the authorities that they are getting too much, nothing will.

I am a working woman and can't afford a trip to Washington, but taxes are withheld from my salary—much of it going for this and other welfare handouts to many loafers, demanding undesirables, and just plain trash. The trash being those who have illegitimate children every year by different men.

And to think that they are now organized is the last straw! Such organization means one thing—more and greater demands.

It's time to call a halt—it's already out of hand. As the newspaper account of the $800. will show, individuals who can't manage their own finances are being given these large lump sums. As of now they only have to sign a paper that they need relief to get it. I have to work hard for 8 weeks to earn $800., *before* tax withholding.

My own representative is getting a similar letter, but since you are in a good position to try to alleviate this deplorable situation, I am writing this to you to strengthen the opposition to the continued handouts.

Believe me, everyone I know feels as strongly as I do.

With the sincere hope that this and other protest mail will help stop this abuse of taxpayers' money.

Respectfully yours,

——— ———.

SEPTEMBER 20, 1967.

Senator RUSSELL LONG.

DEAR SENATOR: Moments ago I heard your excellent comments on TV, regarding those arrogant welfare people there in Washington.

You were speaking my thoughts, Senator Long, 100%.

Could be home baking as I was happy I could, in depression years, and canning and mending and laundering for a well to do family.

I hope you shout these thoughts in Congress and over the air as often and earnest as possible.

Too many lazy ones giving those of us who have struggled to get a home and raise a family, a hard time keeping up with taxation and these loafers get a good share.

So I wish to be one of your many listeners to say you were great, speaking up for us and the cause of America.

Don't be run over by these ignorant shiftless bluffers.

——— ———.

DEAR SIRS: Here is my answer to this article as a mother who once was on relief and had to raise a family through thick and thin. When a person brings a child into the world, that person *alone* is responsible to bring up that child and for its welfare! The only exception is if the parent his or herself, is a minor under 21 years of age, then they should reside with or near the grandparents for mutual help until they get on their feet economically and mentally or mature. Welfare agencies split or separate families according to status and do not consider age. I know, because this exists in Cleveland. They destroy family ties and the cooperation and great help that is so needed in young families or minor children. I do not condone welfare, it has its place when circumstance makes it necessary. But I do feel that recipients should first be told that welfare personnel are not responsible for bringing their children into the world, only they as parents are responsible. Ask them if they will work and support and care for some one else's children. You will hear an uproar and clamor!

Work and dignity should be returned to welfare; by parents having to work to support themselves and their families in some meaningful way whether they receive full support or partial welfare. This should cover fatherless children, where the mothers are unwed and have many children. I've seen 19 year old young mothers on relief and weighed over 200 pounds. They are young enough to work and if healthy enough to give birth should work for their "keep." After all people 30 to 40 years older must live on $25 a week strike pay and this money had to be earned first to be put into a strike fund. Many social security checks are not much larger with this weekly average. What shocks me is, after being on relief before myself, is that how many relief recipients have lovely clothes, color television, fine jewelry that I *still* don't have myself today yet. But their homes show filth and neglect, rats and vermin, as if they are never home. These people should get welfare *and work;* together plus a good dose of housekeeping training. Ask them if they will care for and support *your* families.

Families of children who reach 16 and drop out of school; put them *immediately to work*, else you will spawn a new generation of "leaners", and you'll have a vicious circle. It feels good to be proud and independent and not have to answer to anyone, I am my own master. Earnings are only $4000 a year, yet part of it goes for taxes and part of that goes for welfare.

So naturally I have a strong feeling for even my little share, to be just handed over to some one else after I work so very hard for it. I have to live on what's left; rent, utilities and food. I must buy the cheapest cuts of meat, produce in season, make my own clothes or haunt the used clothing stores, etc. I thank my experience on welfare for being able to make out now. It was nice to be able to hand a card out and receive something in return like groceries, a ham, or clothing but it was like getting a gift every day and I was getting to the point where I was beginning to think, this beats working for things. But when we were given a card stating we are well and healthy and assigned a job, it was over. Failure to show up for work or not working on the job, cut many off from relief automatically! I still consider myself lucky. My parents came here from Europe with only the clothes on their backs and nothing else but raised us up well and healthy but not rich. I have only 3 rooms but won't change with anyone. I am well and healthy, have a little job and have my own dignity and self respect. You can't buy that.

Yours truly,

P.S.—I don't begrudge help to blind, helpless and aged or little children, only well persons over 16.

SEPTEMBER 24, 1967.

Sen. RUSSELL LONG,
Washington, D.C.

DEAR SENATOR LONG: Bravo! If only Massachusetts could produce a man of your calibre. Do act on this bill!

The enclosed "blurb" has incensed me as nothing I have read in recent years. Your quote in the fourth paragraph expressed my sentiments so clearly that I just had to write to you. Obviously, you are fed up with the doles to lazy individuals just as I am. When our state governor set forth a new increased welfare plan recently, it almost sickened me.

Why should I see my husband rise early each morning, work and return exhausted, and know that much of what he has earned will go to those who *no nothing?*

Please, *please* continue to speak for those of us who feel that this country is the result of those who stood on their own feet. What are we going to become if our citizens expect the government to subsidize indolence?

If there is any way in which I can support your efforts and your thinking, please let me know.

Sincerely,

CHAIRMAN,
Senate Finance Committee,
Washington, D.C.

DEAR SIR: There have been many famous "mass-mania" in history, but nothing like the present attempt to secure "government by mob demonstration." It seems if anyone wants something and thinks he has a "right" to it, he gets before a committee in Washington and behaves like a schizophrenic (refusal to face the facts and accept them) and behaves emotionally, self-righteously, with a little hysteria and screaming thrown in.

I have in mind the poverty and welfare clients who think the depression of 1929–1932 is still going on and want the govt. to support them indefinitely. You people should have ended or "phased out" all welfare, relief and public housing during the prosperous war years 1940–45. By 1946 it should have been ended absolutely, without regards to political vote-buying schemes.

For every hysterical wretch who makes threats etc, before you, there are a million who think otherwise. Why must you listen to every crackpot when they represent tiny microscopic groups of no real political significance? Don't the rest of us have anything to say? Ignore them and get on with the job of running this country!

I'm very shocked by the very notion of "poverty rights" and welfare "rights". They don't exist! It has been said the only rights we have are those that don't cost the taxpayers anything:—freedom of speech, press, religion, etc. What they want is BENEFITS as Barry Goldwater called them. Benefits are NOT rights!

Taxes are now unbearable! We can't go on like this any longer. Abolish all give-aways and let us keep our hard-earned money so we can live like Americans should.

When you decide to resist one of these absurd groups, don't "chicken out" or you'll only make *yourselves* look absurd as in the case of the rat-control amendment to some law recently passed.

Thank you.

Respectfully yours,

———— ————.

SEPTEMBER 20, 1967.

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

DEAR SENATOR LONG: In regards to the article in the article in the *Washington Post* of September 20, 1967, on the welfare mothers' "wait-in," on the Senate Finance Committee, I write to you.

In listening to this group's pleas, I ask you to remember us, the mothers who would not think of asking for a handout for ourselves or our children. I am a mother who obtained a part-time job to help out our family income. Why can't these mothers do the same if they are in financial need? I have a husband who brings home a paycheck, but if I didn't I would get a full-time job to support my child. Why don't the nonmarried mothers work? I do not think it fair for them to be given part of my tax money to keep them at home. And if they really care about their children, they shouldn't even think about "putting them out on the streets," as one mother was quoted in the newspaper.

I read that the president of the welfare mother's organization, Mrs. Tillman, is from the Watts area. It costs $200 to fly from California to Washington. Why isn't she putting this amount, or whatever amount it cost her to come here, to better use? To feed her supposedly starving children, for instance. And who is caring for these mother-deprived children while Mother conducts "stand-ins." If these mothers are so great at organization and so effective as to get a Senate Finance Committee hearing, I suggest that they put their talent to work by organizing baby-sitting pools so that Mother can go to work occasionally.

How about giving these mothers with so much time to spare a five-minute talk on pride, self-help, dignity, and the ability of a child to hold up his head in the knowledge that someone who cares has worked and put out an effort so that he may live without depending on the general public?

Let's leave welfare payments to the elderly, the sick, and to those few mothers who are in need of help just until the first paycheck arrives. Let's not give away working mothers' hard-earned money to those who insist on staying home.

I work to help support my child. Why don't they?

Sincerely,

———— ————.

SEPTEMBER 21, 1967.

Hon. RUSSELL B. LONG,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: I understand from newspaper reports that the Finance Committee is now considering the Omnibus Social Security Bill. I would like to urge you to withstand the enormous pressures being brought to bear by the welfare groups, and to vote in favor of what I believe is known as Title II thereof, *i.e.* the new system for requiring states to overhaul and tighten up on welfare programs. An affirmative vote, in my opinion, would represent a long overdue decision to use common sense and constructive firmness in dealing with low income citizens.

Sincerely yours,

——— ———.

SEPTEMBER 20, 1967.

Senator RUSSELL LONG,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: Bully for you! The Congress has suffered long enough under pressure from groups who seem to think that working tax payers are doing their part to support the Federal Government just to have that government provide a bed of roses for them.

I work and have provided for the care of my two children ever since they were born and it burns me up to have women who get pregnant year after year just to have their welfare checks raised, refuse to even attempt to provide support for themselves and their illegitimate off spring.

I am not opposed to aid to dependent children where it is absolutely necessary, but I do think that some restraints should be provided and that healthy and capable people should be working instead staying home while I and countless others work to support them,

Sincerely yours,

——— ———.

SEPTEMBER 21, 1967.

Hon. RUSSELL B. LONG,
Senator, State of Louisiana,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: I want to commend you on your stand regarding the "restrictive welfare measure". I believe in helping those in need, but I resent the attitude put forth by the women at your committee meeting recently. Where do these women, supposedly so destitute, get the money to travel here in such numbers, to buy lunches away from home and all the other incidental expenses that go with traveling? Many of us who are bearing the financial burden of this country cannot afford any of these things. Perhaps this is beside the point, but the majority of the people are willing to work hard to support their families, and if they can't manage that they limit the size of their family, at least get by on what they have. I would never deny any worthy human help of any kind, but this situation appears to me to have been spawned and kept alive by this man George A. Wiley. It must be profitable to him.

I sincerely hope you will hold fast to your convictions—someone, sometime must take a stand against such demonstrations, the demands for something for nothing—and more and more for nothing! Our nation is being undermined by such attitudes, because as I'm sure you know, they are passed on from generation to generation. It takes courage to do what you are doing, thank you for doing it.

Sincerely,

——— ———.

SEPTEMBER 29, 1967.

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

DEAR SENATOR LONG: The Rocky Mtn News carried an article (Sept. 20, 1967) on the protests made against the new A.F.D.C. regulations.

This is to let you know that your good efforts, to control the abuse of welfare benefits, is greatly appreciated.

Just keep up the good work.

Thanks very much.

——— ———.

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

DEAR SENATOR LONG: I was outraged by the conduct of the people who appeared before your Committee on September 19. How dare they be permitted to act in this manner before a Senate Committee? What kind of rot is getting into this country when these people continue to receive welfare aid and refuse attempts to find them jobs? They were all fatties—so they must be getting enough to eat. The riots in our cities are caused by these lazy loafers with too much time on their hands. I hope the Congress will take positive action against those who abuse our welfare roles.

There is no need to reply to this letter.

Sincerely,

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

DEAR SENATOR LONG: Although there is a group that is noisily interfering with and obstructing the work of your committee, asking not what they can do for their country, but what their country can do for them; there are millions of self-respecting Americans who do not stage sit-ins nor would think of holding picnics in the Senate Office Building, who should be considered. This letter is being written on behalf of those of us who have lost a married partner through death and must manage alone without the help of a husband or a wife.

The present Social Security Act restricts the survivor of a marriage partnership to one only of two earned pensions. With the death of one partner expenses thereby are not cut in half. Often there is a mortgage on the home and taxes, public utilites, and similar expenses do not decrease for the survivor. As with other insurance plans, it would seem equitable if the Social Security Act, as revised, could provide some continuing increment from the working partner's coverage during his or her lifetime. Some considered provision for a widow or widower, where both marriage partners have been salaried, would go far in easing the financial strain for the surviving partner.

Sincerely yours,

SEPTEMBER 20, 1967.

DEAR SIR: These welfare recipients look mighty well fed and clothed to me. They can't be too bad off.

From what I read in the newspaper they were protesting one of the provisions requiring the mothers to take job training. These women don't want to do anything but have children and expect everybody else to support them. My husband and I worked to support our children and raised them to be good citizens without any help from anyone.

No one can tell me they can not find a job nowadays. During the depression it was understandable. If these women have husbands why should they receive welfare if they are able to work. If they can't why shouldn't the women work. They can do one thing, protest and mouth.

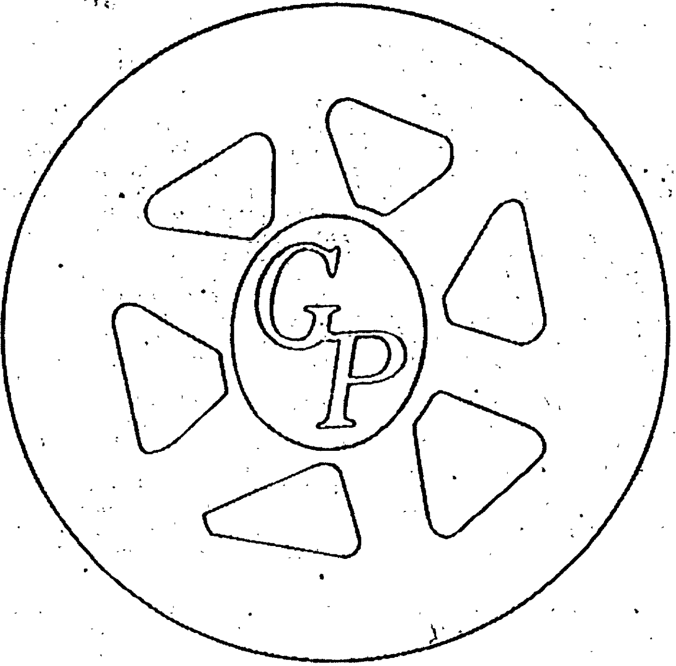
The youngest of 12 children raised without welfare.

SEPTEMBER 29, 1967.

Senator RUSSELL LONG,
Senate Office Building,
Washington, D.C.

DEAR SENATOR: Referring to the telecast in which you discussed the welfare problem, people who can disrupt committee meetings and are not able to work. I have tenants on welfare, who are so dirty the health dept. sends me letters to carry out their trash and mop their floors. I think this is ridiculous. I cannot keep my trash off the ground and in the cans or the yard clean due to lack of cooperation of tenants (most of whom are on welfare). It is me who has to go to court about it. I think the offenders should be cited. After all I can just do so much. It seems that it takes me and my whole family to clean up after these people. We just don't get that kind of rent for the services we are forced to render. A man's home is his castle and I think he ought to keep his own castle clean. I'm tired of working all the time to pay taxes so these bums can lay around doing nothing except drawing their checks, and disrupt committee meetings.

(Whereupon, at 1 p.m., the committee adjourned, to reconvene subject to the call of the Chair.)



Appendix

Kaiser Foundation Health Plan, Inc., Supplemental Statement to Senate Finance Committee Regarding H.R. 12080, Submitted in Response to Questions Asked

On August 30, 1967 Dr. Donovan McCune and Scott Fleming appeared before the Senate Finance Committee and presented a statement on behalf of Kaiser Foundation Health Plan, Inc. In the course of this presentation members of the Committee asked a number of questions, some of which called for specific information—mostly statistical—which the witnesses did not have immediately available. The following information is submitted in response to these questions:

Question No. 1

"Senator Long. I am told that in your Foundation Hospitals you are discharging patients at about eight or nine days for Medicare patients and that our average is about fourteen day." (Senator Anderson also asked a similar question.)

The source of the Senators' information was a letter dated August 4, 1967, written by Dr. Ernest W. Saward, Medical Director of The Permanente Clinic, which provides professional services to members of the Kaiser Foundation Health Plan in our Oregon Region. This Region now serves about 90,000 Health Plan members or about 5.8% of our total Health Plan membership. Of these, approximately 5,500 are Medicare beneficiaries.

Recent data from our single hospital in the Oregon Region indicates an average length of stay for Medicare beneficiaries of about 8 days as compared with about 5.4 days for the total Health Plan membership in the Oregon Region. The 8-day figure is derived from a relatively short time period and a relatively small number of admissions in the over 65 age group. Comparable figures for the full calendar year 1966 indicate an average length of stay in the over 65 group of 8.4 days as compared with an average for total Health Plan membership in Oregon of 5.4 days.

Our experience in the two large Health Plan Regions (Northern California and Southern California) where we are dealing with a much larger population (about 1,400,000 of whom about 50,000 are Medicare beneficiaries) and 16 separate hospitals shows an average length of stay of approximately 11 days for Health Plan members in the age group 65 and over.

Fuller information on hospital utilization experience for the prepaid membership of the Kaiser Foundation Health Plan and comparative information from other sources is set forth in response to question No. 3 below.

Question No. 2

"Senator Long: As I understand it, you are meeting their standards as far as results obtained * * * as far as improvement of health, recovery of patients and that sort of thing are concerned; is that correct? * * * I wish you would provide us as much as you can on that, because I note that you have taken an interest in it, to see how well you are doing with your program."

As we understand the question it is directed to the very elusive problem of "quality" in the health care field. We are not aware of any meaningful quantitative data because of the absence of an objective definition of the product "health care" and the problem of comparability. Thus, for example, a death rate per 1,000 persons (which was referred to in some of the discussion) only becomes significant by comparison with a similar rate for another population which is comparable with respect to age, sex, medical history and state of health. To the best of our knowledge reliable data which would provide a basis for this type of comparison does not exist.

Thus, as a practical matter at the present time, "quality of care" must be approached on a judgmental rather than a statistical basis. The quality of care in the Kaiser Foundation Medical Care Program has been studied a number of times by qualified and objective observers. The conclusions have consistently been favorable as evidenced by the following extracts and citations:

I. SPECIFIC QUALITY STUDIES BY RESPONSIBLE OUTSIDE SOURCES

The Permanente Medical Groups—the professional partnerships or associations providing services to Health Plan members—are of course continually concerned with quality of medical care within the program and have their methods of maintaining and monitoring quality. However, opinions of persons involved in the program may lack or appear to lack objectivity, so we will refer only to reputable external observers for material responsive to the Committee's questions regarding quality of care.

A. *Commission on Medical Plans of the American Medical Association.*—During the late 1950s the American Medical Association established a commission on medical care plans commonly called the "Larson Commission." This Commission concluded, on the basis of field visits and other sources of data, that good medical care was provided through group-practice prepayment programs including the Kaiser Foundation Medical Care Program.

"Report of the American Medical Association's Commission on Medical Care Plans: Findings, Conclusions and Recommendations". *The Journal of the American Medical Association.* 169:1-96, Special Edition, Jan. 17, 1959. P. 49.

B. *Columbia University Study.*—The School of Public Health and Administrative Medicine of Columbia University conducted a comparative study of the Kaiser Foundation Medical Care Program and two other prepayment programs (one Blue Cross-Blue Shield program and one insurance company program) in the early 1960s. This study concluded that the quality of care provided to members of the Kaiser Foundation Health Plan was high.

Trussell, Ray E., M.D., M.P.M., Study Director, The School of Public Health and Administrative Medicine, Columbia University. *Family Medical Care Under Three Types of Health Insurance.* New York. The Foundation on Employee Health, Medical Care, and Welfare, Inc., 1962. P. 177.

C. *Study of United Steelworkers of America.* In 1960 the United Steelworkers sponsored a study of medical care programs for steelworkers and their families. This study was conducted under the direction of Dr. I. S. Falk, a medical economist of national reputation. The following excerpt reflects the conclusions of the study.

"In our study of steelworker experience under contract with the Kaiser Foundation Health Plan (KFHP) in California, we found our members and their dependents receiving their services from organized staffs of physicians and supporting technical personnel. We found them covered for comprehensive hospital care, all kinds of general and specialist medical and surgical care, and all necessary laboratory, X-ray, physical therapy and other technical services. We found that KFHP costs had been held down mainly by their much lower rate of hospitalization and their more extensive resources for serving patients in well-equipped clinics. Moreover, the services provided by KFHP were not only coordinated but, despite the economies of the group practice, were apparently of high quality. . . .

"[The Kaiser Plans in Fontana-L.A., and S.F.-Oakland] were recently visited and surveyed by the Commission on Medical Care Plans of the AMA and found to be providing good medical care."

United Steelworkers of America. *Special Study on the Medical Care Program for Steelworkers and Their Families.* United Steelworkers of America Tenth Constitutional Convention, Atlantic City, September 1960. P. 3.

II. EXAMINATIONS BY ACCREDITING AUTHORITIES

Naturally the various Kaiser Foundation Hospitals meet all applicable legal standards for licensure. In addition it is the policy of the Board of Directors to meet applicable standards established by responsible reviewing or accrediting organizations.

A. *Joint Commission on Accreditation of Hospitals.*—All of the various Kaiser Foundation Hospitals are fully accredited by the Joint Commission on Accreditation of Hospitals, which represents the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons.

B. *Hospital Staff Inspection Program of California Medical Association.*—Inspection committees have been established by the California Hospital Association in cooperation with the California Medical Association to survey compliance with the "Guiding Principles of Physician-Hospital Relationships of the California Medical Association." Several of the Kaiser Foundation Hospitals in California have been inspected under this program, and the findings have been complimentary.

C. *Council on Medical Education and Hospitals of the American Medical Association.*—This Council establishes standards and surveys institutions wishing to establish medical internship programs and residency programs in the various medical specialties. This Council naturally emphasizes quality factors because of their concern that medical students and young physicians in specialty training receive their education under circumstances which will establish high standards for the interns and residents. Most of the larger Kaiser Foundation Hospitals have internship and residency programs approved by the A.M.A.'s Council on Medical Education and Hospitals.

III. CONSUMER SATISFACTION

It is well recognized that the patient is not necessarily a competent judge of the quality of medical or hospital care which he receives. Nonetheless it is unlikely that a health care program which is deficient in quality will enjoy rapid growth and consistent consumer support over an extended period without benefit of advertising, solicitation or members or other commercial-type promotional activities.

Enrollment in the Kaiser Foundation Medical Care Program has increased at an average rate of more than 10% per year over the last 6 years and has approximately doubled since 1960, even though the program has been closed to new enrollment in many areas during much of this time because we have not been able to recruit personnel and establish facilities rapidly enough to keep up with the demand.

A. *California State Employees Retirement System Study.*—In 1963 and 1964 the California State Employees Retirement System, which administers health benefits programs for state employees, sponsored a study conducted by a panel of experts, including leading medical educators. Results of this study were described in a front page article in the San Francisco Chronicle on June 15, 1964, as follows:

"A panel of distinguished California Medical experts has just reviewed the major health insurance plans in the State, and has compared their costs and services in detail for the first time.

"The experts, including four noted physicians, conclude that the overwhelming majority of the members covered by the voluntary plans are highly satisfied with the health care coverage and service they get.

"But of the major health plans, the Kaiser Foundation apparently emerges on top—in terms of consumer satisfaction and lowest cost to members."

B. *U.S. Civil Service Commission.*—In 1961 the U.S. Civil Service Commission surveyed a 10% sample of Federal employees who elected various coverages under the Federal Employees Health Benefits Program. The Commission's finding showed a high level of satisfaction by the overwhelming proportion of Kaiser Foundation Health Plan members. This finding is confirmed in that Federal employees given the option of changing plans periodically consistently contribute to Kaiser Foundation Health Plan membership growth.

(Bureau of Retirement and Insurance, U.S. Civil Service Commission. *Health Benefits Survey—Comparison of Employees Responses.* Washington, D.C., 1961.)

Question No. 3. Hospital utilization in general

Both Senator Anderson and Senator Long asked a number of questions indicating the desire of the Committee to receive significant information on hospital utilization, especially for the 65+ age group, experienced in the Kaiser Foundation Medical Care Program as compared with hospital utilization under conventional health care arrangements. These questions focused primarily on "length of stay."

Even in this area, which is much more subject to numerical measurement than the elusive subject of "quality of care," significant comparisons are still difficult because of questions of comparability of populations served, geographical differences, variations in composition of the population, patterns of practice with respect to hospital use, etc. A comprehensive view of hospital utilization necessarily involves the number of "admissions" or hospitalized cases because the total days of care are the product of admissions and average length of stay. Another problem of comparability between the Kaiser Foundation Medical Care Program, which deals with a defined population, and hospitalization in the country at large, is the difficulty of relating the latter data to a definable population. We hope that the following information, including some comparative data, will be responsive to the questions.

In 1963 we made a special utilization study in the Northern California Region on an "age specific" basis. The results of this study are summarized as follows:

KAISER FOUNDATION HEALTH PLAN, NORTHERN CALIFORNIA REGION

HOSPITAL UTILIZATION BY AGE—HEALTH PLAN PATIENTS DISCHARGED DURING YEAR ENDING JUNE 30, 1963

Age	Hospital days per 1,000 members	Hospital discharges per 1,000 members during year July 1, 1962 to June 30, 1963	Average length of stay (days)
0 to 44	358	77	4.7
45 to 64	988	98	10.1
65 and over	2,353	184	12.8
All ages	598	87	6.9

As a comparision of nation-wide experience for the age group 65 and over during the calendar year 1962, see the following table:

Utilization rates for persons aged 65 and over in short-stay hospitals

[Table 9.7, p. 354, "The Aged Population of the United States," 1963 Social Security Survey of the Aged, U.S. Department of Health, Education, and Welfare Research Report No. 19]

Hospital-days per 1,000 persons	2,594
Discharges per 1,000 persons	171
Average length of stay (days)	15.1

The following table entitled "Hospital Utilization Trends" relates to all ages rather than only to persons 65 and older and reflects utilization trends over a period of time.

HOSPITAL UTILIZATION TRENDS—NATIONWIDE BLUE CROSS MEMBERSHIP AND KAISER FOUNDATION HEALTH PLAN MEMBERSHIP COMPARED

[5 recent years]

	Cases [1] per 1,000 members	Days per 1,000 members	Average length of stay (days)
Nationwide Blue Cross experience: [2]			
1961	142	1,101	7.75
1962	144	1,126	7.85
1963	146	1,160	7.92
1964	150	1,202	8.03
1965	148	1,199	8.10
Kaiser Foundation health plan experience: [3]			
1962	95	588	6.2
1963	92	567	6.2
1964	87	539	6.2
1965	83	526	6.3
1966	81	508	6.2

[1] Blue Cross information is on the basis of "admissions." Kaiser Foundation health plan experience is on the basis of "discharges." The difference between the 2 methods of relating cases to time periods is not significant for purposes of comparison over a period of years.

[2] Blue Cross experience from "Medical Care Financing and Utilization," Health Economics Series No. 1-A, Public Health Service Publication No. 947-1A, February 1967.

[3] Kaiser Foundation health plan experience from health plan department of medical economics. Average health plan membership by year was as follows:

1962	941,000
1963	1,035,000
1964	1,156,000
1965	1,329,000
1966	1,461,000

Note: This table is intended to indicate comparative trends; hospitalization per 1,000 persons on the west coast is significantly below the national average. Thus in 1965 the total California population used about 890 days of hospital care per 1,000 persons, and the average length of stay was about 6.5 days.

RECENT INFORMATION ON LENGTH OF STAY FOR MEDICARE BENEFICIARIES

Unfortunately we have not been able to obtain recent information on length of stay for Medicare beneficiaries either in the country at large or in particular geographical areas which is comparable for statistical purposes to the data which we have for Medicare beneficiaries in the Kaiser Foundation Medical Care Program. For example, information currently available through the Social Security Administration relates to the month in which a claim was approved for payment and thus does not tie precisely to the calendar month or other period during which service was rendered. The American Hospital Association has length of stay information on the basis of month of discharge derived from a sample of 656 hospitals from a universe of 5,812 short-term general and special hospitals, not including federal and psychiatric facilities.

The Division of Health Insurance Studies, Office of Research and Statistics, of the Social Security Administration, reports that the average length of stay in short-stay hospitals represented by claims approved during March 1967 was 13.5 days—the highest average length of stay recorded to date. On a cumulative basis from the inception of the Medicare program through June 1967 the average length of stay represented by approved claims was 12.9 days. This figure is presumably lower than typical on-going experience because it includes the first months of the Medicare program during which many hospital stays (which had commenced before July 1, 1966) were not fully covered by Medicare.

Source: Telephone report from S.S.A. Office of Research and Statistics; data to be published in October.

The latest "Hospital Indicators" published monthly in the Journal of the American Hospital Association (issue of August 16, 1967, page 27) covering the month of May 1967 shows an average length of stay of patients 65 years of age or older of 13.9 days. Average stay for patients under 65 was 6.9 days per admission.

For Kaiser Foundation Health Plan members in the Northern California Region who are in the age group 65 and over, the average length of stay in our hospitals was 11.6 days during the first full year of the Medicare program. In the Southern California Region of the Health Plan the average length of stay for members in the age group 65 and over for the same period was 10.5 days.

STATEMENT OF HON. CARL D. PERKINS, SEVENTH DISTRICT OF KENTUCKY

MEDICARE FOR THE DISABLED

Mr. Chairman. During all of my 18 years in the Congress of the United States, one of my major concerns has been with our responsibility to help those among us who are hopelessly disabled. I think the record shows this concern not only in the bills I have introduced over the years but in speeches on the Floor of the House and before Committees. And I have been sustained in this concern not only because of the letters describing their hardships which I receive regularly from these badly maimed people, but also in talking with them. I recognize the fact that they represent a relatively small group in our total population, but because they are workers who, through no fault of their own, have been beset by misfortune, I am convinced that we have a special obligation to them.

The Congress has recognized this particular problem in a number of ways. In the 1950 amendments, we established a Federal matching plan to enable the States to set up programs for those disabled people who were determined to be in need. In the 1956 amendments, at long last, we established the right of these people to Social Security benefits at age 50 and we have since broadened that original program to include those at any age, and their dependents, who could qualify on the required work record.

I was pleased, therefore, when the Advisory Council on Social Security in their report in January, 1965, established by the Congress to look into the whole program, recommended that the Medicare program be extended to include people entitled to disability benefits along with people aged 65 and over. As you know, this Report took the position that disabled people, along with older people, have a special need for protection against the cost of hospitalization and related services. In the words of this report:

"Hospital expenses are a serious problem for the totally disabled too. Like the aged, they too are hospitalized frequently and in many cases their hospital stays are long. According to a survey of workers found disabled under the social security disability provisions (conducted by the Social Security Administration in 1960) about one out of five disability beneficiaries under social security received care in short-stay hospitals in the survey year; and, excluding hospitalizations in long-term institutions, half of those hospitalized were in the hospital for 3 weeks or more."

At the time the survey was conducted, the worker had to be aged 50 or over to be eligible for disability insurance benefits. While the age requirement has now been removed, as I stated earlier, disabled people aged 50 and over still represent about three-fourths of all people receiving disability benefits, I am informed, so that the data for this age group are representative of the major group of disabled now receiving disability benefits.

I was again particularly gratified when, in the opening days of this Congress, the Administration bill, for the first time, included a provision for extending the benefits of Medicare to the disabled. The force of this position was strengthened over that of the Advisory Council, in my mind, because we had by this time some experience with a Medicare program in operation. This was also the position taken by the Secretary of Health, Education, and Welfare in his testimony presenting the bill before the Committee on Ways and Means on March 1st of this year. He said:

"Medicare is an unqualified success. Nevertheless, there are improvements which can be made and shortcomings which need prompt attention.

"The 1.5 million seriously disabled Americans under 65 who receive social security and railroad retirement benefits should be included under medicare. The typical member of this group is over 50. He finds himself in much the same plight as the elderly. He is dependent on social security benefits to support himself and his family. He is plagued by high medical expenses and poor insurance protection."

Equally important is the fact that supplementary medical insurance protection under this proposal would be made available on the same basis as it is for the aged—that is, on a voluntary basis, with the beneficiary paying a monthly premium and the Federal Government paying a matching amount. The 1.5 million people who, it was estimated, would qualify for these benefits included 1.2 million disabled workers, 200,000 adults getting childhood disability benefits, and 100,000 widows under 65 who are disabled.

But largely for reasons of cost, I am told, the Committee on Ways and Means decided to drop this provision in its Report on the bill. Since the bill came to the Floor on a closed rule, as is our custom with Social Security measures, our only choice was to vote for or against the whole bill—which contained many other desirable features. It was because of my continuing concern with this particular change, however, that I requested permission to appear before this Committee because it is within your power to restore this vital provision.

I hope, too, that the Committee, in its wisdom, will see fit to further strengthen our disability insurance program by restoring the provision in the Administration bill which provided benefits for disabled widows, rather than accepting the more limited House version which included only widows aged 50 or over at greatly reduced benefits, depending upon the age of application. I hope you will accept the good provision, added in the House, which allows a worker who became disabled before age 31 to qualify for disability benefits if he had worked in one-half the quarters between the time he was age 21 and the time he became disabled, if he had six quarters of coverage. Certainly it seems to me to be unfair to apply the same labor force attachment requirement—five years out of the last 10 in covered employment—which applies to most workers who have a longer work life to those few younger workers who have the special misfortune of being disabled. It seems to me to be simple logic to protect them and their dependents in much the same way we provide for the survivors of workers who die in their younger years.

The extension of hospital and hospital-related services under social security to include all of these groups of severely handicapped people is, I believe, a necessary next step in providing the kind of protection against the risk of income loss from personal catastrophe, which our Social Security system was designed to do. I appeal to your compassion and your conscience to extend the hospital and medical care provisions contained in Title XIII for the aged to include those most unfortunate among us—our people who are so severely disabled that they cannot continue to work.

PITTSBURGH RETIRED TEACHERS ASSOCIATION,
Pittsburgh, Pa., August 12, 1967.

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

DEAR MR. LONG: I received the Legislative Report from Mr. Ernest Giddings, Legislative Representative of the National Retired Teachers Association and the Association of Retired Persons.

As President of the Pittsburgh Retired Teachers Association, comprised of over eleven hundred members, may I state the proposed changes as suggested by the members of our group in reference to Item 3, H.B. 12080—Social Security Amendments of 1967.

1. Age changed from 72 to 70 years.
2. Any retired person, age 70, without the required earned quarters be eligible for payments regardless of any local, state, or federal government annuity.
3. The minimum be set at $50.00 and that any future benefit increase would apply to this minimum.

The reasons for asking for the above changes:

1. Thousands of teachers had retired before social security became available to them; hence were unable to secure required earned quarters.
2. Thousands of retired teachers are in the poverty class according to the annunities received, even though they have given on an average of forty years to the youth of the nation.

The additional income derived from a social security check would provide them with additional necessities of life.

Sincerely,

MARTHA S. WOLFF, *President.*

STATE OF ALABAMA,
DEPARTMENT OF PENSIONS AND SECURITY,
Montgomery, Ala., August 21, 1967.

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

DEAR SENATOR LONG: We have reviewed H.R. 12080, the Ways and Means Committee's Amendments to the Social Security Act, which may be cited as the Social Security Amendments of 1967. We understand that this bill was considered under a closed rule in the House and, therefore, no changes were made by that body. On the whole, we think the provisions of H.R. 12080 improve the Social Security Act, but are concerned about some of its provisions. I am outlining below our recommendations on some of the major provisions of this bill.

SOCIAL SECURITY BENEFITS

We are delighted that this bill contains increases in the social security benefits, both regular and Special Age-72. We are concerned, however, that the provision which prohibits simultaneous payments of old age assistance and special social security benefits to persons 72 years of age and over is still contained in this legislation. We believe such provision is contrary to the principle on which the Social Security Act was originally enacted.

The extension of benefits to a dependent child on the basis of his mother's earnings record, and the new definition of eligibility for young disabled worker for disability benefits, are positive steps in eliminating some inequities. Likewise, we think the extension of eligibility to disabled widows and widowers of the wage earner will help to alleviate need among these groups. We are concerned, however, about the fact there is one kind of definition on disability for this group and a more restrictive definition of disability for the wage earners disability benefits. We think that disability provisions should be broader, and should be consistent. We are also pleased that there is some liberalization in eligibility for children in adoptive homes, and that there is provision for the Social Security Administration to provide to appropriate courts addresses of deserting parents of needy children.

We think the transfer of out-patient diagnostic service to Part B of the Health Insurance Program is a step in the right direction. Also, we are glad that persons may present an itemized bill for physicians' services, rather than a paid bill, under Part B of the Health Insurance Program.

It is difficult for us to understand the provision of the bill with regard to payment to the patient if the itemized bill presented by the physician contains charges higher than the reasonable charge for service as determined by the carrier.

We note there is provision for financing on an apparently sound basis for the increased benefits and coverage provided under the bill. We believe this is extremely important.

PUBLIC ASSISTANCE

We are deeply concerned about the limit on the number of children of deserting fathers that can be paid under the aid to families with dependent children program. The arbitrary proportion of the population receiving such aid as of January 1, 1967, is in direct conflict with the over-all philosophy of the program. It violates the equity in treatment principle as it would necessitate states finding certain children ineligible who are in the same circumstances as other children which they find to be eligible. Furthermore, it would be almost impossible to administer. Likewise, the provision for protective or vendor payments on behalf of needy children violates the basic money payment principle under which the public assistance titles of the Social Security Act were established. If such payments are to be authorized by law there should be more safeguards written into the legislation than is true under H.R. 12080.

The work-in-training programs required for families of dependent children under Title IV will be quite expensive to operate. We would like to reiterate our position on this matter; i.e., that the public welfare agency should utilize such projects administered by another agency instead of attempting to administer them itself. We believe it would be less confusing in the minds of the public if one agency has responsibility for such projects.

If the public assistance program is to take care of needy people, we think it should be financed adequately so that the needs of people could be met without the disregard of "earned income", or other income. If this is not done, however, there should be some consistent method for the handling of exemptions now permitted as well as the additional earned income of AFDC recipients proposed to be required under the bill. It is most confusing to public assistance recipients as it is administered today, and the work incentive provision would make it even more confusing.

We are at a loss to understand why emergency assistance under the aid to families with dependent children program should be financed on a different basis from the other aspects of aid to families with dependent children program. Likewise, we have the same objection to the provision for repair on homes of public assistance recipients. Why should these provisions be on a 50–50 matching basis when the other provisions of the public assistance program are to some extent based on variable grant formulas, taking into account the relative fiscal capacities of the various states?

We continue to believe that there should be no mandatory provision for giving aid to families with dependent children of the unemployed father. It was difficult for us to be certain whether this is a mandatory provision under H.R. 12080. Under this bill there is provision for child welfare services to be moved to the section of the law under which AFDC is provided. We think, however, that the decision as to how the child welfare services and services for aid to families with dependent children programs are handled should be left to the states because of varied administrative and organizational patterns and staffing plans. We do think it would be constructive to require that both services be provided by a common, single state agency. We are pleased to see the increase in authorization for child welfare services for non AFDC child welfare services. We should like to point out, however, that the appropriations consistently have been lower than the authorizations in the past, and even the bill's authorizations are lower than are needed. We should like to reiterate our stand of many years, that child welfare services should be financed on a variable grant basis, taking into account the relative fiscal capacities of the states, and that the appropriation should be open end. In fact, our position has been that public assistance, child welfare services, and administration should all be funded on the same variable grant formulas.

MEDICAL ASSISTANCE—TITLE XIX

While we agree that there should be some income level limits set for eligibility for medical assistance under Title XIX, we think the provision in this bill discriminates against low income states. The more alternatives that are established for maintenance of state effort, the better, as far as we are concerned.

We are pleased to see some efforts to resolve the comparability provision for medical care for persons 65 years of age and over and those others who might be eligible for medical assistance. We do not agree, however, with the proposed change of the five basic services (now required) to any seven of the services listed under Title XIX.

We are pleased to note a provision relating to freedom of choice of providers of services by recipients of service. We believe the Department of Health, Education, and Welfare needs to revise its present civil rights regulations to accommodate this concept.

We object to the fact that there is a different provision in the bill for reimbursement for physicians' services for cash assistance recipients from the non-cash assistance recipients. We think there should be a single reimbursement plan for all people under Title XIX. We agree with the principle that when a third party has a legal obligation to pay for medical expenses of a person covered under Title XIX, that resource should be used first. We find from our previous experience, however, that this is difficult to administer. It would become doubly difficult in the event the single state agency to administer Title XIX is not the agency which administers the public assistance program.

MANPOWER AND TRAINING

We have no objection to the proposed grants to schools for increasing the number of qualified social workers. We believe, however, that the bill gives too large a proportion of the proposed grants for undergraduate training. While we recognize that it will be many years before we have sufficient social workers trained at the graduate level, we believe the pendulum is swinging too far in the the other direction. We still do not understand why there are not the same provisions for the Federal government to defray the entire cost of adequate stipends for training of public welfare personnel as is provided for other types of personnel under other titles of the Social Security Act.

CONCLUSION

We hope very much that your Committee will consider carefully the points which we have made about Federal legislation to improve the Social Security Act. We think real progress has been made in the past, and we hope that favorable consideration will be given to constructive amendments this year.

We should like to request that this letter be included in the records of the hearings which we understand your Committee will hold on the Social Security Amendments of 1967.

Cordially,

RUBEN K. KING,
Commissioner.

MEDICAL ASSOCIATES,
Chelmsford, Mass., August 22, 1967.

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

DEAR SENATOR LONG: Perhaps the most glaring deficiency of HR-12080, the Social Security Amendment of 1967, is that provision for payment for diagnostic x-ray, laboratory procedures, and for physical therapy services is made only for these services when they are provided in a hospital. These services can be provided in a non-hospital setting at far less cost. There is absolutely no medical necessity for hospitalization of patients requiring these services. However, if the provision is enacted, there will be much demand for hospitalization, simply because of the payment mechanism. The result will be a further increase in the hospital bed shortage, and further increases in the total cost of medical care. All of this can be obviated by providing for payment when these services are performed in a doctor's office or medical group facilities.

Private insurance companies and Blue Cross organizations have contributed to spiralling medical costs by refusing to provide for payment of these services, unless they were done in a hospital. The many officials I have talked to have stated there is a fear of exploitation by doctors, and that the out-of-hospital system would be uncontrollable. Certainly, it must be admitted that Blue Cross Blue Shield organizations and the independent insurance companies have demonstrated that they are not experts on the subject of controlling medical costs. Don't let the Medicare Program become an economic millstone around our country's neck by making the same mistakes which have been made in the past by the Blue Cross-Blue Shield and private insurance companies. Provide for payment for services delivered out of the hospital, and help eliminate unnecessary hospitalization. There are many who feel that such a step would be significant in greatly reducing the total cost of medical care.

I request that my letter be given consideration by your Committee in its current deliverations on this matter, in the same manner as if I had made a personal appearance.

Very truly yours,

CHARLES E. WESTCOTT,
Administrator.

CITIZENS' COMMITTEE FOR MEDICAID,
New York, N.Y., August 23, 1967.

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

DEAR SENATOR LONG: The Citizens' Committee For Medicaid is composed of labor, religious, business, professional and voluntary agency people from organizations that represent over one million New Yorkers. We are vitally interested in successful implementation of our State's Medicaid law, enacted pursuant to Title XIX of the Social Security Amendments of 1965.

One area that greatly concerns us is the threat of amendments contained in HR 12080, Social Security Amendments of 1967, now being considered by the Senate Finance Committee, that would restrict the amount of federal reimbursement for states that enact *Medicaid programs.* This would be done by tieing medical need to welfare levels with a maximum Medicaid eligibility ceiling no higher than 133⅓% of a state's maximum cash assistance.

It is our view that enactment of any such amendments at this time would directly contradict the original intention of Title XIX—to provide quality medical care for Americans who are unable to afford it, with special emphasis on the needs of children.

We are all aware of the high correlation between low-income and the frequency, longevity and intensity of illness. The President's recent report on health reveals such frightening statistics as the fact that there are 3 million American children who today need glasses and don't have them, and that almost half of the nation's children between the ages of 4 and 14 have never seen a dentist. Clearly, a large number of our citizens are not receiving proper medical care.

Our Committee believes that the provisions of Title XIX—as they *now* exist—provide the means whereby the states can finally begin to move against the fundamental causes of disease and illness among the poor, whose gross sickness and mortality rates are as high as the rate for the entire country a half-century ago. To tamper with Title XIX now, less than a year after the program became operational, would only add another layer of problems upon the already serious ones that now exist.

In our view, it would also be unfair, since the federally administered Medicare program under Title XVIII was given a full year after enactment to shape up its administration and even longer for certain phases of the program.

In New York we are proud of our Medicaid plan and, despite expected problems during these first months, have great hopes that it will elevate medical care standards not only for the medically indigent, but for everyone.

We urge you to oppose the restrictive Medicaid provisions as proposed in Section 220, subparagraphs B and C, which amend Section 1903 of the Social Security Act.

It is the hope of our Committee that you will agree that restrictions on a most promising medical care program scarcely one year old would oppose the best interests of the entire nation, particularly in this time of crisis in our cities.

We look forward to hearing from you.

Yours sincerely,

FREDERICK W. RICHMOND,
Chairman.

TARBORO CLINIC,
Tarboro, N.C., August 22, 1967.

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

DEAR SENATOR LONG: As manager of a private twelve doctor medical clinic responsible for the administrative functions connected with the rendering of medical care to a population of approximately 40,000, I feel qualified and compelled to express my views concerning certain provisions of the proposed Social Security Amendments of 1967.

Under the proposed law 100% payment will be made for all charges (including radiologist and pathologist) for diagnostic x-rays and laboratory procedures provided bed patients in the hospital. The deductible will be the ordinary hospital deductible of $40.00. A patient receiving the same services as an out-patient of a hospital or in the office of a physician or a medical group will be required to pay 20% of the fees for the procedures plus a $50.00 deductible. Why must the payment for these services be tied to the occupancy of a hospital bed? This change will cause most patients under Medicare to demand that they be hospitalized for diagnostic procedures because it is cheaper for them; thereby causing a tremendous increase in the occupancy of hospital beds. Why not provide the same benefits whether the patient is hospitalized or is not hospitalized?

Under Sec. 125(a) Section 1842(b)(3)(B) the House Ways and Means Committee proposes to add a third system of payment of physicians bills to eliminate criticisms of the present law. It is proposed that payment will be made to the individual receiving such services upon his submission of an itemized bill, if the physician has not submitted his bill in the form and manner as the Secretary may prescribe and within such time as may be specified in regulations. In this manner the carrier and the patient will be penalized because the carrier will be required to hold up payment to the individual until the expiration of the "time specified in regulations". The simple way to eliminate the requirement of a receipted itemized bill which will answer the criticisms directed at the present law would be to pay the physician if he takes an assignment or pay the patient if the physician does not take an assignment.

I trust this letter will be given the same consideration by the Committee as would my personal appearance.

Respectfully yours,

TARBORO CLINIC,
R. M. THOMAS,
Clinic Manager.

THE NATIONAL ASSOCIATION OF
SOCIAL SECURITY BENEFICIARIES,
BEDFORD, VA., *August 21, 1967.*

HON. RUSSELL B. LONG,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I know you don't favor discrimination in your judgment. There is a severe discrimination in the Social Security Bill as passed by the House.

Louisiana has 108,210 Social Security recipients of which average $69.00 monthly. Forty-six per cent are in the lower brackets, ranging from $39.00 to $69.00, more or less, therefore, 12½% means nothing to them. The other 54% range from $75.00 to $145.00. So you can see who gets the advantage of a per cent raise.

In total close to 7 million people are in the lower brackets. It would be better to raise the lower brackets and leave the higher ones as is, which would be fair to all and would not penalize the working people of over 70 million to pay for this raise, plus anticipating the income tax raise that is coming.

Several employers of 4 or 5 workers who have to pay their own Social Security and then match the employees payments are being chased out of business.

My figures are taken from the United States Department of Welfare and Social Security Administration Accounts Payments Status by States, dated 12/31/62. Since that time 7% has been added which changes it just a little.

One other thing, just as soon as the raise is passed the "hawks will jump the doves". Old folks don't fight back, so if it can be done freeze maintenance costs in homes. As I know of raises last time the 7% was passed maintenance costs doubled to 14 and 15%. Hospital and drug bills also doubled. A young man raising a family has his pay check knicked in order to give the old folks something and who benefits—nobody. What the youngsters give the hawks get.

Respectfully,

EDGAR J. KELLY.

ALABAMA LEAGUE OF AGING CITIZENS, INC.,
August 17, 1967.

Re America's Senior Citizens Social Security Benefits.

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

DEAR FRIENDS: Today in the midst of our multi-billion dollar economy a majority of America's senior citizens live in poverty and sickness in a country where they are surrounded with abundance and great wealth untold. America's elderly people, as a class, are in desperate need of many improvements in social security structure, cash benefits and in the Medicare Program: more so, than the one the House Ways and Means Committee reported out, and the House Ways and Means Committee resumed the ultra conservative way to sharply cut back social security and old age pensions benefits proposed by President Johnson. It seems that they are determined not to improve the social and health programs of the aged but to enslave them unjustly and deprived them from the civil, economic and social rights to live and die in decency.

We know from experience, that the Senate Finance Committee is a Committee who has dedicated itself to better the plight that confronts our aged citizens, therefore, we appeal and memoralized you to strengthen the Social Security benefits and the Medicare program.

First by eliminating all deductibles and co-insurance features; by eliminating waiting period and enrollment deadlines; by lowering the 65 age limit for women to 60; by permitting the sick, aged persons to be referred directly to nursing homes from out-patients clinics, instead of requiring hospitalization prior to admission to an extended care facility. To rehabilitate the Mental Health patients with some work therapy. (If a patient in the mental institution is given a job, and then is paid for his work, he is likely to recover quickly. Even decidedly schizophrenic patients can often work and will work and get well, when they get a little pay check every month. Also, a patient who, while in mental hospital, learns that he can make some money, is much more willing to leave the place and try to get a job outside. He has feeling of self-confidence, self-respect and dignity.) In this area, we need your help and we are told by experts, that most patients in a mental hospital prefer to be occupied and productive, and any training they get in some occupation will help them to get a job when they go out into the world.

Let us never forget that the factor that keeps hundreds of patients from leaving a mental hospital, when they are able to is that they have no home or job to go to.

We need a protected boarding house program under Medicare Program where discharged patients who are still afraid of slipping back into insanity can work and live with occassional help from a kindly psychiatric nurse or psychiatrist.

Medicare and other federal-state benefits are contributing materially toward an easier old age, but they do not offset the problems created by inflation and the devaluation of the dollar. Many of our senior citizens cannot afford many basic necessities of life. The therapy is "There is no medicine so good and effective as a $100 per month pension check for all America's senior citizens."

It would be helpful for the federal government to give more help and guidance to unemployed aged persons to help them get back into the midstream of the employment market. There is a great need to be private pensions plans into the social security system or to issue special government bonds, redeemable only at age 65.

Present tax laws should be revised whereby specified funds can be placed in reserve in federal bonds for retirement, sickness and for the purchase of housing for a worker and his family.

The goal of the Social Security Program must be to protect, to enhance, to strengthen the most important asset the nation possesses, our people. We must seek to conserve our most precious human lives from the ravages of man's most ancient enemy, hunger, disease and insecurity.

The problems that confront more than 21 million American senior citizens of both races and creeds are indeed legion, but not impossible. All are short of mere necessities of the good life. We earnestly urge the Senate Finance Committee to give a favorable consideration to President Johnson's Social Security Program bill that legislation may be enjoyed as speedily as possible by millions of deserving American citizens. In the name of humanity and democracy, you and other well meaning leaders must help our elderly citizens. If you have a better solution to offer than the President's increases in social security benefits, let us hear from you.

Let it be known to all that I have faith in Senator Russell Long and his Senate Finance Committee, the President and in the American people. The dark, foreboding clouds that hang so low over the elderly for generations that threaten the very fiber of our American freedom of security, happiness and health must pass. As we withstand the enemy from without, we must beware of internal decay that would rip the foundations from our Nation. Life, liberty and the pursuit of happiness must be for *All* Americans regardless of age, race, color or origin of nationality.

"O let my country be a land where liberty is crowned with no patriotic wreath, but opportunity, equality is real, and life is free. Freedom of choice and economic security is in the air we breathe."

Sincerely yours,

RUBIN MORRIS HANAN.

PHILADELPHIA PUBLIC SCHOOL RETIRED EMPLOYEES ASSOCIATION,
Philadelphia, Pa., August 23, 1967.

Hon. RUSSELL LONG,
Majority Floor Leader, U.S. Senate,
Chairman, Senate Finance Committee,
Washington, D.C.

MY DEAR SENATOR: We are addressing your committee re H.B. 12080 (S.S. amendments of 1967) passed by the House of Representatives August 17, 1967 and now to be considered by the Senate Finance Committee.

We should like your committee's valued support, in amending H.R. 12080, so that it will include a section, to give minimum Social Security benefits, to those retired public school employees, who are presently not eligible, because they retired before Social Security benefits were made available to retirees in their particular area, and they also retired on very inadequate pensions, which were predicated on the low salaries they earned during their teaching career and therefore their pensions are very inadequate today, when the real value of the dollar has depreciated so very much.

Since 1951, states have been integrating their pension systems with S.S. In Pennsylvania for instance, those retiring before 1956, were not eligible to full or any Social Security benefits, first payment of such full benefits made payable July 1957. In many cases, these deprived people have not had any adjustment in state pension either, although a bill has been passed in Pa. giving some relief as of July 1, 1957, first payment October 1967.

When a House Senate Conference 3/9/66, deleted retired public school employees, from the provisions of the Prouty Amendment passed by the Senate (3/8/66) gross discrimination resulted. It was a form of class legislation. The cost of rectifying this wrong would be slight and temporary, as these people are rapidly dying off. The new Social Security bill now before your committee, will raise full S.S. benefits 12½% and even those who were benefited by the altered Prouty Amendment are to receive a 6% increase.

Therefore, money canot be the stumbling block. Very large sums have been needed to give teachers retiring (as in Pa. 1956) full S.S. benefits plus full pension (on payment of a small offset sum). Even those retiring end of term 1967 could not have paid too much into the S.S. fund, and they will receive full S.S. benefits. Also, many who retired before integration date, could work 6 quarters full time, and receive full S.S. benefits. We could give other examples that money to finance minimum benefits for those 70 and over, not yet covered, cannot be the deciding factor in opposing it.

In the deliberations of your committee, re H.B. 12080, we trust that you will see the gravity of this injustice, and report the bill to the Senate floor with an amendment to correct this situation. As you know, when the bill reached the House floor, the procedure was such, that no amendments were permitted, due to closed rule procedure. Therefore, the responsibility for rectifying the omission, must be in the main, your task.

We trust that you will do so.

Sincerely,

JOHN GUTHRIE, *President.*

STATE OF OHIO,
OFFICE OF THE GOVERNOR,
Columbus, August 25, 1967.

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

DEAR SENATOR LONG: We have reviewed the proposals for change in the Social Security laws as provided in H.R. 12080. We are in accord with most of the purposes of the proposed legislation. However, there are some provisions which would create serious problems for Ohio and perhaps for many other states. I am therefore taking the opportunity of noting the following comments on some of the questions that I understand are being raised before the Senate Finance Committee.

1. The proposed limit on the number of children from broken homes should not be adopted. Measures to reduce the number of children in need of help, such as improved efforts to obtain support, are required, but if the children are in need the federal government should match on the payments.

2. The proposed ceiling on Medicaid would not affect Ohio at the present time. So far we have not extended health care to low income families. The proposed ceiling would be high enough to accommodate the standard that has been considered for Ohio.

3. The requirement for work training should apply to all AFDC mothers. The decision on exemption of mothers from training programs should be made on individual situations where training is impractical or where plans for care of children during the day cannot be made.

4. We see no reason for changing the present program for unemployed parents. The proposed restrictions in the bill would complicate the administration of the program unnecessarily. The sole test should be that the children are in need and that the father is unemployed, but able to work.

5. We would urge that the matching ratio on the new self-help program be fixed at 90/10 rather than the figure in the bill. To implement its programs, it would be important that available state funds go as far as possible. This ratio would certainly not be out of line with the provisions of the Economic Opportunity Act since the federal government now is paying the full cost of the Title V program.

6. The disregard of all earnings of part-time students might lead to abuses and is not recommended.

7. The self-help programs appear to be of the kind that proved successful in many communities under Title V.

8. There should be no requirement for the states to meet 100 percent of their definition of need unless there is a drastic change in the federal share. The major problem in Ohio would be in ADC. It has been pointed out before that the federal matching formula is much less adequate in this program than in the adult program. If the same formula was applicable, Ohio could make payments meeting its definition of need.

9. It is possible for the state now to finance training of welfare workers with the present federal matching formula.

We will appreciate the consideration by the Committee of our comments.

Sincerely,

JAMES A. RHODES, *Governor.*

COMMITTEE REPORT OF THE POMONA, CALIF., CHAMBER OF COMMERCE, SUBMITTED BY G. BRYAN WALKER, PRESIDENT

COMMITTEE REPORT UNANIMOUSLY APPROVED BY THE BOARD OF DIRECTORS, AUGUST 22, 1967

Committee.—Governmental Affairs, James Marquis, Chairman.

Subject.—H.R. 12080—Social Security measure drafted by the House Ways and Means Committee.

Recommendation.—That the Board of Directors accept the report of the Governmental Affairs Committee and that the following statement becomes the policy of the Pomona Chamber of Commerce.

Statement.—The Pomona Chamber of Commerce supports across the board increases in social security comparable to the actual rise of the cost of living (currently an 8% increase.) The Chamber is opposed to as sharp an increase as that proposed by the administration or that passed by the House of Representatives since such increases tend to make the social security program a form of welfare rather than insurance which was the program's original intent.

Background.—The Pomona Chamber of Commerce feels that the proposed increases are too high. A general across the board increase of 8%, which is comparable to the cost of living increase, would keep the program "in step". This increase would keep the program financed without use of general funds. We feel that a system financed through the general fund, instead of the present self-financed program, through payroll taxes on employer and employee, carries with it the danger of degeneration into one more form of welfare.

Conclusion.—The Governmental affairs Committee recommends that the Chamber's position be communicated to our elected officials urging the opposition of H.R. 12080 as it now stands, but supporting a cost of living increase in social security benefits.

THE UNIVERSITY OF UTAH,
GRADUATE SCHOOL OF SOCIAL WORK,
Salt Lake City, August 25, 1967.

Re H.R. 12080.

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

DEAR SENATOR LONG: I am very much concerned over some of the proposed amendments to the public assistance provisions of the Social Security Act. May I take this means of drawing to the committee's attention those provisions which I think will tend to defeat a major purpose of the program to strengthen family life.

On the whole, H.R. 12080 does provide for some much-needed changes in public assistance and I would strongly urge supporting most of it. However, the proposed amendment to Section 403 (Sub-Section D) limiting the number of child recipients to an established ratio is unrealistic. It penalizes children who may be in need but who were unfortunate enough to be born in a state where social disorganization and family breakdown may be progressive. In addition, it would tend to penalize states that have made some effort to reduce public assistance loads.

The proposed amendment to Section 402A, which would withhold assistance from a relative or dependent child who refused to participate in a work training program is unnecessarily punitive and again fails to recognize the complicated factors that go into such dependency.

There are two points in Section 201a of H.R. 12080, Sub-Sections 15 and 16, which may be detrimental to the overall objective of strengthening family life. Emphasis on "assuring to the maximum extent possible that such relative, child, and individual will enter the labor force and accept employment so that they will become self-sufficient" may not be in the best interest of the child or in long-range planning for family stability. Although this is qualified by reference to "appropriate cases" this qualification is frequently overlooked in employment planning. I have seen a number of instances in which mothers have been encouraged to go to work to the detriment of our future generation.

Similarly, the requirement that states "shall" refer cases of child neglect and abuse to the courts, and "shall" establish paternity and secure assistance for children born out of wedlock, may be detrimental to the welfare of the child or family. Certainly training and employment opportunities and legal services should be made available and utilized by those people who can use them productively, but this massive attack would tend to overload and spread too thin what resources are available. Inappropriate legal intervention tends to be destructive rather than rehabilitative and should be used very selectively. Both of these provisions ought to be qualified by emphasizing "if in the best interest of the child or family."

The provisions for additional day care services and foster care are again very much needed, but unless we are willing to encourage stronger family life by providing more adequate support for the child in his own home there is again danger of disrupting families unnecessarily.

I sincerely trust that your committee will give careful consideration to these particular points.

Respectfully yours,

(Miss) ZELLA D. ALLRED, ACSW,
Assistant Professor.

KEARNEY CLINIC,
Kearney, Nebr., August 24, 1967.

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

DEAR SENATOR LONG: I am writing regarding HR 12080, the proposed revisions of the Medicare Program, which have been passed by the House and are very shortly to be considered by the Senate Finance Committee which you chair. I am sure that members of the House are to be congratulated for their decision to take a close look at the various Title 19 programs throughout the country, their cost, their recipients and their justifications, and also action related to initial hospital certification.

On the other hand, it seems very hard to believe that the same group has apparently failed to grasp the implications of other of the proposed changes which your committee is asked to consider.

In this category certainly would fall the suggestion regarding diagnostic X-ray and laboratory procedures. As I read these items, I interpret the changes to mean that if a patient receives certain diagnostic X-ray and laboratory tests as a bed patient in a hospital, 100% of the costs are paid by Medicare. On the other hand, if the same patient receives the same diagnostic procedures either in his physician's office, in the office of the clinic, or even as an out-patient of the same hospital, then he is reimbursed only to the extent of 80% of the charges. Many physicians offices as well as medical group offices have as good or better facilities and trained personnel as do the local hospitals. Costs of doing the same procedures in a group office do not involve room and board, they do not involve doctors calls to the hospitals, and as a result of these things, total cost is some 50% to 60% of what it would be as a bed patient. If the people in Washington who indicate their dire concern about the cost of Medicare are truly interested, they might consider leaving the indemnification at 80% rather than increasing it to 100% and even more important, they might consider paying for these procedures as they were intended to be done rather than making a prerequisite a hospital bed.

Also, and certainly more important, the obvious tragic result is the complete misuse of the hospital beds which are intended for sick people. The same interested cost-cutters might do well to bear in mind the $25,000 to $30,000 it takes to construct and equip a hospital bed as they are searching for methods of economy.

Another provision along the same line seems to be the suggested method of handling physical therapy services. I understand that it is recommended that these services be covered only when furnished by a hospital physical therapy department. It is obvious that the only treatments given by a hospital physical therapy department are going to be on patients in the hospital, so the same comments might be made, particularly inasmuch as 98% of the therapy done by our physical therapy department here in Kearney is done in our office as an out-patient basis, 1% of it is done by our therapist treating clinic patients in the hospital, and the other 1% is done by his going to local nursing homes. From our experiences, we would feel reasonably safe in saying that for the most part, physical therapy services are an out-patient procedure, and it would seem completely illogical to require that all such service be done in the hospital and again utilizing a needed bed.

I apologize for the length of this letter. As you will see, I am sending a copy to the members of your committee and it is certainly to be hoped that your group will be able to temper the recommendations sent you with some of the practical considerations of medical care of which you are aware.

Respectfully,

HAROLD E. FREESE,
Business Manager.

CHICAGO, ILL., *August 24, 1967.*

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

DEAR SENATOR LONG: The Federal Government last year charged me a cash "fine" of $342.10 for having the initiative and energy to remove myself from the roll of Social Security "Old Age Benefits" recipients through earnings from self-employment.

I am sending the enclosed memorandum to all Senators on the Finance Committee in the hope that a change correcting this unfair discrimination against the industrious aged citizens will be introduced into the legislation under consideration.

Sincerely,

JOHN ASHENHURST.

To: The chairman and members of the U.S. Senate Finance Committee.
Re: Social Security Inequity.

OLD AGE BENEFITS, "TAX-FREE" WHEN DISTRIBUTED SHOULD BE "TAX-FREE" WHEN REFUNDED TO GOVERNMENT

I had to earn $1,742.10 last year to repay the Government the $1,400.00 in Social Security "Old Age Benefits" which I received but had to refund because I was fortunate enough to be able to remove myself from the social welfare rolls by earning through self-employment.

I do not object to returning the $1,400.00 in benefits. I know that, in paying the full amount of Social Security assessment every year since the very beginning of assessments until 1960, I was paying premiums on a subsistence insurance policy—not on an annuity.

I object to being charged $342.10 by the Government for the privilege of earning money instead of just sitting back and collecting it from the taxpayers. I had to pay $256.00 income tax on $1,400.00 and $86.10 self-employment tax on the same amount. There must be hundreds of thousands or maybe millions of others who suffer from the strange ingratitude shown them for being willing and able to continue to be productive members of society.

I should think this problem could be settled simply by a provisions that "Old Age Benefits" money was tax free whether it was being paid out by the Government or being paid back to it and by a provision that persons, once enrolled as beneficiaries of Social Security, need no longer make contributions to the Social Security Administration, regardless of earnings.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE, SAN FRANCISCO, CALIF., SUBMITTED BY JAMES J. FEFFER, M.D., PRESIDENT

THE USE OF DRUGS

The American Society of Internal Medicine is composed of 9,000 internists—physicians whose practice consists primarily of diagnosis, prescribing, treating and, as individual circumstances warrant, referral of patients to other medical specialists most capable of treating their individual illnesses. The objective of the Society is to maintain the highest quality of medical care for Americans, and constantly to elevate the standards of such care.

The prescribing of drugs is an integral part of that care and constitutes both the physician's prerogative and his responsibility.

Accordingly, we have followed these hearings before Senator Gaylord Nelson's Subcommittee thus far with deep interest and growing concern. We feel statements have been made by witnesses which, if left unchallenged, will produce a record as faulty scientifically as it is dangerous medically.

There is no greater concern to the physician than the safety and the efficacy of the drugs he prescribes. This is most assuredly true with respect to the internist in whose practice the prescribing of drugs plays a major role. Daily, he is faced with a wide-ranging variety of medical problems, and must in each case select the particular medicine he believes is most suited to deal with the condition he has diagnosed.

Our apprehensions have been aroused by the rather sweeping generalizations before Senator Nelson's Subcommittee on the therapeutic equivalency of drugs, as reported in the press, and by argumentation which seems to emphasize the cost of drugs to the exclusion of quality considerations. Our purpose in testifying is to offer our opinion, as physicians and internists, on these and related matters which comprise such important aspects of our professional lives.

We would like to begin by pointing out that under the American system of medical care the doctor alone arrives at a diagnosis, and he alone should decide precisely what medicine is to be prescribed for his patient. This is a vital function in the performance of his professional duty. It cannot be delegated without endangering the quality of care each individual receives.

The physician is the most familiar with the medical needs of his patient. He is also best qualified to observe the effects of medication on the patient, and he is, above all others, the person most responsible for, and responsive to, his patient's well-being.

When a physician or dentist prescribes a drug, he is attempting to relieve a specific disorder in an individual patient. His prescription represents his best medical judgment, his practice of his profession. It represents his past experience with the drug, his opinion as to its usefulness, at this time, for this particular patient and his preference for it over any other avalaible drug or combination under the existing circumstances.

These are elements which appear to be overlooked in the statements and recommendations of a great many non-medical and non-pharmaceutially oriented persons who are currently arguing matters affecting the manufacture, prescription and sale of drugs.

It is, of course, possible to compare the "efficacy" of drugs, based on the average results recorded in laboratory or clinical testing or experimentation. But "efficacy" in this sense is a term of limited meaning. Physicians do not practice medicine on the average. A physician does not treat a group of 10 cases of hypertension and average the results. He treats 10 individual persons, each a separate and unique human being, each of whom has a medical problem he has diagnosed as hypertension.

It is possible that he will find the same dosage of the same form of the same drug to be efficacious in each of his patients. It is equally possible, and more likely, that he will find one or more of them who need different dosages or different forms of the same drug. It is possible, indeed, that one, two or three of them will be allergic to the non-active ingredients used in one make of the drug, and that only a different make with more or different non-active ingredients provides the answer.

There are, indeed, significant differences in drug products produced by different manufacturers even though they contain the same active ingredient—a fact our practice of internal medicine has demonstrated beyond a question. We say this in full awareness of the nature of much of the testimony which has been recorded before Senator Nelson's Subcommittee.

Two generic drugs produced by reputable and conscientious manufacturers will undoubtedly yield the same results in their chemistry when submitted to the same tests. But in the selection of a drug in a particular case, a physician must bear in mind the many differences in physical properties among the various drugs of the same generic name and the differences in his patients.

There are differences in the size of particles in the finished form of the product. There is the difference in solubility, which directly affects the rate of assimilation of the drug by the patient once it has been administered. There is the difference in filler material, or excipient, which is used in the finished product. There is the difference in the compression used to hold the product together in its finished form. There is the difference in coating. There is the difference in the necessary time required for release of the drug itself from the excipient after the medicine has been ingested. And there is the difference that can come about through interaction between the drug and the excipient as the product stands on a shelf awaiting use.

Each of these is significant in the treatment of disease.

Each is an emphatic reminder that the physician should not be deprived, by government ruling or decision, of the right to use the drugs that he believes are medically indicated for any one patient. Nor should he be limietd in his choice of available medications by any artificial barriers such as those that would be erected by requiring a generic prescription rather than a brand name prescription.

A generic prescription, without identification of the manufacturer, is simply an open-ended request for any drug of the genre which happens to be on the pharmacist's shelves. Thus the decision as to precisely what drug is to be administered is transferred from the physician to the pharmacist. With all the respect we have for pharmacists as colleagues of long standing in the combined efforts to improve health care, we must insist that the treatment of the patient is solely the physician's responsibility, and should remain so.

When in the physician's best judgment a generic drug can safely be dispensed, there is nothing to prevent him from writing a generic prescription. Many undoubtedly do so in cases compatible with the patient's needs. I personally prescribe only pharmaceutical products which I know or with whose manufacturers I am familiar.

Of particular concern are patients on long-term drug therapy. Successive refills of the same prescription from products of different manufacturers can cause variations in response which are misleading to the physician and harmful to the patient. During these extended courses of treatment, generally referred to as maintenance therapy, it is important to arrive at and sustain drug equilibrium; that is, to maintain adequate concentrations of drug in the blood and tissues to guarantee the physiological integrity of the tissue or organ under treatment.

The use of digitalis glycosides in the treatment of congestive heart failure is a good case in point. While under care for this condition, patients are initially digitalized by frequent administration of the drug until desired cardiac rhythm and strength are attained. Thereafter the patient is maintained on less frequent but regular doses of the drug. Any change at this point in the tissue level of the glycoside in the heart muscle could cause serious consequences. If, for example, a change in the product being administered resulted in a less than adequate amount of the drug in the tissue, the patient could revert to decompensation. On the other hand, if the second product, for any reason, was hyper-potent, it could result in serious arrhythmias which could be fatal for some patients.

Hormone therapy is another example of the sensitive type of long-term treatment in which the outcome can be seriously affected by a change in brands of the same drug. The amount of thyroid or its derivatives given to patients suffering from thyroid deficiency will depend, of course, on the degree of hypothyroidism. In treatment, it would therefore be necessary to select a dosage which will offset the symptoms arising from deficiency but will not result in development of hyperthyroidism. The establishment of an adequate dosage is somewhat of a trial and error proposition but, once established, the patient can be maintained very satisfactorily so long as there is no change in the strength of the thyroid preparation being administered. Any variation, such as might be caused by a change in the brand of the drug, or a change to a generic drug, could result in either hypo- or hyperthyroidism, depending on the potency of the preparation administered.

Treatment of diabetes with some of the new oral antidiabetic drugs is still another example of maintenance therapy in which the delicate balance of physiologic equilibrium is exceedingly important. Failure to carefully regulate blood sugar levels in the use of these drugs can result in one of two dangerous clinical situations.

Subpotency in such preparations can lead to development of hyperglycemia which in the extreme can lead to a condition known as diabetic coma. Hyperpotency, conversely, can lead to the depletion of blood sugar and give rise to the opposite condition known as hypoglycemic shock. The dosage must provide consistent blood levels of the drug which, in turn, maintains normal blood sugar. Once established, maintenance of such blood level is reasonably well assured with the product that was used initially. A change to a product of another manufacturer can immediately upset the delicate balance.

These are a few random examples of the importance of consistency in drug therapy. Others include further types of hormone therapy, treatment of other forms of cardiovascular disease, and maintenance of electrolyte balance in certain forms of heart and kidney disease. All reflect the same basic problem with which physicians are continually confronted—Drug products of different manufacturers can meet the same chemical or pharmaceutical specifications but they can, and often do, vary widely in activity in human beings through variations in vehicles, particle sizes, hardness of tablets, etc. The physician must know what he is prescribing, what it does and where it came from. If he is coerced into prescribing by generic name, he would lose control over what drug is used to fill his prescription, hence be deprived of his prerogative to treat his patient's individual condition according to his best medical judgement and his experience.

Not only do we see interference with medical practice in spreading government attempts to control the prescribing of drugs, we are also concerned over the inescapable effects this trend will have on the industry. The therapeutic advances it has produced in the past three decades have been truly marvelous. An amazing 75% of the 200 drugs most commonly prescribed today were unknown just a decade ago.

But if the price of drugs is permitted to become the paramount consideration in their selection over quality, we foresee a discouragement of the striving for excellence which has marked this progress. For the two are tied together, and this must be realized. Drug industry research is financed from its receipts; it is one of the normal costs of remaining in competition in a business where the struggle for new discoveries is intense and unceasing. Take away the receipts on whatever grounds and you sap the strength and viability of the industry.

This is a vital factor for the physician. Of all members of the health team, he is the one most acutely aware of the extent to which the armamentarium against disease and suffering has been enlarged and strengthened over the years by industry efforts. He depends, as we have tried to indicate, on quality, research-oriented manufacturers, not only to produce new and better drugs, but also products of proven effectiveness and performance.

If we are going to legislatively discourage such a system, with its unparalleled record of achievement, we submit that Congress should have an equally good or better alternative ready.

Despite pre-marketing clearance procedures administered by the Food and Drug Administration and despite the standards established by the United States Pharmacopia and National Formulary, some drug products reach the market without biological testing, without the original New Drug Application procedures designed to guarantee clearance of safe and effective new products. Since the producers of such drugs frequently have questionable quality controls, their products are naturally cheaper. It takes less time, manpower and effort—it is less expensive—to imitate a successful drug or to "cut corners" in producing it.

In the interests of quality medical care for all Americans, the American Society of Internal Medicine believes that Congress could take no more constructive step than to insure the preservation of the right of the doctor to make the final selection of the drug product for his patient or to delegate that right to the pharmacist if he wished to do so. It should also help to lay to rest the totally misleading statements concerning the generic and therapeutic equivalency of drugs. The public has been thoroughly confused and tempted to believe that generic prescribing would drastically reduce the price of drugs without adversely effecting the quality of medical care. These false impressions should be corrected.

The major differences in the prices of drug products of *quality* generic firms, and there are a number of them, and the products of brand name manufacturers is not in the production or the packaging or the advertising of products. True quality controls are as costly for one manufacturer as for another. Promotion is certainly a proper and constant factor. The difference is primarily in the research. Most generic firms, producing and marketing established drugs of proven effectiveness, do little of this. It is on the other hand a major expense for the leading brand name manufacturers. And we believe that, on reflection, you will agree it is worth every penny of the difference in product prices. It is an expense on which medical progress has depended for more than a quarter of a century and must depend in the future.

In summary, we suggest that until the quality of *all* drugs reaching the market can be assumed there should be no attempt to tamper with the historic right of the physician to prescribe for his patient on the basis of his knowledge and experience. The application of that knowledge and experience on a patient by patient basis amounts to an individual determination by the physician of the clinical effectiveness of the drugs being used. Physicians do not prescribe a drug without evidence that it has worked on others under similar conditions, either through their personal observation or from the necessary information from sources they respect. A drug which is ineffective for a particular individual is quickly replaced by another. There are no standardized patients any more than there are standardized drugs to meet their needs.

Under existing circumstances, it can hardly be wondered that the nation's physicians continue to rely on the most practical and reliable measure of trust which they know in selecting drugs for their patients.

Lacking vast laboratories staffed by scores of pharmacists and chemists, and unlimited travel funds for plant inspections, etc., individual physicians place their reliance on the products of manufacturers whom they know and trust. They select those pharmaceuticals which they know are of the highest quality and which their experience tells them will deliver the best results. For unless the drug (whether marketed under generic or brand name) is made by a reputable and qualified manufacturer, there is absolutely no way to tell which drug is good and which is poor before it is used, without access to analytical and biological testing facilities more elaborate than physicians, pharmacists and hospitals possess.

As has been recorded in previous testimony, the overwhelming majority of prescriptions filled last year, more than 90%, called for a product by brand name or the product of a particular manufacturer in whom the physician had placed his confidence.

It has also been stated here that 86% of the dollars spent by the federal government last year went for the purchase of products of brand name manufacturers when all the testing and elaborate screening procedures were completed.

Surely there is a message in these two sets of figures which cannot in good conscience be ignored.

Physicians, depending on manufacturer integrity to secure the highest quality medicines for their patients—and the government, refusing to accept anything except scientific proof of quality—both arrived at roughly the same drug counters to secure healing agents for those for whom they are responsible.

At this time, we have tried to discuss certain paramount considerations to physicians which are involved in these hearings. Our apprehensions have been aroused by the demands in some quarters for mandatory generic prescribing, or suggestions that our choice of drugs be limited by legislation and regulation. If such laws ever pass, they would take away from the physician the right to designate the drug in which he has confidence, and place this important decision in the hands of a third party.

As professional men, we are opposed to giving up our prerogative and our medical responsibility to choose the drug and its manufacturer which we believe is the most suitable for our patient. The physician must have the privilege of choosing the drug to be prescribed because it is the physician who ultimately must be responsible for the result of the drug in the patient for whom he is prescribing.

Under our system, as we have always known it, Americans enjoy the best of medical care. Our earnest request to you today is that you take no steps which would drastically alter that system or which would retard the continuing and expanding flow of useful drug products to the public.

NEW HAVEN, CONN., *August 25, 1967.*

MR. TOM VAIL,
Chief Counsel, Committee on Finance,
New Senate Office Building,
Washington, D.C

DEAR MR. VAIL: Since I cannot appear to testify at the Senate Finance hearing relative the new Social Security Bill, I would like to go on record as being opposed to any increase in benefits even though I am approaching retirement age if the various states are permitted to decrease Old Age Assistance benefits by the amount of the Social Security benefit increase.

In Connecticut, the State Welfare Department decreased benefits by 7% several years ago when the Social Security Administration increased benefits by 7% so that the State benefited from this increase rather than the poor indigent citizens who are on Old Age Assistance.

I believe there are other states in the Union that have followed the same procedure. The states have been taken off the hook by the Kerr-Mills and Medicare bills and they will undoubtedly want the few paltry dollars from increased Social Security benefits.

Very truly yours,

FREDRIC M. ROSENSTEIN,
Public Accountant-Auditor.

GEORGIA FEDERATION OF THE BLIND,
Conyers, Ga., August 24, 1967.

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

MR. CHAIRMAN AND GENTLEMEN OF THE COMMITTEE: You now have before you, for consideration, HR 12080 as adopted by the House. This bill contains many excellent and progressive amendments to the social security act and in general, the Georgia Federation of the Blind supports this bill.

However, Section 156 contains the most regressive and punitive definition of disability ever to be included in a public assistance law since the days of the Elizabethan "poor laws". This provision makes the existence of a theoretically possible employment for a disabled person sufficient grounds for denying public assistance payments, whether or not such employment opportunities actually exist for him. It is our belief that public assistance in all categories should be granted on the basis of definite, objective criteria and not be made subject to the whim of Federal and State officials. The great majority of the severely disabled earnestly desire to become self sufficient and contributing members of society. They should be encouraged and assisted to reach this goal. This certainly would not be the effect of the provision written into this bill by the House Committee.

We would like to see the present criterion for assistance to the "totally and permanently disabled", which admittedly is severely restrictive, modified so that the criteria used for eligibility for benefit payments to the disabled under Title II of the social security act would also apply to applicants for assistance to the disabled under Title XIV. This would require the elimination of the word "permanently" in this Title and the substitution in the definition of disabled, wording similar to that now contained in Title II.

We respectfully request that the Senate Finance Committee eliminate the phraseology to which objection has been voiced herein, and the inclusion in the Senate version provisions which will allow the totally disabled, whose disability has lasted or is expected to last for at least twelve (12) months, eligible for public assistance payments under Title IV of the Act.

Respectfully submitted,

NED FREEMAN,
President,
Georgia Federation of the Blind.

THE ORTHOPEDIC CLINIC,
Tulsa, Okla., August 22, 1967.

HON. RUSSELL B. LONG,
Senate Finance Committee,
U.S. Senate, Washington, D.C.

SIR: I wish to bring to your attention one of the proposed amendments to the Social Security Act of 1967, which I understand your committee will be discussing in the next week or so. I believe this is HR Bill 12080.

It is our understanding that one portion of the amendment deals with the proposed payment for physical therapy services under the Medicare Law. This particular amendment indicates that payments for physical therapy treatments would be made only if these services are given in the Physical Therapy Department of a hospital. We feel that this is an unfair amendment. Many medical groups in the United States, including our own, have well organized and well staffed physical therapy departments. In our own clinic we have full time registered physiotherapist and four subordinate physical therapy employees. We take great pride in the fact that our physical therapy department is superior to that of many of the local hospitals. Much of the treatment in orthopedic practice requires follow-up physical therapy treatments, and it is unrealistic to require a patient to go to a hospital in order to receive this treatment. We feel that the cost of doing this would be much greater than for a patient to come to a clinic which has a bonafide department for their treatment.

I would appreciate your giving this section of the bill a great deal of thought, and attempt to convince the members of your committee that professional physical therapy procedures need not necessarily be confined to a hospital, in order for payment to be disbursed. We feel that having our clinic in control of the physical therapy program prescribed is vital to the well being of the patient.

We know, from past experience, that we can give it at a more reasonable charge than that assayed by the hospitals.

Any help that you can give us in this area will be greatly appreciated.

Very truly yours,

FRED B. SCHWARTZ,
Business Manager.

THE NALLE CLINIC COMPANY,
Charlotte, N.C., August 25, 1967.

HON. RUSSELL B. LONG,
Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SIR: I respectfully request that you strongly oppose the proposed change in the Medicare law wherein a patient will only pay a 40 per cent deductible for in-patient diagnostic procedures. Certainly it is a fact throughout the United States that there is a general lack of hospital beds yet there would be much more incentive for a patient to be admitted for diagnostic procedures if they do not find it necessary to pay a deductible under Part B. Many private offices as well as such groups as ours are completely adequate to render out-patient diagnostic services at a much cheaper overall rate than can possibly be rendered to a bed patient. If there is concern over x-rays being indiscriminately taken in a private office, I might suggest that consideration be given to the fact that such out-patient care would be authorized only by residency trained radiologists or Board Certified radiologists. As in the case of this group, we have a full time radiologist, Board Certified, on our staff that is as well equipped and trained to render diagnosis x-rays as the patient radiologist. Also our laboratory is well staffed with A.S.C.P. registered technologists who again can offer equal services to any in-patient service offered by the community hospitals.

I would also like to personally plead that there be no change in the present method of compensation whereby a physician is paid directly if he accepts an assignment or else the patient is paid directly upon receipt of a paid statement. I personally have found that this works very satisfactorily and I do not believe that we have encountered any incident where the patient is being penalized nor is there any adverse penalty being levied upon the doctor under this present procedure.

I would appreciate any consideration you might take concerning these expressions of my opinions.

Sincerely yours,

RALPH L. DRAKE,
Clinic Manager.

OHIO STATE MEDICAL ASSOCIATION,
Cincinnati, Ohio, August 26, 1967.

U.S. Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: In regard to your Committee's current hearings on H.R. 12080, I respectfully solicit your serious consideration and support of amendments to this worthy measure.

The amendments we strongly recommend are in keeping with and in furtherance of the excellent purpose statement contained in the U.S. Department of Health, Education and Welfare's February, 1967, "Report to The President on Medical Care Prices." This tremendously significant statement, found on page three of the report, declares:

"Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

In keeping with the intent of this statement, this Association urges the following amendments to H.R. 12080:

On page 47, strike out line 10.

In line 14, after the word "to," insert "the individual receiving the service,".

On page 48, lines 4 and 5, strike out "or directs that payment be made to the individual receiving the service." It is not a part of the practice of medicine for a physician to say how a party with whom his patient has a contract shall make payment under that contract. Medicare is a contract between the patient and the Social Security Administration, and the physician is not a party to the contract.

On page 159, line 19, strike out "at the option of the State,".

On page 159, line 20, strike out "not".

It is our deepest hope that you and your Committee will adopt these suggested amendments as a means of carrying out the intent and purpose of these public programs as described in the previously cited "Report to The President on Medical Care Prices."

Thank you for your kind attention.

Sincerely,

ROBERT E. HOWARD, M.D.,
President,
Ohio State Medical Association.

LOS ANGELES, CALIF., *August 22, 1967.*

HON. RUSSELL B. LONG,
Senate Office Building, Washington, D.C.:

At its meeting today, on motion of Supervisor Ernest E. Debs, the board of supervisors adopted the following positions regarding public assistance provisions of H.R. 12080, the Social Security Amendments of 1967:

1. Federal participation in the cost of foster home placements: section 205 of H.R. 12080 provides Federal matching funds for foster care payments for children only if they are placed by court order and were eligible for AFDC for a specified period of time prior to the foster home placement. Federal participation will not be available to approximately three-fourths of the placement cases aided by the department of public social services. Federal matching funds should be extended to all these case situations.

2. Freeze on Federal participation to aid to families with dependent children: Section 208 sets a ceiling on the amount of federal participation. In absent father AFDC cases based on the proportion of AFDC children in January 1967 to the total number of children in the State's population. This provision could require a substantial increase in local funding by arbitrarily freezing the Federal share. There should not be a closed end Federal cost sharing in this family assistance program.

3. Aid to children of the unemployed: Section 203 changes the eligibility requirements for the AFDC unemployed parent program which we have had since 1964. This proposed section requires that all families currently receiving AFDC-U under existing regulations and who do not meet the new requirements would have to be removed from the rolls. County cost would increase because of loss of Federal participation. We are opposed to changes which would transfer aid payment costs from the Federal Government to local government.

JAMES S. MIZE,
Clerk, Board of Supervisors,
County of Los Angeles.

STATEMENT OF GEORGE S. BULLEN, LEGISLATIVE DIRECTOR, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

The National Federation of Independent Business appreciates this opportunity to submit a statement for consideration by your Committee.

With a current membership of more than 239,000 smaller, independent enterprises, the Federation has in its membership more than 1 of every 20 small businesses in our Country. This membership is broadly representative of all small business by type, size and geographic distribution.

SUMMARY OF COMMENTS AND RECOMMENDATIONS

I

Federation members voted by a large majority against increase in old age survivors, and disability insurance benefits, and are opposed to enactment of these provisions.

II

Federation members voted by a substantial majority in favor of permitting older people to earn as much as they want in private employment without forfeiting any part of their Social Security income and therefore, favor enactment of and/or broadening the provisions of Title I, Section 106.

III

Federation members are opposed to including the cost of prescription drugs among medical expenses covered under the Medicare program.

FEDERATION POLLING

The Federation's position on any legislation is determined by the majority vote of the nationwide membership. Although we have not polled our members on the specific bill (H.R. 12080) being considered by this Committee, we have presented the issue of amending the Social Security Act to provide cost of living increases in benefit payments; raising benefits by an overall average of 20 percent; increasing the amount an individual is permitted to earn without suffering deductions from benefits; and including the cost of prescription drugs under the Medicare program.

I

Polls on increasing Social Security benefits were presented as follows:

Mandate Ballot No. 315 (October, 1966).

4. *Should Congress Amend* the Social Security Act to provide cost of living increases in benefit payments?

Arguments *Pro* and *Con*, which members were asked to read before voting, were:

4. *Argument for the proposal.*—Proponents point out that while Social Security benefits were increased by 7% across the board last year (the first increase in seven years) the cost of living since the last increase in 1958 rose by some 11%. In a word the trouble is inflation. Those on fixed pensions whose monthly checks do not rise automatically, to offset the impact of higher prices, are the ones who suffer most. If the cost of living as determined by the Labor Dep't goes up by three percent, the amount of Social Security checks would be increased by a corresponding three percent.

4. *Argument against the proposal.*—Opponents want to know where the money is going to come from to finance the additional cost. Smaller, independent businessmen are already overburdened with Social Security taxes. Employers and employees each had their tax rate raised from 3.6% each to 5.65% each by 1987. The earnings base was raised from $4800 to $6600, effective Jan. 1, 1966. The self-employed rate rose from 5.4% to 6.15% in 1966 and to 7.8% by 1987. If increases follow automatically the increases determined by the Cosumer Price Index, the Congress is relinquishing its tax writing power and authority.

Results of the poll were: *For* 34%; *Against*, 62%; *No Vote*, 4%.

Mandate Ballot No. 317 (Jan.-Feb., 1967).

3. *Are You For or Against* Congress raising Social Security benefits by an overall average of 20 percent?

The minimum payments would rise by 59%—from $44 to $70 a month, and guarantee a minimum benefit of $100 a month for those with 25 years of coverage,

Arguments *For* and *Against:*

3. *Argument for the proposal.*—The President made this proposal in his State of the Union Message. However, the idea has bi-partisan support from legislators from both sides of the aisle. The increase in Social Security taxes has never kept pace with the increase in the cost of living. Those on fixed incomes (monthly pension checks) have a most difficult time making ends meet. It seems only fair, and not too burdensome either, to provide for the welfare of our own citizens in their advanced years when we can fight a costly war, and poor millions into foreign aid.

3. *Argument against the proposal.*—Opponents of this proposal note that the increase would require adding $4.1 billion to Social Security payments in the first year. This would wipe out any gain from revenue from the proposed 6% surtax increase, assuming the additional tax is approved. Even with only a 10% increase in benefits, the SS tax would have to be raised to 4.6% or the taxable

base raised from $6,600 to $7,800. There are other proposals to increase benefits by 8% that would not require increased SS taxes.

Results of the voting: *For*, 21%; *Against*, 76%; *No Vote* 3%.

II

In polling the members over increasing the amount an individual is permitted to earn without suffering deductions from benefits, Mandate Bulletin No. 320 (May, 1967), presented the issue, broader in scope than the provisions under Section 106, as follows:

4. *H.R. 4489.* A bill to permit older people to earn as much as they want in private employment without forfeiting any part of their Social Security benefits. (Cong. Kupferman, N.Y.)

Arguments *For* and *Against:*

4. *Argument for H.R. 4489.*—Proponents believe a person who pays for insurance can expect to collect on it, regardless of the amount of money he is earning when he's eligible to collect. This is only fair, and should apply to Social Security which is basically retirement insurance. Presently Gov't is penalizing older people just because they want to supplement their income. This favors the wealthy oldster who has invested wisely and injuries the less fortunate, because if he works for wages and makes over $2,700 a year, he loses his pension checks entirely. This bill would end this unfairness.

4. *Argument against H.R. 4489.*—Opponents say this bill carries with it a built-in pressure for a Social Security tax increase. The facts are clear; raise the ceiling and you're going to have more people drawing down pension payments. More people drawing payments naturally means a bigger drain on Social Security system income. The bigger the drain, the greater the pressure for increasing Social Security taxes. And don't forget . . . Medicare is financed through the Social Security program. This requires more funds, more and greater taxes. Let's don't add fat to the fire!

Results of the poll were: *For*, 72%; *Against*, 25%; *No Vote*, 3%.

III

The issue of amending the Social Security Act to include the cost of prescription drugs under Medicare was carried in Mandate No. 318 (March, 1967), as follows:

5. *H.R. 26-S. 17. Are You For or Against* a bill to include the cost of prescription drugs among the medical expenses covered under the Medicare program? (Cong. Dingell, Mich-Sen. Montoya, N.M.)

Arguments *For* and *Against*:

5. *Argument for H.R. 26-S. 17.*—Proponents of this bill state that the failure of protecting our elderly citizens against the cost of needed but expensive prescription drugs and medicines leaves a great gap in the Social Security Act. The cost of these drugs is a great financial burden to be borne by millions of our senior citizens, particularly those persons who must take drugs on a continuing basis. Certainly prescription drugs are as necessary to the medical treatment of the elderly as the hospital and physician care.

5. *Argument against H.R. 26-S. 17.*—Opponents of this bill only need to point out the many difficulties that have arisen since the enactment of Medicare to feel justified in predicting that this extension of benefits will bring with it a whole new raft of problems. This gets the government deeper and deeper into the business of independents. The medical doctors have not found the regulations under the Medicare to their liking. This Federal intervetion will prove to be harmful to pharmacists and retail druggists.

Results of the voting: *For*, 30%; *Against*, 64%; *No Vote*, 6%.

COMMENTS

I

In the opinion of the Research Staff of the National Federation of Independent Business, the negative vote on increasing social security benefits is based upon the belief that any increase in the taxes on business, either on the rate, or in the base, will create greater problems for the small businessman as well as adding to inflationary pressures.

While the Federation has never taken the position that the needs of the elderly can be ignored, it has in the past pointed out the fallacy of increasing the payroll taxes that an employer must pay as this in turn, forces up the cost of goods and services, an definitely tends to lower employment.

II

As long as the Social Security System penalizes no senior citizen who has money working for him, there should be no penalty for those who have their hands or minds working for them. It is felt that by allowing senior citizens to earn more without relinquishing social security benefits, the purpose of increasing their total income is served, the Government will realize increased income tax revenue, and the employers will not be faced with higher social security taxes.

III

It is understood that the Committee will consider amendments to the Social Security Act, including those relating to the providing of drugs under the Medicare and Welfare programs. As the poll in Mandate No. 318 above shows, the majority of our members oppose any amendment which would provide for the inclusion of prescription drugs under these programs. Apparently the opinion is based on the belief that such an amendment would get the Government deeper and deeper into the business of independents, and would prove particularly harmful to pharmacists and retail druggists.

STATEMENT OF AIR LINE PILOTS ASSOCIATION, SUBMITTED BY JAMES E. MEALS, LEGISLATIVE REPRESENTATIVE

On December 1, 1959, the then Administrator of the Federal Aviation Agency promulgated a regulation providing: "No individual who has reached his 60th birthday shall be utilized or serve as a pilot on any aircraft while engaged in air carrier operations." The above regulation became effective March 15, 1960. The Air Line Pilots Association and the individual airmen affected opposed the adoption of this rule under the limited means available within the administrative procedures and subsequently in the courts. These efforts were in vain and the regulation became an enforceable rule on the date above stated. Since March 15, 1960, therefore, the Air Transport Companies in the United States have not utilized any member of an operating crew after he has reached his 60th birthday.

We believe, briefly, that if the Federal Government requires retirement at age 60, then the Social Security program of the Federal Government should be adjusted to provide full benefits at age 60 for those people affected. We do not limit this plea to just members of our group, though as far as we have been able to determine, we are the only group outside of Federal employees affected by Federal rule. We understand that there are some state and municipal law enforcement agencies whose personnel face retirement prior to age 65, but how many people are so affected and how many of these participate in the Federal Social Security program, we do not know. We have been given to understand that certain employees of the C.I.A. are required to retire prior to age 65 and that appropriate redress has been made for these people under the Federal Employees Retirement System. Social Security is not involved in this instance.

The actual loss to the individual is difficult to compute as the end result is affected by many variables. The maximum table base has increased over the years, and the employees number of years paying the maximum base will vary. We do know that every time the maximum table base is extended, our people will suffer all the more, as they lose the last five years contributions an thus further reduce benefits. Each case must be figured individually, but we believe that any reduction is unjust.

Some people have observed that the retirement programs should be adjusted to cover the financial loss in these cases, while others have noted that with the abundant retirement to the individual in the cases at hand, he doesn't need the money and that there are other, more deserving individuals. In answer to the first proposition, let us state that, first, we do not believe that it should fall the lost of private enterprise to take up the slack in a Federal program under one department when the inequity was caused by a regulation promulgated by another agency of the same Federal Government. The employer has already contributed over the years to this federal program. We don't believe he should contribute more where the inequity arises through no fault of his. As to the second proposition, be advised that the Air Transport Industry is comparatively young, as are their benefi programs. The pilot retiring today is doing so at a figure somewhere between $25 and $300 per month. We hardly believe that this constitutes such a staggerin amount that his voice should be ignored. This benefit amount is still reduced an out of proportion to his contributions. We also want to note that several of th pension plans are still tied to Social Security and the benefit amount from th plan is reduced by the amount paid by Social Security when it starts at age 65.

All of us in our profession must face the reality of this compulsory retiremen regulation. While it exists, we must recognize the fact that we will be unemployable during a five year period when most of our fellow Americans are enjoying their peak earnings and greatest professional rewards. As this committe may be aware, the principles of seniority are fundamental to promotion an earnings in the airline industry, and consequently, the loss of earnings during our most senior years is a very heavy one indeed. I am sure the committee will also quickly realize that a man who is forced to retire from his profession as a commercial airline pilot at the age of 60 can scarcely train himself for a new career, and will find it virtually impossible to find alternate employment suitable to his skills, training and background.

In conjunction with the federally required compulsory retirement, the committee should also consider the fact that our members, during their years of gainful employment pay the full contributions required by the Social Security laws. Those laws presently contemplate that a man should be entitled to the full benefits of the program at his normal retirement age of 65. However, another Federal program, presumably designed to serve other purposes of the Federal Government decrees that members of our profession may not work until the age of 65. Certainly, the same considerations which prompted Congress to provide benefits at the normal retirement age of 65 would also be applicable to the man who is faced, through no fault of his own, but pursuant to a Federal program, to retire at an earlier age. To put it very briefly, there is no reason why the individual should have to suffer a deferral or reduction of his Federal Social Security benefits where his retirement is pursuant to another Federal law or regulation.

We would generally support the provisions of H.R. 12080, but strongly suggest to this committee that the provisions of H.R. 7582 be embodied in the final version of H.R. 12080 so the inequities heretofore cited can be overcome. A copy of H.R. 7582 is attached for the information of each member of this committee. In short, this bill provides for payment of full Social Security benefits upon the compulsory retirement of the airline pilot.

[H.R. 7582, 90th Cong., first sess.]

A BILL To amend title II of the Social Security Act to permit the payment of full retirement benefits thereunder at age sixty in the case of certain individuals who are forced to retire at that age under Federal law or regulation

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 202 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Benefits in Case of Certain Individuals Required To Retire at Age Sixty

"(w) For purposes of subsections (a) and (q) of this section (and for purposes of sections 214(a)(1) and 215(b)(3)), any individual who, after having been employed by one employer for five or more years, is required by such employer to retire at age sixty in compliance with an Executive order of the President, or a regulation or order issued by a Federal department or agency and published in the Federal Register, which establishes a policy of early retirement for employees in positions of the type held by such individual and to which such employer is subject, shall be deemed to have attained age 65 in the month of such retirement and continuously thereafter until he actually attains such age. This subsection shall not apply in any case in which a higher primary insurance amount would result without its application."

SEC. 2. The amendment made by the first section of this Act shall apply only with respect to monthly insurance benefits payable under title II of the Social Security Act for months after the month in which this Act is enacted on the basis of applications filed on or after the date of the enactment of this Act.

PENNSYLVANIA SOCIETY OF INTERNAL MEDICINE,
Harrisburg, Pa., August 25, 1967.

To: Mr. Thomas L. C. Vail, Chief Counsel, Committee of Finance, U.S. Senate.
From: Alexander M. Minno, M.D., President, Pennsylvania Society of Internal Medicine.
Subject: Compulsory Generic Prescribing.

HOUSE OF DELEGATES, ASIM,
San Francisco, Calif.:

RESOLUTION

Whereas the ASIM is striving to maintain high quality of medical care and to further improve such care, both in hospitals and in the office of the practicing physician;

Whereas the physician is responsible for the safety and efficacy of the drugs he prescribes for his patients;

Whereas dosage forms of drugs formulated by different manufacturers may differ significantly in therapeutic action;

Whereas production of pharmaceutical equivalents in products from many producers is not presently feasible;

Be it resolved that the ASIM opposes any federal legislation proposed to make prescribing and dispensing by generic or trade name compulsory;

Be it further resolved that this resolution be transmitted to the Congressional Committees studying such bills and supported in person by officers of the ASIM, if appropriate.

Adopted, April 1967.

THE NORTHWESTERN CLINIC,
Crookston, Minn., August 24, 1967.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate,
Washington, DC

DEAR SENATOR LONG: The doctors of the Northwestern Clinic have asked me to address this letter to you as Chairman of the Senate Finance Committee in objection to several proposals now being considered under H.R. 12080, the Social Security Amendments of 1967. We feel very strongly it would only add confusion and costs to the present Medicare program.

It is our opinion that diagnostic x-ray and laboratory procedure payments should be left as they now exist and not changed to provide the payment of 100% of all charges while a patient is in the hospital. By incorporating 100% of the fees, it will only increase the demand for hospital beds in a period when they are already short. Naturally, this would add to the cost of the Medicare program also in that a patient would have to be hospitalized for many procedures which can be done on an out patient basis in a doctor's office or medical clinic.

Basically, people are the same throughout the world. If they can gain financially from such an arrangement, they will do so and will insist on being hospitalized.

We object to the third system recommended for the payment of physician's bills. The proposed changes would add to the confusion which already exists. We feel it is a very simple arrangement at the present time to either accept or reject assignment of benefits. We have had little or no problems with the patients regarding this and would certainly hesitate to try to explain the monstrosity the present proposals would create if enacted.

We do not have a physical therapy department in our Clinic so could not be accused of objecting from a monetary standpoint that physical therapy payments be limited to hospital facilities only. This just does not make sense. Again, this would only add to the cost of the Medicare program and actually to the cost of the patient as well. After all, many patients can be seen by the physician in his office and the physical therapy carried out after he has been examined at the same office or clinic if physical equipment is there.

It is our opinion refractions should be covered under Medicare completely and should not be subdivided. At any rate, if you do not wish to incorporate payment for all refractions, then we would certainly object to the present proposal.

In the short period of one year, statistics have already proven that Medicare costs far exceed the estimates before the program was instituted. Most of the proposed changes mentioned in my letter would only add to the already underestimated cost of the Medicare program. We would appreciate our letter be given the same consideration as though a member of the Northwestern Ohio had made a personal appearance before your Committee. Thank you for your consideration.

Sincerely yours,

JUNE E. SHAVER.

SILVER SPRING, MD., *August 24, 1967.*

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

DEAR SENATOR: I understand the Senate Finance Committee is now holding hearings on the Social Security Bill. I respectfully call your attention to the fact that the earnings limitation in this bill operates I think unfairly especially as to beneficiaries who are not drawing retirement benefits.

I am a widow, with a five year old daughter, paying around $125.00 a month, plus transportation, for a baby-sitter five days a week while I work as a typist to earn around $300.00 a month take-home pay. When I went to work in February of this year the social security payments I was drawing because of the death of my husband were $100 a month for me and $100 a month for my daughter. My social security payments of $100 a month were stopped when I went to work. My case is not a hardship case for my husband left a little insurance which I would like to save for emergencies. Also I like my work and plan to continue in any event. The point is we could not be expected to live on our social security income ($2,500.00 a year) and yet after baby-sitter and transportation expenses, and after the deductions from my pay checks for State and Federal taxes, insurance and Social Security we are not much better off financially than we were when I did not work.

Last Sunday's Washington Post carried an editorial urging the elimination of the earnings limitation in the social security law. If it is not proper to eliminate the earnings limitation entirely (for reasons that are probably over my head) I think it should be confined to persons who are paid retirement benefits. The needs of a widowed mother and children are much different from a retiree and a fair social security bill could give some recognition to this difference in applying the earnings limitation.

A retiree is by definition a person who has left the work force for life. It might make some sense to have an earnings limitation for a retiree but it does not seem to me to make sense to have such a limitation apply to a widowed mother of small children who will only receive benefits (which are like insurance payments) until her youngest child reaches age 18. She should be expected to join the work force not only because her social security benefits would not support her, but also because she needs to work and pay social security taxes to earn her own retirement benefits.

She would qualify for welfare relief is she had to live on her social security payments. I believe I have read that the welfare provisions of this same law are designed to encourage welfare recipients to work. It seems strange that those who receive benefits in the nature of insurance, for a very limited number of years, under social security must not work under penalty of losing the benefits the deceased worker paid for.

Very respectfully yours,

PATRICIA J. THOM.

SIXTY NOW INC.,
Toledo, Ohio, August 21, 1967.

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

YOUR HONOR: On behalf of the more than 200,000 members and supporters of Sixty Now, Inc., I am requesting you and your committee, to support and vote for the following changes in our Social Security law, by recommending to the

Senate the adoption of these changes, when the Senate considers the bill passed by the lower house of Congress. The changes are:

1. Lower the retirement age to 60 with full pension, for all retirees.
2. Raise minimum and maximum benefits to $100 and $250 a month, respectively for primary beneficiaries. (With proportionately increased amounts for derivative beneficiaries).
3. Eliminate age requirements for wife's and widow's benefits. Increase the widow's benefit, to 100% of PIA.
4. Provide for automatic increases, to reflect rises in the cost of living.
5. Use the 5 highest years of an individual's earnings, to compute the benefits.
6. Permit any group of workers, not now covered, to elect coverage.
7. Increase annual earnings used for benefit and tax purposes to, $10,000.
8. Establish contribution rates of 5% for employees and employers. Self-employed pay 8%. The Federal Government pay any deficit, up to 5% of taxable income, each year.
9. Make all changes applicable to persons, now drawing Social Security benefits.

The supporters and members of our organization, feel it is no more than right Congress should make it possible for all persons, covered by Social Security, to retire at age 60 with full increased pensions. In view of the fact, Congress in 1966, made it possible for Federal employees to retire at age 55 and the Unions, under private pensions have made it possible for thousands of Union members, to retire at age 60, they ask. Why should those persons who have to depend on Social Security, for their retirement, be forced to work to age 65?

I would also like to mention that all of our members and supporters know they will have to invest more money into their Social Security, while working, to maintain the actuarial soundness of the fund. This they are willing to do, because they know the increasing of our Social Security benefits and lowering of the retirement age, will provide them with more job opportunities, better wages while working, job for our youth, greater insurance protection for their families and increased benefits when they wish to retire.

An answer from you with your comments will be greatly appreciated.

Wishing you the best of luck, I remain.

Yours truly,

SIXTY NOW INC.,
JAMES C. PIFER,
Executive Vice President.

[TELEGRAM]

PITTSBURGH, PA., *August 24, 1967.*

Senator LONG,
Chairman, Senate Finance Committee,
Washington, D.C.:

As chairman of the Subcommittee for Hearing in Children of the Committee on Conservation of Hearing of the American Academy of Ophthalmology & Otolaryngology, I have been authorized to support the passage of the Senate version of House bill 12080. Passage of this legislation will again place the crippled children's program in close relationship to the maternal and child health program. It is our opinion that such a close relationship will insure greater continuity for the rehabilitation of the handicapped child.

RAYMOND E. JORDON, M.D.

BRONX, N.Y., *August 19, 1967.*

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

DEAR SIR: I am writing in reference to the proposed Social Security Amendments of 1967.

Enclosed please find a copy of my letter to the chairman of the Ways and Means Committee. The program of Aid to Families with Dependent Children has recently come in for reevaluation and restriction by the House. I am requesting consideration of the expansion of the educational opportunities available under the AFDC program. The Social Security Amendments of 1965 enabled children whose families were receiving AFDC to attend school or college through the age of 21. The companion measure enabled children in receipt of survivors benefits (OASDI to continue their education through age 22. At the very least, children in receip of AFDC should be permitted to remain eligible for benefits through age 22, i attending school or college.

When the Revenue Act of 1964 was being debated on the senate floor, you managed the bill for the Administration. During the debate a few senators raised th objection that the bill would benefit high and middle income groups, while providing no benefit to those who were unemployed or unemployable. At that time you made the point that it was quite obvious that people who did not pay taxes, or very much in taxes could not possibly benefit from a tax reduction; but that you were willing to sponsor a welfare bill. At that time you were the ranking Democrat on the Finance Committee, now you are the chairman.

Since then the budgetary and fiscal policy situations have changed drastically and the AFDC program has come in for strong criticism; but this should not stand in the way of expanding the best features of that program. The focus of the criticism is on the self perpetuation and growth of a vast subculture constituting "the other America." Those who are able to avail themselves of college attendance break the vicious cycle of welfare dependency, this proposal is thus a preventive measure which the congress should consider as an investment, and a highly profitable one at that. The values of middle class America have long held this view, this includes college students, their families, economists, businessmen, professionals and bankers. The financial rewards of the investment are undisputed, its common in our private lives, the former chairman of the Finance Committee, the late Senator Byrd was frequently urging government to keep its house in order by acting as a private individual (and balance the budget). Perhaps with regard to education the senator was quite modern. The social security amendments of 1965 and the Higher Education Act of 1965 committed the nation to encourage children with few financial resources to attend college, we must continue and broaden this commitment.

We have heard a great deal, this year about complex plans to get private industry involved in the slums, this has come from prominent individuals in both parties. These plans have included investments in housing, slum rehabilitation, home ownership, job creation in the slums and job training. But we have not heard anything about investment in higher education. This may be because we have come to assume that the scholarships of foundations, universities and civic groups together with bank loans can take care of the needs. The poverty of a student has been an accepted transient state. The student can see beyond tomorrow into the future when his earning capacity will make his temporary sacrifice worthwhile. He can postpone immediate gratification in return for a greater delayed gratification.

This is not true of students or prospective students from low socio-economic groups, who constitute the recipients of AFDC. Community values, peer group values, family expectations and the lure of "getting some money" now, tend to pull an 18 year old into the labor market to obtain a low skill, low paying job. At the same time there is pressure from the same forces mentioned above to get married and have children. The pressures to get some spending money and clothes after a subsistence level of income for a long period of time, makes it very difficult for an 18 year old to elect to continue to subsist economically in the culture of students poverty. Thus continuation of the grant helps mitigate the financial aspects of student poverty and can serve to aid in acceptance of deferred gratification and postponement of immediate gratification. This transformation of values is indeed a government investment in the slums.

Very truly yours,

ARNOLD GORE.

APRIL 6, 1967.

Hon. WILBUR MILLS,
House Ways and Means Committee,
House Office Building,
Washington, D.C.

DEAR SIR: I am writing in regard to the proposed liberalization of the Social Security Act.

In 1965, the congress amended the provision on surviving minor children, to enable such children to continue receiving benefits after the age of 18. Students who are in full time attendance at a school or college may receive survivors benefits through age 22. Similarly the Federal Aid to Dependent Children program, which is a part of the Social Security Act, was expanded to include payments to an eligible payee for students attending a school or college through the age of 21.

As a social worker for the New York City Department of Welfare, I have seen the wisdom of this legislation bear fruit. Unfortunately there are not enough children taking advantage of this excellent social investment.

Children of families receiving FADC are eligible for benefits only until age 21. If anything can be said of these families it is that they have a multitude of complex problems which in most cases are not faced by the more normally developing family. These problems would militate towards a higher age limitation. Equality would demand at least age 22, equity would require an even higher age limitation.

In conclusion, may I request that you and your colleagues give favorable consideration to amending the FADC program so as to enable full time students to attend college through age 22, while otherwise remaining eligible for FADC.

Very truly yours,

ARNOLD GORE.

NORTHEAST NEIGHBORHOOD COUNSELING CENTER,
Kansas City, Kans., August 18, 1967.

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

DEAR MR. LONG: Yesterday the U.S. House of Representatives passed H.R. bill 12080. It is my understanding that this bill will now go to the Senate Finance Committee of which you are chairman. My purpose in writing you this letter is to register the strongest possible objection to portions of this bill which affect public assistance recipients.

My specific objections to this bill are based on the following provisons:

(1) The bill changes the basic aim of the A.F.D.C. program from protecting the welfare of dependent children to forcing "employability". The bill: (a) forces mothers to leave their dependent children to accept work or training, and (b) forces *all* recipients sixteen or over and not in school to accept work or training, with no provisions for adequate job or training standards.

(2) It freezes federal aid for A.F.D.C. families at the January 1, 1967, level for each state. This provision is a ruthless attempt to force the states to limit A.F.D.C. case loads without providing any real alternative for the poor people arbitrarily denied assistance. It ignores the fact that O.E.O statistics show that for every A.F.D.C. recipient in January, 1967, there was another equally needy person not receiving aid.

(3) The bill proposes a drastic reversal of a basic purpose of the A.F.D.C. program.

The stated purpose of the A.F.D.C. program is the "care of dependent children in their own homes or in the homes of relatives" by enabling such parents and relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection (Social Security Act, section 401). H.R. 12080 proposes to change the A.F.D.C. program from a child welfare program to a job training and employment recruitment program. Since our program at the Northeast Neighborhood Counseling Center was originally funded in 1965 through O.E.O., we have discovered that many persons who are eligible for public assistance had been unreached by the public assistance program. By freezing the number of families on the A.F.D.C. rolls H.R. 12080 prevents aid to millions of additional eligible and destitute children.

I am writing you, Senator Long, because of your important position on the Senate Finance Committee. It is not too late to strike out the ruthless provisions of this bill and to make improvements which would be truly helpful and enable poor people to help themselves.

Because of our extensive experience here in working with public assistance recipients and understanding their problems I would make the following positive suggestions as to what Congress could do to improve welfare legislation:

(1) Establish work *incentives* (not the proposed compulsory training and employment). Allow welfare families to keep all money they earn, until their family income reaches the O.E.O. "low income" poverty line.

(2) Set nation-wide minimum welfare grants which would require all states to raise all welfare grants at least to the O.E.O. "low income" poverty line.

In city after city this summer cries of anguish and frustration have come from America's poor. The U.S. House of Representatives has responded to these cries by proposing to force mothers to leave their children and making ineligible for welfare millions of needy children.

Senator Long, I urgently ask you to use your influence to correct these abovementioned errors and show the poor people of America that someone in Congress cares.

Very truly yours,

NORTHEAST NEIGHBORHOOD COUNSELING CENTER,
ROBERT C. AGARD, *Supervisor.*

COMMUNITY COUNCIL OF GREATER NEW YORK,
New York, N.Y., August 29, 1967.

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

DEAR SENATOR LONG: The Citizens' Committee On Aging of the Community Council of Greater New York, formerly the Mayor's Committee On Aging, is composed of more than 100 key citizens and professional leaders drawn from labor, management, medicine, voluntary and governmental agencies, civic and church groups. Since its formation, its major efforts have focused on income maintenance, health, housing and supportive services for the elderly. We are writing to you as Chairman and Vice-Chairman of this committee.

The vast majority of the aging, aged 65 and over, depend on Social Security benefits for their basic income and medical care. It is imperative that Social Security legislation insure a decent and adequate standard of living and medical service to these citizens who for all of their working years have made a basic contribution to our society. The Social Security legislation is now in serious danger. Not only are the minimal advances of the Administration Bill (HR 5710) being seriously cut, but more important, long established, basic health and welfare provisions are being challenged. This can lead to tragic cuts in living and medical standards for our elderly citizens.

As the Senate Finance Committee and the Senate as a whole reviews the pending Social Security amendments, we wish you to give consideraton to the following points:

OASDI GENERAL BENEFIT INCREASE

We reluctantly supported the recommendation for a 15% increase in cash benefits, as proposed in the Administration Bill (HR 5710). We felt that it was a step in the right direction, but very inadequate to achieve the original intent of Congress in the 1935 Social Security Act. In 1935 the Congress visualized a social insurance system which would maintain for senior citizens a decent American standard of living.

We strongly recommend that the Senate adopt as a goal, a level of benefits at least equal to a "modest but adequate" budget. The Budget Standard Service of the Community Council of Greater New York estimated the monthly cost of such a budget, based on October 1966 prices, as totalling $199.75 for an elderly, retired man, and $184.17 for an elderly retired woman. These costs compared to average monthly Social Security payments to retired workers in New York City, of $91.96 as of December 1965 and only $78.08 to widows and widowers.

Because further substantial increases are needed to alleviate wide spread poverty and present health deterioration, we advocate the use of general tax revenue to supplement appropriate Social Security taxes. To keep this program on an actuarial basis, is to penalize the poorest and most needy sections of our country.

While we recognize that a general increase of 12.5% is a step in the right direction, this small amount will have a negligible impact on the needs of the senior citizens of America.

In the light of this discussion, the general benefit increase of 12.5% in cash benefits is even more inadequate than the original 15%.

MEDICARE OUT-PATIENT AND IN-PATIENT BENEFITS

We laud the inclusion of in-patient pathology and diagnostic radiology in Part A of Medicare. We feel, however, that it is imperative that hospital outpatient benefits be continued under Part A rather than Part B of Medicare. For many patients the placing of these services under Part B will be restrictive because they will be subject to deductibles and coinsurance. Thus, even fewer patients will be able to avail themselves of these services.

MEDICARE BILLING PROCEDURES

We concur with the new billing procedure, and agree that a third choice be provided to a patient whereby he can be reimbursed for an itemized bill. At the present time, the bill must be receipted which sometimes necessitates that senior citizens borrow cash for immediate payment of doctor bills. In addition, we highly recommend that payment on assignment be encouraged and continued.

MEDICAID

The Citizen's Committee On Aging regards Title XIX as being one of the most important and potentially far reaching pieces of social legislation ever passed by Congress. It can establish a pattern to meet the urgent medical needs of our nation. We have always been appalled by the Bill's determination of medical indigency in relation to public assistance standards. It is well known that levels of public assistance are well below the minimal living standards in many states. HR 12080 not only would continue this tie-in between medical indigency and public assistance levels, but it reduces the standard for determining medical indigency to such a low level that the original intent of Title XIX would be nullified. In New York State this would mean a drastic cut in the number of persons eligible.

MEDICAID REQUIRED SERVICES

In the existing law as well as in the Administration Bill HR 5710 at least the five following services were required.

(1) In-patient hospital.
(2) Out-patient hospital.
(3) Laboratory and X-ray.
(4) Skilled nursing home.
(5) Physician's.

The original five basic services are fundamental to minimum adequate medical care. The deceptive extension of the number of choices of services actually can reduce the number of basic services and so lower standards of medical care.

In addition, it is essential that Home Health Services be included in the list of mandatory services. Home Health Services would extend medical care to many ill persons. It would drastically lower the occupancy of hospital and nursing home beds. It would also serve to cut the high cost of in-patient care.

We urgently hope that the Senate will seriously consider these proposals so that the 90th Congress will pass amendments to the Social Security legislation that will extend and broaden benefits to the nation's aging.

Sincerely,

LAURA PRATT,
Chairman, Citizens' Committee on Aging.
ROBERT L. POPPER,
Vice Chairman, Citizens' Committee on Aging.

THE WELFARE FEDERATION,
Cleveland, Ohio, August 31, 1967.

HON. RUSSELL LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: As chairman of the Public Welfare Committee of the Welfare Federation of Cleveland, Ohio, I am writing to express our views on Title II, (Aid to Families with Dependent Children) of H.R. 12080. Our committee, composed of business, civic, and professional leaders of the community, has a long history of interest and concern with the standards and effectiveness of our local public welfare programs.

In our opinion H.R. 12080 has many provisions which can result in desirable changes in the Aid to Families with Dependent Children program. There are other features which we believe unreasonably coercive on one group of citizens, and should be modified.

We concur with Secretary John W. Gardner that the proposed legislation "offers great opportunities." We believe with Secretary Gardner that "the bill offers a new kind of focus on the family as a total entity."

On August 8th in a Wall Street Journal article New York's Welfare Director Mitchell Ginsberg was quoted as saying, "The main problem with the welfare system is that nobody likes it. The average citizen doesn't ever expect to use it and he doesn't have much respect for the people who do. The system has failed to free the poor and has locked them into dependency." The desirable features of H.R. 12080 for the first time since the original legislation was passed in 1936 offers the opportunity and the challenge to make the Aid to Dependent Children program fulfill the purposes for which it was originally intended.

We support fully the principle that agencies administering the program be required to develop a comprehensive plan for each family and to review it frequently. We believe this type of individual family review, plus readily available expanded opportunities for training, work experience, and day care facilities for children, can hasten the restoration of dependent families to self support. We believe this is the goal of most welfare recipients for themselves as parents as well as for their children.

With regard to the work-training provisions, we are strongly in favor of expanding such opportunities to more AFDC family heads, but believe the Congress should take a more realistic approach than the present bill contemplates. In the first place, public welfare agencies are not equipped to administer such programs on any major scale. We believe the Congress should provide for broad work-training programs through other government agencies and the private sector of our economy. Furthermore, any massive work-training program must take into account the dangers of preparing people for non-existent jobs.

Our Cleveland experience with work-training under Title V of the Economic Opportunity Act has confirmed these points.

We support the general principle in the bill that women who are physically able should have the opportunity to work, and believe it is unwise to encourage these women to stay home. At the same time safeguards must be provided other than the existing appeal procedure to prevent compulsion on those mothers who choose to remain at home because they regard the rearing of their children under close parental guidance and supervision as their primary responsibility.

We strongly support the principle of work incentives. However, in our opinion the incentive provisions in H.R. 12080 are too limiting and will not accomplish the objectives sought. We do not believe there is much incentive in a program which sets as a maximum exemption an amount equal to the assistance payments to which the individual would otherwise be eligible. Many of the people on welfare, especially the women, could find jobs, part-time or full time, that pay less or the same as they could receive as a welfare subsidy. If all or a fair portion of these earnings could be in addition to a subsidy, there would be an incentive in the American tradition.

The effect of such an incentive program on labor costs for certain types of small business, such as neighborhood restaurants and other employers of part-time help, could be beneficial to the worker, the employer and the community's economy. We respectfully urge that the incentive program for Aid to Families with Dependent Children be patterned after the incentive program in Aid for the Needy Blind. Another good plan is that proposed in New York City where effective this fall, welfare recipients can keep the first $85.00 earned each month and 30 per cent of the remainder up to a reasonable income standard before being dropped from the rolls. We believe a more liberal incentive program is especially justified due to the fact that a majority of the homes are headed by women. Like other women in the labor force in America today, AFDC mothers also should have the opportunity for part-time employment while still devoting time to child rearing and caring for the home.

We ask that the Senate Committee restore the provision requested by Secretary Gardner which would make it mandatory upon the states to meet full need, as defined by each state itself, of public assistance receipients, and to reprice commodity standards each year. The coupling of an incentive program and payments at the level of full need will go a long way toward making the work-training and work experience programs successful.

We urge deletion from the bill that section which imposes a limitation on the number of children for whom the Federal Government will make matching payments to states. We refer here to the section which would freeze the proportion of the children on the rolls due to absence or desertion of a parent at the proportion which obtained in January of this year. If left as now written the states would be encouraged—virtually compelled—to establish even more restrictive eligibility requirements, or to lower the already inadequate payments. The net result of this provision as it now stands, would be to further burden the children with the short-comings or sins of their parents.

We urge the Senate Finance Committee to amend H.R. 12080 to encourage the maximum possible strengthening of families and growth and development of their children.

Sincerely yours,

IRVING KANE,
Chairman, Public Welfare Committee, Welfare Federation.

PHILADELPHIA, PA., *August 30, 1967.*

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

DEAR SIR: The Philadelphia Inquirer, issue of August 29, carried the story of a delegation of Philadelphia mothers—75 in number—who traveled to Washington to attack a house passed bill which would establish stringent new eligibility standards for families on welfare.

I did some investigating here, by contacting an office concerned with this problem and the organization which puts on the pressure on senators and others. In fact the newspaper reported that both Senators Clark and Scott promised to see that the bill afford some relief to the mothers on RELIEF. It seems as tho this Philadelphia group is affiliated with a national group, and generally speaking I would say that eligibility standards are very much in order.

My own work involves me in the problems of the aged, most of whom have contributed considerably to the growth of this land of ours. Yet because they cannot travel, in any great numbers, and do not molest and threaten some of our legislators, these older Americans are getting nowhere fast.

So much for this matter. And now to another matter before your committee.

It seems as tho you are conducting hearings on some amendments to the Social Security act, dealing with Medicare.

It is reported that Dr. Milford O. Rouse, President of AMA, testified that a plan which would subsidize Social Security beneficiaries so that they could buy private health insurance, would be more practical than our present supplementary to medicare and would be more to the benefit of the government, insurance carriers and physicians.

I am very much amazed at the very brash manner in which this doctor offers his in-expert advice to your committee and thus to the congress of the United States. It would seem to me that the AMA would be more in tune with its oath if it devoted its efforts to increasing the number of doctors in our country, and educated these doctors to be professional first, last and always. If it devoted its efforts to keep doctors out of hospital management affairs. What doctors are doing these days is messing the things they know nothing about, and from where I sit it looks like $100 a day for a hospital bed in the next 5 to 7 years.

Would you like to know how to help keep hospital costs in line? Send a committee of several members of your committee in Philadelphia and I will gladly testify, without any thought of personal gain.

Cordially,

ROBERT I. ERLICHMAN.

THE HARBIN CLINIC, *Rome, Ga., August 28, 1967.*

Re H.R. 12080, the Social Security Amendments of 1967.

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

SIR: We wish to go on record as following regarding H.R. 12080:

(1) We feel that the same benefits for diagnostic x-ray and laboratory procedures should be available to participants whether the patient is hospitalized or not hospitalized.

(2) We do not favor the proposal to add a third system of payment of fees. Our position is simply that the physician should be paid if he takes an assignment of benefits, or, the patient should be paid if the physician does not take an

assignment. It would appear that there is wisdom in eliminating the requirement for a *receipted* itemized bill.

(3) We feel that physical therapy services should be covered when rendered by an independent physical therapists even though performed in the office. Benefit should not be limited to patients using a hospital physical therapy department only.

We will appreciate your consideration of our position when the Senate (Finance Committee) considers the proposed amendments to the Social Security Law as it relates to Medicare.

Very sincerely yours,

THE HARBIN CLINIC,
By DAVID M. BOWEN, Jr.,
Business Manager.

STATE OF CONNECTICUT,
STATE WELFARE DEPARTMENT,
Hartford, Conn., August 30, 1967.

Re H.R. 12080, amending sections of the Social Security Act.

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

DEAR SENATOR: We have already expressed our concerns about some sections of H.R. 12080 which we believe will have a negative impact on the people we are trying to help.

We now wish to express our approval of the Social Work Manpower and Training section, as amended, and request your strong support for its passage.

We believe this program is basic to the implementation of the services required in the Social Security Amendments. In the last few years, as Federal funds have been made available for teaching and supervising staff, the schools have been able to increase their enrollment. Unfortunately, the demand for trained staff in so many other fields also increased, so that the supply continues to fall far below the demand. With increased funds, schools could further increase their enrollment and we in the public agencies would also benefit.

The proportion of applicants to schools of social work to the protection of acceptances is still infinitesimal. We believe our picture is representative of all states. Out of some ninety applicants for educational leave this past year in the Connecticut State Welfare Department, only 17 candidates were approved for educational leave for the first year. While we could not have approved all the applicants and some withdrew before the screening process began, many could not be accepted by the schools of social work because of lack of teaching staff or lack of supervisory staff for field work placements.

We strongly support increased financial grants for professional graduate training.

We also approve the provision to extend, improve, or develop undergraduate programs in social work. We employ, and for some time to come will have to continue to employ, college graduates for social work positions, and provide in-service training on the job. We have found that those persons who have had courses in social work or the background courses grasp the principles and objectives of the program and the service component much more readily.

We consider the sections relating to the Social Work Manpower and Training section, as amended, a very valuable element in the Social Security Amendments Act of 1967 and request your support.

Sincerely,

BERNARD SHAPIRO, *Commissioner.*

FEDERATION OF PROTESTANT WELFARE AGENCIES, INC.,
New York, N.Y., September 1, 1967.

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

DEAR SENATOR LONG: The Federation of Protestant Welfare Agencies, while welcoming many of the advances proposed by H.R. 12080 which your committee is now considering, notes with deep concern certain regressive features of the bill.

Our Committee on Legislation made a thorough study of H.R. 5710 before it was supplanted by H.R. 12080. On May 15, 1967, a detailed statement of our views was sent to Chairman Mills and to the members of the House Ways and Means Committee. I am enclosing a copy of that statement and request that you your fellow members on the Senate Finance Committee give consideration to our thoughts as expressed therein.

As Secretary Gardner has pointed out, among other things, the bill as it now stands would impose deprivation upon thousands of children because of inadequacies or misconduct of their parents. For example, the bill proposes removal from parental care of children in AFDC families where there is "multiple illegitimacy." It would fix a ceiling on the proportion of all children within a given state who could receive AFDC on the basis of the absence of a parent from the home—a ceiling which obviously would have no effect whatsoever on the absent parents, but which would impose cruel hardship on their children. To speak in more general terms, the bill tends to treat AFDC as a means of enforcing patterns of conduct and family life on poor families, under pain of depriving them of their means of subsistence.

We earnestly hope that this session of Congress will enact a bill to improve the Social Security Act, but that this bill will be free of such harsh and repressive provisions.

Sincerely yours,

THEODORE PEARSON, *President*.

MAY 15, 1967.

HON. WILBUR D. MILLS,
Chairman, Ways and Means Committee,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN MILLS: The Federation of Protestant Welfare Agencies, which has as members 232 Protestant and non-sectarian health and social welfare agencies in the Greater New York area, is keenly aware of the gigantic task, as well as the opportunity, with which your committee in confronted in its deliberations and actions on H.R. 5710. The opportunity which your committee has to improve the Social Security, public assistance, and medical care programs in this country is of tremendous importance. The Federation wholeheartedly endorses the intent of H.R. 5710 to bring about needed improvements in the Social Security Act. Based on its experience, however, it recognizes the great need of the citizens of this country for increased benefits over certain provisions of H.R. 5710 as it now stands. We are therefore respectfully bringing to your attention certain sections of the bill which we especially support or which we would like to see modified.

The Federation, while endorsing the provisions of Title I, Part 1, Benefits under the Old-Age, Survivors, and Disability Insurance Programs, wishes to comment especially on Sections 101 and 106. The increases proposed in Section 101 averaging 15% are, of course, a step in the right direction. However, since Social Security is the sole retirement income for approximately 85% of the aged, most older persons will continue to be financially insecure, will be unable to attain a reasonable standard of living, will in many instances require supplementary public assistance, and the majority will continue to remain at, or below, the poverty level. The proposed national average monthly benefit for retired workers, as we understand it, will be approximately $96.60. In New York City a "modest but adequate" budget for a retired man is $199.75 monthly.[1] This amount is needed for a man living in his own home or apartment and does not provide for extraordinary needs such as major medical care or protective living arrangements such as nursing homes. Therefore, while endorsing the proposed increase, the Federation is keenly aware that it will not solve the problems for the majority of our older citizens in New York City.

With respect to Section 106 which deals with allowable earnings of recipients, the Federation recognizes that this involves one of the most perplexing problems which has faced the Congress since the inception of the Social Security program. Started as it was during the depression days of the thirties, the Social Security philosophy was intended to retire persons from the labor market rather than to encourage opportunities for continued use of their skill, knowledge and wisdom. Since such marked changes have taken place in our economy in the last thirty years, we hope the Congress will give full consideration to updating this section of the Social Security Act so that it will more nearly meet the current

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[1] October 1966 budget standard, Community Council of Greater New York.

needs both of individuals and of communities. Because the retirement benefits have rightly been thought of as social *insurance*, Social Security has been administered without a means test as to total resources of the individual. It therefore quite properly is not limited by income from sources other than employment; such resources can be limitless. But, again in an effort to discourage persons 65 and over from continuing in the labor market, drastic limitations have been placed on income from covered employment. While welcoming the minor increase from $1500 to $1680 per year as the amount which an individual is permitted to earn before his retirement benefit is reduced, the Federation earnestly solicits your consideration of a basic change in H.R. 5710 to remove the earned income maximum entirely and permit an individual of retirement age to work to his maximum strength and interest and nevertheless receive his full Social Security benefit.

The Federation makes this strong recommendation based not only on its philosophic conviction of the importance of work to the individual, but also practically, on its experience as an employer. The Federation has long had a policy of making maximum use of the skill of older individuals and has employed on its staff full-time, part-time, or for limited temporary periods, persons with unique skills which are not readily obtainable in the labor market. In the present day, when every ounce of experience and expertise that can be made available is desperately needed throughout the country in every field of endeavor, we believe it is sound practice to encourage older persons to work and continue their usefulness even though they may not wish to work full time. Most health and welfare agencies, in this period of extreme shortage of qualified manpower, could not operate if they did not make use of the skills of older persons. This policy, however, is not pursued without difficulty, both for the individual staff member and for the employer. To be sure, an individual 65 and over is not *compelled* to stop work; he may at any time stop his Social Security benefits or in fact simply not apply for them. The decision, however, is not usually this simple, and there comes a point when full or part time work brings somewhat diminished returns and it seems simpler to receive his benefits and work only as much as permitted without suffering a deduction in his benefits. We have first hand knowledge of the incentives which individuals need to return to work and their reluctance to give up their Social Security benefits in order to take temporary or part-time jobs. We know also of the inconveniences to the employer when an individual, who has not stopped his payments, thinks it best to cease work when he has reached his annual maximum allowable income from employment, even if this occurs before the project for which he is employed is completed. We therefore urge that you give serious consideration to abolishing the maximum amount for earned income, in order that our whole society, which has changed so much since the economic conditions of the depression days, can be given an opportunity to strengthen its productivity through its employment of older retired specialists whose contribution can be invaluable.

The Federation also endorses Section 125 of Part 3 in Title I, which calls for the inclusion of health insurance for the permanently disabled under the Medicare plan. This is a vulnerable group with respect to health needs and including them in the Medicare plan will do much to promote their physical well-being and rehabilitation.

With the exception of Section 203, the Federation endorses all of Title II, Part 1, dealing with the public assistance amendments. However, it does wish to make certain recommendations for further improvement and sincerely hopes that the Congress will give consideration to these recommendations which are based on years of experience within this Federation.

The earnings exemptions of public assistance recipients provided for in Section 201 are indeed another sound step in furthering family life and attempting to help individuals and families rise above the poverty level. We earnestly suggest to you, however, that in principle the exemption should be increased and made uniform, especially in relation to AFDC families. It is in these families that the lack of money so often results in an entire childhood spent in deprivation with little or no opportunity for wholesome, new and broadening experiences which are impossible on public assistance allowances. As the section now stands, it continues the discrepancies between the adult categories and AFDC families. In the interest of both equity of treatment among the categories and simplification of administration for public departments, we urge that consideration be given to ironing out the differences as to amounts permissible in each category. The Federation commends the provision that all such exemptions will be mandatory upon the states beginning July 1, 1969.

It is heartening to note in Section 202 that it will now be mandatory on the states to meet full need according to their own standards, and that these standards cannot fall below those in effect in January 1967. We sincerely trust, however, that the Congress will take leadership in making it possible for the Secretary of Health, Education, and Welfare to ensure that the state standards are indeed *adequate* to meet full need, and that they continue to be examined and updated, not only for cost-of-living increases, but also as to whether the kinds and amounts of goods and services included in the standard are truly adequate to meet need in accordance with modern knowledge regarding "adequacy", and in order that public assistance payments will help to bring individuals above the poverty level.

We urge a re-drafting of Section 203, pertaining to income in determining eligibility for cash assistance. We oppose the intent to establish a proportionate relationship between eligibility for cash assistance and eligibility for medical assistance under Title XIX. We seriously question whether the provisions in this section (203) and those in Section 220 which also seeks to correlate the two standards will lead to precise consideration and reconsideration of the adequacy of *either* standard. Relating the two standards in this way can well lead to inadequacy in both.

It is gratifying to note in Section 204 that the Congress is providing again for the cost of community work and training programs which means so much to families receiving AFDC. The provisions of this section, however, seem unnecessarily complicated with respect to the division of labor between the Secretary of Labor and the Secretary of Health, Education, and Welfare. The Federation commends the training incentive of $20.00 per week and would recommend that further consideration be given to providing this same amount in Section 101, since it is a more realistic incentive both in training programs and in motivating individuals toward employment than lesser amounts proposed in Section 201.

The Federation especially commends Section 208, and proposes that the Congress make this mandatory rather than permissive. The importance of AFDC allowances to "intact" families cannot be over-emphasized. It is unthinkable that we could continue the provisions which led to the charge that public assistance caused fathers to desert their families in order that the family become eligible for AFDC when the father was unable to obtain employment. In this connection, we suggest that Congress also consider federal assistance to the states for families receiving general assistance. In New York City there are approximately 13,000 families at any one time who, because of the size of the family, must receive general assistance to supplement the minimum wages of the head of the family. These families, where every effort is being made for self-support, are indeed deserving of federal consideration as much, if not even more, than the ones who are temporarily unemployed.

As indicated earlier, the Federation strongly recommends that Section 220 of Part 2, Title II, which limits federal participation in medical assistance, be eliminated. This program is so new as to be not yet fully operable, and to make changes in its eligibility structure at this time would, in our opinion, be such a retrogressive step as to seriously retard the program. Time must be permitted in order to evaluate the success of this program and how well it achieves its purpose, especially in relation to the provision of early medical care for children and adults. If this program can continue long enough to provide a sound evaluation, we believe it will prove one of the best investments the federal government has ever made, insuring as it can early medical care for children who before this have had their health problems neglected and have seldom received attention at the stage where truly preventive health care could have taken place.

The Child Welfare Services Amendments contained in Part 3 of Title II will, of course, bring some relief to cities and states struggling to provide adequate child welfare services. However, it is almost certain, even at the outset, that they alone will not enable the states to fulfill the 1962 mandate from Congress to make available comprehensive child welfare services by 1975, nor will they ensure that states will achieve the goals defined by the President in his Message on Children and Youth.

This Federation, through its member agencies which work directly with thousands of deprived and neglected children in the City of New York, is fully aware of the complex and perplexing problems which beset those who attempt to provide more imaginative and effective services to the children in our troubled urban areas. We appreciate also that the Congress has a particular concern for the young children and youth of this nation. Voluntary agencies in New York City have struggled long with these problems and have provided leadership in the establishment of new and different services such as expanded use of homemakers, day care centers, and protective services. Even the combined resources of all concerned, however, have fallen far short of meeting the need in this city. It is well known that the desired degree of prevention of family breakdown and protection of children is not being achieved through our present methods and within the limits of the funds and staff available. The financial and human resources of the voluntary agencies, the state, and the localities have been taxed to the breaking point by efforts to bring about such prevention and protection.

This Federation strongly supported H.R. 1977, commonly known as the Burke Bill. We now sincerely urge you and your committee to substitute for Sections 235 and 236 the provisions of the Burke Bill, which would grant 75% reimbursement immediately for personnel providing child welfare services, and for the training of such personnel. We would, of course, support the position that states should not spend less than they have in the past, but to limit reimbursement from federal funds to 75% of *additional* staff costs over present expenditures is to limit seriously the opportunity for expansion.

The Federation also urges federal participation in the costs of child welfare programs such as foster care, day care, and adoptions. The 1962 Amendments, setting forth as they did the goals for providing child welfare services throughout the country, have not been achieved because the funds and staff necessary to implement these goals have not been available. Because of this and despite intensive efforts on the part of localities, children who were mere babies in 1962 have now had the dubious opportunity to grow older and into possibly delinquent ways because the help they needed early in life was not provided.

The federal government pays millions of dollars, as we believe it should, to the AFDC program in an effort to keep children in their own homes. The children, however, who are deprived of both parents and must be removed from their own homes do not share in this dollar concern of the federal government. In New York City alone, there are more than 22,000 children outside of their own homes, many of them in institutions and foster homes run by agencies that are members of this Federation. The New York City Department of Welfare and the many voluntary agencies which work closely with it have tried numerous approaches to meeting the needs of these particular children. New York City, however, is in a sense penalized because it has done so much. It needs federal help in reimbursement *now*, not after it has spent millions more in trying to develop these new services to an even greater degree. The effects of poverty and the "cycle of dependency" have become obvious to all in recent years. Because of its deep concern and many efforts to prevent poverty, dependency and the proliferation of problems now and in the future, the Federation earnestly proposes to you that the provisions both for reimbursement on program and staff as provided in H.R. 1977, be substituted for Sections 235 and 236 of the Amendments.

The Federation welcomes Section 401 of Title IV of the Amendments which would authorize grants to public or non-profit private colleges and universities and accredited Graduate Schools of Social Work, to meet part of the cost of the development and expansion or improvement of graduate and undergraduate training in the field of Social Work. It sincerely hopes that an even larger appropriation can be made available, since the problem which this section seeks to alleviate is basic to all social welfare needs both in New York City and throughout the country. The plight of agencies trying to obtain trained staff is such that in desperation they often pirate staff from each other, since so little is available. The member agencies of this Federation working in the health and welfare fields are confronted daily with the human suffering which is compounded by the shortage of trained social workers. Whether it is a small child awaiting a foster home, an aged person needing counseling and help in planning his meager resources, a young family searching for help with a problem so grave as to threaten its very existence as a family group, or a youngster on the verge of delinquency because there is no opening for him in a community center, all suffer from the lack of professionally trained social workers. There must be intensified efforts to increase the pool of such social workers. The need for them is immediate.

You are undoubtedly familiar with the frequently quoted statistics which so graphically point up the need for more social workers, i.e., in New York State there are 4,500 vacancies in *approved* budget lines and the informed finding that 100,000 *new* social workers will be needed throughout the country by 1970 in the *public* social services alone. The Federation therefore heartily endorses this section of the Amendments and petitions you to increase the grant if possible.

The Federation appreciates the efforts of Congress to increase revenue through Title V, Sections 501–507 on the Tax Treatment of the Aged, but it has serious question about revision of the tax system for the aged at the same time that such major amendments are being proposed and considered. The major and far-reaching changes which are proposed in this Title we believe require intensive and prolonged study to determine the effect they will have on persons now receiving or about to apply for retirement benefits. This Federation urges that this Title be excluded at this time and that instead, provisions be made for thorough study of the tax treatment of the aged, including whether even under the present tax system there is an element of "double taxation" in relation to private pension plans which should be corrected. Even a rather cursory study of these proposed amendments leads many of us to the conclusion that they will affect adversely and possibly drastically those who are just above the poverty level. Individuals who have planned on private pensions supplemented by Social Security, tax free, and have made careful plans for retirement, will be caught, we fear, under this Title, and be forced to a standard of living so close to the poverty line as to bring despair to many who retired thinking they had made ample provision for their futures. The disruption of the older segment of the population which could be caused by these tax revisions is a matter of grave concern. Despite the attempts made in the proposed Amendment to safeguard a third of the Social Security benefit from taxation, it is difficult to determine, without intensive study, whether taxing any part of the benefit may not increase the possibility of double taxation.

The Federation respectfully submits the above recommendations and comments for your consideration and sincerely hopes that they will be of value to you in your very grave deliberations.

Sincerely yours,

THEODORE PEARSON, *President.*

WINTER PARK CHAMBER OF COMMERCE,
Winter Park, Fla., August 30, 1967.

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

DEAR SENATOR LONG: Resolution adopted at its regular weekly meeting, August 25, 1967 by the Congressional Action Committee, Winter Park Chamber of Commerce:

Resolved, That the committee commend Chairman Wilbur Mills of the House Committee on Ways and Means for publicly challenging the concept of welfare as a "way of life".

Resolved, That Congress should exhibit a comparable concern over the fact, noted even by the liberal Washington Post (editorial August 20, 1967) that social security costs of young people already are higher than costs of comparable retirement annuites from private companies.

Resolved, That the Congressional Action Committee urge the Senate Finance Committee and the Senate to accept the 12½% benefit increase and the $50 a month minimum benefit voted by the House.

Resolved, That the Congressional Action Committee opposes further expansion of welfare type benefits under guise of social security old age insurance.

Resolved, The present and future social security legislation be directed to the objective that there shall be no benefits without contribution.

Resolved, That the Congressional Action Committee commend the provisions of the House bill requiring each state to make work training available to "appropriate individuals" on assistance as a condition to Federal aid to the state. And also to require denial of assistance to individuals failing to show good cause for refusing employment.

Resolved, That the Congressional Action Committee endorses for present or future legislation the increase of annual earnings to $2400 without loss of social security benefits and reduction from age 72 to age 70 of the privilege of unlimited earnings without loss of social security benefits.

And resolved, That House conferees be urged to stand firm against any liberalization of the House bill which may subsequently be voted by the Senate.

Respectfully,

TYN COBB,
Chairman, Congressional Action Committee.

STATE OF COLORADO,
DEPARTMENT OF PUBLIC WELFARE,
Denver, Colo., August 31, 1967.

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

DEAR SENATOR LONG: I am sending you a copy of a letter I wrote to our Colorado Senators in Washington, D.C., concerning H.R. 12080. I thought you would be interested in the comments of the Colorado State Department of Public Welfare.

Sincerely,

COLORADO STATE DEPARTMENT OF PUBLIC WELFARE,
CHARLINE J. BIRKINS, *Director.*

AUGUST 31, 1967.

Hon. GORDON ALLOTT,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR ALLOTT: I have been carefully studying the amendments to the Social Security Act that passed the House in H.R. 12080. I favor most of the provisions of the Act, but would like to call your attention to some of the provisions that I feel would adversely effect the welfare program in Colorado and would result in a hardship to the state and counties.

First, let me comment that I favor the provisons that increase the Social Security benefits to the insured beneficiaries. From our experience with the cost-of-living increases since October 1965, we have raised the Old Age Pension payment $5.00. Naturally, these increased costs have effected the Social Security beneficiary costs and should be reflected in their payments. This increase will also mean that several aged persons in Colorado will not find it necessary to apply for Old Age Pension. It will also eliminate a few from the Pension rolls.

The new provison to cover disabled widows and disabled dependent widowers will reduce the Aid to Needy Disabled expenditures. Colorado has not kept a statistical record of these widows or widowers, as this information has not been pertinent unless the recipients were in their early sixties. The county directors report that there are several widows on Aid to Needy Disabled.

Colorado has tried to develop a good program of services for recipients of public assistance and has taken advantage of Title V, Work and Training Programs, in the counties where the volume of cases made it feasible. These programs have been quite successful and well accepted by the public and staffs. Several counties have also had a sufficient number of Aid to Dependent Children families with unemployed parents to justify Work and Training Programs. We endorse the principle of Work and Training Projects in conjunction with other rehabilitation services.

However, I would like you to give consideration to amending Section 407, page 119, of H.R. 12080. Page 120 (1)(C)(i) requires "such father has 6 or more quarters of work . . . in any 13 calendar-quarter." I feel that this will eliminate several Colorado applicants or recipients from deriving benefits from Work and Training Programs. Most of our people in training have limited education, poor work history or skills. Also, many are young couples who married while in school or after dropping out of school. We feel that these are the individuals who need the adult education and work training. This is their opportunity to develop skills and a work history which can make them eligible to compete in the labor market. If they are not eligible to qualify for Aid to Dependent Children, they will have to be cared for on county General Assistance. To exclude fathers who have no work experience does not make sense. They have the greatest need for training. Also, one successful case we had recently was a man released from the penitentiary who took training and is now fully employed. He would not qualify under this law. A good example of training young men with no experience was at the Project in Lamar where they remodeled the welfare building under good supervision. These men thus learned skills in the building trades.

We also object to the fact that a man cannot be receiving Unemployment Compensation Benefits and be certified to Aid to Dependent Children of Unemployed Parents and Work and Training. In certain selected cases with large families, we have trained men for better work skills so that they could have a better chance for employment that would support their families. The amount of Unemployment Compensation did not meet their minimum needs, and Aid to Dependent Children of Unemployed Parents supplemented the amount necessary to meet their minimum budget requirements while they were in training. If employment within the scope of their skills became available through the Employment Service, they left the Project. We would like to continue this procedure where the circumstances in the cases make it advisable.

We endorse the provision for exempt earned income and incentives as provided in Section 202, pages 115–119. The Colorado State Department of Public Welfare has endorsed this concept for several years. Also, this year, several county commissioners have asked us to recommend such a plan, and one county requested a special project so that they could try to demonstrate the value of incentive allowances. Some counties feel that $30.00 exempt and one-third of the remainder of the earnings is too low. Some suggest 50 per cent instead of one-third.

We strongly object to Section 208, page 140, of H.R. 12080, which imposes a limitation on the number of children with respect to federal reimbursement.

This section of the Bill provides "the number of dependent children who have been deprived of parental support or care by reason of the continued absence from the home of a parent with respect to whom payments under this section may be made to a state for any calendar quarter after 1967 shall not exceed the number which bears the same ratio to the total population of such state under the age of 21 . . . to such state for the calendar quarter beginning January 1, 1967."

Most families today are on Aid to Dependent Children because of family breakdown. We agree that every effort possible should be made to rehabilitate families, and/or to get support from fathers for their children. We also agree with providing family planning services but do not feel that the above requirement is a proper way to reduce caseloads. If employment is not available, we will not be able to reduce caseloads through jobs and thus make applications for other families to apply. It is not feasible to turn needy people away "because our quota is filled." In many cases, it is a better plan for the family to have the mother remain at home and care for her children. Every effort should be made to rehabilitate families, not discriminate against them and the children.

The Aid to Fathers of Dependent Children Law provides that there will be federal reimbursement for foster care if the child was on Aid to Dependent Children at the time the court orders foster care placement. We object to the requirement that the child, to be eligible for this care, must be placed by a court order. There are times that the child welfare worker determines that the circumstances in the home or the particular problems of the child could best be handled by foster home placement (mother's temporary illness, child's emotional problems, et cetera). Courts rarely order children removed from their homes unless documented proof of neglect, abuse, or there is delinquency. We do not feel that this program can be effective if we have to rely on placements only by court order and would like this provision deleted. We do not feel that all these children should have a court record. Many parents, for the benefit of the child, ask to have placement made and this type of placement does not have to go to court in Colorado.

Section 209, page 141, of H.R. 12080, provides for necessary repairs to be made to homes owned by recipients of all categories except Aid to Dependent Children. We agree with the principle that recipients should not live in substandard housing. Approximately 25.3 per cent, or 3,126, Aid to Dependent Children families own their homes and wonder why repairs cannot be included for mothers who are trying to raise their children in their own homes.

I endorse Section 206, page 137, which provides for federal reimbursement for emergency assistance to meet crises that occur before categorical assistance can be provided or could tide a family over an emergency until another plan could be made. This will help county departments and, no doubt, provide assistance in some counties that might not otherwise help the family. Many counties in Colorado, at present, do not provide General Assistance, except for medical emergencies. However, a 30-day limit would not be too effective in some cases. This should cover a period of 60 to 90 days. Emergencies frequently cannot be solved in a 30-day period.

I will appreciate your serious consideration of possible revisions in the sections of H.R. 12080 that I have discussed above.

Very truly yours,

COLORADO STATE DEPARTMENT OF PUBLIC WELFARE,
CHARLINE J. BIRKINS, *Director*.

STATEMENT OF V. E. CARLOUGH, NORTH MIAMI, FLA.

I am too poor to collect my old age benefits owed to me by Social Security. What can be done to correct a system that gives to the rich but denies the poor?

WHO DOES COLLECT OLD AGE BENEFITS?

To mention a few, it's men of affluence, semi-retired business men—Union workers with a Pension Plan—men with large investment income—and those of many other categories get their Old Age Benefits. But no person, like myself, who has no supplemental income to fall back on, is eligible for OAB.

Just think of it, the one who needs it most is "Shut Out." What a negative and frustrating situation. . . . "The Rich, Yes; but the Poor, No." How many more thousands, like myself, are caught in the same bind—who will have to live through their declining years without ever sharing in that proverbial "Pot of Gold at the end of the rainbow." And who are these people who are denied their Old Age Benefits? For the most part they are the Solid Citizens of America that are seldom heard from when it comes to looking for hand outs—who lead exemplary lives—obey the laws of God and man—work all their lives, believing that it is mans duty and destiny to take care of his obligations to Church and Charities, and as far as possible work for his own livelihood and that of his family.

What hope is there in the foreseeable future for them to secure for themselves benefits from Social Security on the same equitable basis as those who *are* getting them? How can such a change be brought about?

One of two methods could be employed to accomplish this:

(1) Organize to put our case before Congress to get the laws changed, or

(2) take a case to a *Court of Equity* where it could be determined if the law itself or the administration thereof is Equitable in the light of circumstances that have arisen since the law was passed during the depression days of 1934–1935. If a suit at equity could be deemed to be a "Class Suit" then a favorable decision for one complainant would effect all persons in a similar class.

In either case the cost to a lone complainant would far surpass any benefits that could accrue to a single person. Attorney fees, cost of research, public relations expenses and other costs would run into the thousands of dollars. But, if a suit becomes a "Class Action," then thousands of people could join in and raise enough money to make it worthwhile.

To start, then, one person would have to file suit against the Social Security Administration for refusing to dispense Old Age Benefits to persons who have passed their 62nd Birthday, "Because they are working and earn over $1,500 (Gross) per year or over $125.00 per month." Who will start the venture to put a stop to this farce and travesty against justice?

In connection with plan (2) going to court, a faint ray of light has come from a recent decision by the United States 4th Circuit Court of Appeals, Richmond, Virginia. On May 1, 1967 this high Court ruled that the Social Security Administration cannot deny disability payments simply because an applicant makes more than $100.00 per month (the limit allowed when that suit was started). The Court said Congress did not intend to deny disability payments to persons, who, because of character, and a sense of responsibility chose to work to supplement social security payments. The Court further stated that the complainant who worked to supplement his SS payments did so because he had the "admirable motivation to insist upon working for the support of his family despite physical inability to do so." When his job cost him the right of disability payments, the Court said, "the administration showed more logic than common sense."

This same humane ruling could well apply to old age benefits payments to those who chose to maintain a responsible position in the community by continuing to work even after they became eligible for such payments.

Involved in SS administration comes the question "Is it true that the men who drew up the original SS Law (Economic—Security and Advisor Council on Economic Security) appointed by President Roosevelt June 29, 1934 and the Congress of 1935 intend to "Shut Out" 65 year olds who had to work on after 65 because they had no supplemental income to fall back on when they became eligible for Old Age Assistance? The answer is a definite *No.* Concrete evidence to support this No will be presented in a future dissertation on this subject.

But how and why have I been so engrossed in the subject of Old Age Benefit administration?

It all began on May 23, 1964.

This was my 65th birthday, and with much anticipation built up over years of growing old, I introduced myself at the 79th Street Office of the Social Security Administration. There I gleefully announced myself as a Senior Citizen and inquired "Where do I get the money"?

A friendly clerk smiled indulgently at my expectations of getting "Old Age Benefits", but was quick to caution me that "the money tree was not shedding its goodies just that easy. "Formalities such as establishing my identity and my rights to SS would be undertaken and then passed on in Washington or New York or some place for approval. Well, all that seemed logical to me, so I filled out forms, gave proof of Age and of payments into the SS fund since the year 1937, and complied with all other regulations required of me.

Within a reasonable time thereafter I received notice that sure enough I was qualified and could draw $116.00 per month now, and more if my future *earnings should bring my averages up.* However, there would be no payments as of *now* because I was still working!

Well, this was a shocker to me. In effect it meant that I would have to quit my $5,000 a year job in order to get the "Old Age Benefits" promised me 30 years ago. But how come, I reasoned with myself that for years I have been cashing SS checks for other people who came to Miami Beach for a tour or vacation that some times lasted as long as 3 or 4 months. From my vantage point as a front office man in a hotel these people seemed affluent—owned businesses, spent a lot of time at the stock exchange office of Bache and Company on Harding Avenue, and generally lived like wealthy people. The men of the family went to the Horse Races most every day, while the women spent their time at a friendly card game in the private card rooms of nearby hotels. Many of these people were so affluent that they paid a room rental of $30.00 per day or more and in many cases season rates up to $6,000.00 and still both members of the family presented me, each month, maximum "old age benefit" checks for encashment. On many occasions I heard remarks that the money produced by their checks would make it convenient to go to the "Dog Track" that night with "Fresh Money."

Now I never regarded these remarks with anything but a passing interest because I figured that each person could do what he wanted to with his money if he or she qualified for "Old Age Benefits". However, it becomes very difficult for me to understand now how these wealthy people were entitled to benefits, in the light of me being "shut out" from benefits, when this little extra help would help to meet the growing inflation costs of living at a time when I, because of age, could not command any increases in my salary and earning capacity.

With these perplexing questions in mind, I decided to analyze the financial position of some of those who cashed OAB checks with me. I put these people into classifications which I will enumerate:

1. Mr. "A" is a man of great wealth, a high executive getting $25,000 a year salary and has a $100,000 income from investments. He received OAB checks—Why? He is over 72 years of age.
2. Mr. and Mrs. "B" have investments that enrich them $150,000 per year. They have a going business which brings them in $25,000 a year. They each receive OAB checks. Why? When Mr. "B" became 65 years of age he announced that his son was taking over the management of the business and he took himself off the payroll and henceforth would take his emoluments from the business in "Dividends" not salary. He claims he does not give substantial time to the business and no one can prove it otherwise. He goes to business when and if he desires, and leaves in the same manner. He does not, of course, punch a time clock and has absolutely no check on his activities, either while at his office, the broker's office, the golf course or other places of rendezvous with business cronies.

Mrs. "B" was put on the business payroll at a time when only 5 years of covered employment was necessary to qualify for OAB. Any work she did for the company must have been at home because she was not the business woman type. They both get maximum OAB checks.

3. Mr. "C" for the past 25 years worked for a company that set up a retirement plan. When he quit work his company turned over to him $28,000 in cash and stock in the company. In addition he will draw $600.00 per month the rest of his life. His company calls him in for consultation occasionally (or whenever they want to) but he is not on the regular payroll for any amount. He gets OAB without question.

4. Mr. "D" worked for an industrial corporation that had a strong Union. One of the important benefits of the Union-Company pension retirement fund contemplated stoppage of work at age 65, at which time he started receiving $100.00 per week for life. He gets OAB without question.

There are many other circumstances which permit a person to draw OAB. They are too many to detail, but in all cases the same pattern exists, e.g., those who have money Get. Those who don't have money are "Shut Out". All of the types of people mentioned above followed the same procedure that I did. We all had deductions of the same amount withheld from our pay over the years, but at that point we begin to differ. I have nothing to supplement my OAB—to maintain my status in life—but the others have. Comparing all of us, I need OAB most of all, but by employment of the standard of administering on the basis of law instead of equity, I am shut out of my rightful inheritance.

All things considered I believe that I have a more valid claim for OAB than most of the above persons. But, in the light of the lawful administration of SS, the question is "How to go about presenting my claim". Perhaps I could persuade my boss to pay me a salary of $1,200 and put me on a retirement pension of $3,800 which would put me in the same category as #3 previously mentioned. Would this subterfuge qualify me?

Another thought occurs to me. Supposing I should quit work altogether. Assuming I received my OAB of $116.00 per month, and that was my only income, I would then establish myself as being in the lower area of the Poverty class. Under such circumstances I would have to sell my home, and rent. I would then be eligible to rent a low rent government subsidized apartment for about $50.00 per month (which would cost the government at least another $50.00). Then I could get a poverty food package (I don't know the cost of that). I could get medical and surgical service for free (as an indigent)—and perhaps there are other free rides which I don't know about at this time. The thought arises, is this a better solution than paying my OAB in the first place.

What would be some of the "side effects" of giving up my job to retire? Based upon my May 1967 checks the following results would ensue.

Gross pay	$484.62
Deduction for income tax	70.90
Deduction by SS F.I.C.A. OAB	21.32
Net to me	392.62

A résumé of other losers

U.S.A. (income and FIAC OAB)	$92.22
City taxes ½₂ of year	4.38
County taxes ½₂ of year	11.48
Sales taxes	17.08
Total (tax losses)	125.16

An amazing fact is brought into focus by this analysis. By denying me my OAB of $116.00, the Federal—state—and local government stands to lose $125.16 per month. This is just one of the many enigmas that results from this uneconomical handling of my situation. When you add to this government subsidies of low cost rent, free food allotments and other government hand outs, it is easy to see that the present policies of SS administration take on the mantle of being self-defeating.

Another economic situation is worthy of note. If OAB is to help in your declining years as is often stated in various pieces of literature of SS, then what about a situation like this. Up to about 4 years ago my salary with my present employer was about $5,400. Under ordinary circumstances, I would have been advanced about $500 per year in salary. But, because of my advancing age, my employer reasoned that I was slowing up in activity and productiveness and therefor did not feel inclined to give me salary increments. Besides where could I get a job that would even pay me what he was paying. Right there I needed help, because since 4 years ago prices of everything a person needed was going up. According to statistics such elemental things as Real Estate Taxes, Car Insurance, Food, Clothing, and many other basic necessities had gone up-up-up. But because of my age, I did not qualify for more salary. In fact my employer assumed the attitude that he was being magnanimous in even keeping me on the payroll. I find it hard to believe that in 1934/35 when SS was being born, that the people interested in founding it would not have made provisions for such conditions, had they been able to foresee the situation in 1965.

Let us research a little into the question of the intent and purposes of the 1934 Committee of the Social Security Council and of the Congress that passed the Social Security Law.

The Country, under the leadership of President Roosevelt, was trying to pull the Country up out of the Depression by its proverbial "Bootstraps". It was the hey-day of the NRA and the beginning of many another alphabetical agency. There were 10,900,000 unemployed people looking for jobs, many of them dependent upon the government for food and fuel. Homes were being foreclosed and farmers were defending their homes and farms by armed force. Mortgages on homes were being transferred to Home Owners Loan Corp. to bail out homeowners unable to pay, and for the additional purpose of supplying weak banks with cash. Thousands of banks and Building and Loans that had been closed were trying to become solvent by getting cash from the Federal Government.

It was in this atmosphere that the Social Security purposes were thought out, compromised and battled over. Time was of the essence because President Roosevelt had promised the people a bill early in 1935. It was no wonder then that the original framers of the SS law had to compromise on many issues as will be outlined later. It is also understandable why they could not foresee needs under conditions that would effect their finding 10-20 of 30 years hence.

After months of study, the Social Security Council drafted the original contents of the law and presented it to the House. The members gave it long and searching study adding and amending as they went along. Finally they voted the first SS bill on April 19, 1935 by a vote of 371 to 33. This original bill did *not include* any prohibition against a man being paid "Old Age Benefits" because he continued to work after he otherwise qualified as being 65 and having contributed to the SS fund. A salient fact to always keep in mind is that the wording of the Bill stated that 65 year old men and women should receive their benefits as a matter of right from funds to which they had themselves contributed.

The bill then went to the Senate, where it was referred to the Finance Committee. This committee was busy on other matters and did not start its hearings for almost two months, and time was running out.

After the Senate committee started they followed rather closely the pattern of thought of the House. But about half way through a disturbing action was injected when Mrs. Perkins, Secretary of Labor was belabored by some source to carry a message to the President asking him to use his influence to have the Senate impose a condition of securing OAB only if the recipient quit his regular employment. Madam Perkins based her request for this change on the theory that the actuaries had originally based their feasibility reports on the premise that all recipients would quit their jobs to make room for some of the millions unemployed. It appears then that the actuaries were the original source from whence came this major line of thinking, and not the security council or the legislature.

Madam Perkins took her plea to the President, and filled him in on this new line of thinking. No one knows what the conversations were, but one can envision what the President said to her plea. It can only be surmised that in his anxiety to fulfill his promise to pass a bill, he probably told her to "let's go for anything that might stymie passage, because we have plenty of time in the future to make corrections to improve the act."

The President, on the say-so of the actuaries, then made a pronouncement to all that he wanted to expedite passage of the law, and that he wanted an amendment included which would require a man to retire from *Regular Employment* as a condition of receiving his Old Age Benefits.

The main objector to this amendment was Mr. Middleton Beamon. He raised the point that "Active Employment" needed to be defined, and he subsequently rejected every proposed definition. The matter was then referred to a sub-committee which considered many, many definitions, and then finally adopted a motion to drop the subject and strike out the provision entirely.

Now it is a notable fact that all during the hearing of the Senate Finance Committee, the subject of retirement from regular employment never came up for discussion *until* the very last item of the last meeting of the Senate Committee. It was then that an amendment by Senator LaFollet was proposed and adopted without discussion, which stipulated that a person must quit his job before he could get OAB to which, up to this point, he would have been entitled to. This resulted in putting into the senate bill the Section 202D which modified Section 202, as follows: Whenever the Board finds that any qualified individual has received wages with respect to regular employment after he attained the age of 65, the old Age Benefit payable to such individual shall be reduced for each calendar month in any part of which such regular employment occurred, by an amount equal to 1 months benefit.

This amendment shows conclusively that at the last moment the full intent and purpose of the Security Council and both houses of the Congress was negated by a pronouncement of the President, which was born in the minds of the actuaries who said the entire SS system was threatened, if retirement from regular employment was not included in the bill.

In retrospect, it turns out that the scare tactic of the actuaries never materialized because the SS Insurance Fund has never been threatened by a shortage in all its existence.

The manner in which the Social Security has been administered shows clearly that they have never had a clear cut interpretation of the earnings phase of 202D. The wording of this amendment says "Received wages with respect to regular employment" which surely leaves the door open to earning wages from some other type of employment.

Somewhere, among the 44 subsequent amendments to the law some legal authority has probably validated the methods and reasonings now employed to "shut out" a wage earner, but the exact point of this occasion can only be found by an intensive legal research.

(N.B.) It is worthy of note, however, that no where in the original law was there any provision for paying Old Age Benefits to any of the following:

(1) Millionaires past 72 years of age, regardless of earnings of any amount.

(2) Rich businessmen who did not give so-called "Substantial Services" to their business.

(3) Affluent men who changed from working for wages to getting their income from stock market operations, dabbling in real estate developments, and sundry ways and means of massing large incomes.

At this point it is surely well to note the following influences cast on the Congressional voting in 1934–35.

(a) The actuary's scare statements to Mrs. Perkins that was transferred to President Roosevelt.

(b) The lack of ever arriving at an acceptable definition of what constituted regular employment.

(c) The cloudy definition in the LaFollete resolution and the resultant amendment.

(d) The then existing unemployment situation with 10.0 million persons idle.

(e) The Townsend plan and its pressures on the President and Congress. Effects of unemployment on original planning of SS.

As previously mentioned, after the Ways and Means Committee of the Congress thoroughly discussed and digested the reports of the Economic Committee, they passed HR 4120. This bill *did not* contain any Means Test, such as requiring a man to quit his job as a prerequisite of getting Social Security Insurance. However, when the Senate committee took up the matter under their Bill S-1130, they co-incided with the thinking of the Congress Bill until in some mysterious manner an unknown pressure group had inserted, the philosophy that SS insurance payments should require that a man should "retire from his regular employment" in order to be eligible. This is how this blight got into the final Bill 7260, Public Law 271.

Now the question always has been a secret as to who caused this blight to be put into the law. Some are of the opinion it was organized labor who wanted to push older men out of the active labor force so as to make room for younger men who were on the unemployment rolls. This transition was probably desirable—if—when a man was so removed from the labor force—his old age benefits were within reasonable proximity of his normal needs for sustenance; but to make *him quit his job* without adequate reserve income, which would force him to slide down the economic ladder to a position of poverty, was never envisioned by anyone. Overall total income is necessary for a man to be happily retired. In no case should the lack of adequate reserves be an excuse to deny a qualified person from getting his just payments.

In 1935, the total unemployment reached 10,900,000 and the hopes of many of these, hinged, they thought, on pushing the oldsters out of the labor market. All this was fallacious thinking because over the years the unemployed rolls showed a continuous drop. By the time SS started payments the number of idle had dropped below 5½ million. Subsequent to that time the idle dropped to as low as 670,000 in 1944. At this point all restrictions could have lifted because this figure was far below the accepted norm of 2 to 3 million as a point below which we never go.

This is the present day average level, and were it not for several million persons moon-lighting on a second job, we could very well say there is a serious shortage of labor force. In fact the Labor Department keeps on advertising that many jobs go begging for lack of takers.

All these facts and figures make ridiculous any further attempts to use the crutch of unemployment as a valid reason to further deny many fine Americans their Old Age Benefit Payments.

As an observation, I have heard people say "naturally you can't expect to get Old Age Benefits and your working salary, too". This presumption might have some merit if your OAB payments in 1965 were comparable with the living scales of 1935. The original law prescribed a formula which allowed as high as $85.00 per month.

Below is a comparative analysis of pay scales of the two periods:

Wages	Annual average, 1935	Annual average, 1966	Percentage increase
Hourly	$0.54	$2.71	401.0
Weekly	19.91	111.92	462.1

A casual observation of the above figures indicate that if present day SS payments had kept pace with income requirements then the present old age benefit payments would be $612. per month, in which case it would be no problem to retire.

These facts cause us to pause and inquire "If the law-makers in 1935 knew that the cost of living would increase over 400% by 1965, would they have written an automatic increase in the SS law they were then enacting."?

It should be noted here that the payroll taxes did increase 440% from 1% in 1935 to 4.4% in 1967. However, the Congress from time to time, has seen fit to apply the money to covering new classifications brought under the system.

Even now, at this writing (July 1967) the House Ways and Means Committee is discussing a New Amendment to spend 4½ Billion dollars from the Trust Fund to cover payments to persons not now legally entitled to these funds, and at the same time will call for additional payroll taxes from Senior Citizens now still working to support themselves.

Threat of *actuaries* to Social Security *Trust Fund:*

During the latter part of their discussions about the SS Law, the Congress was confronted by the actuaries with a prediction that the U.S. Treasury would have to appropriate funds out of general revenue to support the Trust Funds by 1965 if they persisted in adopting the provisions of HR 4120. This was the blight which brought about the present unfair administration of the SS law. It scared the legislators at a most unfortunate moment, because publicity of this report would have possibly killed the law altogether. So they had their way, or perhaps it should be said that the unknown pressure group had their way.

But how wrong they were in their predictions. Year after year the year end balances of the Trust Fund have mounted: 1940—$1,744,698,000—1945—$6,613,381,000—1955—$21,141,001,000. and so on until Feb. 1967—$21,014,727,000. All this despite the constant success in increasing coverage to more and more people. Some of whom are drawing full benefits with only a relative few years of contributions. And the Fund is still being tapped by millionaires. Affluent Business Men and johnny-come lately self employed businessmen who were allowed to buy "annuities" at bargain prices.

Another glaring inequity reveals itself, when the Hospital and Medical amendment was passed, as between the men and women who have to continue working as against all others. The Millionaire, and the affluent businessman on retirement can afford to vacation at the best hospitals at the slightest sign of physical distress, but the man who has to continue working in his declining years can ill afford to go to hospitals when he will lose his salary during the process.

Considering all the facts, it is evident that the arguments of the unknown mysterious opponents to working Senior Citizens being paid the Old Age Benefits, were specious then and now. It becomes more clear each year that this "political trick" to shut out these non-union salary workers has been a blight on the honest administration of Social Security. This cruel hoax on a portion of our citizens, who for the most part are not demanding of their rights, who stand forthright for the American Tradition of providing for their dependents, even when they have to overcome physical obstacles so to do, and who refuse to throw themselves absolutely and completely upon the State to support them, should, at least be accorded a token of recognition by payments of their equitable Old Age Insurance payable as a matter of right, to wage earners, from funds to which they had contributed.

It seems self-evident that to secure Justice, we must first ferret out the unknown and mysterious forces that are making a mockery of justice in Social Security. Is it organized labor; is it the nation wide insurance companies who want to sell supporting Annuities to the Salary Worker, or, who?

It still seems two courses are open.

(1) Appeal to the "good Conscience" of Congress.

(2) Press for a decision of the United State Supreme Court on the equity of SS Administration.

UNION DE MUJERES AMERICANAS,
CAPITULO DE PUERTO RICO,
San Juan, P.R., September 2, 1967

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

SIR: Ever since the creation of the Social Security Act, you have been most frequently improving the Law, and we greatly appreciate all your efforts in bringing welfare to the disabled, to the elder, and to their dependents.

This year our Hon. Resident Commissioner, Lcdo. Polanco-Abreu, introduced in the House Ways and Means Committee some amendments to the Act, and in view of our high cost of living, we trust that you will be so kind as to consider his proposals favorably. Among the bills that he introduced, there were three based in our petition to the Honorable Congressmen:

H.R. 2010—"To remove the present prohibition against social security coverage for service performed by an individual in the employ of his or her spouse;"

> According to present law, an aged or middle aged, disabled, divorced women, who for a long time was employed by her husband, may still have no wife's, no widow's, no old age, and no disability benefits. Therefore, we trust that you will kindly eliminate this great inequity.

H.R. 2011—"To amend Title II of the Social Security Act to increase the amount of a widow's insurance benefits from 82½ to 100% of her deceased husband's PIA;"

H.R. 2012—"To amend Title II of the Social Security Act to provide that a woman who is under a disability may become entitled to widow's insurance benefits without regard to her age."

> If similar benefits are being given to disabled husbands and children, now it only rests for you to be so kind as to grant widow benefits, at any age, to the young disabled widow.

We are confident that you will act, with respect to the above amendments, as wisely and fairly as ever. Your approval of these measures will be very much appreciated by this group of women who love justice, have faith in your ability, and admire your great task.

Yours respectfully,

UNITED WOMEN OF THE AMERICAS, P.R. CHAPTER,
SAMIRI DE PÉREZ, *President.*
ANGELITA S. DE MERCADAL,
Chairman, Committee on Legislation.

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, August 21, 1967.

Hon. RUSSELL LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: I hope that you will have an opportunity to discuss with our Tennessee delegation the excellent services provided by Crippled Children's Service in Tennessee to the needy crippled children who have received so much benefit from the one program that has received practically no criticism during my professional lifetime in Tennessee.

I understand that there is a proposed reorganization of the Department of Health, Education, and Welfare that will have the effect of Moving Crippled Children's Service from the Children's Bureau and assinging this service to the Rehabilitation Services administration.

Allegedly this step is contemplated to lessen fragmentation of rehabilitation services and I, personally, have been a severe critic of fragmentation of services at the federal government level as well as at the state government level. From our point of view in Tennessee, this objective will not be reached. While Crippled Children's Services definitely can be classified as rehabilitation services, the service actually is habilitation, not rehabilitation, of the physical child (many times mental conditions exist), and should be logically closely associated with services to normal children such as the Maternal and Child Health Service and the health services to school children. If the objective is to lessen fragmentation then this service belongs in a service that is primarily health oriented and we respectfully urge that you in your position as Chairman of the Senate Finance Committee include phraseology in the law that would guarantee administration of this service only by a medically oriented bureau as is recommended in the report of the Ways and Means Committee on H.R. 12080. (My personal choice would be the Children's Bureau.)

The Children's Bureau has had a 55-year history of most successfully administering services to crippled children. This agency has developed a good working relationship with private physicians who must provide the service, with state agencies and many of the State Departments of Public Health that must administer the service that is unequaled in the history of federal, state, local relationship. Why destroy this?

I know, as do my contemporaries, that changes must occur, that new programs must be instituted and new techniques developed, but a change just for the sake of a change is not necessarily good and we believe that due consideration should be given to the overall effects that this change will have on the children and the parents of the children who look to us in time of need for service that can be provided by no others, the physician who treats a child and his family.

Yours very truly,

R. H. HUTCHESON, M.D., *Commissioner.*

BARNES-HIND PHARMACEUTICALS, INC.,
September 8, 1967.

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

DEAR SENATOR LONG: May I request that the remarks contained in this letter be made part of your hearing record on S. 2299.

I sincerely believe that this bill, if enacted, would not accomplish its alleged goal and, at the same time, would seriously injure the American public health, the medical community, and the pharmaceutical industry.

In hopes that a brief description of my background would lend more weight to the contents of the letter, may I mention that in my career that extends over thirty years (1) I have been trained in the sciences in Europe; (2) I have been a practicing pharmacist under socialized medicine in Hungary; (3) I have been engaged in teaching and research in the United States; and (4) I have served the United States and international pharmaceutical industry.

Finally, I would like to mention that enactment of S. 2299 would not be directly injurious to the commercial interests of our company, and, consequently, my motivation in communicating with you has no self-serving background.

I am greatly concerned about the United States Formulary provision of your bill, which I believe would have far-reaching, serious and undersirable "side effects."

The first effect of the Formulary would be to cause subtle change in the research and development effort by the pharmaceutical industry. This change will lead to a low-grade research effort since the commercial success of the research fruits will be entirely dependent upon the listing of a product in the Formulary. Reduced research efforts in the pharmaceutical industry will lead directly to the erosion of public health standards. This chain of events can be well documented and demonstrated all over the world where dispensing by the Formulary system is made mandatory.

I am sure that I do not have to point out that public health is one of our nation's most significant assets; that its value can actually be expressed in monetary terms; that its political significance can be measured; and that the outcome of World War II has been decisively influenced by the superior drug armamentarium of the Allies. I doubt seriously that your bill, which you claim may reduce direct expenditures by $100,000,000, would pay for the loss incurred in public health standards.

Let me point out another area of loss this country will suffer. Your bill is the first step toward violating the economic principles upon which our country is built, since an indirect, and later direct, price control measure will emanate from the existence of a Formulary and, therefore, will place the pharmaceutical industry under economic regulation unprecedented in our history.

I am indeed appalled at the support for your bill from the American Pharmaceutical Association (of which I am a member), since it clearly reveals their ignorance of the economic experiences of pharmacists who operate under a Formulary system. Pharmacists will not profit from a system restricted to the use of Government-selected drugs and, at the same time, it will degrade their professional status as members of the health care team. The relegation of the pharamacist to a dispenser of Government-selected and listed drugs will then seriously affect the curricula of our seventy-two Schools of Pharmacy, who will have to revise their standards downward—a step contrary to the philosophy of our educational system.

Herein are only a few points on the "side effects" of your bill. I am sure the testimony will bring out many others, such as the discrimination against a certain segment of the American population, the interference with and restriction on the physician for selecting the best drug for the patient, and some that I cannot yet foresee.

I trust that your desire to save the taxpayer and the Federal Government money will not overshadow your decision when you ponder the harm that may arise from false economy.

Yours very truly,

IVAN J. SZEKELY, *President.*

OREGON ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN, PRESENTED BY HELEN L. GORDON, PORTLAND, OREG.

POSITION STATEMENT IN HR 12080

We wish to support the testimony on HR 12080 presented by the National Association for Social Workers, Oregon Chapter.

In addition, we wish to caution on several matters inferred by the bill. Let us enumerate the areas we consider has having danger signs:

1. Specific penalties seem to be authorized if one of the presumably employable teenagers or adults in families receiving Aid to Dependent Children grants refuses employment. The alternative penalties seem clearer under this Bill than the "good cause" for which the applicant may decline employment.

2. The intent of the Bill to cut the number of children on the rolls because of illegitimacy or desertion by a variety of methods seems clear.

a. States are required to offer programs of family planning, and to report the numbers to whom it has been accepted." Although compulsion is not extended to the family, will not a coercive approach be invited?

b. Cooperation with law enforcement agencies in determining paternity, locating absent fathers, and sharing the cost of enforcing support orders is required of all states.

HR 12080 proposes a drastic reversal of a basic purpose of the ADC program. The original Social Security Act stated the purpose of the program was to care for dependent children "in their own homes or in the homes of relatives" by furnishing financial assistance and other services so that those parents and relatives "attain or retain capability for the maximum self-support and personal care and protection." HR 12080 specifies [Sec. 201(a)(1)] that the objective is one of "assuring to the maximum extent possible, that [ADC recipients] will enter the labor force and accept employment."

Secretary of Health, Education and Welfare John W. Gardner, in testifying against the changes, said, "I do not believe that children have to pay for the real or supposed sins of their parents. . . . There is a real question as to whether society gains if a mother leaves four children to go to work." And Alvin L. Schorr, in his *Poor Kids:* A report on Children in Poverty, says, "To put the matter cautiously, the weight of evidence leaves open the possibility that a preschool child may be damaged if his mother must work."

While we recognize that these many mothers and teenagers want employment, we question of where are the jobs? Every city of any size has large groups of unemployed. To date there has been little sound economic planning for the creation of additional employment opportunities with an understanding of the training components necessary to prepare people. Unless this is coupled with a more reasonable approach to ADC families, training for those who can more adequately leave home and be employed, we really augment the extent of poverty in our country.

Coupled with such economic planning, then must be comprehensive planning of the Day Care services needed for children from infancy to high school age. It is well to say that State must provide these but there must be time for planning and implementation. If not we are apt to find ourselves in a more aggravated situation than exists today.

In our own state, title V training programs for mothers administered by Public Welfare in county after county were not successful for lack of day care services.

The Congress of the United States included in its Public Welfare Amendments of 1962 a directive that an Advisory Council on Public Welfare be appointed to thoroughly review public assistance and welfare services and to recommend improvements. Their report, "Having the Power, We Have the Duty," published in June 1966, included recommendations for increased Federal financing a variety of services, for greater incentive exemption of earned income—for many of the provisions contained in the HR 12080. But the Advisory Council would not limit these to the broken family caseloads. Stressing the interrelatedness of problems and needs as changes in modern living reduce the capacity of family and neighborhood to respond, the Council concluded: "Ways must be found to bring the comprehensive social services that modern living requires to all who need them, when and where they are needed."

These goals cannot be carried out under the show of coercive and repressive policies applied to that segment of our population which offends our sense of morality. HR 12080 goes against almost every aspect, fact and recommendation to be found in the report of their own creation, the Advisory Council on Public Welfare.

OREGON CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

POSITION STATEMENT ON HR 12080

We have carefully reviewed HR 12080, recently passed by Congress, and note with satisfaction that a number of provisions long sought by many welfare organizations have been included in the new amendments. Among these are: (1) An increase in Federal financing for a variety of social services such as Family Counseling, Day Care, Family Planning, and Foster Care Services. (2)

Financial support for work training programs. (3) Support for the training of Social Workers and Social Work Aides and a requirement that all states have an earnings exemption to provide motives for work by AFDC recipients.

However we note with alarm that HR 12080 unfortunately contains many negative and retrogressive provisions. The freeze on the proportion of ADC cases to the general child population, as of Jan. 1967, is especially serious since in effect it asks the states to choose certain children who will not receive AFDC, not because their situation differs from that of others or because of anything they themselves can control but simply because there are too many in the same plight.

The ADC–UN provision is both puzzling and contradictory to the supposed intent of the entire legislation since it would remove from eligibility the very families with the poorest chance of becoming self-supporting—those with the greatest need of the learning opportunities that the community work and training programs might provide. We also take exception to the provision which would remove from eligibility families (especially large ones) for whom unemployment compensation meets only a limited part of total need. We also wish to call your attention to the: (1) failure of this bill to make any kind of provision for child welfare and protective services for children not on AFDC who need such services, (2) the failure of this bill to obligate states to maintain a 100% level of minimal need, (3) and finally we question the wisdom of providing an earnings exemption to families who happen not to be on welfare but could be eligible if the same exemption rule were applied.

CHAMBER OF COMMERCE OF GREATER PITTSBURGH,
Pittsburgh, Pa., September 7, 1967.

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

DEAR SENATOR LONG: Social Security Amendments contained in H.R. 5710 prompted adoption of the attached position by the Chamber's Executive Committee on recommendation of our taxation subcommittee. Copies were sent to members of the House of Representatives in early August.

Social Security Amendments are now before the Senate Finance Committee, we understand. On behalf of the Executive Committee and the Chamber of Commerce, I respectfully request your consideration of the points outlined in our position in terms of its effect on the integrity of the American social security system and its effect on an inflation-bloated economy.

We trust this information is helpful to you in your deliberations on the measure.

Yours truly,

N. B. FRY, *President.*

H.R. 5710—SOCIAL SECURITY

The Chamber of Commerce of Greater Pittsburgh favors the basic principles of Social Security but finds that the changes proposed by H.R. 5710 introduce totally new concepts that would convert Social Security into a welfare-type program. A fundamental principle of Scoial Security is that benefits are paid as a "matter of right" and have always followed the basic premise which relates benefit amounts to wages earned.

H.R. 5710, however, would inject a "needs test" by first reducing the value of the benefits through taxing benefits of the retired worker who has "too much" income, and secondly by limiting the wife's benefits to $90.00 even though her husband's prior earning would qualify her for a larger amount. The Chamber is opposed to these new concepts.

The Chamber of Commerce of Greater Pittsburgh also strongly feels that increases in benefits should be kept in step with the increase in the cost of living. The 15 per cent increase as proposed by H.R. 5710 exceeds this need. An eight percent increase would be more "in step" with the realities of the cost of living increases.

The Chamber also feels that benefits should relate to prior earnings. H.R. 5710 would eliminate this traditional provision by relating benefits for some to the number of years of coverage, e.g., a minimum benefit of $100.00 per month after twenty-five years of coverage. The Chamber opposes this departure.

The Chamber also emphatically opposes any raids on the U.S. Treasury to finance additional Social Security or Medicare Benefits. The Trust Fund concept as adopted originally should be retained as the keystone of Social Security financing.

AMERICAN SPEECH AND HEARING ASSOCIATION,
Washington, D.C., September 6, 1967.

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

DEAR SENATOR LONG: The American Speech and Hearing Association, which is the national professional organization for speech pathologists and audiologists, represents the concern of its 13,000 members that high quality professional service be made available to individuals of all ages who have disorders of speech, hearing, and language. The great majority of our members support the Medicare and Medicaid legislation enacted by Congress, and will participate wherever possible in programs to provde urgently needed help to individuals covered under Titles XVIII and XIX. We recognize the urgent need for diagnostic and rehabilitative services in the older age group, where speech and hearing disorders incident to strokes, cancer and other organic disease are prevalent. We assume that Congress has in fact recognized this need, and intends that the Medicare and Medicaid programs should authorize such services. Present problems, which in fact limit the provision of adequate services to speech and hearing handicapped individuals, are believed due primarily to a lack of specificity in Public Law 89-97. If we correctly interpret the intent of Congress in this regard, we must rely upon Congress to spell out its intent more clearly so that agencies responsible for administering these programs may be guided toward positive implementation.

We would like to point out three factors in the present law (PL-89-97) which we feel adversely affect the provision of services to the speech and hearing handicapped:

A. Use of the term "speech therapy" in PL-89-97, rather than the recognized term "services in speech pathology and audiology" has led to a restrictive definition of the scope of such services by governmental agencies responsible for drafting requirements and regulations. Initial requirements by the Social Security Administration that "speech therapy" be provided only upon written prescription by a physician completely violated established relationships between physicians and speech pathologsts, and made it impossible for most speech pathologists to participate in the program. Revised SSA regulations have apparently corrected this misinterpretation of professional function, but there is need for more specific statement in the legislative history which would recognize that Congress intends that adequate professional services in speech pathology and audiology be authorized under Titles XVIII and XIX.

B. PL-89-97 does not provide for direct payment to agencies or individuals offering services in speech pathology or audiology. Hospitals, extended care facilities, and home health agencies may provide such services or may contract with a qualified agency or individual for services. However, in many geographical areas of the country there are no existing ECF or HHA programs, and present regulations governing the provision of outpatient service by hospitals do not usually permit utilization of available speech pathologists or audiologists. A private physician cannot refer in the usual manner to a speech pathologist or audiologist due to the requirement that such services must be provided in the physician's office or be directly supervised by him—a situation which is almost totally non-existent. As a result, there are many instances where there is a qualified speech pathologist or audiologist available, there is a patient urgently needing treatment for a disorder of communication, there is a physician willing and anxious to make the referral—but there is no provision whereby the service may be authorized under the Medicare program.

C. Under Title XIX of PL-89-97 there is no specific mention of services for individuals with disorders of speech or hearing. While it may be assumed that Congress intended to provide for such services under Section 1905 (a) (13) which authorizes "other diagnostic, screening, preventive, and rehabilitative services", discretion is apparently left to the Secretary of Health, Education, and Welfare as to what services may be included. In actual fact, the Bureau of Family Services, in drafting regulations, apparently elected to include speech pathology and audiology under Section 1905 (a) (11) which authorizes "physical therapy and related services". In so doing, the Bureau incorporated the restrictive requirements initially adopted as guidelines under Title XVIII. The status of speech pathology and audiology under Medicaid is thus confused, and there is little question that individuals with disorders of speech and hearing are being denied qualified and adequate services.

To resolve these problems, we suggest the following possibilities:

A. The most effective remedy for the problems which exist would be to secure amendments to Title XVIII which would substitute the term "services in speech pathology and audiology" for the term "speech therapy" wherever this term appears; and to provide for direct payment to a qualified speech pathologist or audiologist who provides services to a patient referred by a physician. Title XIX should be amended by adding a new subsection under Section 1905 (a) to provide for: "services in speech pathology and audiology".

B. A partial remedy might exist, short of amendment, through inclusion in the Committee report on the Social Security Amendments of 1967 discussion which would make clear the intent of Congress that adequate diagnostic, evaluative, and rehabilitative services be made available under the provisions of Title XVIII and Title XIX for individuals with disorders of speech and hearing. Specifically, the role of the qualified speech pathologist or audiologist as an independent professional should be recognized, and "speech therapy" services should be more accurately defined as "services in speech pathology or audiology". Section 1905 (a)(13) of Title XIX authorizing "other diagnostic, screening, preventive, and rehabilitative services" should be defined as including services in speech pathology and audiology.

A further partial remedy could be provided by revising Section 133 of the Social Security Amendments of 1967 to include speech pathology and audiology services as well as physical therapy services under provisions of this Section, and by authorizing payment under this provision when services are carried out either in the patient's home or in a facility or office maintained by the physical therapist, speech pathologist, or audiologist. While this provision would still not permit direct referral by a physician, it would probably allow some additional service by authorizing hospitals to contract with qualified speech pathologists and audiologists for services not directly incident to a physician's service.

We are fully aware that these problems are minor ones in terms of the total scope and complexity of the Medicare program. We would like to emphasize that we are not seeking an extension of services beyond those intended by Congress, nor do we wish to circumvent any necessary and appropriate requirements for administrative control and supervision. Our primary interest is in the individual who is handicapped by a disorder of speech or hearing, and in facilitating the participation of speech pathologists and audiologists throughout the country in Medicare and Medicaid, to the extent that Congress intends that these services be provided.

Any assistance your Committee may be able to provide will be deeply appreciated.

Sincerely yours,

KENNETH O. JOHNSON, Ph. D.,
Executive Secretary.

MACHINERY AND ALLIED PRODUCTS INSTITUTE,
Washington, D.C., September 7, 1967.

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

DEAR SENATOR LONG: We are pleased to offer for inclusion in the printed record of the hearings our views and comments on the Social Security Amendments of 1967, H.R. 12080. Since the manufacturing sector of the economy pioneered and still maintains leadership in the development of work-related retirement benefits, the Institute's membership is not only concerned with but has a large stake in the "employee benefit" aspects of this measure. We, therefore, welcome this opportunity to express our views.

At the outset we would like to point out that our comments are directed to those provisions in the measure which deal with benefits for retired employees—

i.e., the old-age, survivors, and disability insurance (OASDI) and the so-called medicare programs. We have so limited our commentary because we want to highlight our view that now is the time for Congress to consider the important interplay of private benefits and those provided under federal law. While the House did not legislate on this matter, we are pleased to note that the provisions of H.R. 12080 are not inconsistent with this approach as is the case with the Administration's proposals. We urge the Senate to engage the question directly.

To explain more fully, to date much of the discussion before this Committee has centered on the needs of the beneficiaries of the system. We think, however, that the time has come when equal—and perhaps greater—attention should be given to the place of the social security system in the overall scheme of the economy.

These two issues are, of course, not mutually exclusive. Increased emphasis on the latter, we think, will point up the need for new alternatives for providing benefits to fit existing needs. Further, with a proposal as far-reaching as that being suggested by the Administration, we think these alternatives must be explored before any particular path—from which we may not be able to turn back—is chosen. In this area *we stand at a crossroads of national policy*. One branch of the road ahead could lead to an ever-increasing social security system and a corresponding diminution of the private pension system. The other leads to a balanced development of both. Our statement emphasizes both the fact of our arrival at this crossroads and our conviction as to which is the proper future course.

THE MAPI POSITION IN SUMMARY FORM

Attached is the Institute's publication entitled *Social Security and Private Pensions at the Crossroads: Crisis or Compromise?* which sets forth our views at length. Following is a capsule of those views.

(The publication referred to was made a part of the official files of the committee.)

As implied by a *Wall Street Journal* review of this publication on August 14, we have employed a provocative title. We did so deliberately for the following reasons:

1. The proposals put forth by the Administration before this Committee—which are substantially those in H.R. 5710—would provide at the minimum a disincentive to the growth and development of private benefit programs by providing duplicative pension benefits. The Administration's suggestions viewed in the full context of other measures now before Congress to directly regulate in a costly and restrictive fashion the overall private pension plan system in the areas of funding, vesting, reinsurance, and fiduciary responsibility provide a further disincentive. That the Administration is fully aware of the direction in which it is going is evidenced by the Treasury proposal—which was put forward on a "trial balloon" basis—to make a restrictive and costly revision in the "formula" for integrating tax-qualified private pension plans with social security.

2. The problem facing companies as to their own plans for their employees is one of both cost and need. If Congress should adopt the Administration proposal for a major boost in benefits, it seems clear that the employer's cost, as well as that of the employee, would rise significantly and greatly lessen the company's ability to add new benefits. At the same time, when under social security, the taxable wage base is stretched out significantly and a 30-percent replacement-of-income factor includes those with higher and higher incomes, there is also a diminishing need for certain protections that a company may have built into its own plan. For example, a company's plan may curently protect certain groups of employees at a 30- to 40-percent replacement level. Should a supplemental government program increase the protection to 60 or 70 percent, the need for "more" company protection is greatly decreased and, in some situations, the company plan might even be an unwanted employee benefit in the sense of employee preference for an alternative form of compensation.

3. The dilemma of the relationship between private plans and the Administration proposals can be brought into sharper focus if we also consider the current difficulty presented by the administrative rules governing the technical integration of the two (i.e., the regulations governing the amount of social security offset a company can build into its pension plan to account for, and thus protect against, rising benefit and cost levels under social security). Specifically, we refer to the so-called "37½ percent test" which, as noted above, the Treasury is considering amending. If, to take the extreme case, technical integration for tax-qualified pension plans were totally eliminated, the prospect of the removal

of tax-qualification for current private plans would lead to their wholesale curtailment or abandonment. Because an employer would be remiss if he did not keep social security taxes and benefits in mind, formal integration has, however, long been accepted as reasonable under tax-qualified plans. For many years now various "generations" of future retirees have had their expectations built on this "37½" rule that, over this period. Treasury has accepted as accurately reflecting an employer's contribution to social security. Further, since private pension planning has obvious long-range considerations, certainty of the future is at a premium. Social security tax increases, taxable wage base step-ups, expanded benefits, and rules governing offsets or integration all become key in terms of planning private benefits. Thus, signposts or discernible trends indicating a potential federal "takeover" have obvious and predictable long-range implications for private plans. The "crossroads" we see plainly is the prospect that the government through various tax, legislative, and regulatory measures would have the effect of establishing a single public pension system rather than continuing with the dual system that currently exists.

4. The prospects viewed in this light have further onerous overtones. Specifically, if the private system is muted, there must be more and more amendments to the public system to fill the gaps. Almost certainly, such amendments must turn to financing increases in benefits from general revenue because the cost burden on potential beneficiaries and their employers will become staggering under the current earned-benefit concept. Restated, the total tax burden carried by individuals and employers in this country—already at too high a level—is aggravated through the back door of social security. When this limit is reached, to spread the tax burden the government must convert the social security system in significant part into a pure welfare program. When that day arrives, not only will the private system be a dim memory of the past, but even the "earned" right to social security will have disappeared.

RECOMMENDATIONS

Our specific recommendations are posed with full awareness that a case can be made that there exist some need-gaps for the current beneficiaries of the OASDI and medicare programs. Nonetheless, we think that Congress must be equally concerned with the longer range considerations. As stated by Congressman Thomas B. Curtis, a member of the House Ways and Means Committee, in his supplemental views in the House Committee report on H.R. 12080:

> "Today social security is certainly an important part of the retirement plans of most Americans. But it is only a part and when it was initiated, it was never proposed as the sole source of retirement income for our people. The discussion today should be around how much a part it should be."

Many, if not all, of the issues dealing with approach and resultant impact have not been fully explored by Congress, although a variety of legislative studies are now pending or in immediate prospect. Studies which, in our judgment, require completion before embarking upon the course proposed by the Administration include (1) the study outlined in the Joint Economic Committee print entitled "Old Age Income Assurance: An Outline of Issues and Alternatives," 89th Congress, 2nd Session (1966); (2) the studies suggested by the Report of the National Commission on Technology, Automation, and Economic Progress entitled "Technology and the American People," 1966; and (3) the obviously relevant study called for in "Public Policy and Private Pension Programs," the Report of the President's Committee on Corporate Funds and Other Private Retirement and Welfare Programs. Beyond these studies now in progress, it would seem to us premature to be committed to a particular approach until the yet-to-be appointed Presidential Commission on "Guaranteeing Minimum Incomes" reports its recommendations on these issues.

Against this background we have two general recommendations to make:

1. The Committee should take positive steps to encourage the growth and development of private pension plans by:

    a. Establishing by statute the principle of accommodation of the two systems. Any further significant inroads on the private pension system by federal programs should be questioned.

    b. Resolving the technically difficult but important integration formula problem through a statutory test of 37½ percent.

2. As for the question of increased benefits, the Committee should accept the House measure as an approach which responsibly recognizes the needs of current beneficiaries but one which at the same time does not foreclose by prohibitive cost burdens the future growth and development of our private pension system.

This concludes our comments on H.R. 12080. We again express our appreciation for the opportunity of presenting these views for the Committee's consideration and for inclusion in the record of the hearings.

Respectfully,

CHARLES STEWART, *President.*

(The following letter was submitted to the committee by Hon. Charles S. Gubser, a U.S. Representative in Congress from the State of California:)

PALO ALTO, CALIF., *August 6, 1967.*

DEAR MR. GUBSER: If the Social Security bill is being revamped, I wish you would consider putting in a modification which will result in fewer divorced women becoming public charges in later life.

The revision would be that the divorced woman is entitled to Social Security payments based on her ex-husbands contributions to Social Security, if she was married to him over 14 years and was 40 years or more old at the time of the divorce.

It is VERY difficult for women to get a job after 40.

It is VERY difficult for women to retrain for gainful employment starting at 40—most scholarships are limited to MEN, or persons UNDER 35.

Despite the law, it is common knowledge that women's salaries are at least ⅓ lower than that of men doing exactly the same work. So a woman starting at 40 simply will NEVER earn enough to carry her once 65.

Starting at 40, with a low income, there simply is NOT ENOUGH TIME to accumulate enough to live on in the years before mandatory retirement.

I believe the law now reads that a woman can get her Social Security if she was married 20 years. THIS DOES NOT MEET THE NEED. How many men could be off the paid labor market for 14 years and then get a job that paid well enough to support them thru retirement—and most marriages break up during the 13th year.

Despite the laws, many 40 year old women are struggling to support their kids and bring them up, and by the time the kids are reared, and the debts left by the ex tackled, there will be roughly 15 years—if she is still healthy and considered employable by some employer—in which to accumulate ALL THAT SHE NEEDS FOR THE REST OF HER LIFE! Men, even with their higher employability and earnings, couldn't do this—and the average woman with lower earnings and less chance for employment simply cannot gather together enough to live on for the rest of her life in 15 years.

This is a serious situation, and one which I hope you will help correct.

Yours truly,

DOROTHY WOODWORTH.

(The following letter was submitted to the committee by Hon. George D. Aiken, a U.S. Senator from the State of Vermont:)

SHAFTSBURY, VT., *February 27, 1967.*

DEAR SENATOR AIKEN: At the last meeting of the Bennington County Medical Society it was resolved that the Society request that the practice of certifying all admissions to the hospital under Medicare be condemned. The members of the Society feel that this rule implies a lack of integrity which is degrading to anyone in the medical profession. It is inherent in the Medicare law that persons over sixty five are entitled to necessary and proper medical care and that we as physicians will use our professional judgement as to proper care.

Sincerely,

ELIZABETH O. FARIS, M.D.,
Secretary, Bennington County Medical Society.

(The following letter, with attachment, was submitted to the committee by Hon. Joseph M. Montoya, a U.S. Senator from the State of New Mexico:)

UNITED STONE & ALLIED PRODUCTS WORKERS OF AMERICA,
Carlsbad, N.M., April 18, 1967.

Senator JOSEPH M. MONTOYA,
Senate Office Building, Washington, D.C.

DEAR SENATOR: At our local meeting April 17, 1967, the membership voted unanimously to support the President's proposals for improvement of the social security law, also to ask you to place this resolution in the records of congress and support and vote for passage of this law.

Your consideration of this matter will be gratefully appreciated.

Very truly yours,

J. D. ROGERS,
President, Local #177.

SOCIAL SECURITY IMPROVEMENTS

Whereas, President Johnson has urged the Congress of the United States to increase Social Security benefits by an average of 20 per cent with the biggest proportionate share going to the 2½ million retirees who now get only the minimum of $44 a month ($66 for a couple); and

Whereas, even the proposed increases would fall short of assuring Social Security beneficiaries genuine financial independence, as contemplated by the Social Security Act; and

Whereas, many other nations, far less affluent than the United States, have far more adequate social welfare systems; and

Whereas, no remotely comparable insurance protection is available to Americans at any price: Therefore be it

Resolved, That the Congress of the United States take prompt, positive action to attack the deficiencies that exist in the Social Security system, so that older Americans, widows and children, and the disabled can live out their retirement years in dignity and self-respect rather than in poverty and despair, and; be it further

Resolved, That since the program's biggest single defect is the lack of adequate cash benefits, that the Congress act to increase these benefits as proposed by the President, and; be it further

Resolved, That copies of this resolution be sent to the United States Senators from (state) and the Congressman (Congressmen) from the (district or districts), requesting them to support the President's proposals, and to place this resolution in the records of Congress; and; be it further

Resolved, That this resolution be given the fullest publicity through the communications media.

(The following letter, with attachments, was submitted to the committee by Hon. Len D. Jordan, a U.S. Senator from the State of Idaho:)

CALDWELL MEMORIAL HOSPITAL AND PROGRESSIVE CARE CENTER,
Caldwell, Idaho, May 19, 1967.

Hon. LEN B. JORDAN,
New Senate Office Building, Washington, D.C.

MY DEAR SENATOR JORDAN: Enclosed you will find copies of newspaper articles which appeared recently in the Caldwell News-Tribune and Boise Statesman. These articles cover the basic effects of Medicare on the Caldwell Memorial Hospital.

One point worthy of comment is the fact that the inadequacies of the reimbursement formula are not only forcing an increase in room rates, which in essence is double taxation to the tax-paying citizens of the community, but also have curtailed the efforts of the hospital in providing additional facilities and services to the community.

The ultimate goal of most hospitals is to provide the most in services and facilities at the least possible cost. The reasonable cost formula destroys this incentive. We would encourage exploring a reimbursement formula based on financial need. The needs of each institution are different in each section of the country. It follows then that, if the reimbursement formula under Medicare is to be fair and equitable for all participating institutions, the formula based upon financial need would be the proper approach.

We feel we have developed a health care program designed to best fit the needs of the community we serve, at a rate favorable to any other area. It is unfair that these programs cannot be expanded and new programs added, as planned before the advent of Medicare. Under the present reimbursement formula, our hospital will have financial problems maintaining the programs already functioning, let alone starting new ones, although they may be in the best interest of the health of the community.

I urge you, as a Senator from this area, to investigate this formula thoroughly and make concerted effort to have the gross inequities under the reimbursement formula of Medicare corrected. The present structure of this piece of legislation threatens the quality of health care we will be able to provide in the future. Your efforts in this behalf will be greatly appreciated.

Sincerely yours,

KEITH A. HOLLOWAY,
Public Information Director.

[From the News-Tribune, Caldwell, Idaho, May 18, 1967]

MEMORIAL HOSPITAL: MEDICARE SETS FINANCIAL LOSS

(Editor's note—This is the first of a series of articles on the impact of Medicare on Caldwell Memorial Hospital and the general financial obligations imposed by the program, along with other money problems.)

CALDWELL.—The Caldwell Memorial Hospital is seeking a specialist to cure its financial ills, which resulted from an overdose of Medicare.

John Hayman, administrator, said that before July of 1966, when Medicare went into effect, the hospital was actively engaged in developing plans for new construction and remodeling its overcrowded facilities.

Also on the planning boards were new programs to provide more services to the community.

"The first two months of Medicare made it quite clear that these programs would have to be set aside, at least for the present time," Hayman said, "in order to keep the hospital out of bankruptcy."

"It is not overly difficult to diagnose an overdose of Medicare," he said. "It is similar to that of strangulation. The first nine months of Medicare will bear out this statement in the fact that the hospital has suffered a loss of $95,000, and by July 1 of this year it is possible to see a loss for the first year of over $120,000."

Hayman said, "The administration of the hospital was caught rather flat-footed since they did not budget for such a huge loss the first year of Medicare. The administration, instead, looked at the law, which states that we would be reimbursed a 'reasonable cost' for our services. However, a reasonable cost in our eyes is entirely different from reasonable cost in the government's eyes.

"They have felt that a reasonable cost would be paying the hospital 88 cents on every dollar. In other words, we find ourselves giving Medicare a discount of 12 per cent. It will be entirely impossible for the hospital to exist under these conditions.

"Two alternatives face the Board of Directors," Mayman said. These he listed as (1) withdraw the hospital from the Medicare program, and (2) increase the rates to offset the 12 per cent discount.

"The second approach," he said, "will be the one which most likely will be considered. It is unfair in the eyes of the board for the government to set up a program, tax the public to provide revenues for this program, only to have the local hospitals increase rates to make up the difference. In essence, this is another tax on the local people to support the Medicare program."

Medicare patients at Caldwell Memorial Hospital make up about 50 per cent of the total patient load.

"This high percentage of Medicare patients places this hospital at the mercy of the government for its continued existence," Hayman said. "Hearings have just recently been conducted in Washington with regard to the inadequacies of the reimbursement program of Medicare. It will now be up to Congress to change the inadequate reimbursement if they expect hospitals to continue as a part of this program. But the effect of Medicare upon the Caldwell Memorial Hospital has placed it in its worst financial position since it opened in 1950."

[From the Idaho Daily Statesman, Boise, Idaho, May 18, 1967]

HOSPITAL IN CALDWELL SUFFERS FROM "MEDICARE OVERDOSE"

CALDWELL.—Caldwell Memorial Hospital is "seeking a specialist to cure its financial ills, which resulted from an overdose of Medicare," administrator John Hayman said Wednesday.

Before July, 1966, when Medicare went into effect, Hayman said, the hospital was actively engaged in developing plans for new construction and remodeling its overcrowded facilities. Also on the planning boards were new programs to provide more services to the community.

PROGRAMS POSTPONED

"The first two months of Medicare made it quite clear that these programs would have to be set aside, at least for the present time, in order to keep the hospital out of bankruptcy," he said.

"It is not overly difficult to diagnose an overdose of Medicare—it is similar to that of strangulation. The first nine months of Medicare will bear out this statement in the fact that the hospital has suffered a loss of $95,000, and by July 1 of this year, it is possible to see a loss for the first year of over $120,000," he said.

"The administration of the hospital was caught rather flat-footed since it did not budget for such a huge loss the first year of Medicare."

The administration, instead, looked at the law which states that it would be reimbursed a "reasonable cost" for services; however, a reasonable cost "in our eyes is entirely different from reasonable cost in the government's eyes," the administrator said.

"DISCOUNT" RESULTS

"They have felt that a reasonable cost would be paying the hospital 88 cents on every dollar. In other words, we find ourselves giving Medicare a discount of 12 percent. It will be entirely impossible for the hospital to exist under these conditions.

"Two alternatives face the board of directors: One is to withdraw the hospital from the Medicare program, and the other would be to increase the rates to offset the 12 percent discount.

"The second approach will be the one which most likely will be considered. It is unfair in the eyes of the board for the government to set up a program, tax the public to provide revenues for this program, only to have the local hospitals increase rates to make up the difference. In essence, this is another tax on the local people to support the Medicare program," Hyman stated.

RATIO NOTED

Caldwell Memorial Hospital, he continued, finds that the Medicare patients make up approximately 85 percent of the total patient load.

"This high percentage of Medicare patients places this hospital at the mercy of the government for its continued existence. Hearings have just recently been conducted in Washington with regard to the inadequacies of the reimbursement program of Medicare. It will now be up to Congress to change the inadequate reimbursement if they expect hospitals to continue as a part of this program, but the effect of Medicare upon the Caldwell Memorial Hospital has placed it in its worst financial position since it opened in 1950," he concluded.

(The following letter, with attachment, was submitted to the committee by Hon. Winston L. Prouty, a U.S. Senator from the State of Vermont:)

MARY HITCHCOCK MEMORIAL HOSPITAL,
Hanover, N.H., June 15, 1967.

HON. WINSTON L. PROUTY,
Old Senate Office Building, Washington, D.C.

DEAR SENATOR PROUTY: Ever since the inauguration of the Medicare legislation, certain problems have become increasingly evident to this Hospital, and in fact, to all hospitals furnishing services to Medicare beneficiaries the country over. Representation by the American Hospital Association to the Ways and Means Committee of the House of Representatives has dealt with these problems in terms of specific changes and it has been strongly recommended that the Committee consider favorably incorporating these changes into H.R. 5710, Social Security Amendments of 1967, when finally reported out by the Committee. It is our understanding that legislation of this type, when reported out by the Ways and Means Committee, is not subject to any amendment from the floor.

The vitally needed changes in the Medicare Act include coverage of the following areas:

1. Of greatest concern is the inadequacy of the present reimbursement formula, together with certain features of the prescribed cost apportionment system.
2. The unacceptable proposals controlling the expenditures by hospitals of funds received as payment for depreciation allowances.
3. The chaotic situation in respect to the handling of X-ray and laboratory services.
4. The fantastic mechanical difficulties in handling outpatient services.

Our concern, in addition to the above, lies in the fact that establishment by the Federal Government of the terms of purchase of hospital care for Medicare beneficiaries is rapidly setting a pattern for adoption by other third-party purchasers of care. The dreadful circumstances that can occur if the present inequities in the Medicare program are perpetuated would very rapidly be crippling to the hospitals of the country, because of the complete undermining of the soundness of the financial structure of these essential health institutions.

The Trustees of Mary Hitchcock Memorial Hospital, members of which are interested citizens of New Hampshire and Vermont, serving voluntarily, have gone on record in connection with this matter by a vote at the most recent meeting of the Board. A copy of the vote is attached.

Your consideration of this position of Mary Hitchcock (and I am sure this position is shared by virtually every other voluntary hospital in the country) will be appreciated. It is our hope that this concern can reasonably take the form of a communication from you to the Chairman of the House Ways and Means Committee urging favorable attention to the changes so urgently needed in the Medicare Law, as specifically recommended by our national organization, the American Hospital Association.

Please don't hesitate to get in touch with us if additional information is needed.

With kind regards.

Cordially yours,

EDWARD M. CAVANEY,
President, Board of Trustees.
WILLIAM L. WILSON,
Administrator.

MARY HITCHCOCK MEMORIAL HOSPITAL, HANOVER, N.H.

A vote unanimously taken by the Board of Trustees of Mary Hitchcock Memorial Hospital at a meeting on June 8, 1967.

Voted to advise members of Congress from both New Hampshire and Vermont of the Hospital's concern over provisions of HR 5710, Social Security Amendments of 1967, with reference to the urgent need for members of the Ways and Means Committee now considering this legislation to support the specific recommendations made in connection with HR 5710 by the American Hospital Association. These recommendations deal specifically with the inadequacy of the present reimbursement, the unacceptable proposals controlling the expenditure of funds received as payment for depreciation and the chaotic situation in respect to the handling of X-ray and laboratory services particularly for outpatients.

(The following telegram was submitted to the committee by Hon. Edward Brooke, a U.S. Senator for the State of Massachusetts:)

BOSTON, MASS., *Aug. 18, 1967.*

Senator EDWARD BROOKE,
U.S. Senate,
Washington, D.C.:

The general direction of H.R. 12080 seems to be negative in relation to the AFDC (aid to families with dependent children) program.

It appears to single out this group of "poor" families to apply required programs which, unfortunately but true, could culminate in mandates for these families not applicable to any other group in our society. As we in the States and large cities are working so very diligently to insure harmonious and peaceful relationships between all our citizens, it is necessary that we be aware of all implication measures that affect all those in need. Massachusetts' statistics indicate, for instance, that the average length of stay of families on AFDC is approximately 3 years. Americans, as a general rule, wish to be independent and self-sustaining. The sweeping requirements of this bill, however, implies otherwise, and as I stated at a meeting with Secretary of HEW Gardner on August 8, 1967, representing the Federal-State-Local Relations Advisory Committee of the National Governors' Conference, "Once again the Federal Government is pointing the finger of moral justice at one class of our population."

Therefore, I urge your assistance in amending those sections of H.R. 12080 relating to AFDC, so that safeguards are provided to insure the dignity that should be accorded to all our citizens—especially the poor.

GOV. JOHN A. VOLPE,
Commonwealth of Massachusetts.

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., August 18, 1967.

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

DEAR SENATOR LONG: I would like to inform you of a decision we have reached regarding the medicare regulations pertaining to directors of independent laboratories.

As you know, under a temporary exception included in the independent laboratory regulations, medicare reimbursement can be made for services of a laboratory whose director does not meet the basic doctoral degree requirements if he has directed a laboratory for at least 12 months within the 5 years preceding July 1, 1966, and if certain other conditions are met. Concern has been expressed about the scheduled expiration of this temporary provision on June 30, 1971, after which date present regulations would not permit reimbursement for services furnished by laboratories which qualified under the temporary provision.

As a result of consultation by the Department of Health, Education, and Welfare with national associations representing laboratory sciences and clinical laboratory administration and the Health Insurance Benefits Advisory Council, the regulations are being modified to permit a director who has qualified under the temporary exception to continue to qualify after June 30, 1971, if the laboratory he directs demonstrates satisfactory performance in a performance evaluation program conducted by the State meeting standards which will be prescribed by the Secretary. Included in this performance evaluation program will be a requirement of successful participation for at least 2 consecutive years between July 1, 1968, and July 1, 1971, and annually thereafter in a State-operated or State-approved proficiency testing program meeting standards acceptable to the Secretary. (The first qualifying year for this part of the requirement would be the year beginning July 1, 1968, because this is the first year that States are expected to have available a comprehensive program of proficiency testing covering the full range of pertinent specialties.)

We believe that this modification in the regulations will provide continuing assurance of a professionally acceptable level of laboratory service and, at the same time, provide an opportunity for those directors who do not meet the academic requirements now contained in the regulations to demonstrate their qualifications and competence.

Sincerely yours,

WILBUR J. COHEN,
Under Secretary.

(The following letter was submitted to the committee by Hon. Philip J. Philbin, a U.S. Representative in Congress from the State of Massachusetts:)

MASSACHUSETTS GENERAL COURT,
COMMITTEE ON FEDERAL FINANCIAL ASSISTANCE,
Boston, August 16, 1967.

Congressman PHILIP J. PHILBIN,
U.S. House of Representatives,
House Office Building,
Washington, D.C.

DEAR CONGRESSMAN PHILBIN; There are many facets of the proposed Social Security Amendments of 1967, as reported by the House Ways and Means Committee, (HR 12080) which are of concern to the people of Massachusetts but, possibly, causing greatest immediate apprehension are the sections amending federal laws relative to public welfare. If under the rules of Congress the bill as reported by the committee is not subject to amendment, it is the hope of members of this committee that you will see fit to vote to send the measure back to Ways and Means for further consideration.

Several of the proposed public welfare amendments are objectionable to citizens of this state and represent, in our opinion, a political philosophy long outdated in urban America. Specifically, the proposal to place a ceiling on the proportion of a state's population which may warrant the protection of aid to families of dependent children is considered a queer expression of a philosophy which the state by legislative edict can place a limit on the number of persons deserving of assistance.

At a time when the Massachusetts General Court is debating measures to have the state assume the full non-federal cost of local welfare, a cost which will add at least $50,000,000 to the state budget, it is upsetting to find anyone in Congress proposing that the Commonwealth also take up part of the burden which previous sessions of Congress agreed should be shouldered by Washington. It need not be spelled out that even if Washington believes a limit can be arbitrarily placed on the number of persons who need and deserve assistance, the Commonwealth will not shirk its responsibility and will continue to provide such assistance to needy childeen.

It may interest you to know that Massachusetts has experienced an extraordinary increase in the number of AFDC cases in the past few years and the upward spiral can be expected to continue. In June of 1960, 48,722 persons were covered in this state by AFDC. Two months ago, the number has jumped to 122,056—an increase of about 150 percent in the short span of seven years.

An abbreviated table of the number of beneficiaries under AFDC follows:

	Statewide	Boston
1960	48,938	16,140
1966	105,763	39,164
967	122,056	44,103

May we have your support in seeking a means to amend this measure which will protect forward looking welfare programs of the Commonwealth?

Sincerely,

GEORGE V. KENNEALLY,
Senate Chairman.
GEORGE L. SACCO, Jr.,
House Chairman.

(The following letter was submitted to the committee by Hon. J. Caleb Boggs, a U.S. Senator from the State of Delaware:)

STATE OF DELAWARE,
DEPARTMENT OF PUBLIC WELFARE,
Wilmington, Del., August 18, 1967.

Hon. J. CALEB BOGGS,
Senate Office Building,
Washington, D.C.

DEAR SENATOR BOGGS: In the past few days I have received copies of HR-12080, a bill to amend the Social Security Act, as well as summaries of this very important legislation, particularly as it applies to public assistance and child welfare programs administered by the Department of Public Welfare, State of Delaware.

As recently as August 16, 1967, I had the privilege of meeting with directors of State Welfare Departments and Federal officials, in meeting to discuss this legislation as well as to discuss the reorganization of the welfare administration at the Federal level.

It is my understanding that HR-12080 was approved by the House of Representatives on August 17, 1967, as reported out of the House Ways and Means Committee.

There are some factors in the amendments affecting the operation of public assistance programs which appear to create areas of potential hardship for children in families dependent on public assistance for financial assistance to meet everyday needs.

I refer specifically to Section 206 which amends Section 403 of the Social Security Act by inserting the qualification of limiting the number of children with respect to whom Federal payment may be made. This amendment would have the effect of placing an added financial burden on the State and Counties of Delaware if the ratio of dependent children deprived of parental support should increase above the ratio applicable to January, 1967, insofar as the relationship of such children is to the total population under 21 years of age is concerned.

Of concern to this agency, also, is Section 203 of HR-12080, amending Section 407, Dependent Children of Unemployed Fathers. This amendment also has the effect of placing an added financial burden on the State and Counties of Delaware, as it tends to restrict the scope of eligibility for this form of Federally financed public assistance.

It is my sincere hope that you will give consideration to these factors when HR-12080 is placed before the Senate for action.

Respectfully yours,

R. E. MILLER, *Director.*

(The following letter was submitted to the committee by Hon. Ernest Gruening, a U.S. Senator from the State of Alaska:)

JUNEAU, ALASKA,
August 15, 1967.

Hon. ERNEST GRUENING,
Senate Office Building,
Washington, D.C.

DEAR SIR: Senior citizens often suffer from maladies of which there is little practical cure—only relief. Arthritis is one of those ailments and I am one of its victims.

The Doctors Clinic of Juneau has taken care of our medical needs for many years. The services rendered by that clinic to myself are presently covered under my $3.00 monthly payments to Medicare.

During the past three weeks our local chiropractor has given me a number of treatments which relieved the pain and did much toward restoring my ability to walk properly. Under present regulations I am not permitted to charge those treatments to Medicare.

It would seem that *relief* should be one, if not the chief, criterion for Medicare recognition. I urge you to give thought to this proposition and possibly to influence your colleagues to do likewise.

Yours truly,

RALPH G. WRIGHT.

(The following letter was submitted to the committee by Hon. Daniel B. Brewster, a U.S. Senator from the State of Maryland:)

BALTIMORE, MD., *August 4, 1967.*

Hon. DANIEL B. BREWSTER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR BREWSTER: As a general surgeon dealing with many aspects of the current laws regulating medicare, social security, and the Maryland Medical Service, Inc., health plans, there are certain regulations presented now in two of my patients which I personally believe are unreasonable and distorted, creating undue hardships on those individuals involved. It is beyond my conception that those of you concerned with the laws of our land could have passed such legislation so biased and unjust for those few individuals I am now about to prescribe. Sincere efforts on my part concerning this matter at my level of operation have invariably resulted in the phrase "That's the law."

Some 6 or 8 months ago, two unrelated couples totally unknown to each other were referred to my office for surgical consultation. Before long, I was to find these couples were not married but were brothers and sisters who had lived together all of their lives as such and not as husband and wife. Both of these circumstances were brought about by the brother and sister's desire to tend their elderly parents and, therefore, neither had sought marriage. The parents involved had, by the time of my consultation, expired, with the brother and sister living together in the old family homestead and/or apartment. Under these circumstances, the brother in both instances continued to support the house and his sister. In one instance, a sister became ill, requiring hospitalization, but, much to my surprise, the sister could not be carried on the Maryland Medical Service, Inc., policy of her brother as a dependent even though her brother was her sole support. Apparently the law reads a male and female married, with the male being the sole support of the female, then a female is considered a dependent of the male. On the other hand, if a brother and sister are living together, as cited above, then the sister is *not* considered a dependent of her brother even though her brother is her sole support. Were this not enough, the situation confronting the other couple is even a more serious matter.

Some 3 weeks ago, the brother of the other couple expired suddenly from an acute coronary thrombosis, leaving his 70-year-old sister, whom he had supported all of his life, *not* eligible for even social security benefits. Apparently the social security regulations specify a sister is not eligible for her brother's benefits even though her brother had been paying the required portion of his salary to the social security agency all of his working life. The local social security officials advise me the sister, my patient, is not eligible for her brother's social security benefits, whereas if she had been married to her lifelong sole support she would then be eligible for such benefits as would appear to me to be rightfully hers. As a result, the sister in this second example is virtually destitute, with no trade or profession offering some opportunity for some type of a meager livelihood. I suppose the only actual current solution to these two problems is for the individuals concerned to apply through the local welfare agencies for what benefits may be available to them. The second female individual likewise has not been able to obtain Blue Cross-Blue Shield coverage under her now deceased brother for the same reasons as stated.

From the aforementioned two case examples, you should now see why it appears biased and unfair to those individuals who are maintained and supported by a brother but, according to the law, are not allowed the benefits of their male supporter because they are not married. Individuals under the same circumstances who are married than allow the female to gain those benefits which may be available through their supporters' employers' insurance programs. I would sincerely appreciate your examination and sympathetic deliberation of this most unfortunate bit of legislation involving case examples as I have exemplified in this letter. Hoping to hear from you soon concerning the matter at hand.

Very cordially yours,

LEONARD H. FLAX, M.D.

(The following letter was submitted to the committee by Hon. Clarence D. Long, a U.S. Representative in Congress from the State of Maryland:)

WESTERN MARYLAND RAILWAY CO.,
Baltimore, Md., August 24, 1967.

Hon. JOHN W. GARDNER,
Secretary of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. GARDNER: Both in my capacity as President of the Prisoner's Aid Association of Maryland and in my other roles in the community I have been concerned for a long time with the problem of those who are on welfare. I take the liberty, therefore, of offering a few observations on the subject as they relate to Title II of the Social Security bill now before Congress.

It seems to me that present welfare practices as well as those proposed in the new legislation tend to drive the Negro male out of the family. Despite denials of welfare officials it is our experience that there is a definite pressure exerted by the DPW on welfare families which forces the putative father underground. Whether this is a result of legislation and regulation or whether it is a psychological problem resulting from the fact that so many welfare workers are women, I do not know. It seems to me, however, that one aim of welfare policy should be to reinstate the Negro male as part of the household he has fathered.

I suggest that one move toward this objective would be to create an incentive by giving a bonus to each welfare family which has a male head of household. Welfare checks could be made out jointly to husband and wife, and I would not quibble over whether the same "husband" was on record year in and year out. Sufficient proposals have already been made by eminent authorities to provide for a gradual transition from welfare to self-support, and I am in favor of the approaches proposed by such persons as Mr. Moynihan and Mr. Keyserling.

I believe the cost of bonuses for male heads of household would be relatively slight compared with the social cost we are now paying by forcing these men to resort to underground existence, including a life of crime. I would urge, therefore, that some consideration be given to this approach while legislation is still in progress.

Respectfully,

YERBY R. HOLMAN.

(The following letter was submitted to the committee by Hon. Robert P. Griffin, a U.S. Senator from the State of Michigan:)

DETROIT, MICH., *August 8, 1967.*

Senator R. P. GRIFFIN,
Old Senate Office Building,
Washington, D.C.

DEAR SIR: I realize you're a busy man but I hope you'll take a few minutes to listen to my problem.

I have an 83-year-old mother that my sister and I have supported for over 25 years. Mother is now suffering from Cerebral Arteriosclerosis and can't eat or help herself in any way. We put her in Moroun Nursing Home. It's a licensed home and accepts Medicare but all we could take was 73 days of it. Besides her other problem she is now suffering from dehydration and malnutrition due to poor care and food. I'm speaking from experience cause we took her, her supper every evening and two meals on Saturday and Sunday otherwise she'd get nothing.

It seems the homes that get government money have very poor service and have the feeling that the old folks are there to die. They have aides giving medication and patients sitting in urine all day.

I'm a registered nurse in Industry and had a number of similar complaints. The opinion of most of the people is that, If Medicare and Medicaid would have a program like the doctor's have that if they don't accept assignment you could pay the home and send in your bills to Medicare or Medicaid. Most of the homes that don't accept government money give excellent care and have registered nurses taking care of patients.

We would all appreciate it, if you could work on a program like this to help our elderly citizens who can't help themselves.

Sincerely,

DOROTHY SZYMANSKI, R.N.

(The following report was submitted to the committee by Hon. John Sparkman, a U.S. Senator from the State of Alabama:)

AUG. 18, 1967.

To: Senators Lister Hill and John Sparkman and Representatives Edwards, Dickinson, Andrews, Nichols, Selden, Buchanan, Bevill, and Jones.
From: Harold W. Steadham, President, Alabama Hospital Association.
Subject: Medicare Report.

The Alabama Hospital Association, after a meeting of its representatives with members of the Alabama Congressional Delegation, would like to make the following report and recommendations concerning our experiences with Medicare—Title XVIII of P.L. 89-97:

In our meeting in Washington we outlined some basic problem areas of hospitals in Alabama, as follows:

1. Reimbursements to hospitals for Medicare are inadequate.
2. Method of determining cost is too involved, time-consuming and not based on "true cost."
3. Misunderstandings Social Security Administration regional offices have regarding private room benefits for medicare patients.
4. Complications of billing for hospital-based physician services and outpatient billing, creating a misunderstanding between hospitals and physicians on one hand and hospitals and Medicare patients on the other.

With the advent of Medicare, the Federal Government promptly became concerned about trends affecting medical care costs. The amendments to the Social Security Act, P.L. 89-97, have stated a principle of paying for services rendered to a patient under Title XVIII which is idealistic. It states that no part of the cost for Medicare patients will be borne by other patients, nor will the cost for other patients be included in the Medicare reimbursement. The regulations given to those responsible for determining this cost have been over-solicitous in eliminating any and all factors bordering on paying for other patients, but the same effort has not been made to compensate for the obvious services where the added cost of Medicare patients is passed on to other patients.

As an example, all cost attributed to Obstetrical Departments is removed from Medicare Audits. On the other hand, no provision is made to compensate for the cost of increased nursing service time for Medicare patients.

With just a cursory glance at nursing care and a limited look at the time to care for an elderly patient, compared to the average adult patient, it is obvious more personnel time is needed for the older patient. For example, it usually requires two people to take an older patient on a stretcher to X-ray; a younger patient would walk or go in a wheelchair. To do the X-ray procedure requires more time, more explanation and, in many cases, more people. It takes only a minute to give an adult a medication, whereas a nurse may spend ten minutes explaining, listening or consoling an elderly patient before the shot can be given. There is no method in RCC for recognizing this extra cost of personnel time used by Medicare patients. These nursing care services are considered part of the room charge, which is the same for Medicare patients as for all other patients.

Probably the best example of the problem associated with determining Medicare costs can be given with a review of recent audits done in three representative hospitals. The following is the story of the results, using the four different methods of determining the average cost per day of caring for Medicare patients:

Hospital	Double apportionment method		Stepdown RCC	Stepdown combination
	Departmental RCC	Combination method		
No. 1	$32.15	$33.81	$31.85	$33.92
No. 2	33.16	36.27	33.21	36.30
No. 3	35.71	38.40	35.51	38.24

Consider, also, that if Hospital #2 had been on an average per diem reimbursement basis, its cost would have been $38.82.

What is the real cost? Obviously, none of these. Which is the nearest? As far as the hospital is concerned, it has to be the highest reimbursement.

The RCC formula is fraught with inherent inequities. Also, to perform the audits required under the present system would cost an estimated additional

$200,000 in Alabama alone, and adequate audits exist already to compute average per diem.

For at least twelve years Blue Cross of Alabama has been auditing its member hospitals and determining their average per diem cost of services offered under the Blue Cross contracts. The hospitals in this state have been reimbursed on a cost plus 5 per cent basis with retroactive adjustments, which has proven satisfactory. Some people with a lack of total understanding of hospital costs and charges have charged that this creates inefficiency and encourages laxness in cost. This cannot be substantiated by fact, and quite the contrary, by using our Blue Cross as an example, our average cost has been considerably below the national average. The average annual increase has been lower than in other areas of the country.

Another inequity in the Medicare program is the provision for the use of a private room by a Medicare patient. This places an unnecessary burden on the physician by requiring him to certify the medical necessity for the use of a private room. The definition of "medical necessity" creates a wide spectrum of opinion as to what constitutes a medical necessity for a private room. We request this requirement be eliminated any anyone using a private room would pay the difference.

The present regulations regarding outpatient services are complicated and difficult for everyone to understand. The beneficiaries do not understand them and they are a monstrosity for a hospital to administer. To further complicate outpatient services, the separation of the diagnostic and therapuetic services in the professional and hospital components compounds the confusion. We believe this should be changed and a flat co-payment provision for each instance of service be charged.

SUMMARY

The first year of Medicare has uncovered some obvious problems, many inequities and promoted a great deal of confusion for all concerned.

The RCC method of reimbursement is lacking in meeting the cost of care to Medicare beneficiaries. It is not producing its proportionate share of revenue. Contrary to the stated intent of the law, the Medicare patient is not paying his full share of the cost.

We feel a third method of payment should be available to those hospitals where RCC is difficult to use and another audited cost is being done for third party reimbursement. This method should be an average per diem for services covered.

The provision for private rooms is not fair to anyone concerned. It should be eliminated and anytime a patient is in a private room, the cost of the difference in semi-private rate and private room rate should be borne by the beneficiary.

The present outpatient benefits are impossible to administer fairly and inexpensively. The deductible should be eliminated and a flat co-payment for each service rendered should be made.

We recommend that the law and/or regulations be amended to reflect a more realistic determination of cost, that a reimbursement rate be determined to compensate for the added care of a medicare patients and the administrative complexities be eliminated.

We are grateful for the opportunity to make this presentation to you. Thank you.

(The following letter was submitted to the committee by Hon. Jack Miller, a U.S. Senator from the State of Iowa:)

AUGUST 29, 1967.

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

DEAR SENATOR LONG AND MEMBERS OF THE SENATE FINANCE COMMITTEE: We are confident that the Members of the Senate Finance Committee will give thoughtful and wise consideration to H.R. 12080.

While we are in accord with the consideration given to our older people and the families of deceased or disabled "covered" workers, we are shocked to note the failure to give equal consideration to the children of our AFDC families. It appears to us that these infants, children, and youth are being set apart from humane and realistic understanding of their needs. They do have very special needs because, through no fault of their own, they are children of deprivation, family breakdown, and unacceptable parental behavior. We believe they deserve the best we can give to them. Actually, they constitute about one-sixth of the total number of children in equally dire circumstances; we wish appropriations and eligibility requirements would permit us to help all children in need. On the other hand, we see no need to further deprive the one-sixth under our care.

Most of our AFDC parents and out-of-school, unemployed youth would work if there was work for them. Most need training; many need basic education. Where do we send them? Existing training programs are not nearly adequate to meet the training and educational needs of the vast majority of the AFDC adults and youth who want to work.

We like the small sample we've had of work experience and training programs, and are gratified by the results. The combination of basic education, personal counselling, and work training is productive in increasing individuals' ability to get and hold jobs. A number of our disabled AFDC fathers labeled "non-amenable for training" by other public training programs have been trained under our program and are now fully employed. However, these programs, financed by OEO grants, are totally inadequate to meet the needs of our people for training. We need more money, more projects, and more staff. Instead of this, we have had to reduce our activities in training and work experience because of the cut back in OEO funds. We wish the programs we did have could have been left intact long enough to more widely demonstrate their value; this here today, gone tomorrow (or Department of Labor tomorrow) fragmentation under OEO has been discouraging. We had hoped for a state appropriation to establish community work and training programs throughout the state. We didn't get it.

This OEO funded work experience program, under our administration, began July 15, 1965, with projects in two counties. It was expanded to include 41 of our 99 counties, but cuts in OEO funds have made it necessary to curtail the program to 35 counties. During the past two years, 2,024 trainees have entered the program. Already 613 have completed their training, and 75 percent of them have obtained employment. Another 647 did not complete their training, but many of them quit to accept jobs. Some had personal family problems—illness, care of children, etc.—which had to be resolved. Only a small number were removed from the program because of their apparent inability to benefit from it. High school diplomas or equivalency certificates were earned by 262 trainees. The 632 who either completed their training or quit to take jobs, were drawing prior to employment $120,080.00 monthly assistance, or an average of $190.00 each for support of their families. After obtaining employment, their monthly earnings were $178,856.00 or an average of $283.00 per worker.

We're glad to see income exemptions as an incentive to work. That will help. However, the fact remains that the under-educated and unskilled must be helped to achieve capabilities for employment. The Iowa Development Commission is working hard to bring new industry to Iowa to provide more jobs. However, modern plants require workers of more skill and education than most of our AFDC adults have.

Iowa does have a program which requires us to make known to all families receiving assistance that family planning information and payment of costs is available. This is state law.

Our state laws also require that AFDC applicants and recipients cooperate with county attorneys in locating and obtaining child support from absent parents. Our county workers are diligent in making these referrals, and our AFDC mothers have cooperated with the county attorneys, but except in a few counties (mostly urban) county attorneys do not act. Will Congress make this mandatory?

Iowa has an abused child act which applies to all children, not just those in AFDC families. Our county departments are actively involved since they are responsible for making reports to the courts. We have more instances of child abuse and neglect in non-assistance families than in AFDC.

AFDC is not the cause of illegitimacy, and it is clearly evident that the increase in it cuts across all segments of society. We're against it, but recognize that the laws of nature are less subject to change than man-made laws, and rather impervious to latter, as well. We will never believe that the way to reduce the incidence of illegitimacy is to fail to feed and care for children after birth nor to deny their mothers decent prenatal care. Nor do we think our courts will ever approve of wholesale placement of such children in foster homes simply because of the circumstances of their birth. An unwed mother who takes good care of her child is generally permitted that privilege by the courts. Refusing AFDC to such mothers and children may reduce the AFDC rolls, but it will not reduce illegitimacy. An attempt to reduce AFDC costs through this method will mean that unless these needy mothers and children are cared for through state and local funds, they will be further damaged and deprived. And this is precisely what will happen in most instances because we do not have state funds to care for them, and neither are our counties able to bear this expense.

It should be noted that the vast majority of out-of-wedlock born AFDC children in our state, at least, were conceived and born before there was an application for assistance. We had no way of knowing the offspring were on the way and, we suspect that most of the unmarried parents did not deliberately plan to produce a child. While we have not been tremendously effective in forestalling such births, neither have churches, schools, parents, laws, and society in general. We recognize the grave problem and are earnestly seeking solutions to it. We don't believe punitive measures directed toward children and mothers will do anything but delay applications for assistance until they are deprived beyond human endurance. Instead, family planning in the future, training for work, education for the children, and respect for higher moral standards are more likely to be beneficial.

We believe H.R. 12080 would further deprive all AFDC families without decreasing the total number of desertions. In order to care for additional deserted families from state funds, we'd have to cut all AFDC grants. At the present time we are paying 95 percent of our assistance standards to these families, and this amount is still below "poverty" level.

ADC CASELOAD EXPENDITURE DATA

	Cases		Expenditures	
	Total	Average	Total	Average
July-December 1961	58,006	9,668	$6,880,296	$1,146,716
January-June 1962	57,691	9,615	7,285,488	1,214,248
July-December 1962	59,560	9,927	8,173,978	1,362,330
January-June 1963	62,199	10,366	8,479,339	1,413,223
July-December 1963	61,022	10,170	7,927,541	1,321,257
January-June 1964	59,066	9,844	7,704,276	1,284,046
July-December 1964	61,345	10,224	8,786,437	1,464,406
January-June 1965	64,404	10,734	9,316,610	1,552,768
July-December 1965	65,542	10,924	10,005,901	1,667,650
January-June 1966	66,630	11,105	10,364,604	1,727,434
July-December 1966	66,345	11,058	10,183,626	1,697,271
January-June 1967	67,653	11,276	11,314,407	1,885,734

PROJECTED

	Cases	Expenditures
July-December 1967	11,433	$1,987,563
January-June 1968	11,593	2,084,891
July-December 1968	11,755	2,208,015
January-June 1969	11,920	2,327,247
July-December 1969	12,087	2,452,918
January-June 1970	12,256	2,585,375

Note: 1.4 percent increase each 6-month period in caseload; 5.4 percent increase each 6-month period in expenditures.

An examination of the records as maintained in the State Department of Social Welfare for the period July 1, 1961 through June 30, 1967, indicates that the monthly caseload average has increased 16.6%. It is reasonable to assume that this increase will continue. The projected figures would lead one to believe that a steady increase in caseload will be equal to 1.4% for each six-month period.

Any decrease in Federal funds covering the area of children from deserted homes and/or illegitimate children would place the burden of care on State funds. The legislative appropriations for the biennium have been set, based on past history. Therefore, it appears that it would be impossible for the State of Iowa to cover any decrease in Federal funds.

Sincerely yours,

IOWA STATE BOARD OF SOCIAL WELFARE,
A. DOWNING, *Chairman.*
HENRY GERING, *Vice Chairman.*
MRS. IRENE M. SMITH, *Member.*

(The following letter was submitted to the committee by Hon. Everett McKinley Dirksen, a U.S. Senator from the State of Illinois:)

SOUTHERN ILLINOIS HOSPITAL CORP.,
Carbondale, Ill., August 28, 1967.

Hon. EVERETT DIRKSEN,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DIRKSEN: Recently, in a public statement, Mr. John W. Gardner, Secretary of Health, Education and Welfare, took it upon himself to blame hospitals for most of the Medicare difficulties incurred during this first year of Medicare. He went ahead to state that hospitals have had a tremendous rise in costs since the advent of Medicare, and he is absolutely correct. But, he failed to mention that a goodly portion of this rise in costs can be attributed directly to federal wage legislation which very dramatically raised the floor of all hospital wage levels.

As a hospital administrator, I deeply resent my hospital being blamed for rising costs without Mr. Gardner mentioning that some of the reasons therefor were the recent federal wage legislation, the increases in social security taxes, and the increase in postal rates, just to mention three items alone. All of these were the direct result of federal legislation over which no hospital in the country had any control whatsoever.

Mr. Gardner went ahead to praise the doctors, the insurance carriers, and the various states for raising health care standards, but he completely ignored the hospitals and the real reason for the rise in hospital costs. He ignored the plain fact that the substantial payroll tax increase, which the workers of America are going to have to face, is that over 90% of these proposed increases have nothing to do with hospital or medical costs, but are occasioned by cash benefits to be paid to the social security beneficiaries. There is not a hospital in the country that will not take the blame where the blame is just and is due, but just to come out with blatant statements such as Mr. Gardner made indicates that he either did not know his own facts or he was deliberately ignoring the true facts of the situation. In either case, hospitals have suffered in the public image by such criticisms.

It would appear to me that a public apology is due from Mr. Gardner to the hospitals of the country who have tried so hard to make the Medicare Program work.

While I don't know what you can or cannot do, will or will not do, I wanted you to know at least one hospital administrator's feelings on such, what I term irresponsible, public statements.

Yours very truly,

JACK B. EDMUNDSON, *Administrator.*

(The following was submitted to the committee by Hon. Len B. Jordan, a U.S. Senator from the State of Idaho:)

STATEMENT OF H. FRED GARRETT, EXECUTIVE DIRECTOR, DEPARTMENT OF EMPLOYMENT, STATE OF IDAHO, AUGUST 31, 1967

(For inclusion in the hearing record of the Senate Finance Committee on the Employment Services Provisions of the Social Security Amendments of 1967—H.R. 12080—with Introductory Remarks by Senator Len B. Jordan of Idaho.)

Mr. Chairman and Members of the Committee: On August 28, 1967, I received a letter from Mr. H. Fred Garrett, Executive Director, Department of Employment, State of Idaho. Although it was not his original intention, he did give me his permission to have his letter included in the record of your Committee with respect to the hearings on H.R. 12080.

Mr. Garrett's letter is concerned primarily with the provisions of the bill which would permit duplicating existing employment services. I am sure you will agree that Mr. Garrett is one of the nations outstanding authorities in the field of employment in light of the following summary of his career and activities:

Chief—Unemployment Insurance, Idaho Agency—1938 to 1943.

Executive Director—Idaho Employment Security Agency—1943 to date.

Served as President in 1952 and 1953 and at least six times as a member of the Board of Directors; three times as chairman of the Administrative Financing Committee of the Interstate Conference of Employment Security Agencies.

Served as one of a ten member Special Committee appointed by the President to develop recommendations for Benefit Standards for Unemployment Insurance, H.R. 8282—1965.

Appeared before the Clark-Holland Subcommittee on Employment and Manpower in 1966 with respect to Manpower Services Act, S. 2974, representing and authorized to speak for 41 separate state agencies.

I would be most grateful if you would include the attached letter in the record of your hearings on H.R. 12080, not merely because it represents the point of view of a very eminently qualified man, but because it appears that the points discussed therein were not afforded exposure in public hearings in the House of Representatives.

Most respectfully submitted.

LEN B. JORDAN,
U.S. Senator.

DEPARTMENT OF EMPLOYMENT,
STATE OF IDAHO,
Boise, Idaho, August 25, 1967.

Senator LEN B. JORDAN,
New Senate Office Building,
Washington, D.C.

DEAR LEN: I appreciate having had an opportunity to talk to you about the House amendments to the Social Security bill while I was in Washington last week. This bill, as I explained to you, was originally introduced as H.R. 5710 but was amended by the Ways and Means Committee and brought out as H.R. 12080.

My interest is with the particular provisions that would permit duplicating employment services and at tremendous cost. There is properly deep public concern with the growing relief costs and a recognition of the necessity of both preparing relief recipients to work and conditioning their payments on taking training that would provide them with the necessary skills. This is the reason H.R. 5710, as it was introduced, contained two sections—409 and 410—relating to work and training programs for welfare clients.

Section 410 would allow the Secretary of Labor to develop work and training programs to meet the needs of welfare clients and to bill the Secretary of Health, Education, and Welfare for the costs of these programs. These costs would be paid from moneys available under the Social Security Act.

Section 409, which is the original Community Work and Training Section and would become the residual program in cases where the Department of Labor could not or would not perform. The bill reported out by the Ways and Means Committee and passed by the House was changed substantially from the original proposal. Section 410 has been deleted and all the manpower program activities that are basically a function and responsibility at the Federal level of the Department of Labor and at the State level of the Department of Employment are now contained in section 409, but in substantially different form.

Under the revision, the Welfare Administration has the authority to develop programs on an 85–15 per cent matching-fund basis with the State providing 15 per cent of the cost. The Secretary of H.E.W. would have the option for good cause of waving the State-matching requirement.

Under the provisions of the bill as passed by the House, it is conceivable that each County Welfare Department of the United States might eventually have a manpower component to serve the clients of that county. This could include not only work experience and training capability, but also employment services. While Section 409 carries a provision permitting purchase of service from the employment service, it is not mandatory. Some national cost projections have been made and it does not seem unreasonable to anticipate an additional Administrative cost of as much as $700 million a year, for an additional 25,000 personnel in the Welfare Department. I am not suggesting that there would not be some additional costs under the original proposal contained in H.R. 5710, but these would only be a fraction of the amount that the House-passed version would involve. There are other implications besides the direct cost.

In order to develop a background for determination of skills and needs, also employment potential, it would be necessary for the Welfare Department to go beyond just administration of training programs and placement services. This would add further to costs and at the same time create conflicts in the fields of labor statistics and public information. It would undermine the job placement potential for unemployment insurance benefit claimants. This would increase costs in that area and multiply frustrations and hamper effective and efficient administration.

I have endeavored to give you a concise summary of the basic differences between the two proposals, and I would be pleased to answer any questions that you may have or to provide more detailed information if you would like to have it.

Let me again express my sincere appreciation for the fine support that you have always given me in dealing with the continuing problems of State-Federal relationships.

With warmest personal regards.

Sincerely,

H. FRED GARRETT,
Executive Director.

(The following telegram and letter were submitted to the committee by Hon. J. W. Fulbright, a U.S. Senator from the State of Arkansas:)

LITTLE ROCK, ARK., *August 21, 1967.*

Senator J. W. FULBRIGHT,
Senate Finance Committee, Washington, D.C.

Urge that Crippled Children Services be left as a part of Children's Bureau as provided for by H.R. 12080. This agency feels that placing CCS under rehabilitation services on State level would be difficult, costly, and unnecessary. And we fail to see what, if any advantages will accrue from such a change.

L. E. BLAYLOCK, *Welfare Commissioner.*

STATE SERVICES FOR CRIPPLED CHILDREN,
THE UNIVERSITY OF IOWA,
Iowa City, Iowa, August 22, 1967.

Senator J. W. FULBRIGHT,
1215 New Senate Building,
Washington, D.C.

DEAR SENATOR FULBRIGHT: As you know, on August 15, 1967, Secretary Gardner announced a proposed reorganization of the Welfare Division of the Department of Health, Education, and Welfare. I am aware that it is the Secretary's responsibility to conduct the Department and his responsibility to determine its administrative structure.

However, there is one section of the proposed change that is of great concern to many. This is the recommendation to place the Crippled Children's Services in the new Rehabilitation Services Administration.

It is the stated intent of Congress to unify child health services and to lessen fragmentation of child health services—"to consolidate and more rationally arrange the various Title V programs" (Report of the Committee on Ways and Means on H.R. 12080, Section C, on Improvement of Child Child, page 124).

It is my considered opinion that the proposed administrative change would run counter to the stated intent of Congress.

It is my considered opinion that the proposed change would be disadvantageous for none. (The Honorable Wilbur Cohen was asked to discuss the advantages to children that would occur. He elected not to answer.)

There is a great advantage in having a *single* agency in government concerned with children as there now is to be an administration on aging.

The present Children's Bureau has been most successful through its administration of the programs in Title V of the Social Security Act in giving direction to comprehensive governmental concern about children.

The Rehabilitation Services Administration and its personnel have no experience in providing comprehensive child health services. "State crippled children's agencies use their funds to locate children, to provide diagnostic services, and then to see that each child gets the medical care, hospitalization, and continuing care by a variety of professional people that he needs. Less than half of the children served have orthopedic handicaps; the rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, heart disease, and many congenital defects." (See page 126(b) of Report of the Committee on Ways and Means on H.R. 12080.) Rehabilitation programs are directed primarily to vocational training. They have no expertise in comprehensive child health programs.

I serve on the advisory committee to the Iowa State Rehabilitation Program and am informed about the strong and weak points about the state and national rehabilitation programs. It would be a great set-back to the Crippled Children's Services if our source of leadership and funding came from the Rehabilitation Services Administration.

This letter concerns the effect that the proposed administrative change would have on the Crippled Children's Service. This is not a local matter as indicated by the statements made by the American Academy of Pediatrics, the National Association of Chairmen of Departments of Pediatrics, the Academy of Orthopedic Surgeons, the Association of State and Territorial Health Officers—and really by all parties knowledgeable about child health.

Respectfully,

JOHN C. MACQUEEN, M.D.,
Executive Officer and Medical Director.

(The following letter was submitted to the committee by Hon. Bourke B. Hickenlooper, a U.S. Senator from the State of Iowa:)

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.,
CENTRAL IOWA CHAPTER,
Des Moines, Iowa, September 6, 1967.

Hon. BOURKE HICKENLOOPER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HICKENLOOPER: We are concerned with three regressive sections of HR 12080 recently passed by the United States House of Representatives and ask your services in securing correcting Senate amendments to the following sections of this bill.

1. The limitation of the number of children in each state who can receive ADC payments because of father's absence, to the January 1, 1967 percentage of such children to the total number of children in the state.

2. The stipulations that parents *must* participate in work training or in day center care of children as requirements for ADC assistance.

3. The pegging of individual State Medicare Grants to individual State Welfare Grants.

Our objections to these sections are:

1. *Exclusion of needy children of deserting parents.*

a. This section violates the following purpose of the Social Security Act:

"For the purpose of encouraging the care of dependent children in their own home or in the homes of relatives by enabling each State to furnish financial assistance and other services. . . . to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain the maximum self support and independence consistent with the maintenance of continuing parental care and protection."

b. Punishment of children through the denial of sustenance is not a deterent to rising dependency costs. If punishment of parents is sought as a deterent, care must be given to the children involved during the deterent period. This care is usually much more expensive than the ADC grant would be.

Appropriate legislation may be needed to help solve the problem of deserting parents but surely it is the parent that should be punished and not the children who are already deprived.

Such legislation should not in our opinion be a change in the purpose of the Social Security Act.

c. The section violates the due process and equal protection clauses of the Constitution and would appear to be unconstitutional.

d. The creation by Congress of a new helpless group of children without sustenance, "over-percentage children", adds to the national problems which Congress is trying to reduce through the War on Poverty and the study of causes of riots.

e. The provision would have the result that children who would fulfill all the provisions of the ADC law would be excluded for no other reason than that they applied later than someone else. The date in which an application is filed should not have any bearing on the effect as to what applications should be granted.

f. We are aware that the section would not prevent the states from providing grants for such children out of their own funds but this would necessarily lead to a harmful decrease in the amount of grants.

2. *Participation in work training and day center use.*

a. Both work training and use of day centers to care for ADC children are generaly constructive programs for both ADO beneficiaries and society, however, such benefits would arise only from proper application to individual families and not from mass application to all beneficiaries. In many instances the best interests of children and society depend on the mother remaining at home caring for the children. It should be clearly stated in the law that in such instances refusal to accept training or employment should constitute "good cause" to refuse such training or work.

b. The legislation passed by the House would incorporate administrative responsibility in the law and thus impair our tripartite government as well as the programs legislated.

3. *State Medicare Grants pegged to State Welfare Grants.*

Medicare grants should be equal throughout the nation to assure equity of health care and therefore, should be related to a national and not a state base. The provisions of HR 12080 to which we refer would have the result that citizens of a state with a low welfare standards would be much more restricted concerning care under Title XIX than citizens of a state with high welfare standards, in spite of the fact that citizens of a state with low welfare standards are more in need of the grants under Title XIX than citizens of a state with high welfare standards.

We have not overlooked and greatly appreciate the benefits provided in HR 12080, especially the increases in Social Security Grants, earnings retentions, in foster home care and the availability of birth control information.

We also want you to know how deeply we appreciate both your present help in securing these critically needed amendments and all your generous past help in welfare matters.

Sincerely yours,

Mrs. Eleanor W. Carris, ACSW, *Chairman.*
Alice Whipple, ACSW.
Rudolph P. Beerman, ACSW.

(The following letter was submitted to the committee by Hon. George McGovern, a U.S. Senator from the State of South Dakota:)

State of South Dakota,
Employment Security Department,
Aberdeen, S. Dak., September 6, 1967.

Hon. George McGovern,
Senate Office Building,
Washington, D.C.

Dear Mr. McGovern: The House has passed H.R. 12080, upon which hearings are now being held in the Senate Education and Labor Committee. H.R. 5710, which was the original administration bill, had hearings before the Ways and Means Committee in the House, but H.R. 12080 was moved out by the committee and is the result of much pressure by the Public Welfare agencies of the various states.

The principal objections that I have to H.R. 12080 appear in Section 204, which in effect sets up a duplicate employment service in the welfare departments for the purpose of making placements. I much prefer section 204 as it appears in H.R. 5710, for the reasons hereinafter stated.

In the past years there have been a number of good manpower training programs authorized by Congress. They are, however, so dispersed among various agencies and the cooperation between these various agencies is not of the best, so that the dollar value of the program is not what it should be. For example, funds for outreach are available from nine manpower sources, adult basic education from ten sources, in addition to the general education sources, prevocational training from ten and work experience from five. On-the-job training is subsidized by five programs and supportive sources can be subsidized from nine sources. Income maintenance is available under nine programs. Eligibility rules, application procedures and all other aspects vary from program to program. This makes for a hodgepodge of competing programs, all with costly administrative expense. Coordinated or centralized manpower training programs would provide more results per dollar.

It seems to me obvious that if all manpower training programs could be centrally administered, a greater degree of efficiency could be obtained. I feel this should be accomplished by, and the logical place for this administration is in the Department of Labor and the State Employment Services.

Section 204 of H.R. 12080 is a step toward further dispersement of manpower training and only continues a trend which should be reversed. Section 204 of H.R. 5710 attempts to get this training at least partially where it belongs, in the Department of Labor.

Briefly my reasons for favoring the Section 204 as it appears in H.R. 5710 are as follows:

(1) Undoubtedly many welfare recipients can profit from manpower training, such training should be directed primarily toward (a) equipping them with skills needed by industry; (b) where there is a reasonable chance of employment once they are trained, and (c) the training will enhance their chance of social and financial improvement.

The Department of Labor and the Employment Services have been working in this area for years and I am sure would be more efficient and less costly than newly created counseling, testing and job development created by another bureau or department as will happen under Section 204 of H.R. 12080.

(2) Many welfare recipients can profit from manpower training, but all of them cannot. It appears to me to be unwise to haphazardly train all welfare clients, spending precious training dollars with a probable minimum result when there are not, and will not be, enough training dollars to satisfy the pressing needs of our economic society.

(3) The welfare people contend that the Employment Service is so controlled to the needs of industry in its work that it is blind to individual needs. This is far from true. In South Dakota, for example, the Employment Service here has worked diligently in areas of the handicapped, older workers, Indians, alcoholics, youth and other handicapped individuals. We have had over thirty years' experience in the field of guiding, counseling and helping *all people* toward gainful employment.

It appears to me that big government is made up of a lot of small king makers that are trying to build themselves into important positions. Therefore, there is no cooperation to speak of on the federal level among the various agencies handling the great number of programs authorized by Congress.

The passage of H.R. 12080 will only provide for more duplication, more inefficiency and more cost to the taxpayer. I hope that you can see fit to oppose H.R. 12080, which has been initiated by the U.S. Department of Health, Education and Welfare and the pressure by all of the state welfare agencies. At least H.R. 12080 should be amended by substituting for Section 204 in that bill, the section 204 as it appears in H.R. 5710.

Sincerely yours,

ALAN WILLIAMSON, *Commissioner.*

(The following statement was submitted to the committee by Hon. Mark Andrews a U.S. Representative in Congress from the State of North Dakota:)

STATEMENT OF THE MEDICAL GROUP MANAGEMENT ASSOCIATION SUBMITTED BY C. WARNER LITTEN, CHAIRMAN, MEDICARE LIAISON COMMITTEE, AND E. B. STEVENS, EXECUTIVE SECRETARY

Mr. Chairman and Members of the Committee: This written statement concerning H.R. 12080, the Social Security Amendments of 1967, is prepared by C. Warner Litten, for more than twenty years the administrator of the Fargo

Clinic, Fargo, North Dakota. He is also a Past President of Medical Group Management Association and is presently serving as Chairman of the Medicare Liaison Committee of such Association. He is assisted by Edward B. Stevens, Executive Secretary of such Association, who was the administrator of a closed panel prepayment medical care plan in Tacoma, Washington from 1939 until June 15, 1957.

The Medical Group Management Association, with executive offices located at 956 Metropolitan Building, Denver, Colorado, is an organization formed in 1926. Members of the Association are the business administrators of medical groups or clinics in the United States. About 700 of the 1200 or so medical groups located in this country are represented in its membership. Members range from the business administrators of larger groups, such as the Mayo Clinic in Minnesota or the Kaiser Permanente Medical Groups in California, down to small groups of a few physicians serving the health needs of the small community. The Fargo Clinic, of which Mr. Litten is the administrator, presently has 43 physicians on its staff. Some of the medical groups represented operate prepayment health care plans but most of them conduct their medical practice on the traditional fee-for-service basis.

The Medicare Committee of the Association, of which Mr. Litten is Chairman, has met on various occasions with representatives of the Bureau of Health Insurance of the Department of Social Security in Baltimore to discuss various problems concerning the administration of the Medicare Law. We have found the staff of the Bureau to be loyal, sincere and dedicated employees, to be cooperative and courteous, and we have appreciated the opportunity of working with them on our problems.

Because the members of our Association are specially trained to administer the business affairs of medical groups, we believe that they are qualified by training and experience to speak authoritatively on the business and economic problems of the practice of medicine and the efficient provision of health care to our people.

We have suggestions we would like to leave with the gentlemen of this Committee concerning H.R. 12080.

First, we would like to talk about Section 131 of the proposed law which provides that the radiologist and the pathologist furnishing services to a patient who is an inpatient in a hospital shall be paid at the rate of 100% of the reasonable charges for such services. Previously the radiologists and pathologists were paid at the rate of 80% of such charges.

In the House Committee Report it is pointed out that this will provide payment in full for the patient for any diagnostic x-ray and laboratory services performed while he is an inpatient in a hospital. In justification of this amendment, the House Committee says, on page 40 of the report, "*This change would provide reimbursement for the services in question in a manner that is comparable to the inhospital coverage of pathology and radiology procedures that is provided by many other health benefit plans.*" (Emphasis ours) This is true and it also epitomizes the criticism we have of this change.

For many years, the majority of carriers of health insurance programs have followed the practice of insisting that payment for diagnostic x-ray studies and laboratory procedures will only be made for bed patients in a hospital. In the industry, it has been called "tying the benefits to a hospital bed".

It has been conclusively proven, time and time again, that this practice of the carriers has resulted in a tremendous increase in the occupancy of hospital beds, in a tremendous increase in the cost of such procedures because of bed occupancy, and a resulting increase in the premium for insurance which is written on this theory.

Whether the actual difference to the patient be 25¢, 50¢ or $50.00, the phychological effect of this change in the medicare law will cause most patients under medicare to demand from their doctors that they be hospitalized for diagnostic procedures because it is cheaper for them. This practice has been going on for years with private insurance carriers and we would not hesitate to assert that it is the principal cause for the present shortage of hospital beds in the United States. We know this can be proven.

To reduce the problem to its simplest proportions, a gall bladder series of x-ray procedures done in the office of a medical group or a physician on an outpatient basis will probably cost in the neighborhood of $30.00. If the patient is hospitalized for the same procedure, a bed charge of $30 to $40 per day will be added for two or more days, plus $10 to $20 for other routine x-ray and laboratory procedures which are required on all bed patients. Thus, the same x-ray series will cost the insurance company or the medicare fund over $100 when it could have been performed with equal effectiveness in the office of a medical group or of a radiologist for less than 30% of that amount. All this is true because there is a *financial advantage to the patient* if the work is done in a hospital.

During many investigations of the cost of health care, some of which have been held in Washington under government sponsorship, it has been alleged that the frequency of hospitalization and the actual amount of hospital costs incurred are substantially less for a patient who receives health care benefits under a closed panel prepayment plan than for patients covered under other types of insurance. These claims are true. This results from two differences in the practical application of the plan:

A. *It is not financially advantageous to the patient* under a closed panel prepayment plan if he is hospitalized for diagnostic x-ray and laboratory procedures. The cost to the patient is the same whether he is in or out of the hospital. Actually, in some cases his cost is less if he is not hospitalized.

B. *It is financially advantageous to the doctor* under a closed panel prepayment plan to perform diagnostic procedures of this kind in the office of the medical group providing service under the plan because most of the cost of operating the x-ray and laboratory department of the group is fixed and is not materially affected by the number of procedures done. On the other hand, if the doctor in the group hospitalizes the patient at great additional expense for bed occupancy and other routine services, that portion of the prepayment fund which is available for payment for the services of the doctor will be decreased.

The Medicare Law, as it now exists, contains a half hearted attempt to halt this sort of unnecessary hospitalization. Presently the fees of the radiologist and the pathologist are paid under Part "B" of the Law and are subject to the annual deductible of $50.00 and a co-insurance cost of 20%, both of which are paid by the patient. The differences are inadequate but some psychological effect is there.

Since 1952, Medical Group Management Association members have been pleading with the insurance carriers to change this policy. We have repeatedly urged that the plans provide the same benefits for diagnostic x-ray and laboratory procedures whether the patient is hospitalized or not. This would mean, in the case of a Medicare patient, that 100% of the reasonable charge for x-ray and laboratory procedures be paid for the patient whether he was hospitalized or not. We insist that there would be two immediate and tangible results in the field of medical economics—

1. The rate of occupancy of hospital beds would substantially decrease as soon as the patient becomes aware that there is no differential in his benefits for these diagnostic procedures if he receives them as an ambulatory office patient or as an outpatient of a hospital instead of an inpatient.

2. There would be a corresponding dramatic reduction in the amounts expended by insurance carriers and by carriers of Medicare for unnecessary hospitalization.

We have talked with representatives of the Health Insurance Council many times about this but our pleas and suggestions have fallen upon deaf ears. However, we sincerely believe that if the Medicare Law is amended to provide equal benefits for these diagnostic procedures whether the patient is hospitalized or not, the large insurance carriers will eventually fall into line resulting in a further dramatic increase in the available hospital beds for the ill patient who actually needs the bed and, in some areas, has difficulty in finding it now.

The second provision of the bill as drawn by the Ways and Means Committee of the House of Representatives which we would like to discuss is that relating to payment for services of a physician.

At the present time the law provides for the payment of 80% of the reasonable charges for the services of a physician rendered to a beneficiary under the law. If the physician takes an assignment of the claim and agrees to accept the determination of the administrators of the act as to the reasonableness of the charge, the payment is made to the physician. If the physician does not wish to accept an assignment, payment is made to the patient on the basis of a receipted bill from the physician and such other evidence as is required by the carrier.

Section 125 of the proposed bill provides a third method. Payment will be made by the carrier on the basis of 80% of the reasonable charges for the service on presentation of an itemized statement and other supporting evidence either by the patient or the physician. In the event the physician's charges are found to meet the test of being reasonable and *he files his claim within a reasonable time*, such payment will go to the physician. Otherwise it will go to the patient.

From our knowledge of the business practices of physicians in the United States this is going to create an administrative monstrosity for the carriers whose duty it is to audit the claims and pay the benefits. It is also going to further confuse the patients. It is entirely possible, if not probable that the carrier will receive the bill directly from the patient. If the carrier does get it from the patient, it will then be necessary for the carrier to withhold payment of benefits to the patient until a "reasonable time" has elapsed because the physician may also file a claim. The difficulty is not only to define what will be upheld as a "reasonable time" but to determine from what date the time will start to run. In the case of older persons with chronic conditions, medical care may be continued for a period of years. In that case, when will the "reasonable time" start to run? We do not understand the purpose of drawing the bill in the language in which it is prepared but we do know that it will create chaos and confusion and we will all end up with a sorry administrative mess on our hands.

We suggest that this provision of the bill be amended so that in the final analysis, the indemnity will be paid to the physician if he takes an assignment and thereby agrees to a possible adjustment of his charges or to the patient in the event a properly supported itemized statement is presented by him or by his physician without such an assignment being taken by the doctor. This will entirely cure the criticism of the present law without introducing bookkeeping and accounting problems which may prove insurmountable.

All of which is respectfully submitted.

(The following letter was submitted to the committee by Hon. Margaret Chase Smith, a U.S. Senator from the State of Maine:)

EMPLOYMENT SECURITY COMMISSION,
Augusta, Me., September 5, 1967.

Hon. MARGARET CHASE SMITH,
U.S. Senator, Senate Office Building,
Washington, D.C.

DEAR MARGARET: I am concerned as to the action taken on H.R. 5710 as reported out by the H.R. Ways and Means Committee on August 2, 1967 which resulted in a revised bill, H.R. 12080. Section 410 of H.R. 5710 was deleted, and Sec. 409 was amended to give the Welfare Administration authority to develop the programs relative to work and training needs of welfare clients.

It would appear that if H.R. 12080 is passed unamended in regard to S. 409 and S. 410, then H.E.W. would be authorized to set up a manpower training component within its administration that would parallel that of the Employment Service specialists already trained and active in the field of manpower services and needs.

I would appreciate anything you might do to prevent further confusion relative to manpower training.

Sincerely,

ROY U. SINCLAIR, *Chairman.*

(The following resolution, adopted by the Vermont Chiropractic Association, was submitted to the committee by Hon. George D. Aiken, a U.S. Senator from the State of Vermont:)

RESOLUTION

WHEREAS the Federal Medicare Act, Title 18, included within its provisions two basic provisions which stated; Prohibition against any Federal interference and free choice of patient guaranteed, and

WHEREAS the Medicare act as presently written constitutes Federal interference with states rights in denying recognition to state licensed and regulated health care professions including chiropractic health care and also denies the free choice of the patient in selection of health care by refusing to provide for allied health care professions including chiropractic health care, and

WHEREAS chiropractic health care inclusion in the Medicare bill will not require additional expenditures of funds in the Medicare program since health care under chiropractic is a substitute at lower cost for medical care: Now, therefore, this convention does hereby

Resolve, That it decries the denial of freedom of choice imposed upon the senior citizens of the United States in the selection of the health care of their choice under the existing provisions of the Medicare act and; be it further

Resolved, That it urges the adopted of amendments to the Medicare Act which will include chiropractic as an optional health care; and be it further

Resolved, That copies of this resolution be forwarded to the Congressional delegation of this state with an appropriate letter urging the passage of amending legislation providing the inclusion of chiropractic health care in the Medicare Act.

Done at Barre, Vermont this 1st day of Sept. 1967.

VERMONT CHIROPRACTIC ASSOCIATION,
G. W. GAGE, D.C., *Secretary.*

LUTHERAN FAMILY AND CHILDREN'S SERVICES,
St. Louis, Mo., September 6, 1967.

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

DEAR SENATOR LONG: We the staff of Lutheran Family and Children's Services in St. Louis, Missouri, have followed with great interest the development of the 1967 Social Security Amendment. We were extremely disappointed with some aspects of the House Ways and Means Committee's Bill which was subsequently passed. This Bill, H.R. 12080, known as the "Social Security Amendments of 1967", now is under consideration by the Senate Finance Committee. Our concern centers around the Title II Amendments. We feel they are paradoxical in nature and reflect the dilemma felt by citizens of the United States regarding public welfare. This dilemma is should we punish those dependent upon public welfare or should we help them. Although the House of Representatives feels that increased numbers in the AFDC program reflects failure on the part of the Social Security Amendment of 1962, we feel the necessity for families to apply for assistance in order to survive reflects failures that run much deeper in American life than the failure of these 1962 amendments to substantially reduce poverty and economic dependency.

The dilemma we spoke of earlier results in measures which on the one hand seem primitive and the other seem geared toward people's needs. "Freezing" federal participation, establishing committees to secure support money, forcing all adults and sixteen year old dropouts to work are measures which purport to be meant for helping people become independent—but in reality will force states and local municipalities to focus on one thing—getting people off assistance. The "squeeze" will be on and people's well-being will become of secondary concern.

On the other hand the amendments offer federal participation in the development of a range of services not heretofore adequately provided. Increasing educational and vocational programs in addition to homemaker and day care programs are excellent proposals.

Allowing for a more flexible use of "purchasing of care" and other services seems to make additional voluntary resources, so sorely needed, available, providing work, incentives and an emergency assistance program capable of meeting emergencies are positive measures needing immediate attention. The value in the above programs lies in their flexibility in relating to individual families and adults. They provide opportunities to strengthen family life and life outside of the family. However, when used as mandatory care for children or mandatory training programs for adults they lose their value. They are no longer flexible measures aimed at helping families with help suited to a particular problem.

Although we agree with the principle that it is good for people to work when possible we don't feel that a mandatory law is the way to accomplish this goal. To assume that forcing an ADC mother to work is the best way to break the cycle of family dependency for economic support raises the question of a mother's role in child rearing. Does a mother best meet her children's needs by working, especially if she has young children? Does her working provide the best chance for her children to grow up and live independent of assistance? Thus work for some adults may be an excellent opportunity—but in the long run it seems that focusing on the adults, on the present at all costs, means that we haven't dealt with the chronic nature of dependency—"from generation to generation".

We also feel that it is good for fathers to support their families. But it seems that many ADC families exist without a man in the family because of our present law. Thus spending extra funds to "hunt down" fathers for support seems to be a weak solution. Why not provide assistance grants and allow unemployed fathers seeking employment to remain at home? Then there may be less of a need to "hunt down" the absent father. Even if ADC fathers were unemployed, their presence at home could be a positive step in the development of stable family life.

We find it difficult to support the "freeze" because in the end it places pressure on the states and local government to arbitrarily cut people off of assistance and seems to be an anxiety provoking situation for all—unnecessarily so. We believe the increased social services should be included and would hope for aid to be granted allowing unemployed fathers to remain at home, thus strengthening family life by allowing families to have fathers.

We feel that although the child welfare amendments include almost doubled expenditures, they are still inadequate. In many states the assistance grants are allowed far below reasonable minimum requirements. We believe that the present administration's proposal that a standard budget be fully allowed in each state is a good and necessary one and that it needs to be made mandatory by amendment if the fine aim of these amendments is to reduce poverty and dependency is to be achieved.

The Child Welfare League of America has aptly pointed out that federal participation in all other categorical programs is much greater (at least 50 percent) than in the child welfare programs (10 percent). As a result States have been reluctant to develop child welfare programs and tend to provide more comprehensive services in programs where federal funds are more readily available. Thus we urge the United States Senate to consider the measures presented in H.R. 1967 Burke Bill, which advocated Federal participation at a 75 percent level for the training of Child Welfare workers and at a 50 to 83 percent level for child welfare services.

We appreciate your taking the time to consider our letter.

Respectfully yours,

Constance Hartner, Rodney R. Johnson, LeRoy D. Zimmerman, Jean J. Pfeifer, Douglas Zopatoiny, Sally Phend, Helen C. Conunos, Arnold H. Bringewatt, Pat Annis, Martha Bringewatt, Carolyn J. Riske, Douglas Zopatoiny.

STATE OF NORTH CAROLINA,
GOVERNOR'S OFFICE,
Raleigh, September 7, 1967.

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

DEAR SENATOR LONG: As you know, Governors have been asked to testify before the Senate Committe considering the 1967 amendments to the Social Security Act. I regret that I will be unable to testify because of a conflict in dates of the Committee hearings with this year's meeting of the Southern Governors' Conference. However, there is one particular provision in the amendments on which I wish to comment.

One of the provisions of the amendments addresses itself to a limitation on aid to families with dependent children eligibles. In summary, this provision states that the proportion of all children under age 21 who were receiving AFDC in each state in January, 1967, on the basis that the father was absent from the home, could not be exceeded after 1967. Even though North Carolina would not be affected immediately by such a limitation, it appears that further consideration should be given before applying such a restriction. The caseload in AFDC in North Carolina is not increasing at the present time. However, in many states, especially those with major cities, there is a continuous rise in the AFDC caseload because of migration of rural families to urban areas. In those situations and in this State, in the event of a change in the nation's economic advancement, such a limitation could create serious inequities and actually dangerous reactions. It does not seem reasonable to deny assistance to children because their number exceeds a certain percentage figure. This does not feed hungry children nor does it consider human needs.

I would personally appreciate your giving further consideration in your deliberations regarding this particular provision.

Sincerely,

DAN MOORE.

STATEMENT OF HON. WARREN E. HEARNES, GOVERNOR OF MISSOURI

I appreciate the opportunity of submitting a statement to the Senate Committee on Finance regarding H.R. 12080.

Let me say at the outset that I am in general accord with the proposed changes in the social security program, particularly with recommended increase in monthly retirement benefits. Although the proposed increase in the minimum benefits is from $44 to $50 instead of $70, as carried in the President's proposals covered in H.R. 12080, any increase will be helpful to those receiving these benefits who are particularly affected by the increasing cost of living. It is my understanding that the 12½ per cent increase recommended in H.R. 12080 would offset increases in the cost of living in recent years.

My primary concern relates to proposed changes in the public assistance titles, particularly with reference to the aid to families with dependent children program. Title II, part I, section 208 of the bill would freeze the number of AFDC children eligible because of the absence of the father from the home, to the proportion on the rolls (in relation to the number of children under 21 in the general population) as of January 1, 1967. I oppose this restriction because it is arbitrary and punitive and would impose hardships and deprivations on innocent children who are in need of assistance through no fault of their own. Moreover, it is unfair to the States to force them to provide for needy children entirely from State funds once the ceiling is exceeded. The establishing of this arbitrary ceiling as to the numbers of children for which Federal participation would be provided amounts to changing the rules in the middle of the game since all States that went into the AFDC program originally were under the impression that Federal matching would be available for all children qualifying under Federal and State law. It is quite conceivable that the AFDC rolls could increase during periods of economic recession or for other reasons thus requiring the States to assume the full cost of this increase at a time when they are sorely pressed for funds to finance other vital State services. If States were unable to assume this additional cost, the only alternative would be to decrease grants or to enact restrictive legislation in order to stay within the Federal ceiling. This, of course, would deprive needy children of assistance, or force the families to live on the reduced grants. I believe this provision is unreasonable and impractical and recommend that it be deleted from the bill.

H.R. 12080 would amend section 204(a), section 409, of the Social Security Act to provide community work and training programs for every adult member and child over 16 years of age not attending school, in AFDC families. These programs would be established in every part of the State where a significant number of AFDC families live and would be mandatory upon the States, effective July 1, 1969. Failure or refusal on the part of the individual to accept such training or jobs would result in his removal from the AFDC rolls.

Although I am completely in agreement with the purpose behind this proposal of offering work training, education and jobs to people on the public assistance rolls, I believe the work and training program should be administered by the Department of Labor as originally proposed in H.R. 5710. There appears to be no justification for a separate agency to operate a work and training program, thereby duplicating the efforts of several State and Federal departments. The State welfare departments could serve as referral sources for eligible AFDC adults for work training, and placement by the Department of Labor through its State units. This procedure would place the operation in the agency best equipped and staffed to do the job, thereby eliminating duplication and confusion.

Missouri has work-experience programs for AFDC mothers, and the unemployed under title V of the Social Security Act, in St. Louis City, St. Louis County, Jackson County, including Kansas City, and several rural Missouri counties. Through these work-experience programs, we have been able to place a number of AFDC mothers, and the unemployed, in jobs after they have received literacy training and on-the-job work experience training. But I believe a better job could be done through the established programs of the division of employment security of the Department of Labor, particularly manpower development and training and the employment service.

I also question the compulsory nature of the community work and training program which requires that an AFDC mother or other adult, or child over 16 years of age, to accept whatever job is deemed "appropriate"—whatever that term means. There is something repugnant to this procedure, as well as the refusal of benefits to persons who without "good cause" refuse to accept job training and work placement. There may be good and valid reasons why people are reluctant to accept work training and job placement, aside from any desire to remain on the welfare rolls, and these decisions can be made only on an individual basis at the local level of government. Above all, in any program to put mothers to work, we should think in terms of what serves the best interest of the child or children. Further, there is no guarantee that every trained person can be placed in employment unless the Government itself acts as the final source for providing employment. Studies indicate that many welfare recipients are very difficult to train and place in private employment due to lack of education, cultural deprivation, opportunity, etc. And, as we all know, the rate of unemployment is highest in the areas where welfare loads are very high. The concept of compulsion ignores the important factor of motivation. An individual who by choice accepts a job placement is more likely to do well than one who is forced against his own wishes to accept a job he doesn't want. In my judgment, a more flexible program would permit voluntary acceptance of training and work after full consideration of all circumstances in each situation.

Although H.R. 12080 does not require the States to meet full budgeted needs of welfare recipients, it is my understanding the Secretary of Health, Education, and Welfare, in testimony before this committee, asked for the restoration of this provision as contained in H.R. 5710. I am in agreement with the purpose of this request, which would provide full budgeted needs to public assistance families, but it must be considered in the light of the ability of many States to assume this additional financial burden. The recommendation as contained in H.R. 5710 made no provision for increased Federal matching funds as far as Missouri is concerned. For many States the assumption of this additional fiscal burden would require more State money which could come only from new or higher taxes. If Missouri paid full budgeted need, an additional $60–$70 million per year would be required, and this could come only from new tax money or by restricting or eliminating other basic public services. This would amount to about a one cent increase in the State sales tax. Missouri is now spending from 20 to 25 percent of all State revenue for public assistance purposes. Needs of other equally desirable State services, such as education, mental health, public health services, probation and parole, mental retardation, the correctional system, must all be considered, and, I mention only a few.

Aside from the cost, there is a fundamental problem of governmental philosophy to be reckoned with. It seems completely illogical to me for the Federal Government, through the passage of laws, to compel any State to undertake, as a mandatory requirement, the expenditure of vast sums of money on any program without proper Federal financial participation, and without the State having an option of accepting or rejecting the program. This amounts to Federal legislation forcing upon the citizens of the States excessive and oppressive tax burdens under threat of withdrawal of Federal aid from programs which have been in existence for years, and which have been predicated upon the thesis that there will be Federal participation in the cost.

Missouri's constitution limits total expenditures to income through tax sources. If there are to be expenditures above the State's income, there must be corresponding taxes to meet these expenses. I am sure other States have like provisions. What I am trying to get across to the committee is that mandatory Federal laws should not be passed which would endanger the fiscal stability of our States, or, as in the case of welfare, could mean reduction in welfare programs and expenditures to the detriment and penalty of poor citizens who must look to the welfare programs for their existence. So, I ask that the mandatory provision of payment of full budgetary needs, as contained in H.R. 5710 not be restored in H.R. 12080.

The committee might want to give consideration to an increase in the maximum assistance payments in which the Federal Government will participate on a matching basis. The present maximum of $75 for the adult programs, and $32 per person for AFDC is woefully inadequate in terms of current living costs. Some States do not have the fiscal ability to make payments above the Federal maximums and this is primarily the reason for low welfare payments. An increase in the Federal maximum matching payments would tend to alleviate this problem without passing the entire cost on to the States.

Heretofore, when increases have been made for social security beneficiaries, increases have also been given to those receiving public welfare aid who are not covered by any phase of the social security system. This would include persons over 65 (not on social security), needy children, the blind and the disabled. I would hope that the committee would again follow this pattern, as it thoughtfully, and I am sure prayerfully, considers the effect H.R. 12080, in its final form, will have on millions of American citizens.

DEPARTMENT OF HEALTH,
UNIVERSITY (DISTRICT) HOSPITAL,
Caparra Heights, P.R., September 6, 1967.

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

DEAR SENATOR LONG: The subscriber is at present occupying the position of Director MIC Project 505 at Northeast Health Region of San Juan, Puerto Rico. During the past years we have had the opportunity to collaborate with the different State and Federal Health Agencies, which deal with programs directed to mother and children care. We have been able to palpate in this manner the problems related to implementation, financing and planning of programs directed towards this group in addition to the effectiveness of the various organizations dealing with the same.

We are aware of the fact that your committee is now considering a Bill No. 1208 of the House of Representatives regarding the place where programs giving assistance to crippled children will be located under Title V. It has come to our attention that the proposed legislation intent is to change Crippled Children Programs from the present management under Children's Bureau to Vocational Rehabilitation. Our group within the health services in the island has discussed this reassignment and we have decided to write to you in an attempt to recruit your decisive opinion in this regard. The philosophy of programs directed towards maternal child health has been relegated for a long time to separate on uncoordinated efforts mostly lost in the more ample horizon of general health care. This situation was corrected by coordinating the efforts within this field under a single agency providing a more ample perspective and a specific well oriented effort towards services in this field, namely the Children's Bureau. The important thing in this decision has been the fact that a group of persons whose problems are of a very peculiar and specific nature and in consequence their needs and solution are also specific and peculiar, was granted for the first time the opportunity of having their health needs plan motivated and implemented in a more efficient manner. This has been our experience in the Island of Puerto Rico and the benefits are here for all to be seen. The fact that this is also true within the States can be ascertained from a perusal of both the lay and medical literatures regarding maternal child problems, especially some with the added impulse that in recent years has been granted by Congress thru the Social Security Amendments. We have finally, seen the results of this visionary attitude in terms of health improvement of both women in the reproductive age and the child they bear.

I speak for the health programs in Puerto Rico in saying that a change in this philosophy would represent a step backward in programs efficiency in this field, while the support of these programs under a united agency would mean continued improvement until this great nation of ours would eliminate the stigma of being only tenth in order of child mother health in the world as it is now, in spite of the fact that it invests more money in these programs than any of the large nations.

For the reasons stated above, I am speaking for the personnel participating in the Maternal Infant Care Project of the Northeast Health Region, I wish to make a plea for the support of an amendment to Bill 1208 which returns Crippled Children Program to its rightful place in the scheme of health services namely, the agency where all other Maternal Child Services are provided in the structure of the Health and Welfare Department. I trust that our opinion may in a small way help your committee to introduce this amendment which we consider of vital importance to the health of children who are our most important product.

Sincerely yours,

JUAN J. HERNANDEZ CIBES, M.D.,
Director, MIC Project 505.

ORANGE, CALIF., *September 11, 1967.*

Senator RIBICOFF,
Committee on Finance.

I am on social security for disability.

I am also a graduate economist.

I have long felt medicare for disability imperative.

HAROLD E. FIELD.

(The following letter was submitted to the committee by Hon. Gaylord Nelson, a U.S. Senator from the State of Wisconsin:)

AUGUST 25, 1967.

Subject: Comments on H.R. 12080, Bill to Amend the Social Security Act.

Mr. WILLIAM BECHTEL,
c/o Senator Gaylord Nelson's Office,
Senate Office Building,
Washington, D.C.

DEAR MR. BECHTEL: We understand the subject bill was reported out of the Ways and Means Committee of the House recently and that the House has passed the bill and referred it to the Senate for action. We have reviewed the bill and compared it with H.R. 5710, which is an administration-sponsored bill introduced last February.

We would like to express concern over the substantive changes in this legislation regarding the delegation of authority for community work and training programs. The original bill, H.R. 5710, Section 204, provided that the Secretary of the Department of Labor would have the responsibility for establishing work and training programs for appropriate individuals who were welfare recipients. The House version of the bill, H.R. 12080, Section 204, provides that responsibility for this work and training program effort be placed with the Welfare Administration.

Our concern with this proposed legislation is directed toward the creation of programs and services which would inevitably parallel and duplicate many of the programs which the State Employment Service has initiated at the local level during the last five years under Federal manpower training legislation. The bifurcation of effort which would result from this legislation would require a considerable coordinating effort and would undoubtedly siphon off a significant portion of the resources to allow for the development of the expertise and labor market information within the Welfare Administration, which is now already possessed by the Department of Labor, and which is an absolute necessity in the successful operation of such programs.

We are presently involved with State Public Welfare officials in the development of a coordinated effort for the training of welfare recipients under Title V of the Economic Opportunity Act. This effort is in recognition of the necessity for the involvement of Employment Service staff and resources in training programs of this nature.

In order to avoid further problems of coordination and cooperation, we suggest that Section 204 of the original version of the bill, as proposed last February in H.R. 5710, be reconsidered.

Sincerely,

E. M. KEHL, *Assistant Director.*

STATE OF MICHIGAN DEPARTMENT OF PUBLIC HEALTH,
Lansing, Mich., September, 8, 1967,

Mr. TOM VAIL,
Chief Counsel, Committee on Finance,
U.S. Senate, New Senate Building,
Washington, D.C.

DEAR MR. VAIL: Thank you for your letter of August 30, 1967. I understand the difficulty you must have in scheduling hearings on H.R. 12080 and am pleased to use this letter to endorse Title III of the bill which amends Title V of the Social Security Act.

The consolidation of the separate programs under Title V of the Social Security Act will allow state agencies to plan and develop programs of comprehensive care for mothers and children not previously possible. This is in accord with P.L. 89–749 which provides for states to develop comprehensive health services.

However, there appears to be some conflict between the bill and the recent reorganization of the Department of Health, Education and Welfare which separated the administration of maternal and child health services and crippled children's services. The latter were placed in the Rehabilitation Services Administration while the former were left in the Children's Bureau. This reorganization would split rather than unify the programs. It is difficult to understand how in this situation a state could develop a single plan and budget for child health services. It also appears certain that duplication of personnel at both the federal and state level will result.

I suggest that the Committee urge that these two programs be administered by one unit. As they are both child oriented programs, I feel they should be administered by the Children's Bureau. Over 80 percent of all children served in the Crippled Children's Program are less than 15 years of age. Over 20 percent of the conditions treated are due to congenital malformations. The role of the vocational rehabilitation agencies has been limited to services to persons over 15 years of age with a vocational objective.

In addition, in Michigan over 60 percent of the children served in the Crippled Children's Program are eligible for welfare services either as categorically related or as medically indigent. Services would be improved by close association with Child Welfare Services and Aid to Fatherless Dependent Children Services (AFDC) which have been assigned to the Children's Bureau.

Because of the interrelationship of health and welfare needs of children, I want to briefly comment on Section 208 of Title II of H.R. 12080. This section would limit the number of AFDC children with respect to whom federal payments may be made. I strongly believe that such an amendment will adversely affect the health and welfare of the less fortunate children of this country.

Section 201 of the same title appears to place the states in a position of forcing mothers on AFDC to go to work. This could adversely affect the health and welfare of their children.

In summary, I urge that the Committee recommend that the Maternal and Child Health Programs including Services for Crippled Children be administered be one federal agency, the Children's Bureau. I urge that Section 208 of Title II be struck out. I also urge that the language of Section 201 be modified so that the best interest of the child is served through the working or staying at home of the mother to care for him.

I appreciate the opportunity to express these opinions to the Committee.

Sincerely,

R. G. Rice, M.D.,
Chief, Bureau of Maternal and Child Health,
President, Association of State Maternal and Child Health and Crippled Children's Directors.

Congress of the United States,
House of Representatives,
Washington, D.C., September 12, 1967.

Hon. Russell B. Long,
Senate Finance Committee,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman. During the recent Social Security hearings held by the House Ways and Means Committee some questions were raised regarding the adequacy of the grievance procedures in the medical profession. Sufficient information was not immediately available at the time of the hearings to give a full airing to this matter. I requested a report from the medical profession to be later made a matter of public record.

This report has just been completed and is enclosed for your interest. Because the record of the Ways and Means Committee is now closed, may I respectfully request that this report be made a part of the record of the Senate Finance Committee's hearings on the Social Security Amendments?

The source material referred to in the report has been placed in the possession of the Library of Congress with a request that it be made available to anyone interested.

Thank you for your assistance.

Sincerely,

THOMAS B. CURTIS.

THE GRIEVANCE COMMITTEE PROCESS OF THE MEDICAL PROFESSION

(By Edwin J. Holman)

Our society and its systems improve in the testing process. Nowhere is this better demonstrated than in the grievance committee process voluntarily established by medical societies in the United States.

Medicine and the practice of medicine are mysteries to most patients and consequently questions regarding the relationships between patients and physicians are bound to arise. Only one knowledgeable in medical practice is competent to answer these questions satisfactorily. Therefore, physicians have tried to develop a mechanism which would provide a prompt, intimate and accurate forum to help patients understand some of these "mysteries" or unknowns.

Like any program of such magnitude where the provision of personal services is involved and where human beings converse about intimate personal problems, the success and the development of the grievance process is evolutionary. The idea is implemented and with each action a body of knowledge is developed and from that body of knowledge comes improvement and refinement in the process. Grievance committees are comparatively new in the medical profession. They received their first great, nationwide impetus in the second half of this century.

Despite the short time that the grievance committee has been recognized as a necessary service process of the medical society it has come of age. It has and is serving the public; it is making itself known; it is developing procedures that expedite resolution of complaints; it has largely overcome a fear that it would not succeed because doctors would not make findings against other doctors.

From a mere handful before 1950, the number of county society committees now exceeds 825. The volume of complaints received, processed and resolved gives testimony to the fact that they are a service, that they are being used. They are becoming polished with the application of abrasives of criticism whether based on insufficient knowledge, prejudices or honest difference of opinion. As a result they operate more efficiently.

There are 300,375 physicians in the United States. Of these, 266,766 are in active practice.[1] If we assume that on the average, each physician sees twenty patients a day, then there would be 5,335,320 physician-patient relationships a day or 1,947,391,700 in a year. There are over 1.9 billion opportunities each year for a misunderstanding to arise in the care or treatment of patients by physicians.

In addition, the physician is not dealing with a normal individual. The patient is ill; he is frightened; he is concerned. Indeed, the physician himself is not a normal individual in the fullest sense of the word because he assumes responsibility for a judgment—the diagnosis to be made or the treatment to be rendered—which will affect, for good or bad, the life of another human being.

The physician's judgment, his professional medical judgment, is his stock in trade. It must be correct. There is no margin for error; no time or occasion to appeal as the lawyer may, no time to turn around and take another route as the traveler might, no chance to write a revised paragraph as the author might. The physician, behind a cultivated facial facade of reassuring confidence, knows the risks involved, the morbidity and mortality rates and, most of all, he knows that medicine is still very much an inexact science. Finally, it must be recognized that in addition to all other conditions of the physician-patient relationship, the relationship is an intimate human-relationship which is unique.

It is not surprising then that in so many settings under the most adverse circumstances, patients not infrequently gain the impression, rightly or wrongly, that they have been ill-served or overcharged or otherwise put upon. Patient impressions sometimes find justification but most of the time they magnify themselves out of proper, logical or reasonable proportions.[2]

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[1] C. N. Theodore and G. E. Sutter, *Distribution of Physicians, Hospitals, and Hospital Beds in the United States.* American Medical Association, Chicago, 1967.

[2] Edwin J. Holman, "Take Your Medical Complaint to the Doctors" *Today's Health*, July, 1967 pp. 71–72.

Criticism of medical organizations and of individual physicians notwithstanding, medicine is humanitarian. For years, physicians have tried to resolve complaints regarding alleged unsatisfactory medical treatment. "Organized medicine" has worked to develop and implement a mechanism "to clarify and adjust differences between physician and patient, and to assist in maintaining the high levels of professional deportment already established by the Principles of Medical Ethics."[3]

WHAT IS A GRIEVANCE COMMITTEE?

First, it should be pointed out that a grievance committee is the result of a voluntary, altruistic action by a medical society (overwhelmingly, *county* medical societies). Secondly, it should be pointed out that grievance committees are unique to the medical profession. They have no counterpart in any other profession. The dental profession, the automobile and insurance industries, labor—none has a comparable system which provides a forum where a question can be answered, a claim reviewed or a misunderstanding resolved. Admittedly, many professions and occupations have *intra* group disciplinary mechanisms where a member's alleged aberrant or unethical conduct is reviewed but among these other professions and occupations the only recourse open to the dissatisfied recipient of service is to approach our civil courts.

Essentially a grievance committee is a standing committee of a county medical society. It was established and is operating *to prevent or resolve misunderstandings, to clarify and adjust differences between physician and patient, and to assist in maintaining high levels of professional deportment.*

To serve these purposes, grievance committees are empowered to receive complaints, to investigate, mediate, arbitrate, and where necessary, refer them to appropriate bodies for adjudication.

A word of caution is necessary. Grievance committees are not disciplinary bodies. They mediate or resolve. They do not punish. If a recalcitrant member is encountered by the committee, it causes a complaint to be made against him before the ethics committee which alone has the jurisdiction to discipline or recommend disciplinary action. Discipline is an *intra* professional affair. Mediation is *extra*-professional.

In short, a grievance committee is an organized group of individuals, members of the medical profession in a given community, which accepts and reviews complaints or questions, regarding any aspect of medical care given or refused by physicians in the community. A grievance committee is a program whereby patients can ask for and receive answers to questions relating to the practice of medicine with answers being prepared by qualified individuals.

COMPOSITION OF GRIEVANCE COMMITTEE

Committees are composed of three or more members.[4] Obviously, they vary in size as medical societies themselves vary in size. No magic number of members exists. The secret lies in the desire of any number of members to accept and discharge a responsibility properly. Admittedly, a committee can be too large if the volume of complaints is small and if the assignment of individual duties has not been carefully made. By the same token, it can be too small. Each society determines committee size according to reason and experience.

Some medical socities elect members of grievance committees from the membership without qualification being imposed on the candidate. Most societies, however, appoint the members and most societies specify qualifications for the members. Some societies[5] limit membership to past presidents on the grounds that a past president is mature, experienced and, as a past president, more likely to be objective—he has no further political aspirations within the society and may therefore "call the shot as he sees it." Other societies select members because of speciality training and practice, others because of geographical location, (on the ground that the member may investigate conveniently and mediate often, es-

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[3] *Guides for Medical Society Grievance Committees,* Report of American Medical Association Committee to Recommend Standards for Grievance or Mediation Committees, Council on Medical Service, AMA, 1957, p. 7.

[4] For example: Bylaws, Los Angeles County Medical Society (California), Article XII, Section 1; Tulsa County Medical Society (Oklahoma), Chapter Ten, Section 8; Jefferson County Medical Society (Kentucky), Chapter VIII, Article B, Section 1; Kings County Medical Society (Washington), Chapter 8, Section 8.2.

[5] Bylaws, Tulsa County Medical Society (Oklahoma), Chapter Ten, Section 8.

pecially on an informal basis). Age itself plays little or no part in the selection or election of members.

Some societies have a limitation on the tenure of a member, usually two terms of three or five years. One society seeks to limit tenure to one three year term on the theory that more members of the society will thereby serve on the committee and be exposed to the nature and substance of complaints from the public.[6]

PROCEDURE

The bylaws of medical societies establish the grievance committee and outline the procedure it will follow. For example, the bylaws of the Chicago Medical Society merely say that the Committee:

"Shall hear complaints and adjust differences between members of the Chicago Medical Society and the public, such complaints or grievances to be limited to circumstances arising from the rendering of professional services." [7]

The Nassau County Medical Society bylaws provide:

"The committee shall receive complaints from anyone: doctor, layman, group or corporation. The complaint shall be made in writing, unless waived by the chairman, and shall contain a detailed description of the grievance." [8]

The Nassau bylaws provide further[9] that after investigation an attempt shall be made to "mediate the dispute and effect an amicable settlement. This is the main purpose of the committee." However, if the facts indicate a serious difference that cannot be mediated, "the committee shall meet in closed session to consider the case formally." The Nassau County Medical Society, like most societies having grievance committees, makes provision for the situation when a member refuses to cooperate:

"Any member who fails to cooperate with the committee when requested to do so, be it by failing to correspond and/or to appear before it, or by refusing to abide by its judgment, shall be referred to the President with recommendations for disciplinary action by the Board of Censors." [10]

Most grievance committees, for practical reasons, insist that the complainant notify the society or the committee of the complaint in writing.[11] A record is thus made from the beginning.

As grievance committees develop they usually find that the majority of complaints are really inquiries regarding custom, usual fees, legal rights or the like. These inquiries can be answered immediately without the necessity of referring them to the committee. The inquiror is satisfied after having had an opportunity to discuss the matter with someone in a position to furnish an answer. Most grievances are resolved because someone connected with the medical society takes the time to converse with the complainant.

Medical societies having a staff find that staff can provide answers immediately or within a very short time to the individual who, for example, telephones the society's office and says: "I was operated on for appendicitis. My health insurance policy paid me $75.00 but I received a bill from my doctor for $100.00. Can he charge me $100.00?" A few questions, by staff, concerning the insurance coverage involved, provides the opportunity to explain that the insurance policy in question is a contract to indemnify the policy holder against the cost of illness but is not an agreement to pay bills in full or to pay the complete costs of medical care. Many people are still unaware of the differences in insurance coverage and some believe that their policies provide complete reimbursement for all their medical care costs.

Frequently staff will get a call like this: "My husband and I are moving to a new community. I called our doctor and asked him if he would give me our medical records to take with us. He refused. Is this ethical?" A description of the physician's records and an explanation of what they do and do not contain helps to explain why the doctor may have refused. It is pointed out that traditionally and for good medical and psychological reasons, physicians do not give their records to patients.

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[6] Personal Report of Executive Secretary, Multnomah County Medical Society (Oregon), August 1959.

[7] Bylaws, Chicago Medical Society, Chapter XII, Section 7.

[8] Bylaws, Nassau County Medical Society (New York), Article 8, Section 2.

[9] Ibid. Article 8, Sections 2, 3, 4, 5, 6.

[10] Ibid. Article 8, Section 4.

[11] Bylaws, Wayne County Medical Society (Michigan). Article IX, Section 10.

Finally, the inquirer is urged to retain the services of a physician in the new community and then the individual is told that if the new physician will request information from the files or records of the former physician, it will be made available.

Also staff frequently receives inquiries about hospital visits although, according to the patient, "the doctor merely stuck his head in the door and said 'how are you feeling today' and walked on. How come he charged me for that; it wasn't what I'd call a visit." The patient is told that the physician has reviewed his records since the last visit, checked the nurses' notes, studied consultation reports, written new orders on patient's chart, perhaps modified his diet and the like. A great amount of the physician's productive time in the hospital is spent on paper work. Actual bedside visiting, while nice, is not, in most cases truly for patient's *medical* benefit.

The frequency of meetings of a grievance committee does not vary greatly from medical society to medical society. Well established committees usually have one formal meeting a month. Few societies schedule formal meetings more frequently than this, and when a large number of complaints come to the committee for action, they are given an initial review before the entire committee and assigned to an individual committee member for investigation. (It not infrequently happens, that the committee member is able to resolve the matter himself, especially if his preliminary investigation includes a discussion with the physician or patient involved.) Insofar as possible, these assignments are based on practical considerations: The complained against physician and the committee member engage in the same specialty, have staff privileges at the same hospital, practice in the same geographic area or the like. It has been found that an obstetrician can talk effectively with another obstetrician, whereas an obstetrician talking to an ophthalmologist (or some other specialist) is not fully effective. Members are expected to report back promptly and, at least, by the next regular meeting of the committee.

HEARINGS

After a complaint has been submitted in writing, referred to the committee, and informally investigated, an *informal* hearing is held if resolution of the matter has not already been accomplished. Experience indicates that the large majority of hearings are *in camera* based on the investigation and report of the committee member. In this case, the parties do not appear: The complainant's only contact with the committee has been his letter; the physician's contact has been his explanation to a committee member.

If oral presentations to the committee are insisted upon, or if there appears to the committee good reason to hold a hearing to which the parties are asked to be present, there is seldom any confrontation of parties. The complainant appears, states his complaint, is questioned and excused. The physician then is invited to appear before the committee. He, in like manner, presents his version of the situation and, in all probability, is questioned and then excused.

Most medical association committees have been reluctant, because they are doctors, not hearing officers, to hold open hearings where the parties confront each other. The degree of formality necessary to insure order and decorum appears formidable to physicians whose main goal is resolution of a hopefully simple issue and whose fear is the development of a hearing into a "federal case." This idea gains support from reports, and by word of mouth, that when confrontation of parties was permitted, it lead to vituperous verbal attacks that were difficult to manage and control.

Some patients resent the lack of opportunity to hear the physician's statement alleging that their inability to cross-examine permits the physican undue liberty to describe the situation most favorably to himself. Grievance committee members believe, however, that their experience both in the practice of medcine, and as members of the grievance committee, enables them to not only question the parties but to evaluate the situation with objectivity, impartiality and thorough understanding.

The medical society believes, that inasmuch as it is making this service available *as a service* it has the privilege of calling on its experience to implement the service in a practical and meaningful way.

NATURE OF COMPLAINTS

Complaints run the gamut, but fully 90% relate to fees. One complaint submitted by the former husband of patient, who by virtue of the decree of divorce was obligated to pay her medical bills, questioned a $10,000 charge for care given his former wife. A specialist had finally performed a bone graft in the upper left arm to correct the fracture which had resulted from an automobile accident. This was the total fee and covered all treatment and the past efforts to effect a complete cure by less radical surgical procedures. There was no question concerning the ability of the party to pay a bill in this amount; it was "a matter of principle."

In cases like this, the grievance committee has an opinion of the AMA Judicial Council as a guideline. The Principles of Medical Ethics state: "His (the physician's) fee should be commensurate with the services rendered and the patient's ability to pay." [12] The Judicial Council interpreted this language to mean that "although there are some services which are considered invaluable, nonetheless their practical value lies within a range—within limits above or below which a fee is unconscionable. . . . a 'patient's ability to pay' is a secondary factor, one to be considered after, not before, value 'commensurate with the services rendered' is ascertained." [13]

In this case, the local specialty society to which the surgeon who submitted the bill belonged, was asked to ascertain for the grievance committee that range above or below which fees were believed to be unconscionable. The surgeon's fee would thus be evaluated by his "specialty peers."

Patients believe that hospital charges include physicians' fees. In emergencies in particular, when patient is provided hospital *and* medical care at the hospital emergency room—for anything from a toe cut while operating a power lawn mower to the swallowing of a bottle of aspirin by a 2-year-old child—the patient thinks that hospital sutures the laceration or pumps out the stomach. Patient either forgets that a physician's services were required and utilized or believes the hospital maintains a staff of specialists competent to handle all manner of medical emergencies and pays these specialists out of funds charged for the use of the hospital's available antiseptic facilities.

Patients in time of stress, pain and confusion are unable to recall at some later time what services were actually performed and are unaware of services performed in the laboratory or otherwise out of eyesight. Physicians in turn are not known to be especially vocal in explaining to patient or his representative that there is a professional, medical service being performed for which a fee will be charged in addition to the fee by the hospital for the use of its facilities.

Patients have little or no way to estimate what a fee will or should be as they might estimate what a new suit of clothes or a piece of furniture would cost. When they receive a bill for professional services, it may sometimes be more than they expected it to be and then they start making inquiries. The American Medical Association urges its membership to discuss fees with patients and has a wall plaque available to its members which reads:

"To all my patients: I invite you to discuss frankly with me any questions regarding my fees or services. The best medical service is based on a friendly, mutual understanding between doctor and patient."

In its Public Relations Manual for county medical societies, the AMA says:

"Most complaints about the medical profession today are centered about fees. The bill is considered too high or it isn't clear. In most cases, such difficulties could be avoided if physicians explained medical charges in advance. Because many physicians—and patients—are reluctant to broach the subject of fees, the AMA sells an attractive office plaque which encourages fee discussions." [14]

The facts remain that human beings are human beings, that patients are reluctant to discuss complaints with their physician, and that physicians are sometimes noncommunicative, brusque, or even tired and irritable. Medical service is a unique "commodity" which cannot be packaged, displayed, sampled, or priced with predetermined accuracy. Fees, therefore, cause misunderstandings. Lawyers and clergymen know something of this problem also, because their services are personal and dependent on all the facts of a specific, individual situation.

One complaint, recently received by the AMA, concerned a physician's bill in the amount of $308 for "emergency surgery; plastic revision and repair of two inch lacerations, inner and outer upper lip; and U shaped laceration of right

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[12] *Principles of Medical Ethics*, American Medical Association, Section 7.

[13] *Judicial Council Opinions and Reports 1966*, Opinion 5, Section 7, page 40.

[14] *Public Relations Manual*, County Medical Societies, American Medical Association, 1960, page 101.

forehead." A serviceman, on liberty, was riding in a friend's automobile a number of miles from his duty station. In an automobile accident the youth was thrown against the windshield and lost consciousness for a short period of time. After discussion with his friend and highway patrolman, the serviceman elected to be taken to a nearby civilian hospital rather than to a more distant military hospital. The serviceman's parents later wrote that their son was in the hospital less than two hours, "after which he spent 4 days resting and recuperating at his friend's home on doctor's orders." About 10 days later, "stitches were removed in the doctor's office." The parents added "our hospitalization will not cover our son since he is in military service. My wife and I both have to work; we have two younger children to support; we are in no financial position to pay this bill." The service was rendered by a physician specializing in plastic and reconstructive surgery.

This is not a typical complaint. On subjective and personal evaluation a fee is determined by patient to be exhorbitant. But, what were the facts? What care was given? Was other medical service performed beside suturing lacerations? In connection with the lacerations, were they jagged, rough, deep? What was the end result of the suturing? Is there any impairment of function? Is there scarring? What is the usual and customary fee for comparable service by a specialist? The fact that patient, his neighbors or friends think a fee is large, small or just right, really does not establish the correct or reasonable value of the service. The grievance committee, the physician's peers, who understand the components of a fee are the only ones really able to determine the reasonableness of a fee.[18]

Other complaints cover almost every imaginable cause for misunderstanding or displeasure. A husband telephoned the AMA and complained that the physician who had given his wife a gynecological examination was wearing a business suit instead of a white coat or gown. An elderly woman formally complained that her family physician made a professional call dressed in ski togs. (He did. Her call came to his residence on a Sunday morning, just as he, his wife and children were getting into the family car to spend the day in the mountains. On the way to the ski resort, the physician stopped, dressed as he was, to see and console his patient.) A woman complained to the staff of a medical society that a physician had walked off with her cigarettes. Couldn't he afford his own? (She had offered him a cigarette from her pack. He took one and absent mindedly put the pack in his own pocket.)

There are complaints from patients who are dissatisfied with the end result of medical treatment. The young woman who has had facial plastic surgery and then finds that she still doesn't look like a movie star complains to the grievance committee about the incompetence of the surgeon. Some patients complain because of the length of time needed to affect a complete cure; some complain of "stiffness," "tenderness," or the like.

Many people never get around to choosing a physician; many have no family doctor. When an emergency develops and they try to get a physician—usually with a "you owe me a duty to respond" attitute—and are unsuccessful they complain. If they go to a hospital in an emergency, they receive care from a physician on duty (as a public service) and complain because of his fee, manner, personality or the like. The patient complains about these things to the grievance committee and, as a human being seeing the matter unilaterally, judges them to be wrong. Patients more frequently than not, want penalty imposed rather than all facts developed. They write: "The physician should be reprimanded; he should be denied the right to practice; his fee should be reduced." Only a minority of complaints ask if, on the facts as known to the patient, or as more fully ascertained by the committee, the fee was correct; if the treatment was in accord with accepted practice; if there was some valid reason for the physician to act as he did.

There is at least one instance of an employer complaining to a grievance committee that a physician testified falsely before a Workmen's Compensation Committee on behalf of an allegedly injured employee.

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[18] *Young Bros.* v. *Succession of Von Schoeler,* 151 La. 73, 91 So. 551; *In re McKeehan's Estate,* 358 Pa. 548, 57A2d 907; *In re Watzek Estate,* 211 Wisc. So, 247 NW 330.

COUNTY MEDICAL SOCIETY ACTIVITIES

In a survey conducted by the American Medical Association of county medical society activities the following information was obtained:

Grievance or mediation committees [1]

Size of society	Number this size	Number having committees	Percent [2] having committees
1 to 15	472	132	28
16 to 49	411	258	62
50 to 99	176	141	80
100 to 299	179	170	95
300 to 499	53	51	96
500 to 1,499	55	53	96
1,500+	20	20	100

[1] "Nationwide Survey of County Medical Society Activities 1966," staff report, American Medical Association.

[2] Rounded off to nearest percent.

PUBLICITY

Although the American Medical Association Guides for Medical Society Grievance Committees [16] states "this service cannot succeed unless the public knows of its existence and how to use it," not all county medical societies are persuaded that publicity is necessary or desirable.

The AMA guides say that "the availability and method of operation of these committees should be continuously publicized through legitimate channels of lay communication." [17]

The guides suggest that the profession be kept informed of the committee's work by utilizing medical newsletters, medical journals, secretary's letters and the like.

The Wayne County Medical Society notifies its members through an annual report. In the 1966–1967 report of its "Mediation Committee" [18] the following statements are made:

"The Mediation Committee received a total of 44 cases, compared to 40 in the preceding year. The major complaint listed in these cases was not the fee per se, but services or lack of them. In 23 cases the patient questioned the bill because of alleged wrong diagnosis, improper treatment, cursory examination, or no service. As stated by one patient, 'after three operations I felt worse than before so why should I pay his bill?' . . .

"In 75 per cent of these cases the Committee found no basis for complaint and the problem was settled by an explanatory letter. In only two cases did the Committee suggest the physician make an adjustment. In two other cases the physician himself cancelled the balance. Four cases were referred to the Ethics Committee, three because of the doctor's failure to respond and send in the requested information. . . .

"The Committee reaffirmed its previous policy that physicians may charge for release of medical records if extensive information is needed but he should not bill for filling out health insurance forms for which he will receive all or part of the proceeds. For further clarification, the Committee referred the following questions to the Ethics Committee:

"May a doctor refuse to give a patient a letter authorizing him to return to work until his bill has been paid?

"May he refuse to sign a health insurance form unless the patient assigns his insurance benefits to him?"

The extent to which a committee reports in an effort to correct abuse is found in the 1965 report of the Committee on Medical Ethics and Deportment of the Hartford County Medical Society: [19]

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[16] Loc. cit. supra. Note 3.

[17] Ibid., page 15.

[18] Report, Mediation Committee, Wayne County Medical Society (Michigan), 1966–1967.

[19] Report, Committee on Ethics and Deportment, Hartford County Medical Society (Connecticut), 1965.

"CASE 3: In this particular matter, the patient was treated 65 times by physiotherapy for a period extending over one year. During this time, the diagnosis was sprain of the cervical spine with radiculitis. The doctor contended that he was meeting the needs of the patient by rendering treatment when required and could not in good conscience deny the patient treatment from which she benefitted. He also stated that he was aware of the fact that, at a certain point, treatment would be paliative and had pointed this out to the patient.

"*Issue:* Was the physician justified in his extended physiotherapeutic applications?

"*Decision:* The committee noted that at no time did the physician seek the benefit of the advice of an orthopedic consultant. They could not help but conclude that, on the basis of their experience and knowledge of this type of case, the treatment pattern here was designed by financial interest. They noted such other aberrations as the application of physiotherapy in the presence of sprains where no swelling was observed and the extensive physiotherapy to and manipulations of the back when the medical reports did not indicate a back injury. In any case, the physician accepted a considerably reduced fee on orders of the committee."

"CASE 6: A patient had had surgery of the nasal septum performed for which the physician originally charged $350. Later on, in gratitude, the patient asked the physician to increase the sum to $450. However, when the physician did do this, the patient complained to the Association.

"*Issue:* Was the physician allowing a patient to set a fee?

"*Decision:* In the first place, evidence given by the physician himself at a hearing indicated that the patient was an unreliable alcoholic and the physician's assumption that he ought to raise his fee on the basis of this patient's suggestion certainly was not professional. In the second place, the $350 fee which the physician set was unreasonably high for the services performed. So that, even without the suggestion of the patient, the fee in the first place was not warranted by the services. The physician accepted CMS reimbursement of $150 as full payment."

The figures[20] regarding grievances submitted by the Grievance Committee of the Chicago Medical Society to the membership reflect that 418 complaints were received during the year. Forty-six percent involved fees (80% were found to be justified, 20% unjustified), 10% came from "obviously psychotic people" 19% concerned diagnosis, treatment and/or general misunderstanding. The balance were about non-members of the Society; or those members who had not cooperated with the committee; complaints later cancelled; negligence in or refusal to fill out proper medical reports for insurance purposes; or complaints in which no physician's name was mentioned. The report contained this statement among others: "Many complaints could be avoided if physicians would try to be more prompt in filling out insurance forms. A delay in completing these sometimes causes a patient to lose his insurance benefits." Such comments and admonitions, constantly made, remind all physicians of their obligations to their patients.

RELATED MATTERS

All grievance committees consider complaints submitted by patients. Many consider complaints or inquiries from insurance companies and other third parties payors. Larger medical societies, however, have established an additional committee to work with these third party payors. These committees have more highly refined and limited duties which relate almost exclusively to a consideration of fees.[21] The advent of Medicare and Medicaid may call for a further refinement of grievance committee activities and suggest the desirability of further developing the powers and duties of grievance committees.

A portion of the Report of the AMA Committee on the Cost of Medical Care is devoted to review mechanisms established by twelve medical societies.[22] These programs involve liaison with insurance companies and operate much on the order of the usual grievance committee. There is this difference, however, the complainant is not the recipient of medical care but rather the one who paid for that care. The patient whose medical bill is covered by insurance or whose charge for medical service is being paid by another is not usually concerned with the cost. The payor is. To accommodate the party who pays these costs grievance com-

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[20] Report, Grievance Committee, Chicago Medical Society, 1966.

[21] Carlton Smith, "What's the Usual and Customary Fee," *Medical Economics*, August 8, 1966, p. 88 et seq.

[22] Report, Commission on the Cost of Medical Care, Chapter 6, The American Medical Association, 1964.

mittees or the more highly refined review committees consider the complaint of the third party. The patient may never know that any question had been raised about the costs of the care he received.

ACTIONS OF GRIEVANCE COMMITTEES[23]

There is no central repository of grievance committee reports. County society grievance committees report annually to their membership. State society committees report to their parent bodies. No one group has attempted to collect and compile these reports.

At medical society meetings and at meetings of staff personnel serving medical societies and in reports that have been sent to the American Medical Association headquarters it would appear that (1) grievance committees do investigate a sizeable percentage of complaints received and (2) in an appreciable percentage of cases suggest corrective action by the physician, usually a reduction in the size of his fee.

When a physician member of the Chicago Medical Society ignored requests of and recommendations by the Society's grievance committee, it filed charges of unethical conduct against the member before the Ethics Committee. The member was found guilty and suspended from society membership.[24]

The Wayne County Medical Society in 1966–67 referred four cases to the Ethics Committee for inquiry into the ethical propriety of the physicians' conduct.[25]

DUTIES OF GRIEVANCE COMMITTEES DISTINGUISHED

The purpose and function of grievance committees are in the realm of public relations and in fulfillment of medicine's obligations to the public whose individual members place their trust in physicians.

It is important to re-emphasize, therefore, that the grievance committee is a forum in which matters of interest and concern *to the patient* are resolved, i.e. size of fee, availability of service, effectiveness of treatment. The end result of the grievance committee action is to resolve patient's misunderstanding or complaint.

Intra professional discipline is not the function or purpose of grievance committees. Ethics committees (usually called Board of Censors) are the medical society mechanism for imposing discipline (reprimand, censure, suspension or expulsion from membership). The medical staff of hospitals review and evaluate a physician's competence and appropriate committees of hospital medical staffs may recommend limitation of privileges for a staff member or recommended suspension or expulsion from the staff. The entire staff, usually, reviews the recommendation and votes to accept, modify, or reject the committee recommendation. Finally, each state (except Washington) through its board of medical examiners has a mechanism for the suspension or revocation of a physician's license to practice. In Washington this mechanism is in the hands of the Washington State Medical Disciplinary Board.

Violation of ethical principles, bylaws and rules of a medical society, violation of hospital rules and regulations, and violation of provisions of the state medical practice acts can result respectively in the loss of medical society membership, hospital staff privileges or one's license to practice medicine. In any hearing involving privileges of such magnitude the concept of due process must be observed and a more formal hearing, in event a violation is charged, must be provided for to protect the rights of the accused.[26]

CONCLUSION

Medical societies have encouraged the creation, operation and development of committee to entertain and answer questions and complaints of patients. These committees have become increasingly active since 1955. They are still growing and, as a result of experience through the years, are becoming more effective. The most frequent complaint to a grievance committee concerns charges for medical services; patient complains that the fee is too high. A significant percentage of

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[23] Report, Grievance Committee, Chicago Medical Society, 1966.

[24] Opinion in the Matter of the Appeal of ——, M.D., to the Judicial Council, American Medical Association, 1964.

[25] Report, Grievance Committee, Wayne County Medical Society (Michigan), 1966–1967.

[26] For a detailed review of medical disciplinary procedures, and a comparison of them with disciplinary procedures of the legal profession, one might review the Report of the Medical Disciplinary Committee of the AMA, 1961.

complaints are resolved in patient's favor. Many more are resolved by explaining to patient, so he will understand, why the fee was in the amount that it was.

Medical society grievance committees are a public service function of medical societies. As such they provide a unique and helpful service. There is every reason to believe that these committees will provide an ever greater service to the public as they continue to function.

STATEMENT PRESENTED BY LOCAL 1199 DRUG AND HOSPITAL EMPLOYEES UNION, RWSDU, AFL-CIO, NEW YORK, N.Y.

Local 1199 Drug and Hospital Employees Union, RWDSU, AFL-CIO, representing 30,000 members employed in drug stores, hospitals and nursing homes, in the Metropolitan New York City Area, supports S. 2209 introduced by Senator Russell Long and Amendment 265, introduced by Senator Joseph M. Montoya and urges the Senate Finance Committee and the Senate to adopt both.

Local 1199 is the largest employee pharmacist organization in the nation, having nearly 3,000 pharmacist members who are employed in drug stores, hospitals and City institutions. We are convinced that S. 2209 and Amendment 265 make a much needed contribution in coping with the high cost of drugs.

S. 2209 (SENATOR RUSSELL LONG)

S. 2209 is practical and workable insofar as government financed drug programs are concerned. It also makes possible future extension of the benefits of reduced drug costs to the consumer in the provate sector. It provides for safeguarding the quality of drugs to be dispensed. It protects the retail pharmacist against financial loss in dispensing the less costly drugs. In all these respects it meets the test of good legislation in the public interest.

The major causes of high drug costs are the monopoly created by drug patents and the manufactures' practices brought to light in the 1961 report on Administered Prices in the Drug Industry by the Antitrust and Monopoly Sub-committee of the Senate Committee on the Judiciary. There seems to be no chance of changing the patent laws at this time and the manufacturers' practices still exist and result in extending the monopoly of trade-named drugs beyond the life of the patent. S. 2209 would help create competition and lowered drug costs. Its provision that government payments be restricted to less costly but properly standardized drugs will guarantee both economy and safety.

The professional fee concept meets the economic needs of retail pharmacists and should encourage them to support generics under the quality safeguards contemplated by the bill. It is our opinion that retail pharmacy will become effective promotors of generic drugs in their private practice once the professional fee achieves broader acceptance. This can eventually help the consumer ease his burden of high drug costs.

AMENDMENT 265 (SENATOR MONTOYA)

When the Social Security Amendments of 1965 were adopted, it ommitted from Title XVIII-B coverage for out-of-hospital drugs. At that time considerable concern was expressed in Congress and assurances were given that this would be corrected.

Amendment 265 is urgently needed to correct an inequity which imposes a burden on those least able to meet high drug costs. By incorporating the generic drug concept of S. 2209, the costs of this benefit can be substantially reduced. We urge the Senate Finance Committee and the Senate to act favorably on both.

STATEMENT OF THE NATIONAL CONGRESS OF PARENTS AND TEACHERS, CHICAGO, ILL., SUBMITTED BY MRS. EDWARD F. RYAN, CHAIRMAN, NATIONAL PTA COMMITTEE ON LEGISLATION

Mr. Chairman and Members of the Committee, on behalf of the National PTA we appreciate very deeply the opportunity of offering testimony in respect to those portions of H.R. 12080 which affect the welfare of children. The National Congress of Parents and Teachers, whose membership now numbers more than eleven million, has supported federal programs for the health and welfare of children from the beginning of its history 70 years ago.

We wish to offer warm support of some portions of the bill, but we are gravely concerned with the likely effect of some other sections.

Section 201. The purpose of Aid to Families with Dependent Children, as we understand it, is to enable children who have been deprived of adequate support through incapacity of one or both parents to grow to maturity and productive citizenship nevertheless. The additional objective of using the remaining parent and older children of such families to increase the labor force, as set forth in this section, seems to us very likely to impair the primary objective.

The continuous care and attention of the mother of a family is ordinarily needed for the healthy growth of children. If the mother *chooses* to work outside the home as suiting her family situation, and is supported in this choice by sound day-care, counseling, and training programs, the well-being of the children may be maintained. But if this choice is made unwillingly or unwisely, children are likely to be hurt, and the program will lose its purpose of bridging to a mature and competent next generation. We find no safeguard on this point in this legislation.

The interpolation at this point of the second additional objective of an AFDC program, that of reducing illegitimate births, seems to us of doubtful usefulness in coping with a problem of complex origin. We would urge not only a separation of these problems, but further study along the lines of developing security within a family in order to assure its integrity, before legislative action is undertaken.

We do warmly support the increased funds proposed to assist states in providing foster care and other services, and also the proposed 75 percent aid to states for training personnel needed to proivde adequate child-welfare and family services. These are most important and badly needed provisions.

Section 202. We warmly support the proposed earnings exemption of $30 a month plus one third of all other earnings. We believe this incentive and its supporting provisions will tend much more usefully to encourage employment than punitive measures, particularly among those parents who at present live in fear of losing minimum subsistence for their children.

Section 208. We very strongly oppose the provision to limit the number of children in the AFDC program in any state to the percentage of children receiving aid in that state on January 1, 1967. We urge that the proposal disregards the large and continuing migration from rural to urban areas, across state lines, caused by the disappearance of employment through automation of agriculture, mining, and other industry. One such receiving city, Boston, on August 16 already numbered 3,600 more children on AFDC than on January 1, 1967, and increase of 12 percent. We would urge that this group particularly are in need of assistance and education to cope with city living and to meet city employment requirements. If this provision should remain in the bill, either children will go hungry or already overburdened cities will be forced to seek additional funds.

Section 223. We ask the committee to strike this section, which would downgrade the level of health and medical care for AFDC children and their caretakers, the disabled and the blind. We ask that the present comparability provisions be allowed to remain in the law.

Section 235. We warmly approve this proposal to amend Title IV of the Social Security Act to coordinate the various child welfare services with AFDC in a comprehensive program with increased funds and broader services. This is an excellent step which will tend to develop strength in state agencies and a base for greater state responsibility in the future.

We hope very much, however, that the administration of child welfare services, with the recent addition of social services for AFDC children, remains in this Children's Bureau, so that established high standards will be maintained, and the programs will continue to focus clearly on the needs of children.

Section 301. Similarly, we warmly approve the consolidation of programs for maternal and child health services and for services to crippled children. We believe that crippled children should have medical treatment as needed, and assistance to develop as normal children, regarding physical handicaps as noncrippling to life. We have therefore been much concerned by the recent removal of services to crippled children from the Children's Bureau, where we believe this responsibility should remain as a part of the Division of Health Services.

The National PTA believes very strongly that the administration of services to children should be concentrated in the Children's Bureau. However highly qualified a professional staff may be, a thorough understanding of children is indispensable to effective administration of these programs. Dilution of administration with adult programs inevitably reduces the effectiveness of child services. We are deeply concerned that the Children's Bureau retain its responsibilities with enhanced rather than diminished resources, and should greatly appreciate any assistance your committee feels appropriate to that end.

Thank you very much for your consideration of these views.

STATEMENT OF LEWIS F. NICOLINI, DIRECTOR, INDIANA EMPLOYMENT SECURITY DIVISION, AND PRESIDENT OF THE INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

I appear before you today on behalf and as President of the Interstate Conference of Employment Security Agencies which is the official organization of State administrators of the Federal-State Employment Service and the Unemployment Insurance program.

These are agencies that bear in large part the responsibility for eliminating joblessness and I can assure you they were undergoing agonizing self-appraisals long before riots ripped apart some of our greatest cities this summer.

The Interstate Conference shares with you a sincere concern for the well-being of all our citizens though our responsibilities are limited to those who are or should be in the labor force. A part of H.R. 12080 deals with a subject of direct concern to us. That is the Section 409 covering Community Work and Training Programs. We are concerned over the proposal to give the manpower responsibilities to the welfare agencies.

A poll of the States was recently completed by the Interstate Conference. It shows that States are in favor of amending H.R. 12080 to substitute provisions of Section 409 and 410 of H.R. 5710, as introduced in the House, for Section 409 of H.R. 12080, by a vote of 37 States for such amendment, 3 against and 11 not voting. The 37 who were in favor represent 68.9 per cent of the covered workers and 67.8 per cent of the covered employers. Those not in favor have 3.0 per cent of the covered workers and 3.5 per cent of the covered employers. The States which did not vote represent 28.1 per cent of the workers and 28.7 of the employers.

Since the early years of this decade, when the national administration turned the resources of the United States inward in an attack on the causes of poverty and key roles were assigned to the U.S. Department of Labor and the State employment services, we have been concerned that our personnel and programs were adequate to the new challenges. We were not always satisfied with what we found and many changes have taken place. The result has been State employment agencies equipped as never before to attack the defects in our society caused by unemployment and lack of job training.

We are concerned that this readiness be utilized in the demanding job of moving welfare recipients into the mainstream of training and employment and that is why we support amendment of H.R. 12080.

We support specifically the re-instatement of Sections 409 and 410 of H.R. 5710, the administration bill to amend the Social Security Act. The deletion of these vital sections by the House Ways and Means Committee, in our opinion, does not move us closer to the goal of putting welfare recipients on regular payrolls and may in fact, by the creation of an immense duplication of manpower services, move us further away.

The administrative provisions for the community work and training program in H.R. 5710, placing manpower responsibility with the Department of Labor and welfare responsibility with the Department of Health, Education, and Welfare, are logical. These are separate responsibilities which the respective departments now hold and which they have fulfilled well. But, I submit, neither department has the administrative machinery nor the expertise to administer the responsibility now held by the other.

Independent analysis of the administration of Title V of the Economic Opportunity Act, which is devoted to work experience and training, supports my contention. In an "Examination of the War on Poverty" for the Senate Subcommittee on Employment, Manpower and Poverty, printed last month, one consultant found the work experience and training programs to be characterized by poor planning, poor content and poor results. He pointed out that the demands of this program, which has been administered by the Bureau of Family Services through State and local welfare agencies, were beyond the resources of these units.

This was one observation of that consultant, Sar A. Levitan of the George Washington University:

"State and local welfare agencies . . . were ill prepared in most cases to take over a program aimed at preparing participants for economic independence. Though public assistance programs are designed to alleviate poverty, they are not specifically geared to help beneficiaries surmount their situation. The essence of the welfare system is income support and, to the extent which resources allow, limited social services. Welfare agencies had little or no experience with training or placement and awareness of labor market operations."

Dr. Joseph A. Kershaw, former Assistant Director of OEO for Planning, Research and Evaluation, stated at the University of California Conference on Manpower Policy on June 20, 1966, that ". . . in all candor (Title V) has not worked as well as we expected . . ."

Parallel statements, I am confident, would have resulted if the employment security agencies in the several States had been given the responsibility of providing total family services to welfare recipients, a job for which none of us is prepared.

However, we *are* prepared for the job of administering work and training programs. We have a manpower—work and training—program administered through the Department of Labor which incorporates the experience of more than 30 years since enactment of the Wagner-Peyser Act and consolidates and coordinates all manpower programs the Congress has enacted over the past half-decade.

All of us connected with employment programs are acutely aware of the criticisms that our Federal-State Employment System is too old and tired to be the innovative soldier required in an attack on the diverse problems of the disadvantaged citizen. These criticisms did not come entirely from outside our ranks and we know that some were not without some basis in fact.

I mentioned earlier that the 60's have been years of appraisal and improvement for the public employment agencies. We are not satisfied that all is well. I hope we never will be. But the public employment service today as never before is ready, eager and better prepared to accept a full share of responsibility in moving the disadvantaged through the barriers of poverty.

That responsibility is offered in Section 410 of H.R. 5710, which would allow us to give prospective trainees unified and proven manpower services that are removed from what some feel to be the stigma of relief.

The division of responsibilities it provides will work. It has worked. One example of inter-agency cooperation has been arrangements under the MDTA by which employment services and vocational education programs at the State levels now conduct an institutional training program for more than 160,000 persons a year, with more than half of these from the disadvantaged group.

On the other hand, the provisions of H.R. 12080 would ignore the mistakes of the past and mandate a massive duplication of existing manpower programs which would be in competition with them. The result would be a waste of money and manhours and a mockery of the cause this bill supports.

This is no uncharted ocean. The failures of Title V program under the Economic Opportunity Act show that the Welfare Administration, admirably suited for its own programs, flounders when called upon to execute the unfamiliar mission of manpower. It is unfair to place the burden on them.

The two departments have worked many years to perfect their services to the public. I urge adoption of the administrative provisions in H.R. 5710 for the community work and training program to allow us to fully direct those services toward solving one of the biggest domestic problems facing America today.

(The following letter was submitted to the committee by Hon. Wallace F. Bennett, a U.S. Senator from the State of Utah:)

UNIVERSITY OF UTAH MEDICAL CENTER,
COLLEGE OF MEDICINE, DEPARTMENT OF RADIOLOGY,
Salt Lake City, Utah, September 11, 1967.

Hon. WALLACE BENNETT,
U.S. Senate,
Washington, D.C.

MY DEAR SENATOR: The Utah State Radiological Society is a professional organization comprising substantially all of the radiologists in the State of

Utah. Subsequent to their deliberations regarding medicare legislation, I have been instructed to inform you that this organization wholeheartedly favors continuing Medicare, that is, Public Law 89-97 as now enacted withough significant amendments. If other problems make changes necessary, we would support the version expressed in H.R. 12080. The organization opposes the creation of a new part C. Likewise, we feel it would be most unwise to enact any legislation which would convert the practice of radiology into a hospital service by placing radiology in Part A of Title XVIII. Any legislation that would segregate physician services for radiology in any way from services of other physicians is inately discriminatory and would have a serious effect on this important medical specialty.

Respectfully yours,

WM. R. CHRISTENSEN, M.D.,
Counselor, Utah State Radiological Society.

JEWISH FEDERATION OF METROPOLITAN CHICAGO,
Chicago, Ill., September 11, 1967.

HON. RUSSELL B. LONG,
U.S. Senate, Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The Jewish Federation of Metropolitan Chicago, through its affiliate agencies consisting of hospitals, social service agencies, and community centers, serves 212,000 people of all religious and racial groups through a variety of health and welfare services. As such, it has a vital interest in any amendments which may be made in the Social Security Act not only because of its concern for the welfare of people affected by such amendments but also because any retrenchment in the public programs financed under the Social Security Act may create demands for services of voluntary agencies which would be beyond their capacity to meet. Therefore, the Jewish Federation would like to express to you its views on the Social Security Amendments of 1967 (HR 12080) which has been passed by the House of Representatives and is now pending in the U.S. Senate.

This bill does contain many desirable features, along with some undesirable provisions, which in our opinion should be eliminated or substantially modified before final passage:

(1) The provisions pertaining to registration for work and acceptance of employment by relatives (including mothers) of children receiving aid to needy families with dependent children are unnecessary and could lead to the compulsory employment of many mothers, under fear of denial of assistance, and contrary to the welfare of their children. At the present time, mothers who are able to work under arrangements not harmful to their children are encouraged to do so, and there is no need for compulsory legislation in this regard.

(2) The provisions pertaining to aid to children of an unemployed father, which specify that the father must have had at least six quarters of covered employment out of the last 13 quarters or that he must have received unemployment compensation in the year prior to application for aid. These provisions would exclude some young families where the father has not yet had an opportunity to build up sufficient employment experience and would thus deny aid to some families in greatest need of assistance.

(3) The provisions pertaining to a quota on the number of children that may be aided, with Federal funds, on account of absence of the parent—limiting the number of such children to not more than the proportion of the child population in a State that was aided on this account in January, 1967. Under this provision, a State that experienced an increase in the number of children needing aid (on the basis of present standards of assistance in the State) would have to bear the resulting increased cost entirely from State funds. Alternatively, in order to keep the number of children receiving aid because of parental absence within the prescribed limits, the State might have to lower its assistance standards, thus causing hardship for all children receiving aid to families with dependent children and not just those receiving aid on account of the absence of a parent.

(4) The failure of HR 12080 to contain the provision of HR 5710 (introduced on February 20, 1967 and replaced by HR 12080) pertaining to the requirement for meeting full need. This provision in HR 5710 would have required States to meet need in full (as defined by State assistance standards) in their public assistance programs, instead of the present situation where a number of States grant only

an arbitrary percentage of minimum needs. The failure of HR 12080 to include this provision of HR 5710 is a serious omission, which should be corrected.

It is our sincere hope that the views expressed above will be taken into account in any action taken by the Senate on the Social Security Amendments of 1967.

Sincerely,

A. D. DAVIS, *President.*

THE FAMILY SERVICE ASSOCIATION OF WYOMING VALLEY,
September 12, 1967.

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

DEAR SENATOR LONG: The Board of Directors of the Family Service Association of Wyoming Valley has discussed House Bill 12080, the Social Security Amendments of 1967, and has asked us to convey their deep concern about certain sections of the Bill and their support of other provisions.

We continue to endorse Section 401 of Title IV, which authorizes extension of facilities for social work education. This will serve to narrow the gap between needed services and available manpower.

We also support the provisions for increased federal financing for social services such as family counseling, day care, family planning, foster care, protective child welfare services, demonstration and research, and incentive exemption of earnings of families on assistance.

However, *we deplore* the restrictive and coercive sections of HR 12080, which are punitive, negative attempts to reduce assistance costs. Removal of children from their parents and freezing AFDC cases would shift and even increase the financial burden. *Penalizing children is not the answer.* Neither will massive compulsory work programs achieve the desired goal.

We hope you will help to eliminate the coercive elements of HR 12080 and continue to work for the improvements in social insurance and welfare programs.

Sincerely yours,

DR. FRANCIS J. MICHELINI,
President.
DR. FRANK P. SPEICHER,
Chairman, Public Issues Committee.

WISCONSIN WELFARE COUNCIL,
Madison, Wis., September 8, 1967.

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

DEAR SENATOR LONG: The proposed Amendments to the Social Security Act, H.R. 12080, currently having hearing before the Senate Finance Committee, contain many constructive proposals. However, two of the changes proposed are of great concern to us in Wisconsin.

Title II, Sec. 208, p. 140 of the Bill limits the number of children who might receive assistance through Aid to Families with Dependent Children on the basis of the January 1967 ratio of such children to the total state child population.

In Wisconsin, children helped through AFDC increased from 31,462 in January 1966 to 39,397 in June 1967, an increase of 25% in 18 months. There was a 7% increase from January 1967 to June 1967. With such fluctuation in need, an arbitrary freeze would mean that some people who meet eligibility requirements would not receive aid, or that their needs would have to be met solely with state and local funds.

Title II, Sec. 201, pp. 107 ff., and Sec. 204, pp. 120, ff., requires that all adults, including mothers and out-of-school youth over 16, engage in work and training as conditions for receiving assistance, with penalties for non-compliance.

While encouragement of self-support is laudatory, the following points must be considered as a base for legislation:

Presently, only one of every 146 people receiving public assistance is capable, in the usual sense, of going to work. The others are unemployable by virtue of age or handicaps, physical and/or mental. Remedial programs taking these factors into consideration are desirable. Coercion is an unrealistic approach.

The advantages to society of compelling mothers of young children to work are questionable. And, as far as cost is concerned, the Milwaukee County Department of Public Welfare states that group or family day care of pre-school children costs from $90 to $100 a month, while average AFDC cost per child are approximately $45. If a basic concern is to strengthen family life, as stated in the Ways and Means Committee report on the bill, these factors must be considered. Plans for families must be individually determined by workers in the field, under broad legislative alternatives.

Furthermore, in the Report of Committee on Ways and Means on H.R. 12080, on page 105, the following statement appears: "The committee urges that the Secretary of Labor find it possible to classify the beneficiaries of this program as not being included under the Federal minimum wage law."

We object to this approach on the basis that, if people are being trained to perform useful work in society, they should not be penalized for having received assistance.

May I ask that you give these points serious consideration, in your deliberations on the Bill.

Very sincerely yours,

Mrs. J. Cabell Johnson, *President.*

(The following letter was submitted to the committee by Hon. Ernest Gruening, a U.S. Senator from the State of Alaska:)

Sitka, Alaska, *September 2, 1967.*

Hon. Ernest Gruening,
Washington, D.C.

Dear Senator: As a receiptent of social security I am vitally interested in the bill now in the Senate.

Let us cut foreign aid a bit, and raise social security to a decent standard of living.

Yours truly,

Tom Fraser.

State of Utah,
Department of Public Welfare,
Salt Lake City, Utah, September 13, 1967.

Re Proposed Amendments to the Social Security Act (H.R. 12080).

Hon. Russell B. Long,
U.S. Senate,
Washington, D.C.

Dear Senator Long: As Director of the Utah Division of Welfare I wish to protest certain provisions in the Public Welfare Provisions (Title II) of the pending Social Security Act Amendments of 1967 (HR 12080) now before the Senate Finance Committee. In taking this action I represent not only myself but the official position of the State Division of Welfare staff who have studied the new legislation and who have over the past years demonstrated a high degree of professional competency in public welfare administration.

It is our conviction that the present bill, while making additional funds available for programs such as day care, foster care, and social services for needy children in their own homes, creates coercive, punitive, and discriminatory conditions hostile to the welfare of children and the promotion of sound family life. More specifically, we cite the following two provisions as an erroneous attempt to reduce the welfare burden and to force and restrict the indigent into self-sufficiency.

1. *The requirement that all adults on assistance, including mothers and out-of-school youth over 16, engage in work and training (unless specifically exempted for exceptional circumstances) as a condition of receiving assistance.*

Under this provision children would be summarily punished because of the hesitancy of their mother to leave them in the care of others. Refusal of a mother to enter or prepare to enter the labor force of her community could mean:

A. The family being dropped from assistance.

B. The family's assistance grant would be severly reduced by eliminating the mother from calculation of the family budget.

C. The children could be removed from the home by court order and placed in foster care.

The citizens of Utah have advocated and supported, through public welfare and other legislation, the need of children to be cared for in their own homes and the necessity of a mother's presence and love. It is contrary to the best interests of everyone to force all AFDC mothers to seek employment as a condition of eligibility for public assistance. In many families the mothers should remain at home for the best interests of the children.

It is the exceptional woman, with many personal strengths, who can prove adequate to meet the basic emotional and life-preparatory needs of her children while at the same time following a full-time pursuit outside the home. This requirement of the bill would serve only to discriminate further against Utah's most vulnerable group of children—those who not only live in poverty but who are also deprived of the care, guidance, and emotional support of two parents.

2. *The proposal that would make it impossible for illegitimate children or those deserted by their father to receive financial assistance if they happen to fall within a percentage of such children higher than that which was receiving AFDC in January, 1967.*

It is easy to agree on the importance of reducing the serious illegitimacy rate; it is another matter to punish these children for the circumstances of their birth. Society should not treat children in need because of parental desertion or illegitimate birth any differently from other needy children. Children themselves do not create the conditions that control their birth nor their lives *after* birth. This amendment would punish them for these conditions by withholding needed assistance and services which could help them develop into adequate productive adult members of our society.

We believe that H.R. 12080 includes many provisions which are excellent and desirable. These include: An increase in funds and other resources for a variety of social services such as family counseling, day care, family planning, foster care and other protective child welfare services, demonstration and other research projects, work and training programs, training social workers and their aides; and an incentive exemption of earned income. We believe the desirable services and programs will be circumvented, and their effectiveness destroyed if the restrictions in H.R. 12080 are enacted. In this respect, a return to the Burke Bill, or even H.R. 5710 may represent far greater progress for children's services in the states than to enact H.R. 12080 in its present form.

It is our understanding that most social welfare groups and organizations nationally—such as the Child Welfare League of America, the American Public Welfare Association, the National Association of Social Workers, the National Social Welfare Assembly, public welfare departments of most states, and organized labor will oppose the punitive and discriminatory elements of H.R. 12080.

I would like to personally state that reading the restrictive provisions of the proposed legislation is a movement backward in time to when there was a stigma attached to destitution, and it was believed that people could be shamed and beaten into self-sufficiency. Based upon 150 years of experience it has been learned that coercive approaches to the problems of indigency ended for the majority of the poor in dismal and often devastating results.

We are requesting you to support amendments which will eliminate those restrictions which are presently in H.R. 12080; otherwise, the AFDC Program will be chaotic and discriminatory.

Sincerely,

(Mrs.) Algie E. Ballif,
Director, Division of Welfare.

State of Vermont Executive Department,
Montpelier, September 8, 1967.

Senator Russell B. Long,
Chairman, Senate Finance Committee,
Old Senate Office Building,
Washington, D.C.

Dear Senator Long: We here in Vermont are very concerned with certain features of the Social Security Bill recently passed by the House. After a careful analysis of the bill I would like to take advantage of the opportunity you have afforded interested persons to send you these comments on the proposal.

I hope that they will be of some help to your committee in its evaluation of the measure.

(1) *Social Security Benefits Increase.* The bill contains a 12½ percent general benefit increase for beneficiaries and increases the minimum monthly primary insurance amount to $50.00. The level of payments as a result of this legislation will not be increased to offset more than normal cost of living increases. Certainly little impact, if any, will be had to offset the criticism that the level of payments do not meet the commonly accepted standards or measurement of poverty.

(2) *Health Insurance.* (Medicare) The bill makes several minor amendments to the Medicare Program. The administration's recommendation of coverage for persons in receipt of benefits because of permanent and total disability was not incorporated in the bill. The administration's proposed extension of coverage seems perfectly logical in that medical expenditures for this group are abnormally high. Private insurance is difficult or impossible to purchase and the disabled as a group are living on low fixed incomes. These are the same reasons that caused the enactment of Medicare for the over sixty-five age group.

(3) *Aid to Families with Dependent Children.*

(a) The bill seeks to place greater emphasis on getting appropriate members of families into training and employment and thus off the welfare rolls. This would be accomplished by requiring state planning to include basic education, vocational training, day care, homemaker and other supportive services. States would be required to provide state-wise community work and training programs as well as exemptions of earnings. I heartily endorse all of these requirements as tools to enhance our own welfare policy goals of prevention and rehabilitation.

(b) The bill would set national uniform standards for Federal matching in AFDC where the reason for the dependency is the unemployment of the breadwinner. The standards spelled out by the bill are more restrictive and will cause us to utilize general assistance programs to accomplish meeting need in situations that formerly would be eligible for Federal matching. The standards we feel restrictive are those that tie eligibility to the unemployment compensation program and deny assistance to those receiving unemployment compensation. Training and work experience will be allowed only for unemployed fathers who have had recent attachment to the work force, even though those without recent attachment to the work force are those over whom society and public welfare should have the greatest concern. Denying benefits of work and training to an unemployed father who is receiving unemployment compensation is to automatically assume the family is not in need by assuming that this resource meets the need. This is not a sound assumption and can lead to increased family breakdown.

(c) Regarding provisions aimed at a reduction of illegitimate births and prevention of neglect, abuse and exploitation of children, as well as required family planning programs, protective payments on behalf of children and calling unsuitable home situations to the attention of the courts, I wish to voice my enthusiastic support.

(d) A limit on the total number of children from broken homes that will be eligible for Federal matching under AFDC will result in some children in need not being eligible under the federally supported program. Under Vermont law as of October 1, 1968, substitute resources for these children will be general assistance administered and 100 percent financed by the State. This may well mean resorting to two sets of standards, one for AFDC children, and another for those eligible due to Federal limitation. This, to me, is rank discrimination. In most states where the substitute resource is local general assistance, there will be no doubt about existence of a double standard.

(e) The administration proposal requiring the states to meet full need as they determine it was not included in HR-12080. We in Vermont now do this as a result of our new welfare legislation, however, many states do not. Anything short of meeting full need is not a sound national policy because it falls short of a standard of decency and health which every citizen of the United States should be assured.

(4) *Medicaid.* The bill imposes a limit on the extent of Federal matching by setting eligibility income tests that by 1970 may not exceed 133⅓ percent of the standard the State uses for benefits for persons on AFDC. The ceiling on the Federal share of medicaid will not have any immediate effect on Vermont by virtue of our State law provision which requires us to use the lowest acceptable Federal standard. This is the actual amount to meet need, i.e., 100 percent. I do not object to some ceiling and as a matter of fact, I see a ceiling as a sound public policy to preserve the private partnership that exists between private insurance and public benefit programs. Any ceiling, however, should not defeat the purpose of the original legislation which is to afford a protection to the large major-

ity of low income people against bankrupting medical expense. So conservative a ceiling as 33⅓ percent is self-defeating whereas 50 percent as proposed by the administration would not be. Provisions of the new welfare bill in Vermont will require the State to afford protection against bankrupting medical expense to a large majority of low income people. This will be sought to be accomplished by utilizing insofar as possible medicaid, and where not available, general assistance. Eligibility for medical assistance under medicaid were it pegged at 150 percent of actual assistance would over the years be of benefit to people of the State of Vermont.

(5) *Social Security Disability Program.* The bill sets a tighter definition of disability than presently exists in the law. The effect of this on the states will be to require denied applicants to seek public welfare under our State-Federal Aid to the Permanently and Totally Disabled Program. This simply amounts to an abrogation of responsibility on the part of the Federal Government and a pass on of the financial burden to the States.

Sincerely,

Philip H. Hoff, *Governor.*

State of Vermont Department of Social Welfare,
Montpelier, September 15, 1967.

Hon. Wilbur J. Cohen,
Under Secretary,
Department of Health, Education, and Welfare,
Washington, D.C.

Dear Wilbur: I have just completed a reading of your statement before the Senate Committee on Finance on H.R. 12080. On page 8 of that statement you say ". . . Vermont will not pay an AFDC family of four more than $140.00, only 67 percent of its $209.50 monthly needs standard. . .".

This statement is accurate based upon your statistics prior to July 1, 1967, those that you would necessarily have to use in your testimony. I am pleased to advise you, however, that Vermont's General Assembly undertook a total revision of its welfare laws that effective July 1 of this year, repealed the statutory maximums and set a policy of meeting 100 percent of need at current cost of living indices. This policy is presently being carried out and has been since July 1 of this year.

I regret that apparently your staff was not aware of this change in our law and its effect or I am certain you would not have cited Vermont in your testimony. The point the testimony seeks to make is certainly a valid one in that even though it no longer has application to the administration of Vermont's programs, similar circumstances exist in many jurisdictions.

I am sending a copy of this letter to my Congressional Delegation and the Chairman of the Senate Finance Committee for the purposes of correcting the record, so to speak. I wish them to know, however, that I am in complete accord with your testimony that legislation should be enacted that would require the states to meet their own standards of need. Anything less is to accept a standard other than that compatible with decency and health and totally unacceptable as a national policy.

There is nothing more frustrating to a social worker or self-defeating in the social work process than to budget need at $210.00 per month and then have to confront a recipient with the fact that they can only receive $140.00 and will have to get by on it.

Very sincerely yours,

John J. Wackerman, *Commissioner.*

National Association of Social Workers,
September 11, 1967.

Hon. Russell B. Long,
Chairman, Senate Finance Committee,
Washington, D.C.

Dear Senator Long: Our association is very much concerned about some of the provisions of H.R. 12080 just passed by the House. We are writing you in the hope that you will encourage your committee to make some drastic changes in the bill.

We should like to see more of an increase in social security payments so that no social security beneficiaries would need public assistance. We believe this could be done by a gradual increase in general revenues for those already retired and an updated wage base for those still employed. We support the administration proposal for providing Medicare to the disabled which was denied by the House. We welcome the inclusion in H.R. 12080 of aid to social work education, even though we should like to see the ceiling removed since we are very much concerned about the increasing shortage of trained personnel.

However, our main concern is the Public Assistance title of H.R. 12080. The bill states that no state may have a higher percentage of children on welfare than it had the beginning of the year. This would, we believe, force states and localities either to deny additional aid when more children are born into a family or to come up somehow with the money needed to pay the difference. The objective of enabling welfare recipients to obtain productive employment is a laudable one, but attempting to compel mothers to take jobs is not the way to do this. Some mothers should not work. If a mother feels strongly that her place is at home with her children, the alternatives of refusing assistance to her and placing the children in foster ~~homes~~ is highly impractical. Foster homes are difficult to find and very expensive.

We object to the provision to freeze (insofar as Federal financing participation is concerned) the largest AFDC category (absent father) at present proportion of each state's child population. We also object to lowered income ceiling in Medicaid. We hope you will consider our views at the Finance Committee hearing.

Best personal greetings to you. You will recall that I am also from Louisiana (Shreveport).

Sincerely yours,

LEAH HEROLD LACHENBRUCH (Mrs. M. C.).

SOUTH DAKOTA CHAPTER,
NATIONAL ASSOCIATION OF SOCIAL WORKERS,
September 8, 1967.

Re H.R. 12080 Social Security Amendments of 1967.

HON. RUSSELL B. LONG,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The Senate Finance Committee should take a careful look at the changes made by the House Ways and Means Committee in this bill.

We support:

1. Extension and expansion of the Social Insurance Provisions which serve as protection to a major share of the population against the hazards created by our economy.
2. Provision of work opportunities for marginal employees. These should be bona fide jobs to serve the public good and should not be tied to public assistance.
3. Provision of auxiliary services to help families with children (especially those with one parent) in the task of child-rearing, such as day care facilities, homemaker services, and above all, counseling. Such services should reduce the need to separate children from their families and place them in the much more costly foster care.
4. Provision of services aimed at reducing the mounting number of children born out of wedlock, available to families in all economic levels, and not tied to the 15 percent of out of wedlock children for whom public assistance is ever requested.

We protest:

1. The assumption that Aid to Families with Dependent Children is primarily a program for children born out of wedlock. About 83 percent of the children in AFDC grants are legitimate.
2. The assumption that all adults in families with dependent children should work.
   a. Rearing children is an important function. Especially where one parent is left with the responsibility, this may take all the time and energy she has. Families receiving AFDC grants tend to be larger than in the total population.
   b. Many adults in these families have obstacles to employment in addition to their need to care for their children, such as poor health, lack of education or work experience, physical handicaps, minority status, and lack

of skills. Others live in small communities or on Indian reservations where jobs simply do not exist.

c. It has been estimated that by working, it costs a woman $780 a year plus child-care costs plus extra cost of food and clothing for her family when she is not at home to produce for them. The woman with minimal earning capacity will continue to require public assistance even if she is able to get a job.

d. Children who do not have the supervision of their mother in the home may frequently require much more from the community by way of services and concern.

3. Removal of children from their families indiscriminately on the assumption that they will be better off in foster care. Family ties are strong and foster care has been found to be not only a more costly type of care in terms of dollars spent but also more costly in terms of human lives.

4. Additional efforts to secure support from absent fathers, most of whom did not support the family when living with them. Many cannot be found and those who can be are found in penal institutions, mental hospitals, unemployment offices, or overwhelmed with the burden of a second family.

In summary, the net effect of the restrictive measures imposed by the House additions to this bill would seem to be to impose more paper work and shadow boxing on already overworked public assistance workers, producing no constructive results in the lives of the recipients and no significant reduction in public assistance expenditures. A much more productive approach would be to eliminate many of the present technicalities in the requirements for receiving assistance in order to free the workers to be of constructive help to these families, to give the children the best possible chance to grow up as self-respecting, self-supporting and contributing individuals in our society.

I trust that you will reflect the concerns of this letter by representing a force for corrective action with all the energies of your personal conviction and power of your offices and responsibilities.

Sincerely,

ROBERT D. MABBS,
President, South Dakota Chapter,
Director Undergraduate Social Work Education,
Augustana College, Sioux Falls, S. Dak.

TOPEKA, KANS., *August 31, 1967.*

Mr. JOHN GARDNER,
Secretary, Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: The National Governors' Conference has asked that the Governors comment on the pending Social Security Amendments of 1967, H.R. 12080. They have raised ten basic questions to which we have been asked to make a response. In the interest of space and precision; I will follow those questions rather closely.

1. Question: Should the federal government continue to pay the full cost of state consulting services to assist hospitals and nursing homes to become eligible for medical programs or should the matching be 75/25 as proposed in H.R. 12080?

Answer: In that Medicare, which is the program basically responsible for the states needing these consulting services, it would seem reasonable to assume that these consulting services should be paid by the federal government.

2. Question: Should the total number of children from broken homes receiving AFDC benefits be limited?

Answer: To establish such a limitation would be to defeat the general purpose of a good, rehabilitative program. The hope of this country rests with the children and youth. It would be short-sighted of federal and state government to establish such limitations. If a state found itself in a position where the case load increased rapidly early in the year and the approved percentage increase was reached then, the state would have to finance from its own funds any cases added or those children's needs would have to be adjusted according to state or local funds available. The federal government would be discriminating against states with greatest needs and denying its citizen with equal needs access to its benefits. "First come, first served" would be the policy regardless of individual need.

An American family would be brought into court and cited for neglect if it were to decide that only the first two of its four children were to be fed and clothed because they happened to be born after the family had reached the limit of what they could support adequately.

3. Question: Should there be a ceiling on the federal share of Medicaid? If so, should it be limited to 133⅓% of the highest AFDC payments to a family or should it be at a higher level?

Answer: In the interest of planning and budgeting, it would seem important to establish a ceiling on the Medicaid program. However, that ceiling should be carefully established.

It must be remembered that many people who are economically dependent get in that position because of catastrophic and chronic illness. Medicaid was designed to help these people in need and to get them back on their feet as soon as possible. If the family income level is set too low, it would tend to eliminate many of those persons who have a one-shot, catastrophic, illness and consequently, at a later point put them permanently on the welfare rolls.

As these medical programs have operated in Kansas, we have observed that vendor costs tend to go up. Operations tend to double and triple to those persons who are welfare-connected which of course raises the cost of program without providing additional services to the needy.

It would seem that it is of great importance to develop a vendor fee system which keeps fees paid within the same range as those fees paid by the non-welfare connected person. The vendor must assume responsibility for control. The needy person should not be the one penalized.

4. Question: Should the requirement for work training programs for mothers receiving AFDC payments include only mothers requesting the training, mothers of children over 6 years of age, or all AFDC mothers as the bill proposes?

Answer: Mothers on AFDC should have the same freedom of choice that other mothers have. If an AFDC mother wishes to be in a training program then she should have that opportunity. It should not be forced upon her. Some mothers should stay home and take care of children, other mothers should work. The difference between the two will have to be decided on an individual basis.

The training programs will serve a useful function in direct relation to the interest and motivation they stimulate in the mother on AFDC.

5. Question: Should the states with AFDC Programs for unemployed parents receive a bonus—such as higher federal matching grants—in order to reward their progress and encourage the remaining states to adapt the program? Should AFDCUP Program be required in all states?

Answer: The AFDCUP Program should be encouraged and supported. Any efforts we can make to keep fathers in the home should be taken. This program encourages family unity and discourages fathers deserting. With the current discussion concerning male identity figures, this could become an increasingly important program in the states. ADCUP should be made an integral part of the ADC program in order to relieve administrative duplication.

Higher matching grants should be considered for those states supporting such a program.

6. Question: Should the matching ratio on the new self-help program to get people off the welfare rolls be 75/25, 90/10 or some other figure?

Answer: The current rate is 75/25. This seems to be a workable ratio in the states. There would be little justification for changing it.

7. Question: Should the exemption of the full earnings of full-time students as a work incentive under AFDC be extended to the full earnings of part-time students?

Answer: Earning exemptions as work incentives should be made more uniform. Certainly if the full earnings of full time students are to be exempt the full earnings of part time students should likewise be exempt. Students attending school part time are usually doing so because of the need to earn increased amounts, so failure to exempt their earnings would prolong the period of time needed to complete school.

8. Question: Are the new self-help programs to be required of the states the proper types, number, and mixture, or should some be deleted and others added or left as is in the current bill?

Answer: The new self-help programs would require little change in the State of Kansas. However, the language of the bill takes on a very negative tone.

The legislation fails to recognize many of the root causes of dependency. It assumes that all people can be removed from the welfare rolls by punitive measures or by training programs which may or may not equip the person for a job in the future.

The matter of illegitimacy is highlighted in the legislation, but it should be remembered that illegitimacy is on the increase in all segments of the population.

The emphasis upon carefully thought out work training programs, family planning services and counseling is good and should be expanded.

9. Question: Should the bill call for the states to make welfare payments at the level of their definition of need? If so, should the federal share be increased to enable the state to meet full need?

Answer: One of the real failures of the welfare program has been to provide too little and it, too late. People are not motivated by failure, by not having enough to live on, to send children to school, to maintain and retain self-respect. If adjutives of a welfare program are ever to be achieved a basic requirement is that the individual's basic needs be met. When the individual cannot meet them himself it would seem that in a democracy he should be able to have the right to have help in meeting those needs. No amount of service can compensate for an inadequate maintenance grant to a requisite to independency is meeting the individual's need, not just a part of it, but in total so he will be able to use his own capacities and agency services to become self sustaining. The federal share of welfare payments should be increased so that payments will be required to meet in full the states' definition of need.

10. Question: Do the states need greater support for maternal and child health or for training of welfare workers?

Answer: Money for maternal and child health should not be played off against the training of welfare workers. There is a desperate need for both and money should be provided for both.

Thank you for providing me with the opportunity to comment on the legislation.

With every good wish.

Yours sincerely,

ROBERT DOCKING,
Governor of Kansas.

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., September 14, 1967.

Senator RUSSELL B. LONG,
Chairman, Senate Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On June 22 and 23, the Subcommittee on Health of the Elderly, of which I am chairman, conducted hearings on "Cost and Delivery of Health Services to Older Americans." Several witnesses during those hearings made various suggestions for changes in the Medicare and Medicaid programs.

Enclosed is a summary of the major suggestions along this line which were made. This summary is transmitted to you for inclusion in the record of the hearing now in progress before our Committee, if you are so disposed.

With kind personal regards, I am,

Sincerely,

GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly.

[Enclosure]

MAJOR SUGGESTIONS FOR CHANGES IN MEDICARE AND MEDICAID OFFERED BY WITNESSES AT JUNE 22 AND 28, 1967 HEARING ON "COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS"

MODIFICATION OF THREE-DAY HOSPITALIZATION REQUIREMENT

Dr. William A. Nolen, Surgeon of Litchfield, Minn. at gallery 84 testified:

"This man should be in a nursing home. The nursing home will charge for, we will say, two weeks or something like that. At any rate, the total bill for the nursing home would be $1,400.

"Now if he admits that patient to the hospital for three days or whatever the minimum requirement is, he can then transfer the patient to the nursing home and instead of paying $1,400 the patient pays $400.

"In other words, by admitting this patient to the hospital for a workup which is not really necessary but which could be medically justified, he will save the patient $1,000.

"Now in a situation like that what do you do? Do you admit the patient for three or four days of hospitalization so you can save him $1,000 or do you send him directly to the nursing facility?

"These are tough questions in medical ethics."

At galley 35: "I certainly think [abolishing the three-day requirement] would save a lot of money and it would take a lot of strain off of the problem of ethics that the doctors face."

(Also see comments of Drs. James and Roemer on galleys 73 and 74.)

MEDICARE COVERAGE FOR PRESCRIPTION DRUGS

1. Mr. John W. Edelman, President, National Council of Senior Citizens at galley 42 testified:

"The exorbitant prices often charged for drugs are another obstacle in the way of modern health care for the elderly. Drugs the elderly must buy—four out of five elderly have chronic ailments—should be brought under the medicare umbrella."

2. Mr. Cary M. Williams, Suncoast Progress, Inc. of St. Petersburg, Fla. at galley 51 testified:

"One of the most serious of the deterrents to the success of the program in our area is the high cost of prescriptions. These folks just can't afford to pay even $10 or $15 a month for medication. I quote from one of the letters recently received: '... for a whole year my husband had a doctor who constantly prescribed pills. Last November the pills were $12, which we could not afford, so we did not get them. He died February 16, 1967.' As a result, many depend on patent medicines for relief. He goes to his favorite druggist and asks what he would suggest for his particular ailment. It is common practice in this area for a drug clerk to diagnose the ailment and prescribe the medication. This practice negates the visit to the doctor. By all means, the cost of prescription drugs should be covered by Medicare."

3. Sister Mary Vincent, The Cardinal Ritter Institute, St. Louis, Mo. at galley 4—PBE testified:

"Extension of the coverage for drugs to all prescription drugs regardless of their association to a hospital confinement."

4. William R. Hutton, Executive Director, National Council of Senior Citizens at galley 46 testified:

"The high prices of prescription drugs constitute a problem of gigantic proportions. Frequently older people have to make a choice between needed drugs or food. At the present time there is no other country in the world whose prescription drug prices are as high as those in the United States. Congress must find a way to provide the cost of prescription drugs—at least on a generic basis—under the part B program dealing with supplemental insurance."

5. Frank Wallick, Legislative Staff of UAW, at galley 50, testified that his union and its President, Walter P. Reuther, favor this change: "... add coverage for prescription drugs used outside a hospital."

PERMITTING PART B REIMBURSEMENT OF UNRECEIPTED BILLS

1. Mr. Hutton, testifying at galley 47:

"It is often all a low-income senior can do to pay the entire amount of his doctor bill in cash so he can get a receipted itemized statement of services performed by the doctors. For the elderly, the majority living on shamefully inadequate incomes, it is a hardship to pay for major operations and treatment out of pocket and then wait weeks or months for medicare reimbursement.

* * * * *

"The National Council of Senior Citizens has asked Congress to simplify collection of medicare claims.

"Congressman Al Ullman of Oregon, a member of the House Ways and Means Committee, has come up with a plan whereby the doctor would give his medicare patient an unreceipted statement of fees for service that conform to fees that are customary and reasonable. The medicare payment agency would be empowered to send a settlement to the patient for transmission to the doctor."

2. Mr. Williams, testifying at galley 51:

"Very few, if any, of the doctors in our area are willing to accept assignments; and patients are compelled to borrow the amount and to pay interest, often exorbitant, until their claim is settled. The position of the Florida Medical Association is that the patient should be allowed to send in his physician's statement and be reimbursed on that basis, in order that he might pay the physician without undue economic hardship."

MEDICARE COVERAGE FOR ADDITIONAL CONVALESCENT AIDS, PROSTHESES, ETC.

1. Mr. Edelman, testifying at galley 42:

"Proper health care takes in vision, hearing and dentistry. Yet Medicare excludes eyeglasses, hearing aids and dental care. These items must be covered if we are really going to bring modern health care to the elderly poor."

2. Mr. Hutton, testifying at galley 47:

"We believe, sir, that medicare will not adequately cover our older people until its provisions include wheelchairs; eyeglasses; hearing aids; all surgical and orthopedic appliances; and all eye, dental, and drug needs as prescribed by a physician."

3. Sister Mary Vincent, testifying at galley 4–PBE:

"Extension of coverage to all surgical and orthopedic applicanes and such items as wheelchairs, and hospital beds for home use, eye-glasses, hearing aids, podiatry, and everything pertaining to eye care and dental care."

ELIMINATING DEDUCTIBLES AND COINSURANCE

1. Mr. Edelman, testifying at galley 41 and galley 42:

". . . I must in all honesty remind the distinguished subcommittee members great members of elderly are being excluded from the benefits of medicare and medicaid. Those being exclueded are the ones most in need of adequate health care . . .. the numbers may run into millions.

* * * * * * *

". . . can anyone getting social security averaging $84 a month— that is a meager $1,008 a year—find cash for the $40 payment required for hospital admission, the $50 downpayment required on doctor bills, the obligation to pay a fifth of remaining doctor bills, and the $20 payment required for outpatient diagnostic care under medicare?

"We just simply think this is impossible for a great many of the persons eligible for medicare simply on the grounds of inadequate income."

* * * * * * *

"We of the National Council of Senior Citizens urge with all emphasis at our command a phasing out of the medicare deductibles. The way it is now, with deductibles and other restrictive medicare features, we offer the elderly modern health care with one hand and snatch it way with the other."

2. Mr. Wallick, testifying at galley 50:

". . . eliminate co-insurance and deductibles . . ."

3. Rev. Lucius F. Cervantes, S.J., Ph. D., Professor of Sociology, St. Louis University and Assistant to the Mayor of St. Louis, at galley 91 testified:

"There is a consensus of opinion from those that I have canvassed in St. Louis area that— . . . there must be some modification of the coinsurance and deductible principles lest the disadvantaged for whom the legislation was primarily intended suffer rather than prosper from this enlightened legislation."

4. The following appears in a statement for the record by Mary E. Davis, M.S.W., Director of Social Service for the Catholic Hospital Association, St. Louis, at galley 3–PBE:

"'Medicare'—Title XVIII . . . There are deductibles and co-insurance features which were one of several compromises made with providers of services in order to get the bill passed. *No program of medical care should have deductibles or coinsurance*. They are a financial barrier to the receipt of medical care and keep the poor from receiving it."

ENCOURAGING THE PROVIDING OF HOME HEALTH SERVICES

1. The following appears in a statement for the record by Elmer M. Johnson, Associate Director of the Metropolitan St. Louis Hospital Planning Commission, at galley 98:

"Increased use and more appropriate use of home health services could be encouraged at the federal level by:

"Requiring that each medicare certified hospital and extended care facility has a transfer agreement with a home health service agency, or itself provide home health services.

"Adding home health services to the present list of five services that are mandatory under Title XIX of the Social Security Act.

"Developing educational materials and resources for local use in interpreting home health services to doctors and the public.

"Stimulating the establishment of national accreditation for home health service agencies which involves review of patient records by a team of competent specialists in medicine, nursing, physical therapy, etc."

STATEMENT OF THE GOVERNMENT EMPLOYES' COUNCIL, AFL-CIO, WASHINGTON, D.C., SUBMITTED BY JOHN A. MCCART, OPERATION DIRECTOR

Mr. Chairman and members of the Committee, the Government Employes' Council and its 34 AFL-CIO affiliates representing Federal and postal employes appreciates deeply the interest of the Committee in those provisions of H.R. 12080 affecting workers in government service.

At the outset, Mr. Chairman, we wish to reiterate our traditional concern over any action by Congress which could lead now or in the future to consolidation of the Civil Service retirement and Social Security programs.

The philosophies and objectives of the two systems differ. Social Security provides needed minimum protection for workers who are no longer able to work and social insurance for families and dependents of workers who become totally disabled or die before attaining retirement age.

As with any staff retirement plan, the Civil Service system was formulated to recognize long and loyal service for an individual employe so that the worker and his survivors can enjoy a modest income during the later years in life.

With this background, we turn to specific proposals related to the pending legislation.

The Administration has recommended Social Security coverage for Federal employes who leave government service or die before acquiring entitlement to an annuity under the Civil Service Act for themselves and their dependents.

As a matter of principle, this is a desirable objective. The method of achieving this goal is another problem.

Members of this Committee are aware that the relationship between staff retirement plans in public service and Social Security is quite complex. It is our belief that proposals to relate civilian service for the Federal Government to the national social insurance system deserve deliberate and careful scrutiny by Congress before decisive action is taken. The Council feels that proper consideration can be given this and related subjects only outside the scope of the pending bill.

The Administration's recommendations for Federal employes in the field of Social Security will entail an increase in the contribution of each worker covered by the Civil Service Retirement Act.

The financial effect of the Administration's recommendations in this area was discussed fully at the Council's July 11, 1967, meeting. Because of the serious economic straits experienced by Federal workers generally and their failure to acquire salary adjustments contemplated in the Federal Salary Reform Act of 1962, we were forced to the conclusion to oppose any legislative proposals decreasing the take-home pay of postal and other Federal employes until these salary deficiencies are rectified. In short, Federal workers now find it impossible to shoulder additional financial contributions to retirement or other benefits.

Now, we desire to comment on taxes on retirement income. For some years, the Council has advocated removal of income taxes on civil service annuities.

This is now the case with pensions under the Railroad Retirement and Social Security Acts. The exemption was included specifically in the railroad retirement system when that statute was enacted in the 1920's. Application by the Internal Revenue Service of a Supreme Court decision to the social security law in the 1930's resulted in the income tax exclusion on these benefits.

Underlying these actions was the valid premise that income taxes should be based on "ability to pay." We submit, Mr. Chairman, that this rationale applies today with equal logic to the pensions of retired Federal workers.

Approximately 85% of present Civil Service retirees receive monthly benefits less than $150. Out of a total of 234,736 survivor annuitants, 73% have monthly payments below $100. Certainly, the conclusion is justified that these men and women have a very limited "ability to pay."

In a restricted sense, Congress recognized this principle some years ago by approving a retirement income credit for Civil Service annuitants equal to the lowest tax rate on $1,200. Currently, that credit is approximately $1,524.

We recommend, therefore, that the committee incorporate in the current bill complete removal of income tax on civil service pensions.

In this connection, we must express serious reservations over any attempt to remove the current tax exemption for Social Security and Railroad Retirement payments.

The AFL-CIO Executive Council, with President George Meany as spokesman, has taken a strong position opposing such a proposal. Thus, it is unnecessary to elaborate on this point.

Our third recommendation involves amendment of H.R. 12080 to permit retired Federal employes to select Medicare coverage for hospital and medical expenses.

Justification for this choice by Federal retirees is persuasive.

A Federal worker who retires is now entitled to continue his coverage for the plan he has selected as an active employe under the Federal Employees Health Benefits Act of 1954, as amended. However, he must continue to contribute to the subscription rates just as he did while actively employed. A large number of plans with widely varying benefits are available to these individuals while in active service.

The following table provides an accurate picture of the *monthly* expense involved for these annuitants and their dependents for the least expensive and most expensive plans available—

	Low option		High option	
	Minimum	Maximum	Minimum	Maximum
Self only	$2.58	$9.01	$3.12	$12.07
Self and family	6.76	29.88	7.67	31.01

Even in the Retired Federal Employees Health Benefits Program approved by Congress in 1960, the premium costs for annuitants can involve financial hardship.

The Civil Service Commission has recently revised the regulations governing the retired workers plan to coordinate it with Medicare so that annuitants' premiums under the Civil Service system are reduced. Despite this action, a retired Federal worker desiring basic and major medical coverage for his family must contribute $14 monthly to retain this benefit.

We recognize, of course, that there is a wide diversity in the types of plans available—from simple payments for hospitalization for short periods to intensive, comprehensive prevention, medical, hospital surgical care. But in terms of cost alone, some Federal retirees are seriously overburdened financially.

Reverting to our earlier comments on the amount of monthly benefits received by former employes and survivors under the Civil Service retirement program, we find some revealing figures.

More than 100,000 pensioners and approximately 173,000 survivors have monthly payments of less than $90. Certainly, their ability to insure against the costs of medical and hospital care is extremely limited. Paying the premiums computed monthly may in many instances result in insufficient food, clothing or inadequate shelter.

In the 1965 Social Security amendments, Congress provided Medicare benefits for a small number of Federal annuitants who had not selected a plan under the health benefits program sponsored for Federal employes.

In addition, Medicare is now available to large numbers of citizens who have never acquired Social Security entitlement.

The Council does not propose that the Medicare program be extended to all retired Federal workers. We do advocate that they be permitted to select the Medicare plan as a means of obtaining necessary medical and hospital care if they find it impossible to carry the financial burden of continued Federal health benefits coverage.

We trust sincerely, Mr. Chairman, these observations and recommendations will prove helpful to the Committee in its deliberations on H.R. 12080, a bill of vital interest to all Americans.

STATEMENT OF THE MEDICAL COMMITTEE FOR HUMAN RIGHTS, CHICAGO, ILL., SUBMITTED BY QUENTIN YOUNG, M.D., NATIONAL CHAIRMAN

The Medical Committee for Human Rights, an organization of physicians and other health workers devoted to fulfilling the health rights of all the citizens of the United States, has a special interest in the proposed amendments to the Social Security Act, HR 12080, under consideration by the Senate Finance Committee.

We support the principle that health care is not, as the President of the American Medical Association would have us believe, a privilege, but a right guaranteed by society to every individual. Within the past decade that principle has become an established goal of our society supported by much enlightened Federal legislation. The Medicare and Medicaid Acts are strong evidence of our peoples' commitment to good health.

In recent years our country has come to recognize a new group of people in its midst: the medically indigent. They have been recognized by the coincidence of several events: increasing health surveillance has led to a greater recognition of disease; with scientific advances, formerly untreatable and unpreventable diseases have yielded to treatment and become preventable; as the general quality of our life has improved, so have our expectations of good health; and finally, and most important, the cost of providing health care has risen far faster than the income of the majority of citizens. At the same time, sickness remains democratic, striking the poor and already unhealthy at least as hard and often harder than the more affluent. Medical assistance programs under welfare laws have provided free care for many of these people, but a larger group which cannot meet welfare standards cannot afford adequate medical care. It is the clear intention of the Medicaid Act to provide medical care for this already significant proportion of our population.

There is a cycle in our society: a child in poor health does not learn well in school; he is therefore less able to hold a good job or to provide for himself or his family adequate shelter, food, and medical care, and his children will then re-enter the cycle. Medicaid was designed to break that cycle.

We believe that the proposed amendments to the Social Security Act, HR 12080, violate the spirit of the law and our commitment to good health care for our citizens. The standards for an adequate program to cover the medically indigent must certainly be assessed from time to time and be changed to meet the changing needs, but we feel that the proposed limit of coverage is thoroughly unreasonable. It is based on an arbitrary and fixed ratio of the difference between absolute and medical indigency which does not accord with reality. If passed, it not only will remove from eligibility large numbers of people benefitting presently, but it will actually set standards lower than the majority of current state medical assistance plans. This will make a mockery of the law, a step away from caring for the medically indigent and a step back from better health.

The Medical Committee for Human Rights believes that Section 201, requiring mothers receiving AFDC to work, is thoroughly unsound. In our society, a child's mother has long been considered the best caretaker. When both parents in an affluent family work it is difficult enough to find a good caretaker. The surrogate parents available to families of low income are most often aged or sick relatives or older siblings who are themselves unsupervised. Under the best of circumstances the prolonged absence of a mother can be devastating to a child. Psychiatrists and psychiatric social workers recognize that often it is most important for the health of a child for a mother not to work in order to care for a child even if it means she must go on welfare. Furthermore, the law will effectively prevent the mother from choosing the person to whom she will entrust her child. The proposed and as yet non-existent day care centers, considering the already low funding for poverty programs, are likely to become the grim, Dickensian institutions which promote mental retardation and emotional disorganization rather than wholesome development.

Section 208, limiting the Federal participation in AFDC programs based on the present proportion of recipients, seems to us an arbitrary and unfair restriction not at all designed to bend to local needs or changing conditions, and it will inevitably deprive innocent children of proper care.

We believe that the savings projected under these amendments are indeed false economies, for the medically indigent today are the welfare recipients tomorrow, and the emotionally deprived and neglected children today are the criminals and mentally and emotionally retarded wards of the state tomorrow.

STATEMENT BY E. H. GOLEMBIESKI, DEPUTY DIRECTOR, NATIONAL REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman, the American Legion appreciates the privilege to make known to the Committee at this time its views on and its reaction to those legislative proposals and others that would authorize the Veterans Administration to be a provider of services for the purpose of payment or reimbursement under the health insurance provisions of title XVIII of the Social Security Act as amended by PL 89-97.

At the present, the provisions of subsection (b) of section 1835 of the Social Security Act state:

"No payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense."

In our statement of April 21, 1967 to the Chairman of the Ways and Means Committee, House of Representatives, we voiced strong opposition to section 120 of HR 5710, which would have removed the prohibition against authorizing the Veterans Administration hospitals to be providers of service for the purpose of reimbursement or payment. Our statement opposed, too, that provision of HR 5740 which would amend title XVIII of the Social Security Act, to the extent that it applied to the Veterans Administration, to provide that services furnished by a Federal hospital may be covered under the program of hospital insurance benefits for the aged in cases where there is a critical lack of space in the other hospitals in the area.

As you know, Mr. Chairman, the Veterans Administration was established by the Congress as the single agency with the exclusive responsibility and mission of serving veterans, and their dependents and survivors. The history of facilities for the care and treatment of veterans immediately following World War I—in fact, even immediately following World War II, at the time of creation of the Veterans Administration Department of Medicine and Surgery—substantiates the wisdom demonstrated by the Congress when it established the Veterans Bureau in 1921, and then the Veterans Administration in 1930.

As early as 1949, the Hoover Commission recommended a United Medical Administration, in which major Federal hospital programs would be consolidated and in which the Veterans Administration hospital system would be given the responsibility for providing medical care for merchant seamen and other nonveterans. This concept was vigorously opposed by The American Legion, on the premise that it would be in basic conflict with the traditional policy that the Veterans Administration as established by Congress should continue as the single agency with the exclusive responsibility and mission of serving veterans.

As recently as the 49th National Convention held in Boston, Mass. August 29, 30, 31, 1967, The American Legion restated its longstanding policy to oppose those reorganization plans, administrative or legislative, which would remove from the Veterans Administration any of its responsibility of serving veterans and their dependents or which would cause the Veterans Administration to share this responsibility of service with other agencies of the Federal Government, or which would dilute its service to veterans by providing care and treatment in its hospitals to those who are nonveterans.

Our constantly growing veteran population with increasing numbers of service-disabled, and the growing numbers of those who are unable to receive nonservice-connected care in community hospitals because of their inability to meet the high cost of such care, and the obligation owed these by the Nation because of their honorable service, demand unequivocally that the Veterans Administration, with its system of medical and hospital facilities second to none, be retained as the single Federal agency with the singular mission of caring for veterans and no others.

In conclusion, Mr. Chairman, The American Legion maintains the firm belief that the authorization of nonveteran care and treatment in Veterans Administration hospitals and medical facilities, along with removing the prohibition against its being a provider of service under title XVIII of the Social Security Act for the purpose of reimbursement or payment, would lead, inevitably, to the dismemberment or disintegration of the Veterans Administration. Since control invariably follows money, in time the Social Security Administration would demand a voice in the administration of the VA hospitals and extended care facilities.

For your information, Mr. Chairman, I enclose a copy of Resolution 315, approved by the 1967 National Convention of The American Legion.

Again may I say thanks for this opportunity to explain our opposition to any plan, program, or legislation which would detract from the unique purpose of the Veterans Administration. Should you need a further explanation of our position, please do not hesitate to let us know.

NATIONAL GRANGE,
Washington, D.C., September 20, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Grange is aware that the list of witnesses concerning Social Security legislation currently before your committee has been closed, and we appreciate the opportunity, nevertheless, to present some suggestions on this subject to the committee which we hope will be made a part of the record and will receive the same consideration that would be received had this testimony been presented in person. We are sure that this will be done, and we are grateful for that assurance from members of your staff.

Social Security is a subject which has drawn considerable attention during the last several sessions of the National Grange, and I would like to use this means of transmitting the thinking of the Grange to you and through you to the Committee.

Without any question, the cost of the social security tax 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 American farmers, they are naturally and rightfully concerned about the increased costs of any segment of their living.

However, they are also concerned about their own future security and are caught in the same troubled quandary that you and the Members of your distinguished Committee are facing at the present time—namely, how to increase the benefits under social security without increasing the costs. As a result of this quandary, the Grange passed the following resolution at its 100th annual session in Minneapolis last fall:

"RESOLVED, that the National Grange recommend the most careful study by the Congress before any further increases in benefits are allowed."

We are not being so presumptuous as to indicate that a responsible committee of the Congress is not going to give this subject its most careful consideration, but we are at the same time pointing out that, despite our concern over the costs of the benefits, the Delegate Body of the National Grange did not close all their options and oppose an increase. I interpret this as being rather a note of confidence in the Congress that they will carefully investigate the cost before adding any additional benefits.

After listening to the debate on this subject, both in the committee and on the Floor of our convention, I would interpret their action as meaning that they are hopeful that there will not be an increase in the rate. This, is our judgment, would not rule out the possibility that there might be an increase in the taxable amount which would give some additional income to the social security funds without increasing the rate of the amount that is being taxed at the present time.

Of almost equal, if not greater concern, and especially if we look at the re-recurrence of this concept in our resolutions, has been the objection of the Grange to the low amount of earning which is permitted while the recipient draws social security benefits.

The Grange makes a suggestion at this point. The breadwinner of the family could earn the same amount while receiving social security benefits as he (or she) and his (or her) spouse could earn collectively at the present time and still qualify for social security benefits.

However, in the next paragraph of the Grange resolution, our Delegate Body specified a minimum amount that could be earned when they stated:

"RESOLVED, that a change be made in the present law which would allow the combined income of a married couple over and above social security to be $3,000 and the same could be earned by either spouse or a combination of their two incomes, thus removing the discrimination against the one breadwinner."

What these proud and independent people are trying to say in their own language is that the present social security payments are not adequate to maintain them in any kind of decency under present conditions. At the same time, they are saying that they do not want to draw more social security, but would rather maintain their independence and their earning ability as long as they have the earning capacity.

We note with interest that the proposal for government salaries would start office boys with this amount.

We recognize that when the social security law was passed that there were other social factors that were involved, one of them being the high proportion of unemployed in the United States. It would seem obvious to us at the present time, that with this change which we have seen during the last few years when the unemployed employables are at probably a minimum number possible in a free society, that the social objectives of getting someone to quit work at 65 to make room for younger people is no longer as valid as it was. This is particularly true if the person is self-employed.

Therefore, it seems logical and reasonable to us, that in the present period of high employment plus relatively high costs of living, that considerable flexibility should be written into the law to permit the elderly retired people to earn a combination of social security benefits plus earn income that would place them at least a couple of steps up the economic ladder 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 believe the payments should be raised in the amount specified in H.R. 12080 before your committee, and we would support these provisions of the bill. We would, however, hope that you could see fit to consider the increase in the allowable earnings which would not cost the taxpayer any additional money and which would go a long way toward completely removing the possibility of those who are without additional resources being limited to an unreasonably low earning and total income level during their declining years.

We would also point out that this provision would not affect many of these people very long, but in the case of some self-employed people and some who are not self-employed, it would permit them to extend the time in which they could live with increased decency and dignity—the real objectives of this legislation in the first place.

With grateful thanks to you and the members of your committee, I remain,

Respectfully yours,

HARRY L. GRAHAM,
Legislative Representative.

STATEMENT OF THE NATIONAL CONSUMERS LEAGUE, WASHINGTON, D.C., SUBMITTED BY MRS. SARAH H. NEWMAN, GENERAL SECRETARY

The National Consumers League which has, since its establishment in 1899, fought for the improvement of working and living conditions, and for the assurance of a minimum of security for all Americans, particularly those at the bottom of the economic scale, wishes to go on record for restoration to H.R. 12080 of *at least* the full scale of benefit increases proposed in H.R. 5710 at all levels. There can be no question that the time has come to overhaul and fortify the Social Security program, created by the Congress in 1935. In spite of the fantastic growth of our economy, and the somewhat more equitable sharing of our nation's wealth, the prosperity for many has still not fulfilled the promise for many more. Poverty, disease, ignorance, the cruel insecurities of old age are all still too prevalent for the wealthiest nation on earth to tolerate.

Thanks to the great strides made by our prosperous nation in the areas of better housing, food, medical care and research, our citizens now live a fuller, longer life. The elderly now make up a larger portion of our population. Today one-seventh of all American families are classified as aged. And for the overwhelming majority of the aged, Social Security provides their only income. Surely, this portion of our citizenry deserves a finer last chapter to their lives than is now possible under the present Social Security System.

Today, there are 22 million Americans on Social Security. The great majority of these are elderly retirees. Yet, a recent statistic of the Social Security Administration pointed out that the aged comprise one-third of all *poor* families. Their plight is a pitiful one. The average weekly payment to a single retired worker today is about $20 a week. For a retired couple, it is $33.50. For the two-and-a half million widows under Social Security, the average monthly payment is $74.00. Most of us, try as we may, can hardly visualize life under such meager incomes.

The Department of Labor budget for a minimum adequate living for an elderly retired couple is based on $3,500 yearly in a large city, and $2,500 in a less urban locale. This budget allows only one-half pound of meat and 2 eggs daily—and that, for two adults. It allows the woman three dresses a year, which includes her house dresses. The man could buy a new coat once in nine years. For recreation, the couple can perhaps have an outing to the movies once a month. This provides a bare minimal life. Yet, a recipient of the average Social Security benefits could not afford even such a meager existence. His income provides only two-thirds of this minimal budget.

Although average wages have risen more than 55% since 1954, the Social Security increases have equalled only 14%. These benefits have been buying less each year. The 15% average increase provided under H.R. 5710 would finally have brought some much-needed, much-deserved relief to this neglected portion of our population, who have contributed so much to the nation's economy during their productive years. The 12% increase voted by the House of Representatives is grossly inadequate, raising the minimum monthly payment from $44 to only $50 a month. Even the $70 minimum requested by the Administration is far below the poverty line.

Some of the specific provisions which the National Consumers League heartily endorses for inclusion in H.R. 12080 are mentioned below:

An increase of *at least* 15% in all benefits.

An increase in the minimum benefit level to $70 for an individual, and $105 for a married couple.

An increase in the minimum benefit level for retired persons having 25 years of covered employment to $100 per month for an individual, and $150 for a couple.

For persons aged 72 or over, who do not have enough covered employment, an increase to at least $50 per month.

Payment of Social Security benefits to severely disabled widows under 62.

Extension of coverage to one-half million additional farm workers.

Inclusion of the original amendment in Sec. 115, Part 1 of Title I of H.R. 5710 which reduced from $150 to $50 the earnings figure which determines coverage of agricultural workers. This would partly correct the gross injustice done many farm workers whose meager earnings are so frequently not credited to their Social Security accounts.

Temporary assistance to migratory workers and others who are ineligible for state's assistance because of state residence requirements. H.R. 12080 lowered the period of temporary assistance from 60 days to 30 days per year and introduced the principle of 50% matching Federal funds—all in all making aid to migrants less certain and for a shorter period.

Extension of hospital and medical insurance to cover the 1.5 million disabled beneficiaries.

An increase in earnings exemptions allowed Social Security recipients.

Changes in Medicare to pay for certain diagnostic treatments and services on an out-patient as well as an in-patient basis.

The League feels that prescription drugs, orthopedic appliances, dentures, eye glasses, etc., should also be covered and that the deductible and co-insurance features should be rescinded. There has been ample testimony that the admin-of funds that the deductibles result in no savings of funds. In addition, these features act as deterrents to early care for the elderly which might prevent greater expenditures later.

The National Consumers League is greatly troubled by the concept of public welfare expressed in H.R. 12080, which would force mothers into training programs and to accept jobs deemed "appropriate". Worse, yet, is the freeze on welfare payments to dependent children which would punish the unborn by eliminating Federal aid for any additional children. Instead, we endorse improved public assistance payments and more day-care facilities for children, thereby freeing mothers for training programs.

All these steps are necessary to bring the Social Security program up-to-date so that it can provide economic security in old age, or upon the death or disability of the breadwinner. In this wealthy nation, we *can* achieve a life of decency and dignity for all.

The National Consumers League urges your Committee to restore the funds and reinstate the other provisions proposed in the original Administration Bill.

(The following letter with attachments was submitted to the committee by Hon. Hiram L. Fong, a U.S. Senator from the State of Hawaii:)

HONOLULU, *September 14, 1967.*

Hon. HIRAM L. FONG,
U. S. Senator,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR FONG: I am very concerned about the effect of some of the amendments to the Social Security Act, particularly the Public Welfare Amendments on the implementation of public welfare programs at the State level.

I am attaching a copy of Hawaii's comments on significant sections in the bill with which I am sure you would want to be familiar as the legislation progresses in the Congress.

Any efforts which you can undertake toward amending some of the restrictive and regressive proposals will be appreciated.

Warmest personal regards. May the Almighty be with you and yours always.

Sincerely,

JOHN A. BURNS.

[Enclosure]

HAWAII'S COMMENTS ON H.R. 12080, 90TH CONGRESS, FIRST SESSION

TITLE I—OLD-AGE, SURVIVORS, DISABILITY, AND HEALTH INSURANCE

PART 3—HEALTH INSURANCE BENEFITS

Method of Payment to Physicians Under Supplementary Medical Insurance Program

SEC. 125. This appears to be a desirable change. Any relaxation of the provision in SMI concerning payment procedures will undoubtedly make the program more acceptable to the medical profession. In Hawaii, the most often heard complaint about Medicare is the amount of paper work generated in order to make it possible for the physician to collect his bill. The vast majority of physicians in Hawaii do not charge more than what would be considered reasonable and customary and for that reason would probably be willing to accept the carrier's determination of a reasonable charge.

Transfer of All Outpatient Hospital Services to Supplementary Medical Insurance Program

SEC. 129. The transfer of the hospital outpatient diagnostic services to Part B from Part A seems to us to be a logical change. The fact that they will then be covered under the deductible and co-insurance features in Part B will probably result in some liberalization from the patient's standpoint because his outpatient services will only be subject to one deductible instead of two.

Extension of Maximum Duration of Benefits for Inpatient Hospital Services to 120 Days

SEC. 137. We favor this amendment. While the projected increase in the number of days of hospitalization would apply to a relatively small number of cases, these are the ones who may need it most. As an individual's medical bills extend to this period of time, the co-insurance becomes very expensive.

Experimentation with Hospital Reimbursement Methods

The payment of reasonable cost for inpatient hospital care has been criticized because no effort has been made to control poor, inefficient administration. The reasonable cost having now been extended to Title XIX programs for inpatient hospital care becomes doubly important for the Federal government as well as the various State governments to seek solutions for this problem.

We foresee increases in overall hospital costs during this fiscal year of as much as 20 per cent. Any brake that can be found to slow down the rising cost of hospital care will be helpful to all states.

TITLE II—PUBLIC WELFARE AMENDMENTS

PART 1—PUBLIC ASSISTANCE AMENDMENTS

Programs of Services Furnished to Families With Dependent Children

Responsibility is placed on state welfare departments for the initiation of programs, which may or may not be essential to meet the individual state's needs, and may be a duplication of services already available through other public or private agencies. We recommend that rather than include specific administrative direction on the type of programs and the methods of organization, the law require assurances that states will take administrative action best suited to meeting their individual problems toward helping families to become economically independent.

SEC. 201. The requirement that states furnish Child Welfare Services which would contribute toward getting families off assistance rolls seems inconsistent with the goals of Child Welfare Services and therefore needs further clarification. Child Welfare Services, as presently defined at the Federal and State levels, are those services in behalf of children which will insure that no child will be deprived of his own home and the care and supervision of his own parents because of financial need and only if his own parents are unable because of factors other than financial need to provide proper care and supervision, shall substitute parental care either temporarily or permanently be made available. Child Welfare Services have never had as their objectives getting families off assistance, but rather preservation of the family home for all children using financial assistance as one of the tools toward that goal in the best interest of the child.

Earnings Exemption for Recipients of Aid to Families With Dependent Children

SEC. 202.1. We recommend that the exemptions of the full earnings of full-time students as a work incentive be extended to the full earnings of part-time students to encourage use of educational opportunities.

2. We recommend that the amount of earnings to be exempted for adults in AFDC families as a work incentive be modified. The amendment creates further inequities in relation to a basic standard of living to which families are entitled as it makes the standard of living dependent on whether the family members are able to obtain employment (physically, mentally, by age and skill) and on the labor market.

Dependent Children of Unemployed Fathers

SEC. 203. This amendment appears undesirable as it could result in the elimination of federally matched assistance to children presently eligible on the basis of the unemployment of the breadwinner. The majority of the children who qualify under this condition have fathers who have not because of their lack of skills and education had "a substantial connection with the work force" nor "have had a year and a half of work during the three year period ending in the year before assistance is granted." The condition exists not because of their refusal to work but because the labor market does not have jobs for which they can qualify. Should this amendment go into effect in October 1967, most states with AFDC–UP programs would either have to meet the needs of these families and children from state and local funds or let them starve unless the father deserts, thus creating whole new sets of problems.

Community Work and Training Programs

The establishment of Community Work and Training Programs by public welfare agencies in every area of the State where a significant number of AFDC families live as a requirement appears unsound.

SEC. 204. The establishment of such programs should be coordinated with the work experience projects and the work and training projects already in operation through other state and federal departments, such as state department of education, state and federal labor and vocational rehabilitation agencies, and private organizations. We recommend the legislation be limited to requiring the state to give assurances that adults and children over sixteen will be expected to use work and training resources available when use of such resource is appropriate.

We recommend that the requirement that all AFDC mothers participate in work and training programs be eliminated. Participation in such programs should be determined by the individual home situation and the need of the family.

Federal Participation in Payments for Foster Care of Certain Dependent Children

SEC. 205. The present law and the administrative requirements with respect to federally matched payments for children in foster care under the AFDC program have not been satisfactory. Many states believe in the principle that foster care is a temporary measure for helping parents to improve their situation so that the children can be returned to their care and that recourse to the courts is a last resort. The amendment appears to perpetuate and expand a program that is not geared to the best interests of children and their right to their parents and their own homes.

It also encourages the development of foster care services for economically needy children to the exclusion of non-needy children by providing matching Federal funds for administrative costs of Child Welfare Services to needy children.

To tie Federal matching funds to a criteria which limits such funds to economically needy children perpetuates the inequities on the part of the Federal Government in its financial responsibility for participation in the costs of services and foster care board payment for any child regardless of economic need for whom foster care is in his best interests.

Emergency Assistance for Certain Needy Families With Dependent Children

SEC. 206. Most crisis situations in families occur as an end result of long time deprivation. Help for 30 days will not solve the problems of long standing which created the crisis. If the purpose of the amendment is to provide immediate help on the basis of presumptive eligibility with Federal matching for necessary vendor payments by purchase order, it is contrary to the present effort of providing for emergency needs with immediate cash payments. The limit of 30 days assistance defeats the purpose of AFDC as a rehabilitative program geared toward providing the necessary services to prevent crisis situations through strengthening family life and employment potentials.

Protective Payments and Vendor Payments with Respect to Dependent Children

We recommend the deletion of the requirement that states provide protective payments and vendor payments to protect the welfare of children.

SEC. 207. If parents are unable to provide adequate parental care to the extent that children are neglected, abused or exploited, they should be provided with substitute parental care.

Giving payment for these living requirements to a third party does not correct parental neglect.

Limitation on Number of Children with Respect to Whom Federal Payments May Be Made

SEC. 208. We recommend the deletion of the amendment. It limits the number of minor children deprived of parental support due to the absence of their father, eligible for federally matched assistance. No child should be deprived of food and the necessities of life on the basis that he does not fall within an arbitrarily established quota of children. The criteria for Federal matching funds should be based on the child's need for financial assistance, not the cause of the need.

The State of Hawaii has always accepted its responsibility for providing for the needs of dependent and neglected children through legislation and appropriations. Its participation with the Federal government in financing the programs for children has contributed immeasurably to the quality and quantity of these programs. We firmly believe that the only criteria which should be considered for eligibility either for funds or services is need for funds and/or services. We have advocated the elimination of categorical requirements for Federal financial participation in the cost of such programs. It would appear that the intent of these amendments is to place further restrictions on eligibility for Federal matching funds by the introduction of additional conditions of eligibility unrelated to need and beyond the control of the applicants.

Federal Payments for Repairs to Home Owned by Recipient of Aid or Assistance

SEC. 209. We agree with the intent of this amendment but recommend it be extended to AFDC. We also recommend that the matching fund be available for repairs of unsafe and hazardous conditions in the home whether it could be occupied or not, and 50% matching be considered on the total cost of such repairs rather than placing a monetary limit for matching.

PART 2—MEDICAL ASSISTANCE AMENDMENTS

Limitation on Federal Participation in Medical Assistance

SEC. 220. We are not entirely in favor of this amendment. We realize that some controls should be built into the law to hold the income eligibility standards to a reasonable level. However, controls which are built to limit these eligibility requirements on a nationwide basis may operate to the serious disadvantage of some states whose money payments eligibility standards are extremely low. They would not be able to provide adequate amounts of medical assistance under the proposed amendment. This amendment would have no effect in Hawaii. Our income levels for eligibility are very conservative by comparison of the proposed requirements.

Maintenance of State Effort

SEC. 221. We do feel that the proposed amendment is a progressive step in requiring all states to show forward movement in their programs covering Medical Assistance. As in the case of the previous amendment, Hawaii is very comfortable within the requirements of the present law. These requirements are set forth in the Handbook of Public Assistance Administration, Supplement "D", Section D–8524.

Coordination of Title XIX and the Supplementary Medical Insurance Program

SEC. 222. Hawaii has given consideration to several alternate provisions in the existing law covering this subject and would like to continue to exercise an option. Certainly, we must take advantage of SMI as a resource. Whether this is done through buy-in, payment on behalf of, or by a cash payment to the recipient has been the subject of much discussion. It would be more convenient if the various states could be allowed the option of one of these three methods to accomplish the purpose of the amendment.

Modification of Comparability Provisions

SEC. 223. We do not feel that this amendment is wise as it would allow a reduction of services by states which should be encouraged to increase the services which they are providing.

Required Services Under State Medical Assistance Plan

SEC. 224. We believe the present law is preferable. Perhaps there are states which need to be given the freedom to enter the Title XIX Program gradually. Hawaii is not one of them. We have been in advance of the requirements of the law in almost all instances, and as far as we can foresee will continue in that manner.

Extent of Federal Financial Participation in State Administrative Expenses

SEC. 225. Hawaii has not used the services of professional personnel in the Department of Health in any other than advisory capacities to the Department of Social Services, the "single State agency" charged with administering the provisions of Title XIX. We do see the possibility of such usage in minor instances but do not feel that the additional Federal matching should be a criteria in any decision relating to the use of such personnel.

Advisory Council on Medical Assistance

SEC. 226. Just as the several states are encouraged to use the services of advisory committees, so would it be wise for the Department of Health, Education and Welfare to employ the services of such a council.

Free Choice by Individuals Eligible for Medical Assistance

SEC. 227. This is a necessary and desirable provision in the eyes of Hawaii. Steps have already been taken to implement this in our State. While the cost of providing all services under Title XIX will be much greater, this seems to be another area which we should follow the policies of Title XVIII. There is no sound reason why the needy and medically needy individuals should be treated any differently in this respect from other individuals.

Utilization of State Facilities to Provide Consultative Services to Institutions Furnishing Medical Care

SEC. 228. We are unable to find in the literature on H.R. 5710 the amendment to which this heading refers. From the explanation given in the summary for committee decisions, it would seem that the amendment might have value to states which may be having difficulty in financing new health programs.

Payments for Services and Care by a Third Party

SEC. 229. We do agree with the purpose of this amendment. Hawaii is already meeting the requirements of this provision. We require the use of all resources to assist in the payment of the medical expenses of either the needy or medically needy individual. Among these are Medicare, private and community health insurance, excess income of the medically needy individual and funds which may become available through liability insurance claims as a result of accident or other circumstances.

Direct Payments to Certain Recipients of Medical Assistance

SEC. 230. We foresee strong objection from the various physicians' organizations to the portion of this amendment which allows us to reimburse the medically needy individual on the basis of an *unpaid* itemized bill for physician services. On the other hand, they would be greatly in favor of the amendment if it allowed such reimbursement after payment of the bill by the individual. This would have a direct reflection on the patient who is eligible for Medicare and also for assistance as a medically needy person under Title XIX. It would enable a physician to be paid for his deductibles under Part B without having to get and accept an assignment under Medicare. From the latter standpoint, Hawaii would support this amendment with the exclusion of the word *unpaid* from the amendment.

PART 3—CHILD WELFARE SERVICES AMENDMENTS

Inclusion of Child Welfare Services in Title IV

The inclusion of the appropriation for Child Welfare Services is Part B of Title IV of the Social Security Act confirms the intent that Child Welfare Services be provided AFDC children and is in keeping with the requirement that Child Welfare Services and family services for AFDC families be administered by states through a single organizational unit.

SEC. 235. The original bill introduced by Congressman Burke (H.R. 5710) was designed to remedy the inequity in Federal funds for administrative costs as well as foster board payments for all children who required Child Welfare Services regardless of economic need. We strongly recommend that the amendment be revised to include open-end Federal matching funds for administrative costs of providing protective and preventive child welfare services and for foster board payments for all children, not just those in AFDC families.

We believe that Federal matching for the administrative costs of providing Child Welfare Services is long overdue. These services should be strengthened for all children regardless of economic need.

TITLE IV—GENERAL PROVISIONS

Social Work Manpower and Training

SEC. 401. We are in full agreement with the authorization for training grants but recommend that the limit on the appropriation to be used for undergraduate training be deleted until more experienced data is available on need.

THE SALVATION ARMY, INC.,
Brooklyn, N.Y., September 18, 1967.

Mr. THOMAS VAIL,
Chief Counsel, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. VAIL: I learn with great concern of the recently enacted Legislation H.R. 12080 which substitutes for H.R. 5710.

As far as Title 1 is concerned I hope that the improvements in Social Security provisions will be so that an adequate income is insured for the lame, the halt, the blind and the aged, I would particularly recommend that the handicapped groups are removed from the Department of Welfare rolls and placed under the Social Security provisions.

Title 2—recently I heard somebody say *"riots do not occur in suburbia"* and I believe that we should keep this very much in mind as Welfare Legislation is enacted.

Instead of punitive restrictions on Services to Children, may I suggest the Legislators make provision for doubling the number of *men* working for *all* Departments of Sanitation (State, City and Town) and that you double the entire force of the Postal Services throughout the entire U.S.A. This would provide a great deal of male employment requiring only a short period of training and there would be far fewer men become discouraged and desert their families if they knew that they would have steady work at a salary that allowed them to make adequate provision for the daily needs of their families.

I thoroughly agree with expansion of Day Care, Family Planning and Social Services in general to families that have sieges of difficulties—the unmarried mother is not the only one that should be considered, I am thinking of young widows, young families where the father is struggling to complete his education, etc.

In addition if there was really substantial housing construction, improvement of educational and health services buildings and general improvement of environment in the inner city areas so much employment would be provided that it would end the sense of frustration and hopelessness which unfortunately is the lot of many of our American citizens and I trust that you will *accentuate the positive* in future Legislation. *Punitive and restrictive legislation solve* nothing.

God bless you!

Sincerely,

MAJ. GLADYS GODDARD.

STATEMENT OF JOHN F. GRINER, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, WASHINGTON, D.C.

The American Federation of Government Employees, the largest Federal employee organization in existence with more than a quarter of a million members, appreciates the opportunity and the privilege granted to it by the Honorable Russell B. Long of Louisiana, the Chairman of the Senate Finance Committee, to submit the Federation's views on H.R. 12080, a bill to improve the Social Security System of the United States.

Before commenting specifically on those provisions of the bill which bear directly on Federal employees, the AFGE would wish to submit several observations that pertain to every American citizen, whether or not a Federal employee.

The American Federation of Government Employees first of all wishes to associate itself explicitly and enthusiastically with the views expressed by the AFL–CIO as expressed by its Executive Council on September 11, 1967.

Specifically the AFGE requests the Finance Committee to consider the following modifications in the bill, H.R. 12080:

1. Raise the minimum Social Security benefit level to $70 for a single person and $105 for a couple, and increase all other benefits by at least 15 per cent.
2. Finance the benefit improvements by an increase in the earnings level on which both contributions and benefits are determined, by steps from the present $6,600 to $10,800.
3. Extend Medicare coverage to the disabled.
4. Establish reasonable controls on unduly high hospital charges and physician fees paid under Medicare.
5. Assure that Medicaid is available to the needy and the medically needy whose limited incomes cannot pay for adequate health care, and that it provides essential medical services to those covered.
6. Improve present public assistance payments and assure adequate day-care for children of families receiving assistance in which the mother is participating in work and training programs.
7. Transfer administration of community work and training to the Department of Labor with provision of adequate safeguards for those assigned to this program, including requirement of payment of prevailing wages and in no case less than the applicable minimum wage.

With specific reference to improving the social security system as it affects Federal employees, the American Federation of Government Employees would appreciate consideration being given by the Finance Committee to several problems which currently affect American employees. These involve especially unreasonable obstacles in the path of needy retired Federal employees which prevent them from participating in Medicare. The other problem concerns the inequities imposed on Federal retired employees whose pensions are subjected to Federal income tax.

MEDICARE

We have a further amendment, this one concerned with the Medicare Program, which we would be most grateful if your Committee accepted. We believe that retired or active-duty Federal employees, 65 or over, who are not now eligible for Medicare's Basic Hospital Insurance Plan (either because of their non-membership in the Social Security System or because of their failure to exercise their options to enroll for health insurance under the Federal Employees Health Benefits Act) should be rendered eligible to enroll in the Medicare Basic Hospital Insurance Plan.

This Amendment, if your Committee is agreeable to accept it, might easily be accommodated at the end of section 136, part 3, title I of H.R. 12080, which would begin as new line 6 of page 64 of the printed text of H.R. 12080, August 18, 1967.

ELIMINATION OF TAXATION OF CIVIL SERVICE ANNUITIES

All of the foregoing portions of our testimony endorsed the bill, H.R. 12080, or supported amendments thereto which we believe are in the spirit of the bill and would perfect it. We have one reservation however.

The one criticism of this bill which we wish to record strenuously concerns the provisions involved in the taxing of Civil Service and Foreign Service annuities. For many years, we have advocated the removal of all income taxes on Civil Service and Foreign Service annuities. In support of our position, we have cited the case of pensions under the Railroad Retirement and the Social Security Acts. With regard to the Railroad Retirement system, the exemption from income taxes was included specifically in the statute setting up that system. In the case of Social Security pensions, the exemption took place through the application, by the Internal Revenue Service, of a Supreme Court decision. In both cases, no Federal income taxes at all are paid on annuities.

We think no income taxes should be paid on Civil Service annuities.

We request that the Federal Government, therefore, discontinue current discrimination against Federal employees whose annuities are taxed as income.

We request it because we believe Federal employees should not suffer discrimination from the Federal Government solely because they are Federal employees.

These men and women certainly deserve of their country treatment equal to Social Security and Railroad Retirement Act pensioners. Their annuities, therefore, should not be taxed.

THE ISSUE OF THE TRANSFER-OF-CREDITS BETWEEN THE SOCIAL SECURITY AND THE CIVIL SERVICE RETIREMENT SYSTEMS

As the Senate Finance Committee is aware, H.R. 5710, the predecessor Bill to H.R. 12080, contained provisions for a mechanism to transfer credits for service of Federal employees who had not yet qualified by five years' service for benefits under the Civil Service retirement system and who were also ineligible for benefits for the period of their Federal service under the Social Security retirement system because the Federal employer had been making no payments to the latter for that period on their behalf.

When the American Federation of Government Employees testified on H.R. 5710 before the House Ways and Means Committee, it endorsed the concept of an equitable transfer of credits to rectify this patent deficiency in the coverage of Federal employees who leave Government service, or are disabled, or die before having had five years of Civil Service so as to have acquired entitlement to benefits under the Civil Service Retirement Act for themselves and their dependents.

During the consideration of H.R. 5710 and later of H.R. 12080 in the House, it was generally agreed that a serious inequity now exists which should be eliminated. A major effort was made to eliminate this inequity. However, the limitations of time for deliberation and the complexity and inadequacy of the principal mechanism proposed by the administration to solve this problem made it impossible to work out an effective, economic and equitable arrangement. Thus, H.R. 12080 contains no provision for a transfer of credits between the Social Security and the Civil Service systems.

The American Federation of Government Employees wishes to reiterate its earlier statement that the absence of an equitable transfer of credits imposes a hardship on Federal employees. The AFGE is now engaged in a study to devise the most simple, effective, economic and equitable mechanism to achieve this goal. After the completion of our study, the AFGE will make recommendations concerning the transfer of credits so as to eliminate this inequitable and unnecessary burden from the life of Federal Employees.

Thank you, Mr. Chairman, for this opportunity to outline our position on this bill and to suggest certain additional changes in the existing Social Security insurance and benefit system.

STATEMENT BY CARL J. MEGEL, DIRECTOR OF LEGISLATION, AMERICAN FEDERATION OF TEACHERS, WASHINGTON, D.C.

Mr. Chairman and Members of the Committee, my name is Carl J. Megel. I am the Legislative Representative of the American Federation of Teachers, a national, professional teachers' union of more than 140,000 classroom teachers, affiliated with the AFL–CIO.

Our organization embraces 660 teacher locals, including locals in Hawaii, Alaska, the Canal Zone, the Department of Defense Overseas Dependents Schools, and in the Department of Interior Indian Schools.

The American Federation of Teachers supports H.R. 12080, a bill to amend the Social Security Act to provide an increase in social security payments and other benefits.

All teachers have naturally become more interested in social security coverage since the passage of Medicare by the Congress of the United States. This is true because the Medicare Act specifies that only those persons who are under social security may qualify for Medicare after July 1, 1967.

Coverage under the Federal Social Security Program for employees of the states and their political subdivisions may be obtained only by means of voluntary agreements between the states and the Secretary of Health, Education, and Welfare, pursuant to Section 218 of the Social Security Act. The state decides within the limits of Federal and State law which group of employees are to be covered and when the coverage shall begin.

All fifty states, Puerto Rico, and the Virgin Islands have entered into agreements which provide social security coverage for at least some employees. At the present time, some twenty-five states have extended social security coverage to the service of most public school teachers, including teachers employed in institutions of higher learning.

In twelve additional states some, but not all, public school teachers are covered by the Social Security Act. In some of the remaining states efforts are being made to provide coverage under the Social Security Act.

The American Federation of Teachers has given active support to the social security idea since its inception, because of its broad social implications. At the same time, individual teachers have complained bitterly about its limitations. Following the enactment of the original Social Security Act, certain states repealed existing teacher pension laws and instituted social security instead. For some teachers this meant reduced retirement benefits since Social Security had now become their pension program. A few states supplemented the social security program with new state teacher pension laws. Even in so doing, the combined social security-pension income for these teachers is less than the pension provided in some states where teachers are not covered by social security.

Accordingly, it is highly important that the proposed increased benefits be incorporated into the Social Security Act. Increased living costs make this imperative. It is estimated that at the present time the average payments for widows under the Social Security Act are $74 per month. Yet, in 1918 a Civil War veteran received a pension of $72 per month from the United States Government. Comparisons are obvious.

Of special irritation to teachers relates to *Section 106*, which provides for an increase in the amount an individual is permitted to earn without suffering full deductions from benefits. Most states require automatic retirement for teachers upon attaining age 65. A great majority of these teachers are required to seek employment compensation since low salaries during their prime earning years preclude any possibility for investment income. Yet, these individuals forfeit their social security if their earned income exceeds $2700. In addition, and perhaps the greatest injustice of all is that, they are required to pay the full regular social security tax upon their earnings even though they are otherwise eligible to draw social security benefits.

In contrast, an individual who is eligible and has an income in excess of $3,000 (it might even be $50,000), but not on earnings, is entitled to receive social security payments and is not required to pay the social security tax. The injustice of this situation is self-evident.

Correction can be attained by increasing allowable earnings and by rescinding the social security tax on earnings after age 65—this latter provision, not withstanding, the "Tax Treatment of the Aged" as proposed under Title V.

AUGUST 18, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Old Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: The National Association for Mental Health, in whose behalf I write, is deeply concerned that the Social Security Act still contains discriminatory provisions so far as treatment of mental disorders is concerned.

I refer, of course, to Title XIX, Section 1905(a)(1), of the Social Security Amendments of 1965 (PL 89-97), which provides payment for "inpatient hospital services (other than services in an institution for tuberculosis or mental diseases)".

We urge that your Committee, in considering H.R. 5710, the Social Security Amendments of 1967, recommend the deletion from the above provision of the wording in parentheses, so that Section 1905(a)(1) would read "inpatient hospital services". This would remove, at long last, the last remaining discriminatory provision in the Social Security Act against the mentally ill.

This must be done if the two major resources for inpatient treatment services for the mentally ill—the private and public psychiatric hospital—are, through Federal assistance, to be made more fully available to the medically indigent who suffer from mental disorders.

The National Association for Mental Health asks that your Committee give favorable consideration to our proposed amendment.

Sincerely,

MRS. BURTON JOSEPH,
Chairman, Council on Legislation and Public Policy.

NATIONAL REHABILITATION ASSOCIATION,
Washington, D.C., September 18, 1967.

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

DEAR SENATOR LONG: The Administration's "Social Security Amendments of 1967" provided that the Secretary of Labor would be authorized to provide work and training programs or recipients of aid to families with dependent children. The House rejected this recommendation, leaving the authority to provide such services to the Secretary of Health, Education, and Welfare.

In the judgment of the National Rehabilitation Association, the House was wise in taking the action it did. We believe the authority to provide the services should reside in the Secretary of Health, Education, and Welfare. We believe he should have the authority to make contracts with the United States Department of Labor, or any other federal agencies, to carry out any part which he finds can be more appropriately administered elsewhere. For instance, certainly the Manpower Development and Training Programs and other United States Department of Labor programs would be used extensively. In addition, however, the state vocational rehabilitation agencies would undoubtedly be used for certain services, as well as other state-federal programs.

We think the retention of the House provisions in this respect are extremely important in view of the recent reorganization of certain functions of the Department of Health, Education, and Welfare. As you know, the Secretary has concentrated in one administration: the Public Welfare, Aging, and Vocational Rehabilitation Programs, under the leadership of Mary E. Switzer, who has been Director of the Vocational Rehabilitation Administration. This new organization gives us the best opportunity we have ever had to bring about a fruitful coordination of all of the programs in the department, which have as their purpose serving the rehabilitation needs of disadvantaged persons. To split off the work and training functions as administration proposals did would certainly be a blow, as related to the purposes of the new reorganization plan.

We sincerely hope that you will give this matter your very careful consideration and, hopefully, retain the House provision.

With best wishes, I am,

Sincerely yours,

E. B. WHITTEN,
Executive Director.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN,
MICHIGAN STATE DIVISION,
September 17, 1967.

SENATE FINANCE COMMITTEE,
Senate Office Building,
Washington, D.C.

DEAR SIR: The legislative committee of the Michigan Division of the American Association of University Women reviewed the 1967 amendments to the Social Security Act—H.R. 12080.

The amendments are in harmony with the findings of our studies of the American family and problems of poverty. We support increased incomes for retired people, improved family services, including adequate day care, extension of training, re-education, rehabilitation and work-incentives for the unemployed receiving public assistance.

However, we strongly urge *deletion of Sec. 208*, which freezes the proportion of children on ADC at the January '67 level.

In Michigan, the ADC rate varies from less than 2% in counties where there is industry, to more than 8% in under populated, non-industrial counties.

Rates also vary over time, dropping when there is a shortage of labor and increasing when the unemployment rate rises.

Inclusion of a limit on ADC in the Social Security Act will bring acute hardship in a time of increased unemployment due to factory shutdown or major production readjustments.

It is excessively punitive to limit the ADC rolls before there are sufficient day-care facilities, job-training programs and job opportunities available in all of our states, and in all of our counties.

Sincerely yours,

Mrs. JOHN A. KING,
Board Member, Michigan Division, AAUW, Okemos, Mich.
Mrs. GEORGE MOSHER, Jr.,
Legislature Chairman, Michigan Division AAUW, Birmingham, Mich.

(The following statement was submitted to the committee by Hon. Fred R. Harris, a U.S. Senator from the State of Oklahoma:)

STATEMENT PRESENTED BY WESLEY D. BURCH, PRESIDENT, OKLAHOMA HOSPITAL ASSOCIATION, ADMINISTRATOR, JANE PHILLIPS EPISCOPAL HOSPITAL, BARTLESVILLE, OKLA.

Senator Harris, we sincerely appreciate this opportunity you have granted us to meet with the delegation of the Oklahoma Hospital Association. As President of the Oklahoma Hospital Association, and in the interest of time, I have prepared a statement expressing the views of the Oklahoma Hospital Association relative to our concern over the Medicare and Medicaid Programs in Oklahoma. After I have presented our statement, each member of the delegation might like to make some informal comments to you relative to this matter. Mr. Kenneth Bond a member of the Governing Board of Baptist Memorial Hospital, Oklahoma City, would like to comment on the problem of amortization of debts.

After 14 months' experience with Medicare, and 20 months of Medicaid, as provided under Titles XVIII and XIX of the Social Security Amendments of 1965, Oklahoma hospitals are gravely concerned over many aspects of this program and its effect upon the financial solvency of our hospitals. We can appreciate the complexities of implementing these vast programs, and are here today to discuss ways and means of strengthening these programs and ensuring their further usefulness to the citizens they serve.

We have studied the Social Security Amendments of 1967, as enacted by the House of Representatives, and are greatly disappointed that the House did not see fit to deal with the problem of definition of "reasonable cost" reimbursement to participating hospitals. The present reimbursement to hospitals, under the existing interpretation of "reasonable cost" for both Title XVIII and Title XIX is grossly inadequate and is causing Oklahoma hospitals to increase their charges to private paying patients at an alarming rate in order to provide a bare subsistence.

First, the majority of Oklahoma hospitals are *not* now able to produce the complex set of accounting devices that was promulgated by the Secretary of the Department of Health, Education and Welfare to attempt to isolate the "reasonable cost" applicable to patients covered by Medicare and Medicaid. Furthermore, we are concerned that the whole series of complex manipulations required by both the administrative agencies implementing Title XVIII and Title XIX is grossly inadequate to reimburse hospitals their true cost to meet the financial needs of the hospitals who are furnishing this care.

How much money a hospital may need over and above its basic operating cost to meet its financial requirements is a difficult question to answer on a general basis. However, there are two broad elements that must be included in any consideration of the financial needs of hospitals. First, a hospital must always recover on a current basis the amount of its day-to-day operational expenses, which are often referred to as "out-of-pocket cost". Second, a hospital must provide itself with adequate resources to meet patients' needs for permanent capital.

Reimbursement under Title XVIII and Title XIX to hospitals fails to give any consideration to the cost that hospitals incur in giving free care rendered to certain categories of non-covered patients. Since all nonprofit community hospitals care for all types of patients admitted to a hospital by a physician, regardless of their ability to pay, causes all Oklahoma hospitals to give some "free care" to a segment of its patients. Caring for patients who eventually cannot pay for this care is a cost of operating any hospital whose doors are open to the public. Although some hospitals in the nation have endowments from private philanthropies to help them furnish free care to these persons, Oklahoma hospitals must finance their free care given to patients by passing on this cost to patients and third parties who pay for their care. Therefore, this cost must be borne on a proportionate basis by the paying patients, whether they are paying patients sponsored by the United States Government, or by a commercial insurance company, or whether he be one who pays his own bill out of his own pocket.

To attempt to finance this considerable cost by continuing to increase rates to a relatively small portion of the patients not sponsored by a third party is of serious financial consequence to Oklahoma hospitals who are not blessed with charity endowment funds.

In addition to the day-to-day, out-of-pocket expenses incurred by the hospital, the hospital also has a critical need for ever expanding the amounts of permanent capital. These capital needs include amounts invested in buildings and equipment, as well as the amounts required in the amount of working capital to finance day-to-day expenses of the institution. The present 2 per cent factor that is allowed in determining "reasonable cost" is just not adequate to meet the financial needs of Oklahoma hospitals.

Another problem deals with the inadequacy of the present reimbursement for depreciation. Many Oklahoma hospitals have financed a major portion of their plant and equipment through mortgages or revenue bonds, and who have a sizeable "debt service" expense. To provide depreciation on a historical cost basis does not permit the hospital to generate enough income to make their payments on their mortgage indebtedness. Furthermore, this inadequate reimbursement for depreciation will handicap hospitals from obtaining long-term capital financing from third parties who must show to the lender's satisfaction that the hospital will be able to meet the payment schedule specified.

In conclusion, Oklahoma hospitals recommend to you, as a member of the Senate Finance Committee, the following:

1. The reimbursement formula for hospitals under Titles XVIII and XIX should be revised to permit reimbursement to hospitals on the basis of an average

cost per diem, as well as any more sophisticated method that might be developed on a sound basis for each individual hospital.

2. The Titles XVIII and XIX Programs should provide to assume its fair share of the hospital system's free care and bad debt cost.

3. That an immediate legislative clarification of the term "reasonable cost" and such other action as may be necessary to permit a significant increase in the 2 per cent factor that is now allowed the non-profit hospitals.

4. That the reimbursement method of hospitals should be corrected to recognize replacement costs so as to compute depreciation on the basis of replacement costs, rather than historical cost basis.

5. That the reimbursement formula allow adequate funds for hospitals to amortize debts in those hospitals forced to borrow to obtain the necessary capital funds.

One other area that we would urge the Senate Finance Committee to consider is the question of hospital out-patient services. We were distressed to see that the House of Representatives took all hospital out-patient benefits out of Part A hospital insurance fund and put hospital out-patient benefits, both diagnostic and theraputic, under Part B, the Supplementary Medical Insurance Program, and, thus, making this benefit subject to deductible of $50 per year and the co-insurance feature of 20 per cent. We believe this would merely complicate this problem, rather than simplify it, and would result in utter confusion to the Medicare beneficiary. We, therefore, sincerely urge that the Senate Finance Committee to place the hospital out-patient benefit coverage back into Part A benefits, so that hospital services, both in-patient and out-patient, will be under the hospital insurance fund.

We sincerely appreciate your permitting this audience of the Oklahoma hospital delegation to discuss these recommendations with you personally.

MEMBERS OF THE DELEGATION OF THE OKLAHOMA HOSPITAL ASSOCIATION

Wesley D. Burch, President,
Oklahoma Hospital Association,
Administrator,
Jane Phillips Episcopal Hospital,
Bartlesville, Oklahoma
J. L. Henry, President-Elect,
Oklahoma Hospital Association,
Administrator,
Baptist Memorial Hospital,
Oklahoma City, Oklahoma
Keith E. Calvert, Administrator,
Memorial Hospital of Washington County,
Bartlesville, Oklahoma
Kenneth Wallace, Lay Administrator,
St. John's Hospital,
Tulsa, Oklahoma
Kenneth Bond, Member,
Board of Trustees,
Baptist Memorial Hospital,
Oklahoma City, Oklahoma
Richard O. Luttrell, Administrator,
Norman Municipal Hospital,
Norman, Oklahoma
James D. Harvey, Administrator,
Hillcrest Medical Center,
Tulsa, Oklahoma
Cleveland Rodgers, Executive Director,
Oklahoma Hospital Association,
Tulsa, Oklahoma
W. R. Bethel, President,
Oklahoma Blue Cross-Blue Shield Plans,
1215 South Boulder,
Tulsa, Oklahoma
(Representing the Part A Intermediary for Oklahoma Medicare Program)

SEPTEMBER 22, 1967.

Mr. TOM VAIL,
Chief Counsel, Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR MR. VAIL: In recent years, I a housewife and mother, of middle-income bracket, living in the Washington, D.C. area, have made a practice of becoming acquainted with and befriending one or two low income bracket families, with children, who want to help themselves, and who seem to want to raise their children to become stable, self-respecting, useful citizens. I prefer to express my concern for those less fortunate this way, than through organized charities.

One of my families is the S——— family, who live in the District of Columbia, They have nine children from the ages of four up through sixteen. The mother and father are in their early thirties. Mr. and Mrs. S are extremely conscientious parents. Apparently all children in their family were legitimate and were born to one set of parents.

Mr. S. has not worked for over five years, due to a recurring skin (eczema-type) condition, which affects his hands. He is under medical treatment, but is active physically, except for frequent bouts with his hands. The family is under public assistance. Because of the number of children in the S. family, they receive a greater amount of money, and or goods through public assistance than they would if Mr. S. returned to work. As I understand the present Social Security law, there would be no partial public assistance available, to supplement Mr. S.'s income, if he were to return to work. He is an unskilled laborer, who could undoubtedly be trained to do other work than the cement work which he did formerly. He could and would like to work, but is reluctant to because he cannot earn as much as his total public assistance amounts to, or the total public assistance to the S——— family. The S——— family is an actual case, which I cite as an example of thousands of similar families throughout the United States.

Mr. S. is losing his incentive to work, is frustrated and is in danger of losing the self-respect of his children. Because of an inadequate provision or much needed amendment to the Social Security law such families are being adversely affected.

Self-respecting persons would rather work, and be useful than live completely and continually on handouts, which demoralizes families. A law which does not provide partial public assistance, to supplement working income to those willing to work, helps to perpetuate "the welfare state".

Respectfully submitted.

(Mrs.) MARY I. BULL.

STATEMENT BY WILLARD B. SIMMONS, EXECUTIVE SECRETARY OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

As the National Organization for owners of over 40,000 independent retail pharmacies, the National Association of Retail Druggists respectfully submits this statement on the Social Security Amendments of 1967, H.R. 12080 to the Senate Committee on Finance. It is the purpose of this statement to emphasize the views of our members respecting titles XVIII and XIX and to comment more specifically on S. 2200.

The National Association of Retail Druggists was created almost a century ago in order that the owners of independently operated drug stores might have a strong voice to act in the public interest and to meet competition effectively. The wisdom of establishing this Association is proven by the spirit and size of our owner membership which is greater than all other national pharmacy organizations combined. As medical care programs are constantly expanding, their effect on owners of pharmacies is resulting in new dimensions daily.

The N.A.R.D. membership dispenses about 75 per cent of the prescriptions filled each year in the United States.

Our Association has a long history of working effectively with Congress and the administrative agencies.

We have worked closely with many officials of the Health, Education and Welfare Department as Titles XVIII and XIX have been implemented and we will continue to offer our services and counsel. It is in this spirit and with this background that this statement is submitted.

In order to emphasize our major concern with the existing XVIII and XIX programs, our major recommendations are grouped and set forth below:

1. Title XIX funds are currently being used to finance "free drugs" in the neighborhood health centers as a part of the Office of Economic Opportunity programs. We are opposed to the "free drug" programs at these centers because these policies are having a demoralizing effect on pharmacy owners and if allowed to continue as planned will destroy many independent pharmacies. These "free drug" policies only duplicate and preempt existing Title XIX vendor drug programs that have operated successfully for years under vendor medical assistance programs prior to Title XIX. We hope these O.E.O. drug policies will be discontinued and that Title XIX funds will not be further authorized for such O.E.O. activities unless a vendor drug program recognizing retail pharmacies is adopted.

Drug store destruction with Title XIX funds in neighborhoods the Government is trying to rehabilitate will be harmful to the poor and disadvantaged.

2. The multiple pricing policies of drug manufacturers are fostering and encouraging O.E.O. competition with existing Title XIX vendor drug programs. Such pricing policies are creating chaos in the drug marketplace in many other ways which will be detailed in our later discussion of S. 2299. We wish to emphasize here that something must be done about this problem to eliminate the predatory competition the drug store owner is now facing in many government operated programs. While we have made such recommendations previously to many other committees and government officials, we feel emphasis should be made here especially at a time when the H.E.W. Task Force is considering "central pharmacies", "government pharmacies" and state-owned drug stores for a Title XVIII B drug program.

We feel the multiple pricing policies of many companies will be curtailed to some extent if their price offerings or "bids" to the Federal Government, Federal agencies, and Department of Defense are made public and are published. The pressures that will arise from such continuous publication of Government prices will do much to bring about drug price equalization, reduced welfare and Medicare drug expenditures and equal opportunities for the independent drug store owner.

In the interest of more economical welfare and Medicare drug programs, we urge the Senate Finance Committee to bring about publications of such drug "bids" to the Federal Government.

3. From many states our members tell us that they have to wait several months to collect money from state agencies for Title XIX prescriptions. In general, our members are complimentary about the vendor drug programs under medical assistance and Title XIX programs but we hope something can be done about these delayed payments.

4. It is doubtful that any medical care or medical assistance program such as Title XIX can be even reasonably successful without a drug program. It is our recommendation that drugs be removed from the Title XIX "optional" category and become a required service. If drugs are available and administered in time, many Title XIX expenditures for hospital, nursing home and physician services may be eliminated or considerably reduced (Sec. 224).

5. The patients' freedom of choice (Sec. 227) under Title XIX is highly desirable but from the standpoint of drugs we recommend that such a XIX provision be specific respecting welfare patients in nursing homes. We have heard of lowest bidder contracts for all drugs for all nursing home patients in a given area. This destroys the freedom of choice concept and almost assures lower quality pharmaceutical services.

6. The welfare drug programs in some states require that vendor pharmacies not charge the state more for a welfare prescription than the stores charge their private patients.

Such a requirement seems fair and in the public interest. We recommend such a provision for Title XIX and XVIII.

7. Under Title XVIII we recommend that drugs be provided the Medicare patient for home use. This benefit should be incorporated in the Medicare law at the earliest possible date to reduce hospital and nursing home expenses. We feel it is essential that such a program assure the patient freedom to select his pharmacy for such drugs. Some of our views regarding such a program will appear later in our referrals to S. 2299. Since S. 2299 does not provide home use drugs, we will reserve, in the interest of brevity, our comments on many aspects of such a program. We would welcome the opportunity to discuss the many facets of such a program with any interested official or group.

8. The great interest in drug benefits for Medicare and welfare recipients strongly supports the inclusion of a pharmacy owner on the H.I.B.A.C. Council. The National Association of Retail Druggists recommends that the Council membership specified in Sec. 162 be increased to 20 members so that a pharmacy owner be included. If the number remains at 19, we recommend that Sec. 162 be amended to specify the inclusion of a pharmacy owner on the H.I.B.A.C. Council.

9. We strongly recommend that Sec. 226 which establishes a 21-member Medical Assistance Advisory Council (Title XIX) be amended to provide that at least two of the Council members be pharmacy owners.

S. 2299; 'Quality and Cost Control Standards for Drugs".

The survival of the independent drug stores of this country and the survival of many patients may depend on the kind of drug legislation Congress adopts for meeting the medication needs of a very large segment of our population. Since the objective of S. 2299 is to deal with many aspects of the problem, S. 2299 is of crucial importance to our association and to our membership. We are most pleased with many of the tributes Senator Long and members of Congress have paid the retail druggists when they have discussed this legislation. Senator Long's recognition of the daily contribution our members are making in medical care programs have been most encouraging. We certainly share his desire to see that retail pharmacy owners and adequately compensated for their services in a government drug program that emphasizes quality and economy.

In recent months numerous government documents and statments have revealed that drug costs have risen little if any in comparison with the other components of medical costs. We maintain this is significant evidence that our members, who are filling 75 per cent of the nation's prescriptions, have kept faith with the public and the government. We further submit these results emphasize that American competition is still a tribute to our democracy. Competition is an incentive for efficiency and the price competition in retail pharmacy is greater than can be found among the other providers of medical services.

We feel it is in the public interest that such competition in the drug areas be preserved.

With this background we are submitting comments and observations regarding S. 2299 in a sincere effort to be helpful. While we would be opposed to enactment of many provisions of S. 2299, we feel our reasons may be of future usefulness as drug legislation is considered. We are cognizant of the many changes that must accompany the expanding medical care programs that are certain to come but from our point of view it is just as important to realize what is practical and workable as it is to visualize what might be an eventual ideal. While we understand the objective of S. 2299, it does not deal with many subjects which must be included in an eventual home use drug program for Medicare patients. If we supported S. 2299 without drugs for home use coverage we would be endorsing open-ended legislation. We have recommended drugs for the Medicare home patient for many months and we feel they should be a part of any legislation such as S. 2299 that establishes authorized drugs and payment procedures. Our recommendation will significantly reduce many hospital expenditures if Medicare patients can get vitally needed drugs at home in time.

S. 2299 will not discourage the multiple pricing practices of many drug manufacturers and it may even encourage an acceleration of special prices to government dispensaries, government agencies, hospitals and dispensing physicians. One of the greatest steps that could be taken to bring better drug prices to the private patient, welfare patient and Medicare patient would be a requirement that the manufacturers' prices and bids to federal agencies be published. If something is not done in an effort to equalize prices and to end price discrimination many retail pharmacies may be squeezed out of business and pharmacy services for the public will be most inaccessible.

For many years our members have been bombarded with all of the pros and cons of generic drugs and brand-name drugs. We will not labor this issue, but we want to make several points. We are opposed to a requirement that will directly or indirectly compel the physician to prescribe and the pharmacist to dispense the cheapest generic drug available. The facts are that many of the cheapest generic drugs are simply not available to all pharmacies throughout the country. Our members know that the Food and Drug Administration is limited currently in the assurances they can give about clinical equivalency. Our point is that eventually standards created by F. D. A. or even the manufacturers may assure adequate equivalency but the physicians and pharmacists have no such assurances today because clinical equivalency of some products is uncertain.

We are confident that members of the National Association of Retail Druggists are cooperating daily with physicians in providing quality pharmaceutical products, generic or brand name, that are in the patients' best interest.

In this respect reference should be made to equivalency tests by the Defense Department and hospitals that use a formulary. It is often observed that the retail druggist is incapable of such tests. In the first place, the Department of Defense is spending several million dollars annually on such a program but they are rejecting about 40 per cent of the drugs offered. A case might be made for buying known drugs in the first place. Regarding hospitals, about 50 per cent of them do not have a pharmacist so they do not have a formulary nor do they do any testing. It is probable that a high per cent of the other hospitals are incapable of doing any more testing than is possible in a retail drug store. So the accolades paid hospital formularies for cost savings may be a fiction. There is even less evidence that such savings, if any, are passed on to the patient. The facts are that the hospital may not even be buying the cheaper generic but only receiving prices unavailable to the drug store. Here again the multiple pricing problem is creating chaos in the marketplace and leaving the impression that generic drugs are cheaper and just as good as brand-name drugs, when it is a brand-name drug that is dispensed under the generic purchasing policy of the formulary system devoid of any testing.

Until F. D. A. can give our members and the physicians much more assurance of therapeutic equivalence than they have in the past we must oppose the mandatory prescribing and dispensing of generic drugs on a price basis contemplated in the proposed U.S. Formulary.

The fact that the patient can pay the difference between what is allowed and a higher cost gives us, as well as the patient, little comfort because our members will be criticized by the patient and probably the physician.

The Formulary Committee provisions of S. 2299 are a source of great concern to our members. The areas of greatest significance are: How will the pharmacy owner know what drug product to buy and how will he get the generic drugs specified if they are not available in his city? How often will the Formulary Committee change the list? How will the owner dispose of an inventory made obsolete at the last Formulary Committee meeting? With more controlled prescribing, will there be any relief for the owner who suffers an inventory loss due to obsolescence? How will insurance carriers coordinate their reimbursement techniques and will members of professions have time to prepare for Formularly Committee actions? Will any allowances be made for continuing patients on drugs after Committee removes drug from Formulary? Prescription refills could be most disturbing situations to a patient since many of these patients will have been on some drugs for years before inauguration of program.

While we have expressed our doubts of the advisability of creating a U.S. Formulary Committee that would attempt to establish therapeutic equivalency when F. D. A. can give no assurances as to such equivalency, we would raise a further question concerning administrative costs.

If such a Committee undertakes responsibility for all drugs the task would not only be overwhelming, if not impossible, but the administrative costs probably could never be justified.

S. 2299 could create grave problems for retail pharmacies in that a customer could receive a "covered" drug in a hospital under the hospital Formulary system but when such a patient goes to a nursing home or returns to his own home such a drug cost would not be "covered" unless the drug is on the U. S. Formulary. This would be most unfair and the lives of many patients on such drugs as anticoagulants might be jeopardized if they were switched to another anticoagulant which the U.S. Formulary Committee specified. Under the existing Title XVIII law it is impractical to prohibit an extended care facility from having formulary compensable drugs when hospitals are encouraged to have formularies. This has created a present hardship for extended care facility patients and retail pharmacies that supply most of the drugs to over 80 per cent of nursing homes. It is disturbing that a government policy that authorizes payment for drugs depends on what bed the patient is in rather than how sick he is or what disease he has or what the physician thinks he needs. An H.E.W. interpretation of the Title XVIII definition of drugs created this problem.

Sec. 2004 "Reasonable Cost Range" may encourage special and discriminatory prices by the manufacturers to hospitals, dispensing physicians and others.

It is in the public interest that these groups fill less government prescriptions in the future and that prescription dispensing for home patients be restricted to retail pharmacies. With the Secretary establishing price ranges for each class or type of dispenser [Sec. 2004(a)(2)(B)] the welfare departments may even ask for denial of free choice of pharmacist and attempt to direct all welfare and Medicare prescriptions away from retail drug stores.

The Professional Fee mentioned in Sec. 2005 and the actual cost are of great concern to the National Association of Retail Druggists. It should be noted at the outset that the percentage of stores that use the fixed fee approach is quite small. We are concerned about any government pricing system that requires all stores to use the same fee fixed by the government because it is too inflexible and too insensitive to operating expenses. A departure from a customary charge basis with movement to the mandatory adoption of a fixed fee approach should take into account existing duties imposed by our federal anti-trust laws and the serious restrictions they place on the extent to which any association can become involved in any price negotiations on behalf of its members.

Many proponents of the fee approach originally were trying to leave the impression that it was a fee in addition to operating expense.

When N.A.R.D. members began to spotlight the facts we have more recently been hearing that operating expenses must come out of the fee. A fixed fee on a statewide basis may not be fair for some pharmacies with higher operating expenses. This is the type of fixed fee inherently presupposed in S. 2299. It recognizes no variation in operation expenses or variation in professional services or professional competence. The more experienced attorney or physician usually charges more and is allowed more under any system because of more professional or specialized experience. The professional fee for prescriptions recognizes no difference in professional abilities but allows the same fee for a prescription filled by a recent graduate that is allowed when the pharmacist has had years of valuable pharmacy experience. Once again we find that the pharmacy points of view vary significantly depending on what is invested. The store owner must be conservative, be proud of our profit system and have an adequate return on his investment; consequently, he is worried about an inflexible mandatory fee fixed by any government agency.

If the fixed fee does not meet the financial needs of 50 per cent of the drug stores or if it is reduced every so often by the state or federal government so that 50 per cent of the pharmacies cannot survive, or if the government agencies refuse to raise the fee during inflationary periods and 50 per cent of the stores have to close their doors, this will only be of historical interest to the academicians.

The responsibility of the National Association of Retail Druggists to its owner members is great and we feel the need for realism is paramount.

S. 2299 contemplates the use of acquisition cost and the professional fee. In today's market acquisition cost can vary depending on so many factors that the government expense in administering such a program could exceed the costs of drugs provided.

We are confident that the professional fee plus acquisition cost will be of great comfort to the predatory discount stores and mail order pharmacies. Those who see the fixed fee as a means of emasculating the discounters are not giving proper recognition to the intelligence quotient of operators committed to destroying independent pharmacies. The fee may become the loss leader gimmick of the 1970's and if our members are locked in with a government fixed and inflexible fee for fifty per cent of their customers their problems with their remaining prescription business will be further magnified.

It is ironical that the hospital pharmacists' support of the fee gave it a great momentum of support when hospitals were told to start itemizing services and at a time that everyone knew hospitals were charging so much on drugs that the pharmacy department was carrying other money-losing departments in the hospitals.

The hospitals paid a fraction of what retailers paid for drugs yet they often charged more for two or three pills than a community pharmacist charged for the entire prescription.

In the interest of providing meaningful assistance to the Senate Finance Committee the National Association of Retail Druggists is engaged in a survey to determine the costs of filling prescriptions. We believe we will have useful information. On the basis of current information it would appear that a government drug program that reimburses pharmacists on a usual and customary charge basis at the prevailing rate in the community will be much fairer than a fixed fee plus acquisition cost approach. We are confident the administrative costs to the government would be much less.

SUMMARY

1. The National Association of Retail Druggists speaks only for the owners of independent retail pharmacies. We are dedicated and committed to representing their interests.
2. We support many provisions of HR 12080.
3. We are opposed to many provisions of S. 2299.
4. We strongly recommend legislation to provide drugs for the Medicare home patient.
5. We feel Title XVII, XIX and XX legislation should state specifically that federal funds are not available to hospitals and physicians for drugs that should be dispensed in community pharmacies.
6. We feel welfare and Medicare recipients should be allowed great freedom of choice in selecting their pharmacy.
7. We are opposed to using Title XIX funds for free drugs in O. E. O. neighborhood health centers. This practice is at odds with the free enterprise and profit systems and is using hospital pharmacists and health departments to destroy drug stores.
8. We feel it is inadvisable at this time to compel, directly or indirectly, physicians to prescribe and pharmacists to dispense generic drugs of unknown therapeutic equivalence on a cost basis when F. D. A. has stated their limitations would make such a program unwise.
9. We do not feel the government is doing enough to reduce drug costs by prohibiting the mutliple pricing policies of some manufacturers and we recommend an immediate requirement that all drug prices to the federal government be given wide publication.
10. We recommend that pharmacists be paid for Medicaid and Medicare prescriptions on the usual and customary charge basis at the prevailing rates.

CONCLUSION

The National Association of Retail Druggists recognizes the monumental and important tasks of the Senate Finance Committee and the House Ways and Means Committee as this legislation is considered. While there are many aspects we have not discussed, we share the Committees' desire that government medical care reflect quality and economy. Since our Association is dedicated to this same end, we extend our continuing offer to render meaningful service and assistance as the many problems are considered.

TERRITORY OF GUAM, U.S.A.,
OFFICE OF GUAM'S REPRESENTATIVE IN WASHINGTON,
Washington, D.C., September 22, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: As the elected Representative of Guam in Washington, I earnestly urge your Committee to make changes in the provisions of H.R. 12080, the Social Security Act Amendments of 1967, to eliminate inequities with respect to Guam's participation. H.R. 12080 now is under consideration by your Committee.

The Organic Act of 1950 established Guam as a Territory of the United States, granted a substantial degree of self-government and extended American citizenship to its citizens. The island now has a population of some 85,000 and despite the Japanese assault and occupation during World War II, our per capita income has grown to within $100 of that of the State of Mississippi.

However, certain of the public assistance provisions in the present law discriminated against Guam and unfortunately H.R. 12080 as now before you does not correct the inequities.

At the outset, I want to make plain the fact that welfare as a way of life is neither popular nor desirable to the people of Guam. Our population is larger than that of the Virgin Islands, yet during the past two years we have received only about half the amounts received under the Social Security Act for public assistance by the Virgin Islands during the past two years. Such payments have actually decreased since FY 1966.

As compared to the Federal contributions available to the States, there are three restrictions or limitations on the Federal share available to Guam:

1. There is currently a $450,000 total limitation each year on Federal funds for matching public assistance payments. No such limitation is placed on any of the States.

2. In the case of the States, the Federal share can amount to 31/37ths of a single public assistance payment; however, in the case of Guam, the Federal share can be but one-half the payment.

3. The Federal share to the States may be applied to payments of up to $90 per case; in the case of Guam, $45 is the maximum Federal share.

In Section 248 of H.R. 12080, it is noted that the total dollar limitation will be progressively increased from $575,000 in Fiscal Year 1968 to over $1 million in 1972 and thereafter. This is heartening and fully appreciated. However, permit me to point out that the benefit is more apparaent than real. Because of the double penalty we pay in receiving only a 50% Federal share against a $45 case ceiling (compared with up to 85% of $90 to the States), the current Federal expenditure on Guam for all public assistance programs is only about $175,000 per year—less than half of the $450,000 per year total ceiling currently authorized. If equitable Federal contributions were authorized, the actual Federal expenditure would still be less than the current or projected limitation.

A primary point of inequity is the manner in which Guam's share is a contradiction of the "equalization factor" contained in the matching formula of the public assistance provision of the Social Security Act. Whereas the distribution formulae in most Federal assistance programs recognize the differences in the States' relative fiscal capacities to support programs and services at a required minimum level—the formula contained in the Social Security Act seems to disregard the fact that Guam can provide only limited benefits—and those only through very heavy local taxation. It therefore appears that our needy are being penalized by the fiscal capacities of other areas with a greater ability to pay.

Again, Section 248(e) of H.R. 12080 provided still another instance of a rather gross inequity, from which we seek relief through your assistance. This relates to the Medicaid program, (Section 1905(b) of the Act) for which Federal matching ranges from 50% to 83% depending upon the per capita income of each State. Under the amendment proposed in Section 248(e) of H.R. 12080, Guam's currently inadequate and inequitable Federal share of 55% would be reduced to 50%—that of the most prosperous State of the nation with the greatest fiscal ability to pay. Frankly, it is difficult for me to reconcile this proposal with numerous provisions throughout the basic Act and the proposed amendments which relate the Federal share of payments to per capita income or are otherwise related to local fiscal capacity.

I will be glad to work your staff in drafting specific language for amendment to H.R. 12080 to correct these inequities.

Sincerely yours,

ANTONIO B. WON PAT.

STATEMENT SUBMITTED ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

BY CHARLES A. SIEGFRIED, PRESIDENT

ADMINISTRATION OF TITLE XVIII

Under P.L. 89–97, the health insurance business, through the Health Insurance Association of America, contributed its services to the Social Security Administration in planning for the administration of the Health Insurance and Supplementary Medical Insurance benefits. Subsequently, five insurance compaies were named as fiscal intermediaries for hospitals, home health agencies, and extended care facilities under Part A (Hospital Insurance Benefits). Fifteen companies were selected to act as carriers under Part B (Supplementary Medical Insurance). These companies operate under actual-cost contracts with no provision for any payment for other than demonstrable expenses.

We believe that their efforts have helped to make this program function as smoothly as possible to the betterment of all its beneficiaries.

As might be expected, this is an intricate and highly complicated program. There are areas in the field of its administration that remain to be perfected. This measure before your Committee contains a number of provisions designed to alleviate problem areas and improve the administrative procedures of the program. These matters are properly discussed in a statement presented to this Committee by the fifteen private insurance carriers and fiscal intermediaries. We commend their efforts and the spirit with which they have conducted themselves in this program and endorse all of their recommendations.

IMPACT OF TITLE XVIII ON PRIVATE INSURANCE

The enactment of Title XVIII has had a severe impact on private health insurance. A costly and painstaking adjustment of coverage was necessary so that private insurance coverages would not unduly overlap the Medicare benefits. Most group insurance contracts, a large proportion of which are influenced by the processes of collective bargaining, had to be reviewed on a case by case basis. Employed persons over age 65, and eligible for Title XVIII benefits, required special considerations. Continued protection of a younger spouse or other dependent of a wage earner or retiree eligible for Title XVIII benefits had to be assured. Similar adjustments had to be made in a large number of individual policies outstanding.

Many insurance companies have developed and offer coverages for persons aged 65 and over to supplement the benefits of Title XVIII. These take a variety of forms, reflecting the varying desires of older persons for additional protection. Our present estimate is that 9.4 million people aged 65 and over, have some private health insurance coverage. The processes of adjustment and developing supplementary coverage are still in progress and the full effect of Title XVIII on the private health insurance business may not be properly assessed for a period of years.

SPECIAL ADVISORY COUNCIL STUDY OF THE DISABLED

There is no doubt that there are disabled individuals in this country who need some form of government assistance to enable them to meet their medical expenses. It should also be made clear that the private health insurance business does not assert that in every instance insurance plans go as far as might be desirable in this area, but we do maintain that the basic mechanism is there and real progress is being made in what we think is the right direction to provide comprehensive medical expense coverage for a vast majority of our population—including the disabled.

The House did not accept the Administration's proposal to extend Title XVIII benefits to include disabled beneficiaries, regardless of age, under the social security and railroad retirement systems. We support the action of the House to establish a Special Advisory Council to study the problems and costs related to the inclusion of this group. We view this as a responsible approach to providing for the health needs of these people and respectfully urge the Senate to preserve this section.

There is a notable absence of current comprehensive data on the characteristics of this particular group, their health care needs and their financial ability to provide for their medical expenses. Administration officials testified earlier before your Committee that new data disclosed that both the rate and duration of hospitalization among disabled persons were much higher than previous information indicated. As a result, the Administration more than tripled their original estimates for the cost (from $225 million to $695 million) of including the disabled under Title XVIII. It would appear that this recent survey places added emphasis on the need for an extensive analysis of the health care needs and resources of the disabled before a determination is made on need for, or form of, government assistance to be provided.

Although highly commendable work has been done to launch Title XVIII, and many accomplishments can be recorded, it would appear that there are numerous problems which remain to be resolved before its administration and full cost impact can be evaluated and regarded as satisfactory. While experience is still limited, and final cost figures on the first year of operation are not yet available, your Committee is well aware of the fact that there is every indication that the costs of this program are well in excess of original estimates. Under these circumstances, it seems questionable whether this is the time to add new problems and additional cost requirements.

The Administration's proposed inclusion of the disabled, regardless of age, under Title XVIII is also questionable in view of the objectives and principles under which Title XVIII was originally approved by Congress. Title XVIII was enacted to provide a coordinated approach for the financing of medical care for those individuals aged 65 and over. It was designed specifically for the particular problems of this age group and with their health characteristics and needs in mind. It is our belief that the kind and extent of assistance which the disabled need do not appear to be best served by the benefits contained in Title XVIII. The benefits contained thereunder are oriented toward acute hospitalization and related services. They do not provide sufficient rehabilitative benefits or long-term, custodial type care required for many persons disabled six months or longer.

Public Law 89-97 not only contained Title XVIII but also provided another new title under the Social Security Act—Title XIX—designed to furnish medical assistance on behalf of aged, blind, or permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services and rehabilitation. We strongly believe that Title XIX is the program to meet the health care requirements of special groups in need of assistance. To provide for the inclusion of the disabled under Title XVIII would be to change the concept of that program, an unnecessary step in view of the existing mechanism for health care in Title XIX.

We therefore respectfully suggest that the proposed Special Advisory Council be directed to take into consideration the assistance provided under Title XIX, and other available programs, to determine which best meets existing needs of the disabled. We stand ready to be of service to the Council and suggest that the health insurance business be considered for representation on the Council.

HOSPITAL REIMBURSEMENT

A question has been raised by the hospitals concerning the equity of the reimbursement formula providing for the reimbursement of hospitals for care of Medicare patients, which has been promulgated in regulations by the Department of Health, Education, and Welfare. It is the contention of the hospitals that this method of apportioning costs to Medicare patients will not accurately measure the cost of caring for patients either over or under age 65.

If the facts support this position, it may mean that those persons insured by insurance companies, and those who pay for care from their own resources, are paying more than their fair share of the total cost of hospital care as a result of the operation of the reimbursement formula.

The reports of the House Ways and Means Committee and the Senate Finance Committee on H.R. 6675 (P.L. 89-97),[1] presented the issue of reimbursing costs under the Medicare program and stated the following position: ". . . the cost of services of individuals covered by the program will not be borne by the individuals not covered, and the cost of services of individuals not covered will not be borne by the program." The health insurance business subscribes to this principle and believes that the administration of Medicare should adhere closely to it.

Although the audits which will provide an accurate picture of the cost of the first year of operation under Medicare are yet to be completed, we respectfully urge this Committee to examine carefully the views of the hospitals with respect to the present reimbursement formula and take such steps as may be necessary to assure that the intent presented in the Committee reports is correctly reflected in the administration of the Medicare program.

PROPOSED AMENDMENTS TO TITLE XIX (MEDICAID)

Title XIX was proposed as a program which would consolidate and liberalize the Federal law under which States receive Federal funds and operate their medical assistance programs so as to make medical services more generally available to those individuals with demonstrable need. This basic premise is in accordance with the policy of the Health Insurance Association of America, which supports programs of appropriate governmental assistance in providing health care protection for people who lack resources with which to obtain private health insurance.

However, Title XIX contains a new concept of the individual entitled to government assistance, that of the "medically indigent." This is used to describe an individual or family with enough income for basic maintenance but not enough to meet health care costs. Largely because of the application of this concept, the

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[1] H.R. Rept. No. 213, 89th Cong., 1st Sess. 32 (1965); and S. Rept. No. 404, Part I, 89th Cong., 1st Sess. 36 (1965).

initial cost of the program and estimates of future costs greatly exceed the expectations of Congress. We feel the concept of the "medically indigent," as presently open for interpretation by the individual States, has created unreasonable implementations which could include a considerable portion of the adult working population of moderate income in some States. The Report of the House Ways and Means Committee on H.R. 12080[8] stated that they expected State plans under Title XIX "would afford better medical care and services to persons unable to pay for adequate care." However, the Committee continued by stating it neither "expected nor intended that such care would supplant health insurance presently carried or presently provided under collective bargaining agreements for individuals and families in or close to an average income range."

The health insurance business was founded, and exists today, upon the principle that virtually every American is medically indigent to some extent without some form of protection against the unpredictable cost of health care. To combat the financial drain caused by the catastrophic illness, the health insurance business developed major medical expense insurance which is available to all Americans of moderate income. Last year, insurance companies covered over 55 million persons under age 65 for major medical expenses—over 5 million more than in 1965. All private insurers, including insurance companies, covered almost 149 million Americans below age 65 for hospital expenses at the end of 1966. This was 85 percent of the United States civilian, non-institutionalized population in that age group—over 7 million more than the number covered the preceding year.

Those who do not have the financial resources with which to meet their routine medical bills should surely qualify for Title XIX. But we do not feel this program was intended to cover the area of catastrophic health costs for individuals who do have the means to purchase private protection against such contingencies, or who have such protection provided for them by virtue of their employment. It therefore appears desirable for the Federal Government to place some reasonable limitation on the definition of the "medically indigent" for which Federal matching funds would be available under Title XIX.

Section 220 of this measure is proposing, for all State plans approved after July 25, 1967, that Federal sharing will not be available for families whose incomes exceed 133⅓ percent of the highest amount ordinarily paid to a family of the same size (without any income and resources) in the form of money payments under the Aid to Families with Dependent Children program. The Secretary is given discretion to make appropriate adjustments if a State applies a uniform maximum to families of different sizes. A further test of the matchability of State expenditures is provided by setting a figure of 133⅓ percent of the average per capita income of a State as the upper limit on Federal sharing when applied to a family of four under the Title XIX program. That figure would be proportionately reduced or increased to reflect the level for smaller or larger family groups. For States with plans already approved, the limit of Federal sharing under both tests would be 150 percent effective July 1, 1968, 140 percent effective January 1, 1969, and 133⅓ percent on January 1, 1970.

We support this action of the House, but it appears that these limitations may produce inequities in some of the States. Specifically, it may result in the exclusion of individuals eligible to receive cash assistance payments from the provision of medical assistance under Title XIX.

In order to keep this program within the realm of what we believe is its intended objective, we respectfully suggest that this section be amended to add the provision that in no event would the operation of the limitations exclude from Title XIX Federal matching funds for any individual or family eligible to receive monthly cash assistance payments from a State. We feel that this is necessary and in keeping with reasonable standards for eligibility under Title XIX based on actual need.

Section 226 would establish a Medical Advisory Council to advise the Secretary on matters of general policy in the administration of medical assistance (including the relationship of Titles XVIII and XIX) and make recommendations for improvements in such administration. We support this provision and believe that representatives of the health insurance business would be a vital asset to this Council and hope that we are invited to participate.

The views presented are based on the long experience of our member companies in providing a risk-spreading mechanism for the financing of medical care; they reflect our sincere appreciation as individuals of the personal and social com-

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[8] H.R. Rep. No. 544, 90th Cong., 1st Sess., 118, (1967).

plexities which surround the economics of medical care. The health insurance business is increasingly aware of its commitment to, and involvement in, the quality and availability of health care in this nation. We are attempting to discharge this obligation in a manner both responsible and proper, to the betterment of all Americans.

STATEMENT SUBMITTED ON BEHALF OF THE 15 INSURANCE COMPANIES PARTICIPATING IN THE ADMINISTRATION OF MEDICARE, BY WILLIAM O. WHITE, JR., CHAIRMAN, MEDICARE ADMINISTRATION COMMITTEE, HEALTH INSURANCE ASSOCIATION OF AMERICA

This statement is presented on behalf of the following insurance companies: Aetna Life & Casualty; The Travelers Insurance Company; Mutual of Omaha Insurance Company; The Prudential Insurance Company of America; Nationwide Mutual Insurance Company; Connecticut General Life Insurance Company; John Hancock Mutual Life Insurance Company; The Equitable Life Assurance Society of the United States; Metropolitan Life Insurance Company; Pan-American Life Insurance Company; Continental Casualty Company; General American Life Insurance Company; Occidental Life Insurance Company of California; Union Mutual Life Insurance Company; and Pilot Life Insurance Company. Collectively, these fifteen insurance companies under contract with the Social Security Administration pay Part B (Supplementary Medical Insurance) benefits to approximately eight million beneficiaries, including all the Railroad Retirement beneficiaries who are served by The Travelers Insurance Company. The first five companies also serve as fiscal intermediaries for hospitals, home health agencies, and extended care facilities under Part A (Hospital Insurance Benefits).

In testimony presented on March 6, 1967, before the Committee on Ways and Means of the House of Representatives, we expressed our concern with the problem faced by the Medicare beneficiaries in the collection of Part B benefits for physician services. As the Act now stands, Section 1842(b)(3)(B)(ii) requires that a Supplementary Medical benefit payment which is based on charges "will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service." The percentage of physicians accepting assignment under Medicare varies considerably from one area to another but the overall percentage appears to be about 50%. This means that in about half the cases a beneficiary must secure sufficient funds to pay the physician's bill in full before he can receive any benefit payment from Medicare. When the amount of the bill is large, as many of them are, the beneficiary may have to borrow money at considerable personal inconvenience or sacrifice to pay the physician in order to be able to present the carrier with the necessary receipted bill.

We are pleased that the House of Representatives took cognizance of this latter situation and proposed to remedy it by means of Section 125(a). While the principle of permitting benefit payments to be based on an unpaid itemized bill, which is enunciated in Section 125(a), is sound, the administrative requirements specified therein are unduly complicated. As this section now stands it will increase rather than decrease the complexity of administering Part B, and hence probably will delay payments and increase administrative costs. Equally important, much dissatisfaction on the part of both beneficiaries and physicians will result. We believe the unwarranted administrative detail can and should be stricken while preserving the principle.

Specifically, Section 125(a) requires that if an unpaid itemized bill is submitted by a physician within a grace period, to be specified by the Secretary of HEW, and is in an amount which is determined to be reasonable, the benefit payment is to be made to the physician. Otherwise payment is to be made to the beneficiary. If the beneficiary submits an unpaid itemized bill during this grace period, the carrier may not pay the beneficiary immediately but must set up a special suspense file. The claim must be held until the grace period has expired, or alternatively, the carrier must contact the physician to obtain assurance that the physician will not exercise his right to claim payment during the grace period.

While the carrier may notify the beneficiary of the unavoidable delay in such a claim situation, the beneficiary will not be happy with the delay and in most instances will not understand the reasons for it. In the event that the carrier attempts to expedite settlement of the claim by contacting the physician for the above-mentioned assurance that the physician would not himself make claim for payment, the physician may react unfavorably to this contact. He may either feel that his furnishing the beneficiary with the bill was sufficient evidence of his intent not to collect from the carrier or he may intend to collect and is merely furnishing the beneficiary a copy of the bill at the beneficiary's request.

This procedure is required as a result of the language in Section 125(a)(2)(iii) at page 47 of H.R. 12080, lines 17 and 18, which reads ". . . and within such time as may be specified in regulations . . ." and on page 48, lines 2, 3, and 4, by the words ". . . fails to submit the bill under Clause (1) within the time specified or . . .". We therefore recommend that this wording be deleted. The recommended change will permit the carrier to process benefit claims promptly on the basis of the first itemized bill received on a particular claim, whatever the source. This will avoid the delays, misunderstandings, and the burdensome administrative costs associated with the maintenance of a suspense file, all of which are inherent in the existing language.

There is a second provision of Section 125(a)(2)(iii) which, if eliminated, would avoid complications in administration and relations with physicians and beneficiaries. This provision prohibits the carrier from making payment to the physician in those circumstances where the carrier finds it necessary to base its benefit payment on an amount less than the full charge shown on the itemized bill. Instead, the determined benefit would be paid to the beneficiary.

We would suggest that a better result would obtain if the carrier could pay the physician the determined reasonable charge (when the physician has submitted the itemized bill, because his reaction would be better than if he were notified that the benefit payment had been made to the beneficiary. Similarly, the beneficiary would have a more favorable reaction because the benefit payment had been made in the manner he had anticipated—directly to the physician.

To accomplish this improvement we recommend the deletion from Section 125(a)(2)(iii) at page 47 of the words in lines 18, 19, and 20, which read ". . . and the full charge is found not to exceed the reasonable charge for the service . . ." and at page 47 the words on lines 22 and 23 and at page 48, line 1 ". . . either because the charge made is found to exceed the reasonable charge for the service, or . . .".

Another matter of concern to the fifteen insurance companies is the lead time for administrative changes which will be permitted between the enactment of the Social Security amendments and effective date of those amendments. This, we are sure, is also a matter of concern to the Social Security Administration. We want to continue to render services to the Medicare beneficiary in the most efficient manner possible. Throughout the past year all of us have improved our processing of Medicare claims to minimize the time lag between the submission of claims and payment of benefits. Certain changes proposed in H.R. 12080 will require considerable reprogramming of computer operations. Also, of course, we do not know the final form the Social Security amendments may take after consideration by the Senate.

We respectfully suggest, therefore, that a small committee of the carriers work with members of the Finance Committee and its staff and with the Social Security Administration to evaluate the time needed for the implementation of each amendment affecting the Medicare program. We assure you that we have no desire to delay the effects of the proposed changes and, of course, will work to implement the amendments in the interest of prompt and effective service to the beneficiaries.

Comments by Harold O. Swank, Director, Illinois Department of Public Aid

CHANGES PROPOSED BY H.R. 12080 IN THE PROGRAMS FOR AID TO FAMILIES WITH DEPENDENT CHILDREN (TITLE IV AFDC) AND MEDICAL ASSISTANCE (TITLE XIX MEDICAID)

The changes proposed in the AFDC and Medicaid programs by the Committee on Ways and Means in H.R. 12080 (which has passed the House and is now under consideration by the Senate) differ considerably from those contained in the Administration's Bill, H.R. 5710, for which the Committee substituted H.R. 12080—and the proposed changes have caused considerable discussion among those interested in welfare administration.

The Illinois Department of Public Aid—which administers these programs in Illinois—therefore wishes to inform the Congressmen and Senators from Illinois, and others concerned, of the Illinois Department's reaction to the Bill's proposals.

OVERALL VIEW

From an overall view and in terms of their declared objectives, most of the amendments are constructive. If administered with vigor and imagination, they should provide both the Federal Department and State welfare agencies with program management aids that, over time, should enlarge public understanding and support, as well as slow or reverse the present trend towards higher AFDC caseloads.

With certain major exceptions and some minor adjustments, the reforms proposed by the Bill would initiate on a nationwide scale measures already in operation in considerable scope in Illinois—*and proved effective*—and in other areas make possible further reforms long advocated by the Illinois Department of Public Aid and its Legislative Advisory Committee but up to now proscribed by Federal law or by the Federal Department of Health, Education and Welfare's *interpretation* of Federal law. A general picture of the present Illinois program and its background is given in the pamphlet (Attachment A) *The Story of Public Aid in Illinois* (particularly pages 8 through 13).

The Bill has several features which we believe merit particular support, including some that have drawn strong opposition from some segments of the welfare community. Chief among these issues is *compulsory* acceptance of employment and training by adults and out-of-school teenagers in the AFDC program, including mothers for whom suitable child care arrangements can be made while the mother is employed or in training. Illinois, we believe, has demonstrated the necessity of these provisions. We shall therefore set out, in considerable detail, our reasons for supporting this and some of the other proposed reforms in the national AFDC program.

The Bill also has certain features which will defeat the objective sought by the Committee in the other changes it proposes for the AFDC program—in particlar, the proposed restrictions in the AFDC-Unemployed program and the proposed "freeze" on the absent parent segment of the AFDC program. It also proposes certain corrections we believe erroneous for the Medicaid program—in particular, the *method* of correcting the "comparability" provisions and the questionable applicability of the per capita income adjustment—and fails to make other changes which would more effectively correct other "costly mistakes" in the original legislation—in particular, the "Maintenance of State Effort" formula and the premature if not invalid, conceptual uniformity with the new and inexperienced Medicare program. These features of the Bill *must be amended* and we shall set out our reasons for so believing.

Finally, the Bill is silent entirely on one essential reform that should be made *now* if the other changes the Bill does contain are to be fully effective. This is a requirement that each State, as a condition for Federal participation, make assistance payments at 100 percent of the State's Standard, review the Standard at least annually, and update it for changes in cost or other appropriate factors. A requirement along these lines was contained in the Administration's Bill (H.R. 5710) but that Bill failed to contain necessary Federal guidelines concerning the lower and upper limits for acceptable State standards. We shall therefore discuss both the need for *State performance at State standards* and the criteria that might be applied as *Federal guidelines for acceptable standards.*

Following, in more retail, are the Illinois Department of Public Aid's comments and recommendations.

CHANGES PROPOSED FOR AID TO FAMILIES WITH DEPENDENT CHILDREN

While we cannot agree with the Committee on Ways and Means in all of the measures it proposes for the AFDC program, we must commend that Committee in particular for the action orientation it has now given that program.

All of us directly responsible for this vital public service know intimately the highly complex human and social distress factors that lie behind the high costs of this program. However, we in Illinois join with the Committee in the view that the time has long passed when we can allay the public concern by citing the factors behind the costs—and stopping there. The State and Federal governments must *act* in an effort to produce change in the direction of the goals and values declared as the public purpose in establishing the AFDC program. We believe our experience in Illinois has established that this can be done by a constructive combination of financial aid and family services, *judiciously balancing recipient entitlements with recipient obligations* for utilizing all available means for improving the family situation and developing capacity for self-support and independence. Costs will be understood—and supported—only if benefits can be demonstrated for recipients and society alike.

On the basis of Illinois experience and management philosophy, the Illinois Department of Public Aid supports the bulk of the reforms in the AFDC program proposed by the Bill (provided certain minor amendments and clarifications, as noted, are made), raising major objection only to the following:

1. The proposed restrictions in the AFDC-Unemployed program.
2. The proposed freeze on the absent parent segment of the AFDC program.

With the modifications or clarifications noted in certain instances, the Illinois Department of Public Aid supports the following proposals:

1. Making it *mandatory* (rather than optional) that the States furnish all adult recipients in the AFDC program—*including mothers*—and teenage children out of school, with those services which will develop their potential for employment or for advancement in their employment (Section 201 of the Bill)—and making it *mandatory* that the foregoing recipients accept employment in which they are able to engage (Section 204(b) of the Bill).

Antedating the service amendments of 1962 to the Federal Act, Illinois provided in its AFDC program the basic education, vocational training, employment counselling, and child care services which the Bill would now require in every State.

It also has *required* that mothers avail themselves of opportunities for employment or training in all cases where the welfare of the children would not be imperiled and suitable arrangements could be made for child care during the mother's absence for training or work.

As a result, the Illinois AFDC recipient load in July 1966 had *decreased* by 5.6 percent from July 1962—compared with a national *increase* of 22.9 percent. This trend has continued into 1967, although at a reduced rate (for reasons which will be indicated at the end of our comments on the AFDC program). The Illinois AFDC recipient load compared with that of other large industrial States is shown in the table given as Attachment B to this Statement.

Clarification Needed:

a. In endorsing this feature of the Bill, we are assuming that the Committee (as stated in its Report) intends that this concept of maximizing the employment potential of AFDC recipients includes encouragement of the children to remain in school, at least through high school. The same would apply to AFDC children capable of education beyond high school and eligible for aid under Section 406(a)(B) of the present Federal law. We are informed that an article in the *New York Times* construed the Bill as not exempting children in school from the employment requirement. To remove all doubt, *the Committee's intent should be stated within Section 201.*

b. We are also assuming that, in determining whether a mother should be required to accept suitable employment, *prior* consideration will be given to the welfare of the children and acceptance of employment required only if appropriate arrangements can be made for the care and protection of the children during the mother's absence from the home. This provision is made in Section 204(a) of the Bill relative to Community Work and Training programs but *not* in Section 204(b) denying aid to those refusing employment "without good cause". *The child protective provision should be made applicable to both and clearly stated in the amendatory language.*

Except for this omission, we believe with the Committee that preparation for employment *on a compulsory basis* offers the best and only avenue of escape from poverty for mothers and their children aided through the AFDC program. Giving the mother a choice (between the minimum subsistence provided by AFDC and self-support for herself and children)—as has been urged by some as appropriate public policy—is both inconsistent with the broader functions women generally, including the poor, have established for themselves in present day America and inimical to the ultimate welfare of the children if they are to be provided with models of parental figures participating to the extent of their abilities in the mainstream of American life. We believe further that this "choice" philosophy ignores the detrimental conditions surrounding child rearing in our urban centers and the aids to cultural adjustment that are provided mothers as well as children by the developing day care programs. This ignoring of present day facts of life—combined with Congressional failure in the past and also in the present Bill to *require* the States to include in their AFDC programs *normal* families with the father present but unable to supply a sufficient livelihood because of unemployment, underemployment, *or low earnings from full-*

time employment—has contributed, we believe, to the high proportion of absent father and "illegitimate parenthood" cases on the AFDC rolls.

On the urgent need for additional day care facilities and other child care arrangements (including use of AFDC mothers to care for the children of other AFDC mothers; use of homemakers; and other approaches), we must call attention to the scattered, uncoordinated, and totally inadequate approach now prevailing at both Federal and State levels. Federal funds are provided through numerous Federal laws (Title V Child Welfare Services, Title IV AFDC, The Economic Opportunity Act, etc.). Yet, in Illinois, in the 12 counties (Alexander, Champaign, Cook, Lake, Macon, Madison, Peoria, Sangamon, St. Clair Vermilion, Will and Winnebago) in each of which there are currently over 1000 children receiving AFDC—for a total of 180,546 children—there are currently in operation only 694 day care centers with a capacity of 26,669 children. Even if this capacity were doubled by using two shifts in each facility, the need would not be met for AFDC children—let alone children of other mothers who are working or taking training for work.

Faced with this lack of facilities, the Illinois Department of Public Aid has established, in cooperation with the school districts and the State Superintendent of Public Instruction, child care facilities in the full time Adult Education Centers for public aid recipients now in operation in Chicago, Cairo, Danville, Decatur, East St. Louis, Eldorado, Mattoon, Peoria and Rockford.

From our experience, we have concluded that the Federal Government and the States might well consider eliminating the present fragmentation and inadequacies in the field of day care for children by making day care a part of the regular function of *all school systems.* We envision a program whereunder school people and child welfare agencies would jointly set standards and program content. The service would either be provided without charge to *all* children who needed the service, or charges might be established on the basis of cost—with mothers unable to pay the charge qualifying for public aid for the necessary supplementation. In other words, we believe a program for Child Care Supplementation will meet an urgent modern need—in the same way that Title XIX coverage of the Medically Indigent has met an urgent modern need.

c. We are also assuming that Illinois—*although it has implemented the provisions in advance of Federal action*—will qualify for the elevated 85 percent matching for these services the Bill makes available until 1969. We have had experience in the past of being denied the more favorable Federal matching provided by the Congress "to encourage implementation" on the basis that the Congress intended only that *new* efforts be rewarded. If there is any possibility that Illinois will again be penalized for its initiative, *we request that the Bill clarify its intent to cover the services in all States.*

2. Making it *mandatory* (rather than optional) that the States develop community work and training programs for AFDC recipients, adding Federal matching of training, supervision and materials costs for such programs, and retaining in H.E.W. and the State public aid agencies the responsibility for developing and maintaining the programs (Section 204 of the Bill).

Illinois is one of the 12 States noted in the Committee's Report as having established such a program. In fact, much of the wording in the present provisions of Section 409 of the present law authorizing the program closely parallels similar provisions in the Illinois Public Aid Code.

These Illinois public service and training program—closely related to the casework services and designed especially to overcome the many handicaps presented by recipients with extremely limited employment potential to begin with—grew up out of necessity. Without this prior highly individualized and carefully supervised work and training experience, we found that the recipients covered had little chance of gaining acceptance by the Department of Labor's Manpower Development and Training program or training programs offered by other agencies. They were rejected here as well as by private employers. Now, with their major handicaps treated successfully through the welfare-oriented program, they have moved on to success both in Labor's more advanced training programs and in private employment.

We are therefore glad to see that H.R. 12080 rejected the plan to divide authority with the Department of Labor, as previously proposed in H.R. 5710. It is our understanding, however, that the Senate is being urged from various directions to restore the divided authority proposed in H.R. 5710. *We oppose this restoration—both for the reasons stated above—and because we deem it improper that Federal law should spell out the detailed administrative arrangements a*

State should make for carrying out a program financed in part by Federal funds. The States should be given appropriate leeway for establishing the administrative structure best suited to the program conditions within the State. In this instance, the Bill otherwise provides for maximum utilization of Manpower Development and Training Act facilities and other resources, *public and private.* With Federal as well as other resources not evenly developed in all States, each State can best determine the most effective plan for both immediate and long range goals.

3. *Requiring* the States to adopt an action program for obtainment of child support, establishment of paternity, correction of unsuitable home conditions, and reduction of illegitimacy through family planning and other services, with attendant development of cooperative planning with law enforcement officials and Federal contribution to the costs involved in enforcement proceedings (Section 201 of the Bill).

All of these measures have been part of the Illinois AFDC program for some years.

In 1965, to improve its enforcement procedures, Illinois centralized in the office of the Attorney General of the State the responsibility for taking to the courts all cases in which court action was indicated. He is empowered to do this through his own special staff or through the State's Attorneys in the several counties of the State. Prior to this remedial legislation, the Department of Public Aid often had to stop short of necessary court action because the local State's Attorneys were unwilling, or unable because of the costs involved, to undertake the action. To date, however, the Federal Department of Health, Education, and Welfare has refused to match costs incurred by the Attorney General of Illinois in his operations for the Department in this area. *We are assuming that this Bill will correct this gap in an effective program for obtaining child support, and that Federal funds will at long last be made available to Illinois for this undertaking.*

On family planning, we commend the Committee for requiring the States to take a positive rather than passive approach in offering the services to all appropriate individuals on the AFDC rolls. We must caution all concerned, however, not to expect dramatic results in terms of immediate reduction of illegitimate parenthood or inordinately large families among the population currently receiving AFDC or likely to require AFDC in the future. The Illinois Department of Public Aid's family planning service has been in operation since 1963—yet we are currently furnishing these services to only 5,283 cases out of a total of 54,572. To be sure, the aid we provide is now augmented by services furnished through public health clinics, OEO Community Service Centers, some hospitals, and other private organizations. *Yet*—the number of persons per AFDC family has risen *in the "broken homes" segment* (absent and illegitimate parent segment) of the AFDC caseload from 3.7 persons in June 1963 to 4.0 persons in June 1967. The AFDC-Unemployed segment, in contrast, has risen but slightly—from 6.4 to 6.5 persons over the same period. But neither has *declined.* There are indications that three factors have contributed to this trend: (1) propaganda circulated to AFDC mothers to avoid family planning as a "plot" to reduce the numbers counted in minority groups; (2) discontinuance of family planning procedures after departure from the AFDC rolls—for cost factors or other reasons; and (3) intermittent rumors or publicity concerning possible health hazards. We have concluded that the only practical possibility for coming to grips with these factors as they affect the AFDC population is to continue family planning aid as an expense chargeable to the AFDC program even if the family no longer needs help for other expenses. Families desiring the aid should be continued—*with Federal matching at a level of at least 75 percent for both family planning costs and casework services*—until there are specific grounds for concluding that the mother will continue the program and use her resources to pay the costs involved.

4. *Requiring* the States to provide for foster home care for AFDC children removed from unsuitable homes, enlarging the numbers of children that might be covered, and providing for Federal matching more consistent with the higher costs required in foster home care (Section 205 of the Bill).

Illinois, by legislative action in 1959, initiated a foster home program for AFDC children removed from unsuitable homes ahead of the provisions first added in 1961 to the Federal Act. Although small—payments were made for only some 377 children during July 1967—we have viewed this provision as a necessary adjunct to the "family home" orientation of the program. Without the foster care program as an adjunct, the courts have often been loath to remove children from unsuitable homes when they were uncertain as to where funds could be found for their support after removal.

However, here again—as in some other areas—Illinois has encountered a program limitation arising from a questionable interpretation of the Federal Act by the Federal Department of Health, Education, and Welfare. The Department in its *Handbook of Public Assistance Administration* has ruled that Federal matching will be available only if it is ascertained in the first instance that the removed child *has a parent or eligible relative* (as defined in Section 406 of the Federal Act)' to whose home he can return or in whose home he can be placed within a reasonable period of time. The Department regulations further state it is expected that the States will not provide foster care for any child *who cannot be returned to his parent or placed in the home of a relative.* This interpretation has also ruled out any child removed on the basis of the physical, mental or emotional condition of a parent (or other relative) when the condition is not likely to improve and there is no other eligible relative with whom the child might eventually be placed.

Under this interpretation, the Department of Public Aid was forced in 1966 to discontinue aid for many children formerly included in its AFDC-Foster Care program and shift responsibility for their care to General Assistance authorities or the limited funds available to the Child Welfare Division of the Illinois Department of Children and Family Services.

We believe this interpretation was not founded on the letter of the present Federal law and it certainly runs counter to the intent of the Committee in the new foster home provisions contained in Section 205 of the Bill. We therefore recommend that the Bill be clarified to provide that foster home care be continued until such time as other suitable arrangements can be made for the child.

We appreciate the Committee's motives in enlarging coverage of the foster care program to cover certain children placed in foster homes prior to receipt of an AFDC grant. We must call attention, however, to the difficulty of determining eligibility, particularly in the area of parental resources, for some prior time. This will be particularly true in the case, cited by the Committee, of a child both of whose parents have been killed in an auto accident. These parents may have had earnings or other resources which would have disqualified the family for AFDC prior to the accident and therefore the child, under the wording of the Committee's Bill, would not "have received such aid . . . had application been made therefor".

We accordingly recommend that the Bill be clarified to specify that the child will be eligible if he had lived with a parent or other relative specified in Section 406 prior to court action for placement in foster home care but at the time of the court's determination (a) he had no parent or (b) his parents lacked sufficient means to meet the costs of foster home care.

5. Authorizing the States to pay—with Federal matching—the public employment offices for costs involved in testing, counselling and placing AFDC recipients in employment, and making this provision mandatory effective July 1, 1969 (Section 204(f) of the Bill).

This provision should aid materially in shifting to the public employment offices a responsibility which is properly theirs and which welfare agencies have often had to carry for AFDC recipients who present limited employability and special problems requiring careful matching of the potential worker to an available job plus individual persuasion of the employer to give the applicant a chance at the job. Payment for the specialized attention and services required should serve the same purpose as use of public aid funds to induce the schools and other appropriate educational authorities to provide education specifically designed to overcome the special handicaps presented by some recipients in the AFDC program. Eventually, these functions should become an integral part of the employment service program—as is already beginning to happen in the case of the educational program. It should then no longer be necessary for public aid agencies to pay these other public bodies for the services provided.

6. Providing an income incentive for the adults in the AFDC family, making this incentive uniform for work or training on Federal programs *and private employment*, and excluding entirely earnings of children in school (Section 202 of the Bill).

An income incentive for the adults in an AFDC program is a long overdue reform. Also long overdue was the elimination of conflicting exemptions made by other laws for Federal program employment or training, and correcting the absence of any exemption under Federal law for earnings in private employment.

We have three *objections*, however, to the earned income proposal as presently contained in the Bill:

a. A *mandatory* exemption at the level proposed may result—in some States—in bringing the spendable income of an AFDC family indefensibly out of line with that received by substantial numbers of their self-supporting neighbors (as has occurred with the Economic Opportunity Act exemptions). This would defeat the "incentive" objective of the provision. It would also considerably affect the financial planning of States like Illinois, which currently budget substantial earnings in the AFDC program. In June 1967, adults in the Illinois AFDC program had earned income budgeted against their basic requirements totaling $952,400. The Committee's Bill, *unmodified*, would reduce this budgeted income by approximately one third. Although some of this reduction will be offset by the scaling down the Bill makes in the exemptions hitherto provided by other Federal laws, we believe the States should be given an opportunity to apply this amendment in a manner which will not disrupt the proper relationship of AFDC standards with the standards of self-supporting families.

We therefore recommend that the mandatory exemption be limited to $30 and that exemptions above this amount be left to the discretion of the States.

b. The formula for providing an incentive above the base figure of $30 is too high, in our judgment, and unnecessarily cumbersome. We agree with the Committee, however, in discarding a dollar ceiling on the overall exemption for all adult or out-of-school earners in the family. Since wages and costs change, a proportion of earnings as a control on the total exemption is a more appropriate device.

We recommend that the formula be revised to permit the States to exempt, in addition to the base $30, not to exceed 10 per cent of total earnings.

c. The earnings exemption should apply equally to *all applicant families* (as well as to recipient families and families off the rolls for not longer than four months).

We appreciate the Committee's concern that this and other features of the Bill not lead to an increase in the rolls, but rather to their reduction. However, an income exemption is not only an incentive to employment and other means of self-help. It is also recognition that persons who try to help themselves should have some recognition for their efforts. It therefore follows that an applicant family that has some income—but not enough to support itself at the same level that would be provided an AFDC family already on the rolls—should be entitled to equal recognition of its efforts and given aid until its total income makes aid no longer necessary.

We therefore recommend that the income incentive be made applicable to applicant families without restriction (as is the case under current Federal law for applicants and recipients in the programs for the aged, blind and disabled.)

We also recommend that the income incentives in the programs for the aged, blind and disabled (and also in the combined AABD programs under Title XVI) be revised and made identical with the income incentive provided for the AFDC program. Any special needs occasioned by the special handicaps of age, blindness or disability are more properly recognized in the public aid standard—rather than in the income incentive. Dollar ceilings should be eliminated, the basic exemption figure made identical and mandatory, and the additional incentive uniform on a permissive basis.

7. Providing for vendor payments as an alternative method of making a "protective payment" in cases of mismanagement of the grant (Section 207 of the Bill).

The Illinois Department of Public Aid and its Legislative Advisory Committee in 1965 and 1966 urged the Department of Health, Education, and Welfare—*to no avail*—to support a correction in the Law along these lines. We viewed it as not only a more practical and common sense response to severe management situations than the "third party payee" method first introduced in the Federal law in 1962, but one which should be more palatable to recipients than having another person take control of their check. We also urged that the change would not erode the "money payment" principle of the public assistance Titles but rather protect that principle by enabling administrative agencies to act in deviant situations—rather than plead, as has been the case, that the principle recognized no deviancy. Although the Federal Department registered its intent to oppose the legislation, Congressman Rostenkowski of Illinois thereupon introduced a Bill in the 89th Congress (H.R. 16850) to cover the AABD as well as the AFDC program. Congressman Rostenkowski's Bill was substantially the same as the provision now contained in H.R. 12080, except that it provided further that vendor payments might be combined with money payments "in such manner as may be appropriate in view of the nature and extent of the fund management problem presented, with the intent that payments to such suppliers be utilized only in cases of chronic and serious mismanagement of funds and in such a way that the needy individual can be returned at the earliest possible time to full control of his money payments."

We believe that the additional provisions of Congressman Rostenkowski's H.R. 16859 should be incorporated in the vendor payment amendment made by H.R. 12080, with appropriate adjustments in language to accommodate the Committee provisions for use of protective payments to meet the needs of children when the parent or parents refuse work or training. Further, should the Senate include in its amendments to H.R. 12080 any amendments for the aged, blind or disabled public assistance Titles of the Act, we believe these amendments should include a like alternative in the protective payment Section of these Titles.

Now for our two major objections to the AFDC provision of the Bill—the two features which we believe it is imperative that *the Senate amend out of the Bill* if the States are to be expected to achieve the program objectives which the Committee on Ways and Means—in its own Report accompanying the Bill—declared as the Committee's objectives in offering the amendments.

These two objectionable and program-defeating proposals are:

1. Restriction of the AFDC program in its coverage of unemployed fathers to deny aid to (a) families in which the father has not previously established attachment to the work force, under criteria set out in the Bill; (b) families in which the father has not been unemployed for more than 30 days; and (c) families in which the father is receiving Unemployment Compensation (Section 203 of the Bill).

Besides believing these restrictions to be unwarranted—for reasons to be set out shortly—this Section of the Bill is so worded that it could be construed as denying Federal aid to a State which chooses to cover such fathers irrespective of Federal matching. The limitations are set down as *State Plan requirements*—rather than as limitations on Federal matching. This ambiguity in the Section should in any event be eliminated. It is not proper that the Congress prevent a State from adopting a program more inclusive than that matchable within the bounds of the Federal law.

Excluding from coverage fathers who do not have the designated "attachment to the work force" will not apply to vast numbers of cases. The exclusion, however, will operate to defeat, in the cases to which it will apply, the declared purpose of the program for stabilizing family life and reducing dependency by providing financial aid and services to persons whose lack of employment or employment opportunity have prevented them from establishing or maintaining a normal home for their children. Suppose, for example, that the mother of an illegitimate child receives AFDC for herself and that child. Later, she marries the child's father—who happens to be a high school dropout of a minority group who has never been able to find employment sufficient to qualify him under the Bill's provisions. This father, the mother, and the legitimatized child would be disqualified for AFDC-U under the Bill's provisions requiring attachment to the work force. This would not only defeat the Committee's declared aim of revamping the program so as to reduce illegitimacy and reduce absent parent cases. It also would preclude the welfare agency from continuing the AFDC program to this family as a means of cementing the family together and equipping both the father and the mother through the training programs for self-support.

A like contradiction of program objectives occurs in the proposal to deny aid unless the father has been unemployed for at least 30 days. Here, however, the adverse effect will be felt mainly by the established family of large size—those without any backup resources, probably with heavy installment debt, and destitute the minute the factory pay check stops. Nothing is to be gained by delaying aid to this family for 30 days. On the contrary, by making it immediately available, the family might be guided into other employment *within 30 days*—and, in any event, started sooner on a training program which should reduce the period of dependency.

The Committee's Report gives no rationale whatsoever for the exclusion of a father who is receiving Unemployment Compensation. Under the Illinois Unemployment Compensation law—and probably those in many other States—fathers in unskilled occupations who have large families qualify for Unemployment Compensation benefits which, if they are the sole income of the family, are less than the amount required for subsistence at the Illinois' AFDC standard.

This is not only irrational treatment of fathers who have demonstrated their "attachment to the work force" and supported their families, but such fathers could not be blamed if, in response, they left their families and thus added to the "absent parent" caseload. For example:

Under Illinois law the most Unemployment Compensation that can be received is $70 per week and this amount can go only to the worker with four or more children and then only if his highest earnings were at least $598 per month—a wage above that of most public aid applicants. At $70 per week a family of a man, wife and four children would receive $306.67 per month. The present Illinois AFDC budget for a man, wife and four children, ages 8, 10, 12 and 16 (assuming a rental of $90) calls for aid totaling $312.89. In this case the family would qualify for only a small grant of a little over $6.

But take an unskilled factory worker or a dishwasher with a wife and four children of the same ages. The unskilled factory worker (with average weekly earnings at $83.20 or $360.53 per month) would qualify for Illinois Unemployment Compensation at only $44 per week or $190.67 per month. This person under the Bill would be disqualified outright for AFDC–U although his resources are over $100 under the State's standard for AFDC. The dishwasher would qualify for $156 per month in Unemployment Compensation. He also would be ruled out under the Bill for AFDC–U although his compensation is $157 below the State AFDC standard.

Here again, the Committee's provision would appear to defeat the Committee's purpose of encouraging employment and independence.

2. The proposed "freeze" on the absent parent segment of the AFDC caseload by limiting Federal participation to cover only the number of such children as constitute the same portion of the child population in the State as obtained on January 1, 1967 (Section 208 of the Bill).

The Committee seeks to justify this proposal on the basis that it will "stimulate the States" to institute the reforms contained in other Sections of the Bill (presumably Sections 201 and 204). These Sections have other penalties for the States, if they are not "stimulated" (no Federal participation whatsoever in the program). We see no sense nor justice in singling out for further deprivation the very children who are most in need of the program's benefits because their father has deserted them, is in jail or an institution for the mentally ill, or has never married their mother. It would be more appropriate, we believe, that the States first have an opportunity to demonstrate what results can be achieved through the other measures the Bill directs at the problem of the absent parent before children are penalized for acts of their parents or acts of the States—over neither of which they have control.

In fact, instead of restricting the AFDC-Unemployed program, this program should be made *mandatory* upon all the States (as had been proposed in the Administration's H.R. 5710) and its coverage extended to include not only the families of unemployed and underemployed fathers but the families of fathers working full time but earning insufficient money to provide the family with a livelihood.

Information available at the time the program was inaugurated in 1961—and now augmented by facts being yielded everyday in the current concern with unrest in our large cities—has pointed to the fact that only by prompt and adequate aid to the *normal* family, do we have real hope of stemming the "illegitimate parent" and "absent parent" segments of our AFDC caseload. It is very possible that the *premium* the original AFDC program placed on the broken home has contributed materially to the failure of the program to stabilize family life—particularly where lack of job opportunities for males has been a factor. Rather than increase costs, extension of the program to normal families throughout the nation should lower dependency by enabling the States to work with the family through the employment and training programs at a time while it is still intact. Indeed, with a provision along these lines added to the Bill, we would see no need for the emergency assistance program provided by Section 206 of the Bill—except as that Section might properly be revised to apply only to emergency care for migrant families and others not meeting State residence requirements—and funded at 100 percent Federal funds with State administration (similar to the program for assisting Cuban refugees).

We note one final discrepancy in the Committee's Bill relevant to the AFDC-Unemployed program. Under Section 407(b)(2)(D) of the Federal law—as this would be amended by Section 203(a) of the Bill—aid is to be denied the *entire family* if the father isn't currently registered for employment or refuses work or training for work. This appears to be out of line with new State Plan requirement No. 20 added by Section 204(b) of the Bill relative to refusal of employment or training by parents or other relatives or teenage children in the other segment of the AFDC caseload. Here, aid is to be denied only to the recalcitrant parent, other relative, or out-of-school teenage child. The children in the remainder of the family are to have aid continued through a protective payment. *We believe a like provision should be made for the AFDC-Unemployed program.*

There is no sense in requiring needy children in one case to be shifted to local General Assistance authorities—if the State has a General Assistance program—but not in the case of a broken family. We believe that the AFDC program should provide continuing aid for the children while withdrawing aid for the parent or other adults who refuse to avail themselves of opportunities for working or training.

We note further that Section 209 of the Bill providing for Federal recognition of payments made for repairs to homes owned by public aid recipients *fails* to include homes owned by the parent or other relative in AFDC families. The amendment covers only the single person categories.

Surely home ownership is equally important as a stabilizing factor for families with young children, as it is the means of security for the older individuals receiving Aid to the Aged, Blind or Disabled. This Section of the Bill should be amended to cover also repairs for homes owned by AFDC families.

We must conclude our comments on the AFDC amendments proposed by the Bill by two observations that do not fit into any particular amendment proposed by the Bill but rather cut across the entire problem of dependency upon the AFDC program.

1. As noted earlier, the Illinois AFDC load has slowed down in the pace of its decline during the past year. Although there has been some sluggishness in the economy, this has not been severe enough to account for this change. On the contrary, we have reason to believe that there is now beginning an *induced* increase in applications stimulated by the activities of Economic Opportunity Act Community Service Centers and others urging families that have hitherto managed without public aid to apply for public aid. We appreciate the fact that the public aid rolls do not represent coverage of all persons who would meet the eligibility requirements if they chose to apply. However, it is quite another matter—in our judgment—for one branch of government to undertake programs which tend to increase demands on another branch of government which is striving to decrease the demands.

With the Committee's intense concern with rising AFDC caseloads and costs, we believe it should look into the cross purpose approach which is apparently being utilized by other tax supported programs.

2. Underlying the ultimate effectiveness of the employment and training programs is the unsettled matter of relocation of individuals or families from communities which offer no employment or training prospects to communities where such are available. Over the years, welfare officials have supported the proposition that American citizens should be free to move wherever opportunity calls and they have cited the States' residence requirements as an unnecessary, if not unconstitutional, impairment of this free movement to opportunity. However, no one as yet has been willing to face up to the opposite side of the coin: should people on public aid be required to accept employment or training even if this means relocation in another community where the opportunity exists?

We believe that attention to this issue is a necessary component of the efforts now under way to develop the maximum potential of public aid recipients for employment and self-support. We believe the Congress should give study and attention to all that underlies the issue. It will become increasingly acute as industries shift their locations with changes in technology and changes in the economy. It will be multiplied should the trend of dispersion of industry from the large industrial centers to smaller communities near markets continue. Involved also are the problems of available housing, of community acceptance of minority groups, and movement across State lines—as well as movement within a State where a special problem is presented when local financing part of the total structure for public aid.

We suggest that this problem and some of the possible solutions be considered before the program is considered completed.

CHANGES PROPOSED FOR MEDICAID

While the controls proposed will not adversely affect Illinois *in the immediate future*, we believe the Bill's approach is erroneous in four major areas:

1. Retention—without modification—of the "Maintenance of State Effort" formula with its fallacious assumptions in important areas of public management of welfare programs (Section 221 of the Bill).

The liberalizations proposed by the Committee do nothing to change the basic fallacy of this Formula. At the time of its introduction in the 1965 amendments to the Federal Act, Illinois called attention to the two utterly fallacious assumptions on which the Formula is founded, namely:

a. that costs must inevitably *rise* in *all* States

b. that *no* State is at present meeting the needs of its people at a standard at least equal to any conceivable minimum national standard the Department of Health, Education, and Welfare might prescribe.

Illinois' Medicaid program under Title XIX—as it did for many years prior to the enactment of Title XIX—generally satisfies the standards set as the national goal for *1975*. Illinois' standards for meeting basic maintenance requirements result in grants for money payments considerably exceeding the amounts matchable under the formulas set out in the Federal law. Yet, under the Maintenance of State Effort formula, Illinois was able to receive the additional Federal aid made available by the 1965 amendments only to the extent that it *increased* its medical payments, its maintenance grant payments, and its administrative expenses by the amount of the Federal aid increases over its prior expenditures in the designated base year.

In its Report accompanying H.R. 12080, the Committee expressed on almost every page its concern and alarm at mounting costs in the AFDC and Medicaid programs. Yet it took little note of this Formula as one generating unwarranted expenditure expansion for the sole purpose of taking maximum advantage of available Federal aid. The fallacy is particularly apparent as it applies to Illinois—and other States which may have had a like record in undertaking comprehensive programs at adequate standards *ahead* of the 1965 amendments and the introduction of the Maintenance of State Effort formula. Except for the cushion-for-compliance that happens to have been provided by cost of living increases and the elevation in charges for medical care that flowed from Title XVIII and Title XIX requirements, such a State—with a dropping caseload or a constant caseload—would have been compelled to elevate its standards and broaden its programs under penalty of losing the additional Federal funds.

As against the argument advanced—that the elevated Federal matching should not substitute Federal money for money already being spent by a State—why shouldn't Illinois and other comparable States have been compensated in small part for their initiative and unmatched State expenditures in providing comprehensive programs at adequate standards ahead of Federal action? The goal of the Formula was to induce substandard States to move in the direction of more adequate standards and program content. But without modification for those States that had already achieved these ends, the Formula was both a sheer affront to the initiative of the high standard States and expression of a dubious public policy that *all* States should find ways to spend more money in the subject fields of public welfare.

We therefore wish to repeat here the suggestion we made in 1965 for modification of the Maintenance of State Effort formula. We believe a provision along the following lines should be added to Section 1117 of the Federal Act:

"The provisions of this Section shall not apply to those States which are providing money payment recipients under State Plans approved under Titles I, IV, X, XIV and XVI with at least those medical services which are mandatory under Section 1902(a)(13) of Title XIX. Nor shall this Section apply to those States which are providing money grants under Titles I, IV, X, XIV and XVI which meet minimum standards prescribed by the Secretary".

We believe, further, that modification of the Formula along the lines suggested will reinforce provisions of the Committee's Bill in other areas which are directed towards stimulating the States to take all appropriate actions to move recipients into employment and otherwise reduce dependency upon public aid.

2. Failure to correct *now* the anomaly of Medicaid and Medicare payments to hospitals and other suppliers of medical services at rates above those *charged* private pay patients and others for the same services.

Section 402 of the Bill recognizes this problem but it provides only for inquiry into, and experimentation with, alternative bases for making payments for medical services, with the objective of lowering costs and increasing efficiency without sacrificing quality of care—at some future date.

While our long experience with Illinois Medical Assistance Program—initiated many years in advance of the Title XIX program—made us fully aware of the persistent rises in costs over the years, these costs veered sharply upward with the advent of Title XVIII and Title XIX. We have good reason to believe that much of this was due to the unfortunate attempt to make the two programs as nearly uniform as possible in basic concept. In developing Title XIX, the experience of State public aid agencies with ongoing programs apparently was not fully utilized, nor were the problems that might be involved in paying hospitals on the basis of reasonable costs and physicians on the basis of usual and customary fees fully explored. Our chief problem at the moment—in terms of public relations—is trying to explain why we are paying hospitals (on the basis of "reasonable costs") more than private pay patients pay for the same services. The same applies also for care in extended care facilities. We see nothing wrong if the hospitals or nursing facilities collect enough for the services they render to be able to meet costs—but we believe that everyone who benefits from the services should share the cost equally.

Until cost accounting procedures can be worked out and until the hospitals and other facilities actually make the same charges for the same services to private pay patients as well as Title XIX patients, we believe that Title XIX should be amended *now* to provide for the payment of charges or cost, whichever is less.

We, therefore, recommend that, in addition to the study of alternatives provision made in Section 402 of the Bill, Section 224 of the Bill should be expanded so that the amendment made therein to Section 1902(a)(13) of Title XIX will include also modification of the "reasonable cost" payment basis for in-patient hospital services to provide for payment on the basis of charges, if less.

3. The erroneous method proposed for correcting *HEW's interpretation* of the "comparability" provisions of Title XIX (Section 223 of the Bill).

The problem with the comparability provisions of Section 1902(a)(10) of the present law is not that the wording of this Section requires the States to provide the recipients of medical aid under any one category with the same services as it provides the recipients of any other category. This is a sound provision—for why should the aged be provided with doctors' care and not AFDC families, or vice versa? Rather, the problem lies in *HEW's interpretation* of the Section. The Department held that inasmuch as the Section contained reference to payment of premiums for eligible persons under Part B of Title XVIII and Part B included *unlimited* use of physicians' services, the States would therefore be required to provide unlimited physicians' services to all categories. We believe this interpretation was not indicated by the present wording of the law.

Our problem in Illinois is not with the range of services provided under Medicare—we give this same range of services to our Medicaid recipients—but rather in the *lack of utilization limits* for physicians' services under Medicare. As against Title XVIII, where Congress imposed deductibles and coinsurance provisions to give the insured person a financial stake when he seeks physicians' services, Title XIX imposes no comparable controls on over-utilization. The public aid agency is to pay whatever the recipient's resources do not cover.

We recommend that the present comparability provisions be retained but the language clarified to make clear that payment of premiums under Part B of Title XVII shall not be construed as prohibiting the States from establishing utilization controls for comparable services made available to other individuals under the State Plan.

4. The questionable validity of the average per capita income control proposed as a ceiling on State Standards of eligibility for Medicaid (Section 220 of the Bill).

Although Illinois' present Medicaid standard for a family of four ($3000) will not be adversely affected even at the point when the proposed 133⅓ per cent ratio to maintenance grant standards would become effective, we question that per capita income is a proper measure of ability to pay for necessary medical care. Since per capita income reflects the available wealth in a given State spread across the total population of that State, the variables resulting from these two factors do not reflect living costs in that State nor the ability of a given family with a designated income to meet its needs. This is particularly true of the States having low per capita income. The difficulty is further compounded when the figure is applied to a family of *four*—as is done in the Bill.

The latest available figures published by the U.S. Department of Commerce as preliminary for 1966 show $3511 for Illinois per capita *personal* income (we understand there are no figures for per capita income as the Bill is worded). In comparison, $3969 is the figure for the District of Columbia, $3480 for New York, $3449 for California, but only $1751 for Mississippi.

On this basis, the formula in the Bill would allow Illinois, beginning in 1969, to impose no standard higher than $4700—well over the present standard, which is not likely to be elevated to the permissible ceiling unless living costs increase even more sharply than anticipated. However, the formula would impose on Mississippi a ceiling of $2600—a figure well below the nationally used "poverty" figure of $3000—*and this would be applied to families who, by definition, are self-supporting except for meeting costs of medical care.*

We recommend that this questionable control on State standards for Medicaid be eliminated from the Bill by retaining the percentage ratio controls to State maintenance standards otherwise provided by the Bill. The Federal Department should have sufficient means of restraining the States from establishing excessive standards for the Medicaid program, particularly if the Department is empowered—as we recommend in the concluding Section of this Statement—to set Federal guidelines for minimum and maximum State standards which will be acceptable for Federal participation in the State program.

STATE PERFORMANCE AT STATE STANDARDS—FEDERAL GUIDELINES FOR STATE STANDARDS

Our final comments on this Bill are directed to its major omission—its failure to *require* that each State grant aid at the standard it sets and, *as an imperative corollary*, to empower the Federal Department of Health, Education, and Welfare to set *both lower and upper limits*—under broad Congressional directives as to the factors to be considered in fixing the limits—which will govern acceptability of State-fixed standards for Federal matching purposes.

Thirty-two years have passed since the enactment of the Federal Social Security Act but only now—through the experience gained from the "bugs" developing in the implementation of Medicaid—has Congressional attention been directed to the role played by State public aid standards in meeting or not meeting nationally recognized needs; on the relationship of these standards to costs and caseload volume; and on their relationship to the management practices of low and modest income individuals and families not receiving public aid.

The Committee on Ways and Means—in the limits it proposes for the Medicaid program—has not addressed itself to the crucial issue: the standards the States set to govern basic maintenance grants for that portion of the population deemed poor enough to require subsistence support as well as medical aid. These standards, with their undefined content, are accepted as controls for the Medicaid Standard—which is not to exceed the maintenance standard by more than 133⅓ per cent.

How valid, however, is the basic maintenance standard of a particular State? Does it cover, at costs prevailing within the State, requirements for food, clothing, shelter, and other commonly recognized essentials? Or does it omit some necessities or recognize necessities at quantity-quality levels known to be below requirements for decency and health? But assume that the standard is valid—covering necessities at appropriate quantity-quality levels—but the State actually pays—to its poor who have no other income whatsoever—only 50 per cent—or less—of the standard?

We believe that unrealistically low State standards *and* State standards which may be adequate but which are not followed in State payment practice are at the heart of many of our problem areas in administration of the public aid programs:

——— they have led to demands that Social Security increases be disregarded as a way of improving the condition of the aged poor—a measure unjustified and unnecessary in a State which has established a proper standard and has kept this standard updated for changes in the cost of living (Illinois increased its food allowances three times since the Social Security increases of 1965);

——— they have led to demands for mandatory earned income exemptions (as in the present Bill) which may prove out to be excessive if the exemption, when added to a State's assistance payment, results in total spendable income far out of line with that of self-supporting families of modest income;

——— they have beclouded the recurring issue of the extent of fraud in the public aid programs—for is it "fraud" if a recipient uses unreported income to buy clothing (when clothing has not been included in the State standard); or is it fraud if he becomes confused and uses more income than the State intended to make up the difference between what the State pays and the State's standard?

——— and finally, they have fostered civil unrest and contributed to the proliferation of other poverty-relieving programs that might not have been necessary—at considerable saving of public moneys—had the Federal-State public aid programs been refurbished earlier to fulfill their proper function—through the correction of standards we are here advocating combined with a positive program of action for moving people off the rolls into employment or other means of self-support.

While we appreciate that national inexperience in the early years of Federal grants to the States for their public aid programs justified leaving the matter of State standards wholly up to the States, the Federal Department of Health, Education, and Welfare now has 32 years of experience with State practices, and the Congress—through its experience with Social Security and other welfare-related national programs, as well as with public aid—is in a position to better define the national intent in aiding the States in their public aid function.

With the large Federal expenditures involved and the numerous Federal programs inaugurated to meet the problem of poverty as a national concern, the Congress can no longer avoid defining the minimum standards for basic maintenance a State must meet if it is to receive Federal aid in carrying out its public aid function. At the same time—because the States have moved at different paces in developing the content of their public aid standards—some recognition and leeway must be given to such States. But just as no State should receive Federal aid if it sets a standard or makes grants at a level below the Federal minimum, a State should not receive Federal aid for any expenditures it may choose to make in excess of the upper limit established as Federal policy. In brief, we propose:

——— States failing or refusing to establish *and perform* at standards meeting the *minimum* Federal standard will not receive *any* Federal participation—*choosing* to forego such aid on the same principle that they now may choose not to participate in any given Title of the Federal Act.

——— States choosing to provide aid above the upper limit of the Federal standard will be expected to meet the excess at their own expense—as is now proposed by H.R. 12080 for States going above the proposed Federal limits on the Medicaid program.

——— States with standards, and performing at Standards, within the upper and lower limits of the Federal standard will receive Federal matching ranging within the present formula of 50 per cent to 83 per cent of expenditures.

There has now accumulated a large body of information which the Congress and the Federal Department can utilize in developing upper and lower limits to govern acceptability of State-determined standards for Federal matching purposes. The Department of Agriculture has developed an "emergency" and a low-cost adequate food standard which well might serve as the upper and lower limits of the food component of the standard. The Bureau of Labor Statistics has accumulated extensive information concerning the consumption patterns of various income groups: This, collated with the management know-how of qualified home economists, can be utilized to develop upper and lower limits for clothing and other essentials. Studies developed by the Social Security Administration in connection with its construction of a "Poverty Index" have yielded information that can be utilized in developing standards in States which are primarily rural—should this adjustment still be necessary in light of the rapid pace of urbanization and the equalizing effect on living costs flowing from nationwide marketing and common consumption practices engendered by mass media advertising.

It will be noted that nowhere are we suggesting a definition of the applicable standards in terms of dollar amounts. Rather, we believe the Congress in the governing Federal Act should set out the items to be included in a minimum standard—similar to the five items it set out in Title XIX as the minimum requirement for Medicaid—and then state in general terms the criteria that should guide the Federal Department in establishing quality and quantity guides for these items. These items would then be priced within the individual States and the money amount necessary to buy these items would constitute the State's standard. Similarly, the Congress through the Federal law would define in general only the upper limits of an acceptable State standard. The Federal

Department of Health, Education, and Welfare would provide quality and quantity criteria and the States would price the standard within the State.

We have stressed the need for realistic maintenance grants for many years for one major reason—in addition to the basic concern over health and decency; this is that work and training programs have less of a chance for success if the adult is *principally* concerned about whether or not the next meal for the family will be forthcoming.

STATEMENT OF IRVIN P. SCHLOSS, NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION, AND CHAIRMAN, LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF WORKERS FOR THE BLIND

The Blinded Veterans Association and the American Association of Workers for the Blind appreciate this opportunity to present their views on H.R. 12080, the Social Security Amendments of 1967. BVA is the national membership organization of exservicemen and women who lost their sight while serving in the Armed Forces of the United States. As the national professional membership association in the field of services to blind persons of all ages. AAWB includes in its roster of members individuals who work directly in a professional capacity with blind individuals affected by Social Security legislation.

In general, BVA and AAWB strongly endorse the provisions of H.R. 12080. We believe that this proposed legislation advances the OASDI, medicare, and welfare provisions of the Social Security Act and respectfully urge the Committee to report this legislation favorably with amendments we are suggesting.

Increases in the cash OASDI benefits are urgently needed. We believe that it would be highly desirable to develop a mechanism for automatic increases related to the Consumers' Price Index to eliminate financial hardship caused during periods of sharp increase in the cost of living.

BVA and AAWB endorse the provision of H.R. 12080, which would make disabled widows, surviving divorced wives, and widowers eligible for benefits under age 62, even if they do not have minor children in their care. However, we believe that the requirement of attainment of age 50 for eligibility would work an undue hardship on these individuals. Similarly, we believe that the definition of disability for these individuals is unduly harsh and should be made the same as the definition of disability for beneficiaries of the disability insurance program. We also would strong recommend that the cash benefits be 82½% of the primary insurance amount immediately upon eligibility for benefits rather than graduated from 50% to 82½%.

BVA and AAWB welcome the extension of the provision covering blind persons between the age of 21 and 31 for cash disability insurance benefits to all types of disabled persons who meet the definition of disability in the law. However, we believe that the guidelines in the new Section 223(d)(2)(A) concerning the definition of disability are unduly harsh. The individuals covered for cash benefits are severely disabled under the definition in the existing law, and this definition should not be made any stricter than it already is.

BVA and AAWB are disappointed that the provisions of H.R. 5710 covering disability insurance beneficiaries, disabled child beneficiaries, and disabled widows for health care benefits under Title XVIII of the Social Security Act were not included in H.R. 12080. Disabled beneficiaries have to subsist on their Social Security cash payments and are in the same or worse position in terms of health care needs and financial resources as beneficiaries over 65. We sincerely hope that the Committee will include these provisions in the bill it reports rather than deferring action with an unnecessary study.

In 1965, the Blinded Veterans Association and the American Association of Workers for the Blind advocated improvements in the program of services for crippled children under Title V of the Act designed to make this program truly effective in preventing and ameliorating disability. Although H.R. 12080 does propose to improve this program somewhat, we firmly believe that the Congress needs to take further action at this time in order to assure that children with sensory disease problems be located and treated promptly to prevent major disabilities. Therefore, we strongly recommend that the name of the program be changed to "Services for Handicapped Children" to realistically reflect the scope of the program intended by the Congress. We also strongly recommend that the financing of the program be changed to the method used in the public assistance titles of the Social Security Act, so that the states will be able to obtain Federal matching for all of the dollars they are willing to appropriate for this program.

Further, we recommend that the state plan provisions in the Federal law be strengthened to require the states to treat children with all types of potentially handicapping conditions. We were shocked to learn that some states do not serve children with vision or hearing problems or serve only a few.

BVA and AAWB would also like to urge the Committee to amend H.R. 12080 to incorporate the provisions of S. 1681. These amendments would make it possible for blind persons with at least six quarters of covered employment to become eligible for disability insurance cash benefits without regard to their ability to engage in substantial gainful activity. In effect, these amendments would make the disability insurance program similar to the veterans disability compensation program by basing the award of cash benefits on a medical determination that blindness exists with the presumption that the condition severely curtails opportunities for employment and is a serious handicap in other than economic ways. Of course, the actual amount of disability insurance cash benefits will vary with the numbers of quarters in covered employment and the wage credits of the individual.

We are firmly convinced that enactment of the provisions of S. 1681 into law will definitely serve to spur the rehabilitation of blind persons. By providing blind persons with an economic floor from which to operate while rehabilitating themselves, the Congress will give them an opportunity to explore various occupations without the risk of losing their benefits should they fail in one endeavor and find it necessary to try something else.

On the other hand, the existing law serves as a deterrent to rehabilitation; for there is no incentive to experiment when a blind person has to risk losing the security of his cash benefits when he accepts employment which may provide an income substantially smaller. As you know, the term "ability to engage in substantial gainful activity" in the present definition of disability is variously interpreted across the country by the different state agencies making disability determinations. Thus, an individual who earns anywhere from $900 to $1,500 a year after rehabilitation will no longer be entitled to receive disability insurance cash benefits, depending on the state in which he resides. Since the cash benefits could easily have been double the individual's earned income, the present definition of disability works a handicap on the disabled individual and his family in the name of rehabilitation.

We know from the experience of World War II and Korean Conflict blinded veterans that the floor of financial security provided by their disability compensation has been an incentive rather than a deterrent to rehabilitation. We can confidently predict that the same will be true of blind disability insurance beneficiaries under Social Security.

In conclusion, the Blinded Veterans Association and the American Association of Workers for the Blind urge the Committee on Finance to favorably report H.R. 12080 with the improvements we have recommended. By so doing, the Committee will assure a needed step forward in the various programs provided under the Social Security Act.

STATEMENT OF THE NATIONAL ASSOCIATION OF MANUFACTURERS, SUBMITTED BY EUGENE J. HARDY, VICE PRESIDENT

The National Association of Manufacturers is pleased to present its views on H.R. 12080. We shall concentrate our remarks on sections of the bill concerning OASI and public assistance programs.

The NAM supports OASI as a self-financing basic retirement system. It is concerned, however, with the increasing costs of the system and with some efforts to convert it into a welfare program.

The NAM welcomes the emphasis in H.R. 12080 on bringing recipients of public assistance into the main stream of economic life and off the relief rolls. At the same time, it questions the need for a proliferation of special programs to accomplish this goal.

TITLE I—OLD-AGE, SURVIVORS, DISABILITY, AND HEALTH INSURANCE

Title I of H.R. 12080 is, in several respects, a considerable improvement over the Administration's original proposals as embodied in H.R. 5710.

Most important, the current bill eliminates the proposed series of changes in the income tax law to include Social Security benefits in taxable income. Such changes would have been unfair to individuals who have borne a relatively large share of total income taxes during their active careers. The phasing-out of special exemptions after certain levels of gross income are reached would have been a discriminatory and inconsistent interpretation of the functions of personal exemptions and progressive tax rates in an income tax system. The changes in income taxation of persons over 65 would have challenged the government's own and consistently held position that Social Security benefits are voluntary and not based on a contractual obligation.

H.R. 12080 is also an improvement over the earlier proposals in that: (1) the same rate of increase in OASI benefits—12½%—applies to all income levels; and (2) the special allowance for those with 25 years of coverage is eliminated. Under H.R. 5710, the minimum individual benefit would have been increased close to 60% and, in some cases under the special allowance, as much as 127%. The costs inherent in such increases would be unfair to other participants in the system, which up to now, has been basically related to earnings.

There remains, however, the fact that under H.R. 12080 the proposed increase in benefits will require an increase in both Social Security tax rates and the maximum amount of earnings subject to the tax. Combined employer-employee contribution rates for OASDI and Medicare would rise from the current 8.8% to 11.3% by 1973. Of more immediate significance, the maximum taxable earnings base would jump from $6,600 to $7,600 in 1968. The maximum employee tax would amount to $344 in 1968, 15% above the current level. By 1971, that tax would be $395 or 36% above 1967 and 22% above the level in 1971 under present legislation. These proposals, although less onerous than those in H.R. 5710, still raise serious economic and policy questions.

In their 1967 *Annual Report*, the Council of Economic Advisers state that "Americans with incomes well above poverty levels also want and are willing to pay for increasing social insurance protection." But a sampling of Congressional polls conducted during the first part of this year shows no such blanket public acceptance. For example:

In the 13th Congressional District of Illinois, 39% approved and 45% disapproved an 8% increase in benefits, described as requiring no increase in taxes. When the proposal was for a 20% increase, the vote was 15% for; 66% against.

In the 3rd Congressional District of Florida, 62% replied "no" to the question: should Social Security benefits, and taxes to provide for same, be increased?

In the 7th Congressional District of Texas, 69% favored benefit increases not requiring tax hikes.

In the 4th Congressional District of Kansas, 64.5% of the men and 65.5% of the women favored an increase in benefits if a tax increase were not required. If a tax increase were necessary, only 20.6% of the men and 10.2% of the women favored an increase in benefits.

In the poll of the 18th Congressional District of Pennsylvania the question was whether the voter would favor increasing payroll taxes sufficiently to hike benefits by (a) 8%; (b) 14%; (c) 20%. The respondents favored the lowest increase more than the others (34% voted for that against 10% for each of the other alternatives). However, 46% said they were opposed to any increase in Social Security taxes.

In the 4th Congressional District of Michigan, 46% favored an increase in benefits; 40% did not. However, 68.4% were against an increase requiring more Social Security taxes.

In the 1st Congressional District of Tennessee, 74% favored an increase in benefits that would not require a corresponding tax hike; only 26% were willing to endorse higher taxes to support a 15–20% increase in benefits. Among college and university students in that District the preference for the increase not requiring a tax rise was close to 80%.

These results should not be surprising. The history of the Social Security program has been one of successive increases in benefits coverage, tax rates, and payroll bases upon which the tax is applied. Many people view Social Security as an insurance policy guaranteeing them a certain scale of benefits upon retirement—a misconception encouraged to a considerable extent by government publications and statements on the subject. However, as the Social Security taxes rise to the point where they are an increasing burden on the average wage-earner, he becomes more critical about what he is paying for.

Even labor leaders, who supported Social Security without question, are becoming concerned. Speaking before the Central Labor Council, William F. Noell, international representative of the Oil, Chemical and Atomic Workers Union, noted recently that many of its younger union members are "irritated that so much of their money goes into Social Security."

It is true that only a certain portion of the nation's over-all resources can be allocated to provide retirement benefits. It is also true that only a certain portion of each family's resources can be allocated for that purpose. In a period in which an individual earning $7,000 a year is already in difficulty because of increases in the cost of living and a likely hike in his income tax, the 15% increase in Social Security taxes is not something he necessarily "wants and is willing to pay for," especially when he realizes that the system is on what might be called a pay-now, hope-someone-pays-for-you-later, basis. In fact, under the Administration's proposed 10% surcharge and the provisions of H.R. 12080, many middle-income families would pay more combined income and Social Security taxes than they did in 1963, completely wiping out the benefit of the 1964 tax reduction.

It used to be axiomatic that the acceptable top limit to the Social Security tax burden is in the neighborhood of 10% (combined employer and employee contributions). Under the new proposal, we will have exceeded that level by 1971. The Department of the Treasury in 1966 testimony opposing H.R. 10, noted that a self-employed $10,000 a year man was devoting 4.2% of his income to Social Security tax payments, and the figure was due to rise to 4.7% in 1969. The Department commented: "It is doubtful that many individuals at these rates can afford to devote appreciably more to their retirement in the form of a long-term program." According to the proposed schedule, the $10,000 a year man who is self-employed would, in 1969-70, pay 5.2% of his income in Social Security taxes.

The NAM believes that OASI functions best as a broad coverage, basic retirement system, which is self-financing and related to past work experience. We are pleased to see the re-emphasis in H.R. 12080 on the taxable earnings-benefits relationship. We do not think the system was intended, or should attempt, to serve as a welfare program which could depend eventually on general revenues for a significant part of its financing. Thus, we are concerned over the provision to expand special payments from general revenues to elderly persons never covered or qualified under Social Security. Although the cost to the Treasury of the higher payments is comparatively small, estimated at $52 million in 1968, it would set another precedent for future inclusion of welfare-oriented programs in the OASI structure. Such special situations can and should be dealt with through existing welfare programs.

Similarly, we urge Congress to resist Administration attempts to restore a disproportionately higher minimum benefit (as originally proposed in H.R. 5710) on the ground that more people thereby "would be removed from poverty." As laudable as that goal may be, it would be better met through other public (not necessarily federal) and private programs that would not encumber the OASI system.

Lastly, the NAM is concerned over the effect of constant expansion of Social Security taxes on personal savings and private pension plans. About 25 million workers, or almost half of total private non-agricultural employment, are presently covered by funded private retirement programs. Growth in coverage has been extremely rapid, and because of their substantial investment income, these plans can provide much larger benefits to participants than under a system such as OASI.

However, if Social Security taxes continue to rise, there inevitably will be a slowdown in the expansion of both private pension funds and individual savings—essential elements in financing basic economic growth. Also, each increase in the Social Security wage base tends to complicate further the problem of integrating private pension plans with Social Security.

The Subcommittee on Fiscal Policy of the Joint Economic Committee of Congress, as well as other groups, public and private, are presently conducting studies as to the respective roles which the private pension and Social Security systems should play in providing retirement benefits for the nation's workers. We had hoped that Congress would at least await the outcome of these studies before approving any further increases in either the present Social Security tax rate or earnings base.

Obviously, there is bipartisan support for an increase in Social Security benefits at this time. Under the actuarial assumptions provided by the Social Security Administration, a fairly substantial hike in benefits, at least enough to offset the inroads of inflation since 1965, could be provided without any changes in the tax structure from present legislation. However, the House has seen fit to go beyond these benefit increases. In a time when the need for fiscal restraint is well recognized and higher income taxes appear imminent, we strongly urge that any additional costs of the Social Security system be kept to a minimum.

The Retirement Test

Under H.R. 12080, the amount that a Social Security beneficiary may earn in continued employment without having his benefits withheld is slightly increased. Although, the cost of this provision is estimated at $140 million in 1968, we believe, in this case, it is warranted as a more equitable arrangement for the elderly employed.

Medicare

The original Medicare legislation provided for 90 days of covered hospitalization. H.R. 12080 would increase the number of covered days to 120, with the patient paying a coinsurance amount of $20 per day for the additional days (subject to adjustment after 1968, depending on the trend of hospital costs). Experience with Medicare has been limited. However, there is some indication that the program has contributed to the sharp increases in the cost of health care. It would seem wise for Congress to refrain from any expansion of Medicare until there is more information available as to its impact on medical costs.

TITLE II—PUBLIC WELFARE AMENDMENTS

Despite the expansion of some programming and the increased cost of these and other provisions in the public welfare amendments of H.R. 12080, there is apparent, nevertheless, a welcome cost-consciousness. There seems to be implicit in them an effort to provide a pattern of policy intended to control, and perhaps even ultimately to curtail, the overall costs of public assistance in the country. In this regard, the restricted eligibility for medical assistance, the emphasis on employment in families receiving aid for dependent children, family planning services, community work and training programs and work incentives are especially commendable as constructive features. There is a pragmatic basis here which is good to see.

H.R. 12080 carries welcome modifications of the medical assistance provisions. They are, in effect, second thoughts after some introductory experience with the permissive eligibility conditions of the original legislation. It is wholly consistent for the national government to establish limitations beyond which there would be no federal participation. The three-year stepping down of the threshold for federal participation would in no way prohibit those states which have more liberal eligibility qualifications from extending medical assistance beyond the levels reimbursable by federal funds. Both the lower and upper limits for federal participation seem reasonable criteria at this point. But if experience with them indicates that general taxpayer protection requires further adjustment of the gauges for federal participation, later legislation can make corrections.

H.R. 12080's reconstructed gauges for federal participation are particularly pertinent as regards the "buy-in" potential for medical assistance recipients of Title XVIII insurance benefits. Since half of the costs of the supplementary insurance program are to be paid from general funds, it is a fitting protection to the general taxpayer to have eligibility for this program, too, appropriately restricted.

The threat of loss of assistance for families where adult members, or children over 16 not attending school, refuse work training or work would be a strong addition to the law. The incentive of 85% (and later 75%) of federal matching funds, however, is excessive when compared with the complete absence of matching under present law. It would seem that states could readily accept the value of community work and training programs and their ultimate benefit, both to assistance families and taxpayers, without a matching formula so high as to invite more, rather than less, dependence on central government funding.

Another practical amendment concerns the provision for increased use of protective payments and vendor payments where needed to prevent the misuse of cash assistance by irresponsible family members. This is a welcome flexibility and can serve to meet public criticism as well as the actual difficulties of providing welfare aid in home situations where there is fiscal irresponsibility.

The "tough" approach would appear to be carried to an extreme in the limitation on aid to families with dependent children. H.R. 12080 would "freeze" federal participation at the January 1967 level of children under 21 in families where a parent is absent from the home. This is an arbitrary and discriminatory feature. If its intention is to curb illegitimate births, it would seem to be an unrealistic and unreliable way of doing so. Family planning services are more to the point. Furthermore, its practical effect will only be to penalize the states, not the parents. State laws would undoubtedly still require that relief be extended where need existed, regardless of the legal status of children in the home.

On the other hand, expression of the new approach in terms of the provision of work incentives is constructive. Here certain earnings are not included as family income for the purpose of determining the level of public assistance. Provisions of a similar nature are also contained in the amendments now being considered in Congress for the Economic Opportunity Act. The aim is, of course, to give welfare recipients incentive to work so that ultimately they may be self-supporting. The particular level of exemption which would be most conductive to this aim is difficult to assess and may have to be finally determined by some experiment. However, the aim is sound and supports a position which NAM has taken:

Public assistance programs should encourage recipients who are willing and able to earn some of their income to do so. Programs which subtract the total of such income from assistance payments for which the individuals are otherwise eligible, do not accomplish this objective.

The mechanics of some of these constructive changes, however, elicit a somewhat ambivalent reaction. To assure that the programs and provisions introduced by the amendments would be put into effect by the states, they are mandatory. H.R. 12080 *requires* each state to undertake the above mentioned programs or services. This, of course, would add to the conditions of grants-in-aid which have come under criticism by those who would prefer to see state and local programs under less direct control and supervision by the central government.

NAM is concerned with the role of the states in the federal system and with a strengthening of their identity as responsible and independent parts of the system. We believe that state and local governments should—separately or in cooperation with each other—find means of carrying greater responsibility for the planning, support and performance of public services appropriate to their jurisdictions. It is thus with some concern that we see in these amendments an expansion of special conditions which lead to greater central government control over state-local programs.

One of the areas where federal control may become more apparent is that of child welfare services. H.R. 12080 would bring these services into the program of aid to families with dependent children. Although the consolidation itself may be beneficial, it involves a procedural question which might have been resolved differently. The single agency requirement which had been in effect for the dependent children program would, under H.R. 12080, apply to child-welfare services as well. Instead of retaining this limitation, a freeing up of this requirement might have been undertaken. Instead of tying the services feature more tightly to the public welfare structure, greater resort to service agencies in the private sector might have been sought. The single agency concept was undoubtedly appropriate in the initial years of public assistance programming. However, the last several decades have brought new developments and competence to state organization, and it is thus questionable whether such rigidity should be continued, far less extended. H.R. 12080 has a liberalizing modification of "single state agency" for purposes of federal participation in certain administrative expenses of the medical assistance program, and this in itself acknowledges the impractical rigidity of the single agency requirement.

Furthermore, a rigid federal requirement could impede a constructive new view at the state level. There, a trend is underway toward a new kind of agency amalgamating a variety of related programs, rather than extension of the old-line, single-purpose agencies. One of the newest examples of this is the Department of Community Affairs created this summer in Connecticut. It will be responsible for a broad spectrum of activities, including coperative and liaison work with agencies in the private sector. An agency of this sort has implicit potential for coordination of related functions, for flexibility and innovation in problem-solving, and for improving and strengthening state vovernment relationships with local governments.

There is a need for a more flexible focus on intergovernmental relations at the federal level, too. Congress for example, could make legislative provision that some of the federal funds for administration of grant programs be applied to better coordination of these programs at state level, which would be a kind of corollary to establishing better coordinating capacity at the federal level. Congress could also take a large step forward in the consolidation of grant programs.

Some advance has already been made in the consolidation of grants in the field of public health and H.R. 12080 furthers the trend slightly. But more could be done. In the field of public assistance, for example, students of government operations have long questioned the need for the continuance of the several categories. Here there is not only the possibility of one consolidates grant for public assistance, but the alternative of two categories: Chronic-need cases and variable-need cases.

Beyond the question of consolidating grants to states for specific or related functions, there is justified concern with growing resort to project grants and demonstration and pilot programs. The use of project grants had been accelerated in the child health field with the 1965 amendments to the Social Security Act and is further extended in H.R. 12080. It is, however, encouraging to see apparent questioning of this trend, since the bill provides for converting project grants for health services to mothers and children after July, 1972 into grants to the states. This provision has the added value of ending, at least in this limited regard, a bypass of state governments which is involved in the very concept of project grants to communities.

There is another area where it would be beneficial to consider simplification, consolidation or greater consistency. This involves the matching formulas. They have evolved with no apparent basis or relationship. Twenty-five years ago the federal share of public assistance was less than a third; now it is over a half, but the averages for groups of states range from about 40% in the richer, industrial states to nearly 70% in the poorer ones. This reflects the equalization features of the formulas. But the formulas themselves vary considerably among programs. What, for example, is the rationale for 40% federal participation in project grants for child health activities, 50% for administrative costs or home repairs of assistance recipients, 75% for the health care of mothers or special services? And why *less* than 100% federal participation for community work and training programs in Section 204 of H.R. 12080, but a *full* 100% for work experience under Title V of the Economic Opportunity Act?

Because of the wide range of intergovernmental welfare programs, and the number of authorities in the national government which deals with them, we question whether there should not be a clearance of ideas among them before the welfare amendments of H.R. 12080 are finally determined. For example, within the Congress itself, the views of the Senate Subcommittee on Intergovernmental Relations as well as the Senate Committee on Labor and Public Welfare should be helpful. There are broad matters of policy and intergovernmental relations which could well be considered before the program specifics of the welfare amendments are passed, thus foreclosing timely corrections to the somewhat archaic structure of public assistance.

For example, what new approach or altered relationships among governments might help solve the welfare problem? Is a two-category division of public assistance a viable possibility? Why not allocate responsibility for chronic-need cases to the national government and responsibility for variable-need cases to the state-local governments?

As an example of the potential allocation, there follows here the last fiscal year data available on the financing of public assistance.

Present distribution of public assistance financing, 1966

[In millions]

	Federal	State-local	Total
Aid to chronic cases:			
Old-age assistance	$1,319	$685	$2,004
Aid, permanent and total disability	321	261	582
Aid to the blind	49	42	91
Subtotal, chronic	1,689	988	2,677
Aid to variable-need cases:			
Families with dependent children	1,031	828	1,859
Medical assistance	473	437	910
General assistance	....	350	350
Subtotal, variable	1,504	1,615	3,119
Total, public assistance	3,193	2,604	5,797

Source: U.S. Department of Health, and Welfare; Welfare Administration "Source of Funds Expanded or Public Assistance, Fiscal Year Ended June 30, 1966," Mar. 2, 1967.

The shift of financing under the hypothetical allocation of all chronic cases to the national government and all variable-need cases to state-local governments would, according to these 1966 figures, roughly reverse the relative balance of financing between the national and the state-local governments:

[In millions]

	Funds by governments	
	National	State-local
Present balance	$3,193	$2,604
Hypothetical balance	2,677	3,119
Difference	−516	+515

This balance would change somewhat as economic conditions affected the variable-need cases, and as the number of persons over age 65 increases. But the general effect would seem to favor NAM policy goals of an increase in the responsible role of state-local governments and less dependence on central government financing.

An additional advantage of national government responsibility for chronic-need cases would be the potential involved for solving the problem of disparities in standards and payments among the states.

The involvement of the national government in public welfare has expanded well beyond public assistance itself. The public assistances were part of the initial step of central government into social welfare, in fact, part of the first "social security" package. But today the total package of related programs is much more extensive; so much so, that the Congressional jurisdiction for public assistance legislation may itself need reappraisal. Would the legislative jurisdictions be more appropriately shared now if the tax-contributory, trust-funded programs were the responsibility of the House Ways and Means and Senate Finance Committees, and all the health and welfare programs financed exclusively from general funds were the responsibility of other committees? This would have the value of subjecting consideration of public assistance legislation to the scrutiny of the substantive committees regularly dealing with intergovernmental programs in the health, education and welfare field. It is, perhaps, a suggestion which might be evaluated before another series of "Social Security" amendments covering two logically separable subjects are again put into one bill.

NAM believes, that jobs, especially in the private sector, are the true source of social and economic security in the nation; and it is pleased to see the emphasis in H.R. 12080 on job training and work incentives. We believe the growing burden of federal government benefits, especially in the welfare fields, needs to be given careful appraisal and perspective vis-a-vis rigorously established spending priorities; and we are glad to see in H.R. 12080 efforts at cost control.

STATEMENT OF M. ROBERT BARNETT, EXECUTIVE DIRECTOR, AMERICAN FOUNDATION FOR THE BLIND, INC., NEW YORK, N.Y.

I appreciate this opportunity to present the views of the American Foundation for the Blind on H.R. 12080, the Social Security Amendments of 1967. The American Foundation for the Blind, which is the national voluntary research and consultant agency in the field of services for blind persons, generally endorses this proposed legislation.

As we all know, increases in the cost of living have made it extremely difficult for OASDI beneficiaries to get along on the cash benefits which have not in fact kept pace adequately with improved salaries and higher costs since the enactment of the Social Security Act in 1935. As a minimum, we would recommend adopting the increases provided in H.R. 12080. We would further recommend the development of a formula related to the Consumers Price Index to provide for automatic increases in these benefits as a means of eliminating the hardship of months or even years in periods of sharp cost increases before the Congress is able to take remedial action.

With regard to public assistance, we believe that the requirement that states at least meet their own minimum standards for public assistance payments contained in H.R. 5710 be restored in the bill you are considering as a means of alleviating the dire poverty of aid recipients in the states affected. With the aid of additional Federal financing for this purpose, no individual on the public assistance rolls should have to subsist on cash aid which even his own state welfare agency considers below subsistence levels. We should also like to recommend that the law be amended to prohibit durational residence requirements in determining eligibility for public assistance. Such arbitrary residence requirements work a hardship on the individuals affected and are becoming anachronistic in view of the increasingly large Federal financial support for this program.

A longstanding oversight in the OASDI program has been the requirement that severely disabled widows must wait until they are 62 to collect widows benefits if they have no minor children in their care. Since we can realistically expect that only a minute fraction of such individuals will be rehabilitated to the point of self-support, we are relegating them to seeking welfare to subsist when they should logically be entitled to the survivors benefits of the program. Therefore, we are delighted that H.R. 12080 will make it possible for disabled widows to receive cash benefits under age 62.

We are also pleased that H.R. 12080 has included disabled surviving divorced wives and disabled widowers for cash benefits. However, we believe that the requirement of attainment of age 50 for eligibility would work an undue hardship on otherwise eligible disabled widows, surviving divorced wives, and widowers. Similarly, we believe that the definition of disability for these individuals is unduly harsh and should be made the same as the definition of disability for beneficiaries of the disability insurance program. We also would strongly recommend that the cash benefits be 82½% of the primary insurance amount immediately upon eligibility for benefits rather than graduated from 50% to 82½%. The American Foundation for the Blind welcomes the extension of the provision covering blind persons between the age of 21 and 31 for cash disability insurance benefits to all types of disabled persons who meet the definition of disability in the law. However, we believe that the guidelines in the new Section 223(d)(2)(A) concerning the definition of disability are unduly harsh. The individuals covered for cash benefits are severely disabled under the definition in the existing law, and this definition should not be made any stricter than it already is.

The American Foundation for the Blind is particularly disappointed that the provisions of H.R. 5710 covering disability insurance beneficiaries, disabled child beneficiaries, and disabled widows for health care benefits under Title XVIII of the Social Security Act were not included in H.R. 12080. We have advocated inclusion of disability insurance beneficiaries in the medicare program in all of our testimony supporting establishment of the program since 1959. Disabled beneficiaries have to subsist on their Social Security cash payments and are in the same or worse position in terms of health care needs and financial resources as beneficiaries over 65. We sincerely hope that the Committee will include these provisions in the bill it reports rather than deferring action with an unnecessary study.

Prevention of disability is, of course, the most effective way of preventing dependency and the high cost to Federal, state, and local governments which dependency entails. Preventable disabilities occurring in childhood necessitate expensive special education, vocational rehabilitation, frequently life-long public assistance payments, and other special programs. At the same time, such disabilities frequently also deprive the national economy of important contributions the individual might otherwise have made.

One of the most significant disability prevention programs is provided by Title V of the Social Security Act as "Services for Crippled Children". Although the Congress has substantially improved this program in the past few years and although the improvements provided by H.R. 12080 advance the program still further, we firmly believe that more needs to be done to meet the problem.

First, we recommend that the name of the program be changed from "Services for Crippled Children" to "Services for Handicapped Children" to more adequately reflect the true scope of the program. To most physicians and lay persons, the term "crippled" means orthopedically disabled whereas the program is supposed to cover vision, hearing, mental, emotional, and other types of health problems as well.

Second, we strongly recommend that the Committee alter the financing of the program to provide that the states can obtain as much Federal financing as they are willing and able to match in the same way that the public assistance titles are financed.

Third, we recommend strengthening of state plan provisions to require the states to serve children with all types of potentially handicapping conditions. Some state crippled children agencies do not serve children with vision or hearing problems or serve only a few.

With the improvements we are suggesting, we believe that a substantial number of children with potentially handicapping conditions can have these conditions treated early in life and lead normal lives without the need for additional costly services.

Most of the programs authorized by the Social Security Act require highly skilled personnel in various disciplines to make them effective. Other legislation in recent years is helping to make possible the training of many types of personnel, but one category in acutely short supply is the skilled social case worker. We strongly endorse the provisions of H.R. 12080 designed to assist schools of social work to increase their facilities to train additional social workers.

We believe that there is a definite need for skilled geriatric social workers to assist elderly persons with their problems. We would one day like to see the Social Security Administration develop a staff of geriatric social workers in each of the district offices in the same way the Veterans Administration has staffed its regional offices with this type of personnel. Unfortunately, the shortage of trained people will put this day off unless Federally assisted programs are enacted to train those needed.

In conclusion, the American Foundation for the Blind endorses H.R. 12080 as urgently needed legislation to improve the programs authorized by the Social Security Act. We respectfully urge the Committee on Finance to report this bill favorably with the amendments we have recommended.

(The following statement was submitted to the committee by Hon. Robert P. Griffin, a U.S. Senator from the State of Michigan:)

STATEMENT OF THE MICHIGAN OPTOMETRIC ASSOCIATION, LANSING, MICH., SUBMITTED BY BOYD B. BANWELL, O.D., IMMEDIATE PAST PRESIDENT

The Michigan Optometric Association, along with other professional optometric organizations of the nation, is unanimous in support of the proposed Ribicoff and Carlson amendments to H.R. 12080, "Social Security Acts of 1967."

We are sure that testimony in recent days has brought out the reasons for optometry's opposition to H.R. 12080 in its present form and we will not burden the official record with further detailed testimony. However, it is significant to note that at a time when the only known opposition to the Ribicoff and Carlson amendments comes from the American Medical Association there is a notable shortage of medical personnel who are schooled and who specialize in vision care.

While optometry, considered the first line of defense against blindness by members of this profession, currently has some 17,000 practitioners in the United States, ophthalmology, the branch of medicine concerned with eye care, has approximately 4,500 practitioners. In the State of Michigan, there are thirty counties without an ophthalmologist, only eight without an optometrist.

The Michigan Optometric Association considers H.R. 12080, in its present form, discriminatory, contradictory, and totally inconsistent with the public welfare. Further, it is the feeling of members of this association that the Ribicoff and Carlson amendments, identified as S. 804 and the "Freedom of Choice" provision, are *essential* if H.R. 12080 is to best serve the needs of those persons who qualify for benefits under provisions of the federal Medicare program.

We sincerely appreciate the opportunity to submit this statement for the hearing record. If in-person testimony by a member of this organization is desired, we will be most willing to send a spokesman to Washington for appearance before the committee.

THE COMMONWEALTH OF MASSACHUSETTS,
DEPARTMENT OF THE ATTORNEY GENERAL,
Boston, September 18, 1967.

Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: The members of the Governor's Committee on Law Enforcement and Administration of Justice Subcommittee on Juvenile Delinquency of the Commonwealth of Massachusetts consider that measures which tend to foster normal child health and development are important elements in the effort to prevent and control juvenile delinquency. Important among such measures are those which help to prepare youth and adults for appropriate employment, and those which help to maintain the integrity of the family and to assure to families the means to maintain an adequate standard of health and decency.

The Subcommittee wishes to express its concern about certain features of the Bill, H.R. 12080 which, we believe, run counter to these principles. In doing so, we are fully mindful of other sections of the Bill which will help to maintain and strengthen family life, such as the requirement that States provide and make available, where appropriate, employment counseling, testing, and job training services for adults and youths over sixteen years who are not attending school.

Our concern is directed particularly to two sections:

1. *Section 208:* "Limitation of number of children with respect to whom Federal payment may be made"

The number of children of broken homes for whom Federal contributions for assistance would be made is frozen at the level of January, 1967. If States are unable to increase their appropriations to meet the needs resulting from simple population increase (for preventive measures cannot be immediately effective) as well as from local or regional economic emergencies, either the level of subsistence would necessarily be reduced or children who need help would have to be denied and would be forced into deeper poverty, despair, and frustration.

2. *Section 201:* "Programs of services furnished to families with dependent children"

A new clause (15) under Section 402(a) of the Social Security Act specifies that services to be provided such as day care for children shall have as their objectives:

(i) "assuring, to the maximum extent possible, that such relative . . . will enter the labor force and will accept employment so that they will become self-sufficient . . ."

This clause with emphasis on "*to the maximum extent possible*" encourages State and local welfare departments to put pressure on mothers of dependent children to leave home and go to work. The aim of AFDC, however, should be to provide for the best interests of children. In many families, the interests of infants and young children, and sometimes of older children, are best served by enabling the mother to remain at home and provide care for them.

There is abundant evidence that when children are subjected to deprivation of maternal care, impairments of character development often occur.

Extensive provision *should* be made, in our opinion, for day care services for pre-school children and after-school care for school-age children of mothers who work and for whom this seems to be the best plan and for mothers who are seeking work or who for other reasons require day-time care for their children. However, safeguards should be provided so that no pressure is put upon mothers to leave their children in order to go to work.

We wish to draw the attention of the Committee, therefore, to the desirability of two amendments to H.R. 12080:

(1) Elimination of Section 208.

(2) Amendment of Section 201 (15) (A) (i) to read:

"assuring the maximum opportunity for such relative, child, and individual to enter the labor force and secure employment, when this is in the best interest of the children."

We respectfully request the Committee's consideration of these proposed changes in the Social Security Act Amendments of 1967.

Sincerely,

ROBERT M. MULFORD,
*Chairman, Juvenile Delinquency Subcommittee,
Governor's Committee on Law Enforcement and Administration of Justice.*

GOVERNOR'S COMMITTEE ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE

JUVENILE DELINQUENCY SUBCOMMITTEE

The Governor's Committee on Law Enforcement and Administration of Justice was created in the fall of 1966 and was charged with the responsibility of designing and achieving a comprehensive program for improving law enforcement and administration of justice in the Commonwealth of Massachusetts.

This Committee has appointed a Subcommittee on Juvenile Delinquency which has the specific responsibility of developing concrete programs for the care, prevention, control, and rehabilitation of juvenile delinquents.

The following are members of the Subcommittee on Juvenile Delinquency:

Hon. Francis G. Poitrast, Justice, Boston Juvenile Court
Dr. William Kvaraceus, Professor of Education, Division of Youth Studies, Tufts University
Dr. Reginald Robinson, Executive Director, Massachusetts Committee on Children and Youth
Dr. Francis J. Kelly, Deputy Director of Field Services, Massachusetts Division of Youth Services
Dr. George Gardner, Director, Judge Baker Guidance Center
Mrs. Frances Olrich, Staff Associate, Labor Relations and Research Center, University of Massachusetts
Mrs. Helen O'Meara, Instructor, Boston University Law-Medicine Institute
Lt. Salvi A. Pascucci, Juvenile Officer and President of Juvenile Officers Association, Framingham Police Department
Robert M. Mulford, General Secretary, Massachusetts Society for the Prevention of Cruelty to Children
Reverend James Breeden, Commission on Church and Race, Massachusetts Council of Churches
William A. Rogers, Executive Director, Big Brother Association
Anthony DiNatale, Chief Probation Officer, Third District Court of Eastern Middlesex
Paul E. Affleck, Executive Director, Springfield Goodwill Industries
Dr. William Schmidt, Professor of Maternal and Child Health, Harvard School of Public Health
Mrs. Edward F. Ryan, Chairman, Massachusetts Educational Conference Board

EX OFFICIO MEMBERS

Hon. Elliot L. Richardson, Attorney General of the Commonwealth, Chairman, Governor's Committee on Law Enforcement and Administration of Justice
Sheldon Krantz, Executive Director, Governor's Committee on Law Enforcement and Administration of Justice

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LOUISIANA STATE BOARD OF HEALTH,
New Orleans, La., August 22, 1967.

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

DEAR SENATOR LONG: I called you while in Washington on Wednesday afternoon, August 16, to relate to you about the meeting which I was attending that was called by the Welfare Administration of the Department of Health, Education, and Welfare, and concerning which I reported later to our State Health Officer, Dr. Andrew Hedmeg. The meeting was called, as our invitation stated, "to discuss the proposed legislation (H.R. 12080) and related administrative matters." However, the manner in which the meeting was conducted appeared to many of us to have been called mostly for the purpose of getting general State approval for the newly organized unit in Health, Education, and Welfare, "The Social and Rehabilitation Services." It was this reorganization (rather than the content of the House Bill which most persons attending the meeting had already read and generally approved) that seemed to provoke the concern of most of the participants from the various States.

The most important area of the reorganization which would affect our health programs on the State level was the removal of the crippled children program and the program for the mentally retarded from the Children's Bureau to a newly created "Rehabilitation Service Administration." This was a shock to practically all of the health administrators in the assembly, because the administration of the Maternal and Child Health Services, the Crippled Children Services, and the Services for the Mentally Retarded Children are all so very intimately intertwined at the operational level, statewise and locally, where the actual work is being done. In fact, it appears to be almost impossible to operate effectively one program without at the same time operating the other programs. We inquired with some apprehension why this fragmentation of services was being advocated, and the only answer we could get was that Miss Mary Switzer, the new Administrator of the Rehabilitation Services Administration, felt that the Crippled Children program and the Mental Retardation program belonged with vocational rehabilitation. This, of course, was scarcely a valid reason to satisfy the inquiring minds of an audience of acknowledged experts in the health and welfare of children gathered from every State of the Union.

I understand that H.R. 12080 will be coming up for discussion soon in the Senate Finance Committee, of which you are Chairman. Many of us would appreciate that you see fit to amend H.R. 12080 with a few words which will put the administration of Title V of the Social Security Act under the Children's Bureau, as it has been in the past. Many, many of us will thank you for your favorable consideration of the above matter.

The compelling reasons for my request that Title V remain under the administration of the Children's Bureau are:

1. Besides the fact, already mentioned, that operationally the crippled children and mental retardation services are so intimately interrelated with the maternal and child health services, the following statistics speak eloquently about this matter:

(*a*) In 34 States, the Maternal and Child Health and Crippled Children programs are in the same agency (the Health Department), and in 18 of these 34 states, the same medical director operates both programs.

(*b*) About 60% of the caseload in the crippled children programs are patients under 10 years of age, and 83% are under 15 years of age (1964).

(*c*) About 80% of the crippled children caseloads are patients with cogenital defects.

With these facts staring one in the face, how could one recommend that crippled children services should be separated from medical orientation?

2. Whenever a reorganization takes place on the federal level, such changes in interrelationship are soon reflected in the States where a competitive scramble for the operation of health programs between various State agencies takes place. Usually this has lead to the fragmentation of State programs, and practically never to cooperation and coordination of programs. If the above mentioned reorganization goes into operation, it can be predicted, from past experience, that a tremendous effort will soon build up for State vocational rehabilitation agencies to want to take over the State Crippled Children and Mental Retardation programs. In fact, Miss Switzer, in answering a question on the subject, admitted that she may actually help to influence the transfer of such programs in some of the States.

3. According to the intent of H.R. 12080, the spirit and fact of this reorganization are in direct violation of the expressed intent of the Bill. The following is a quotation from "The Report of the Committee on Ways and Means on H.R. 12080" page 128, under the heading, Improvement of Child Health: "Representatives of the Department of Health, Education, and Welfare assured the Committee that there is a high degree of coordination between the various executive agencies providing health services to low income children. It is hoped that this legislation will further this coordination as well as lead to more orderly program development. This Bill consolidates the existing authorities into a single authorization with broad flexible categories. H.R. 12080 accordingly eliminates all present earmarked programs beginning July 1, 1968, and replaces them with one total dollar authorization." It is clear then, that the organizational transfer of the Crippled Children program and Mental Retardation program is in direct violation of the expressed intention of the House of Representatives.

4. Based on our experience with the Crippled Children program since the passage of the Social Security Act, we find that a very small percentage of crippled children need special rehabilitation beyond the physical restoration of their abilities and the education of the mothers in the methods of handling these children as much as possible in accordance to the principles of normal growth and development of children. This is particularly true since most of the crippling conditions in children occur early in age, long before children are trained for a vocation.

5. Only competently trained medical personnel can really grasp the implication of the great complexity of medical problems that occur in relation to handicapping conditions in children, and to place such problems in the hands of nonmedically oriented agencies is a real effrontery to the entire medical profession.

6. The Children's Bureau is one of the agencies of the federal government that must be given the highest praise for the *quality* of the health services which it has been influential in developing in the United States for children. This was indeed recognized several years ago when the Children's Bureau was the recipient of the highest public health award in our country at the annual meeting of the American Public Health Association.

Let me mention again and again that the fragmentation of community health services not only depreciates the quality of the service rendered to the people, but also increases significantly the cost of these services because every agency that runs a health program must set up an administrative organization to run such a program, and administration is a costly item in medical care.

There was unanimous agreement among a large group of State administrators of Children Health Services who attended the meeting that we recommend to the Department of Health, Education, and Welfare, that the Crippled Children Program and Mental Retardation Program *not* be separated from the Children's Bureau. This was brought to the floor of the closing session of the meeting when the Honorable Wilbur Cohen asked for recommendations. After I and others arose and presented our recommendations as stated above, the Honorable Wilbur Cohen asked whether anyone wished to make a statement defending the reorganizational plan. Not one individual arose to defend this plan. Only one arose to ask for more information about it.

I hope, therefore, that you see fit to amend the wording of H.R. 12080 so that it will state explicitly that Title V of the Social Security Amendment will be administered by the Children's Bureau.

Sincerely yours,

BEN FREEDMAN, M.D., M.P.H.,
Director, Bureau of Health Conservation.

(The following letter was submitted to the committee by Hon. Frank E. Evans, a U.S. Representative in Congress from the State of Colorado:)

SEPTEMBER 11, 1967.

Hon. FRANK E. EVANS,
Member of Congress,
House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE EVANS: I would like to thank you for sending me a copy of the Summary of Provisions of the "Social Security Amendments of 1967," and also your request for my comments.

First, I am very much in favor of the provisions that increase the social security benefits. As we all know, the cost of living has continued to rise, and the insured beneficiaries will certainly be helped.

The changes in the medical plan seem to be in the right direction.

In discussing the Public Assistance Amnedments, I will discuss each as they appear in the summary.

Family employment and other services

This provision seems to change the theory that the place for a mother is in the home to care for her children. This provision would be more acceptable if it set an age limit for the children, such as 14 or 15 before they were forced from the home.

Family planning services are offered to all ADC families in Las Animas County at the present time. However, I feel that legislating morals is a very difficult thing to do and still say we have a free country.

Community work and training programs

I would endorse this provision 100 percent, as you know we have had such a program in Las Animas County under Title V, and we feel it has been very successful.

Work incentives

We in this department are very much in favor of work incentives. However, we feel $30 of earned income and 50 percent of earnings would be a better formula.

Needy children of unemployed fathers

I object to this provision, as many of our fathers do not have a substantial connection with the work force. This county has been a depressed county for many years; therefore, these fathers have not had a chance to have a substantial connection with the work force. I would also object to the provision that a father was not eligible if drawing unemployment compensation, as the amount thus received is, many times, not sufficient to supply the family with their needs.

To me, this exclusion of fathers without work experience does not make sense, as they are the very ones that need this work and training.

Federal payments for foster home care of dependent children

I find this provision okay.

Emergency assistance for needy children

I agree with this provision, but feel that 30 days is often not enough time to service a case.

Child welfare services

This provision in the summary is not well enough explained for me to comment.

Limitation on aid to families with dependent children

Here I disagree most sincerely. This would mean that the additional children and the mother would not be on the budget, but would still be living on the amount the eligible children would receive.

Thanks again for sending me this bill, and I hope my comments will be of help to you.

Sincerely,

Las Animas County Department of Public Welfare.
Clair O. Roberts, *Director.*

State of Maine,
Augusta, Maine, September 20, 1967.

Hon. John W. Gardner,
Secretary, Health, Education, and Welfare,
Washington, D.C.

Dear Secretary Gardner: It is my sincere hope that you and everyone in your agency and elsewhere in the administration will be successful in persuading the Senate and any resulting Conference Committee of the need to alter the proposed Social Security Amendments of 1967 contained in H.R. 12080. There are many enlightened and progressive features in this legislation, but it also contains measures unduly restrictive and I believe not in the best public interest.

In this time of an increasing cost-of-living, it is imperative that relief be given to those on fixed incomes. Certainly increased Social Security benefits of at least 12% and preferably 15% are needed. However, the increases contained in H.R. 12080, while beneficial, should be restructured. The original bill, H.R. 5710, would have increased the minimum benefit to $70 from its present level of $44. H.R. 12080 increases minimum benefits to only $50. In Maine over 50% of OAA recipients receive Social Security. It is obvious to us that a more reasonable minimum benefit is necessary for these people to live in the dignity they deserve.

It is the view of Maine officials that the provisions contained in Section 201 of H.R. 12080 are both unduly proscriptive and would force unproductive and meaningless procedures. The element of compulsion puts government in the very delicate position of deciding which mothers will work and which ones will not. That this provision is subject to great abuse should be obvious. More importantly, perhaps, in Maine a substantial percentage of the AFDC recipient group are on the program for relatively short periods and except for brief intervals are basically self-supporting families. Forcing us to spend time doing things for these people which they are perfectly capable of doing for themselves is an inefficient allocation of money and energy. I give my whole-hearted support to increased incentive to work with those welfare recipents who *do* need training and guidance to assist them to become self-supporting; however, to make this mandatory may well be self-defeating.

The Maine legislature has just recently, at my request, expanded the eligibility of AFDC to include those homes with an unemployed parent. Not to have done this would have continued a program which put a premium on broken homes. It is unfortunate that coincident with this change in Maine law a very restrictive definition of AFDC-UP eligibility is proposed in H.R. 12080. The definition proposed in Section 203 (a) of the bill restricting assistance to families where the father has been so completely attached to the labor force favors the unemployed parent with better education, more skills, and good work experience; it excludes those who are most apt to become chronic dependents. I recognize the interest of the House Committee in not encouraging this total dependance but I feel it misguided to arbitrarily exclude from the program these individuals whose need is greatest. Let us not forget that our interest is not focused on the unemployed parent, but rather on their children for whose future we have greater hope.

The most troublesome feature in the bill is the limitation on AFDC eligibles. The Congress is understandably alarmed over the increase in desertion and illegitimacy in some parts of the country but to use the public assistance program as a means of controlling human behavior is at best questionable. One wonders what rules and regulations could be adopted to maintain the proposed ceiling and guarantee equal protection under the law. The ceiling proposal does not allow for case load increases resulting from industrial lay-offs or other causes of dependency resulting from varying economic conditions. Indeed, it is extremely doubtful that a mother will not bear another child because the Congress has said the state will support no more than X number of children. There is admittedly an urgent need to get at the causes of these grave social problems and other provisions in H.R. 12080 such as a strengthened Community Work and Training Program, Day Care, Foster Care, Family Planning, and Homemaker Services are useful, salutory, rehabilitative tools and offer a realistic hope of controlling the size of case loads.

In light of action in some states establishing what must appear to some people to be very high income figure defining medical indigency, it is not difficult to understand why the Congress has proposed a limitation on federal participation in medical assistance under Title XIX programs.

I personally feel that with such a new program, it is premature to impose any ceiling. The Maine legislature turned down my request for funds to enable Maine to initiate this program. I am extremely hopeful that we will be participating soon. If a ceiling is to be required, the proposed standard appears to be too limiting. Based on Maine's average AFDC payment, a family with more than $2,400 yearly income would be ineligible for medical assistance should the legislature appropriate funds for such a program. This is a long way from the $5,000-6,000 standards to which the Congress apparently objects. I feel that if a percentage ceiling is to be imposed 150% is more realistic than the proposed 133⅓%.

If some of the negative features of this legislation can be eliminated the proposed Social Security amendments of 1967, taken together, may prove to be one of the most potentially useful and enlightened bills effecting public welfare in many years.

I am enclosing for your information a copy of the resolution concerning this legislation jointly adopted by the Maine Department of Health and Welfare Advisory Committee, the Citizens Advisory Committee to the Bureau of Social Welfare, and the Executive Committee, Maine Conference of Social Welfare.

Sincerely yours,

KENNETH M. CURTIS, *Governor.*

RESOLUTION CONCERNING SOCIAL SECURITY AMENDMENTS OF 1967 FROM THE MAINE DEPARTMENT OF HEALTH AND WELFARE ADVISORY COMMITTEE, CITIZENS ADVISORY COMMITTEE TO THE BUREAU OF SOCIAL WELFARE, EXECUTIVE COMMITTEE, MAINE CONFERENCE OF SOCIAL WELFARE

The Advisory Committee to the Department of Health and Welfare, to the Bureau of Social Welfare, and the Executive Committee of the Maine Conference of Social Welfare, met on September 14, 1967 to discuss the provisions of the Social Security Amendments of 1967, H.R. 12080, as they affect people, programs and financing in Maine, and voted to send to you the following observations relating to the Public Welfare amendments section:

The strengthening of community work and training, expanded day care, improved foster care services, family planning, and homemaking services provided in the bill offer the best hope of controlling the size of public assistance caseloads, because they are aimed at the causes of dependency. Two sections of the bill will all but nullify these progressive features and should be eliminated:

I. *Title II, part 2, Section 201, Family Improvement.*—This section compels the State to decide which mother shall work and which shall not. This element of compulsion is not needed in Maine. The State cannot provide enough training and work experience for those who want to work. We feel this is not a productive measure. It denies the mother the choice she should have.

II. *Title II, Part 2, Section 208, Limitation on Number of Eligible AFDC Children.*—This measure puts a ceiling on the number of deserted and illegitimate children who can be aided with Federal funds. This is a punitive measure, unfair and unworkable, and we question that it is constitutional. What about equal protection to all under the law? We think it unlikely that state governments can control by edict or restrictive policies the number of illegitimate or deserted children.

We citizens of Maine who are deeply concerned with the welfare of the disadvantaged hope you will give this bill your very searching attention.

MARY WORTHLEY,
Chairman, Health and Welfare Advisory Committee, Maine.
VIOLA JASPER,
Chairman, Advisory Committee, Bureau of Social Welfare.
CHARLES KING,
President, Maine Conference of Social Welfare.

STATEMENT OF ARTHUR J. PACKARD, CHAIRMAN, GOVERNMENTAL AFFAIRS COMMITTEE, AMERICAN HOTEL AND MOTEL ASSOCIATION

The American Hotel & Motel Association is a federation of fifty State innkeeping associations having a membership in excess of 6,000 hotels and motels located in all sections of the United States .The Association maintains offices at 221 West 57th Street, New York, New York, and at 777—14th Street, N.W., Washington, D.C.

We would like to comment briefly on the Administration's proposal to revise the social security system and on H.R. 12080, which passed the U.S. House of Representatives on August 17, 1967.

The Administration has requested a benefit increase which would range from 15 to 59 per cent (an average of 20 per cent) for the 23 million people currently receiving payments. Medicare, nursing, and other programs would be expanded and those over 65 would get a tax reduction. To pay for these increased benefits, the Congress has been asked to increase both the tax rate and the wage base on which the tax is assessed. The current wage base of $6,600 would be raised to $7,800 next year; to $9,000 in 1971; and to $10,800 in 1974. The current tax rate of 4.4 per cent would be raised to 4.5 per cent in 1969 and to 5 per cent in 1973. In effect, the Administration asks that in a little more than five years the amount of taxes extracted from employers and employees alike for the payment of these increased benefits be almost double the amount which is currently withheld from earnings.

H.R. 12080 would increase the wage base from which Social Security and Medicare taxes are paid from the present $6,600 to $7,600, effective January 1, 1968. The tax rate would increase from its present 4.4 per cent in gradual steps to 5.9 per cent on January 1, 1987.

We are aware and solicitous of the problems of our senior citizens. However, we do not believe that a solution for them is to be found in a proposal which calls for a drastic increase in both employee and employer taxes.

This committee no doubt will want to be informed of the financial condition of our industry, or any industry for that matter, as it considers proposals which would inflict additional financial burdens, if enacted.

Payroll costs represent the major type of expenditure in the operation of a hotel or motel. In recent years payroll with fringe benefits amounted to 36.1 cents of each dollar of sale made by hotels and motels. This ratio will show a sharp increase in the current year due to the enactment of both Federal and State minimum wage laws. The Fair Labor Standards Amendments of 1966, effective just this last February 1, not only have created a general disruption within the hotel/motel industry, but have also imposed a harsh economic burden on the industry. Citing merely as an example the same 16 Southern State classification utilized by the U.S. Department of Labor in its annual report to the Congress, the recent extension of the $1.00 per hour minimum wage to the industry will increase payroll costs in that area by an *additional* 10.2 per cent! One need not be a statistician to envision the enormous added impact on payroll which will result from the $1.60 per hour minimum rate scheduled for the industry in less than four years from now. The operating costs of hotels and motels cannot be increased any further without serious consequences.

Add to the already high payroll costs in the industry: (1) the proposed ten per cent surcharge on corporate taxes; (2) the Administration's proposed 20 per cent increase in postal rates; and, (3) an anticipated request for higher unemployment compensation taxes—in the hotel/motel industry a 0.15 per cent increase in this tax rate would add over $2 million to the cost of payroll taxes and employee benefits—and we are moved to question the economic logic of the Administration's Social Security proposal. The point here being that you cannot raise the wage-earner by pulling down the wage-payer!

The national Certified Public Accounting firm of Harris, Kerr, Forster & Company has for many years issued a nationwide survey of the hotel and motel industry which tabulates the statistical information with regard to hotel and motel operations covering 700 of such units. This study shows a definite trend towards higher prices charged for room accommodations, but continued declines in number of rooms rented. Occupancy of hotels and motels has declined from 85 per cent in 1948 to 69 per cent in 1958 and down to 65 per cent in 1966. The return on equity invested in hotels and motels is less than can be obtained from a savings bank where there is no risk of investment.

Of course, there is another side to the Social Security tax "coin;" namely, the employee's contribution to the program. Just a little more than a year ago, an employee's yearly maximum payment into the program was less than $175. H.R. 12080 will increase this tax to $334.40 in 1968; to $364.80 in 1969; to $395.20 in 1971; to $425.40 in 1973; and to $448.40 in 1987. All this while the inflationary forces take their increasing toll from the employee's take-home pay. The Congress should be aware that employees—particularly the young wage-earners—are already questioning whether the benefits of tomorrow are worth the costs of today.

While the hotel and motel industry is interested, like every business, in the social and economic program for the underprivileged, it must be remembered that there comes a point of diminishing returns due to increased costs and low investment return. Foreign travel *to* the United States is being discouraged because the rates charged in other countries for similar accommodations are less due to lower labor costs. Many of our citizens are traveling abroad for the same reason. This has affected our Balance of Payments program to which Congress is alerted. Such costs similarly affected travel within the United States, as the foregoing statistical figures indicate. It has been noted that commercial travelers are cutting down their use of hotels and motels by shortening a five-day trip to a four-day trip; a three-day to a two-day, and, in many cases, making a round trip in one day, thereby avoiding the expense of overnight lodging and meals.

The accommodation industry is a tremendously important segment of the economy and on the present basis of cost of operation, the return on investment is low. Any further increases in the cost of operation due to increased labor costs and payroll taxes will have a devastating effect upon the accommodation industry, from an investment, social and economic viewpoint.

As an alternative to the Administration's proposal and H.R. 12080, we recommend that Congress consider an increase in Social Security benefits in the neighborhood of 8 per cent without increasing payroll taxes. We believe that an increase in the neighborhood of 8 per cent can be accomplished without doing damage to the Social Security system. We also favor subsequent increases in benefits based on rises in the cost of living. When one considers that since the effective date of the 1965 Social Security benefit increases the Consumer Price Index has increased more than five per cent, there is merit in such an escalator provision which would relieve the hardships of those elderly citizens who depend on the benefits.

Nevertheless, if benefits are to be increased with payroll taxes remaining at current levels, the question which must be answered is: who pays the piper? Are the increased benefits in such an instance to be paid from surpluses existing in the trust fund? If so, while we see no immediate harm, at the same time we question whether such surpluses will continue to accrue to support added benefits in future years. Or are the increased benefits to be paid through general revenue financing? If this be the case, then we question the wisdom of such a move.

We have always believed that social insurance, in the form of the Social Security program now over 30 years old, ought to be self-financing. We fear that should general revenue financing be used to pay for the program the insurance concept of the system may at some later date become subordinated to political expediences. And this is exactly the type of thing an inusrance system must avoid! Such a system which serves long-term ends must not rely on financing which may be altered to satisfy short-term desires.

As this committee and this Congress consider changing the system—be it an increase in benefits or otherwise—the touchstone of its action should be maintaining the integrity of the financial system on which the whole structure of Social Security rests.

STATEMENT OF NATIONAL COMMITTEE FOR DAY CARE OF CHILDREN, SUBMITTED BY HON. ELINOR C. GUGGENHEIMER, CHAIRMAN, BOARD OF DIRECTORS AND MRS. RICHARD LANSBURGH, PRESIDENT

Mr. Chairman and members of the committee, the National Committee for the Day Care of Children wishes to call to your attention our opinion based on years of experience and professional knowledge that the Welfare provisions of the bill you are now considering are both unwise and unworkable. The result of any effort to implement them, in our judgment, would be disastrous for the whole country.

It is probably difficult for you to appreciate how much anguish this legislation has caused those of us who are dedicated to the promotion of expanded day care programs. For almost ten years, the National Committee for the Day Care of Children has worked to persuade the Federal Government to provide decent day care facilities for the millions of American children who need or might benefit from them. We have campaigned for increased funds, more facilities, better training and higher standards for day care programs. We have repeatedly urged the nation to eliminate the disgraceful situation in which millions of American children are left to fend for themselves or under wholly inadequate supervision during the day. In that time, we have seen the congress take the first steps toward providing for the welfare of these children.

Today we find ourselves in the strange and uncomfortable position of having to say that the largest single Federal day care program ever proposed is a bad program. Yet we have no choice but to tell you so. For the Day Care envisioned by H.R. 12080 as it presently stands is likely to do the children it affects as much harm as good.

When we first heard that the Congress was considering establishing a massive day care program for children of parents on public assistance, we were elated. We thought that such legislation would embody a recognition of the role day care can play in breaking the vicious circle of poverty and dependence. We find, however, not a carefully thought out program to help children develop mentally and physically, but a hastily put together outline for a compulsory, custodial service which is not required to maintain even minimal standards of adequacy.

We believe that the more objectionable features of this legislation, at least in so far as they affect children, are the result of the haste with which the bill was written. We hope, therefore, that you will welcome suggestions for amendment that will eliminate the punitive and destructive aspects that are in the present document.

In the first place, the day care program is, for all practical purposes, mandatory. A 'good' 'mandatory' day care prorgam is a contradiction in terms. No mother should be forced to place her children in day care so that she can go to work. The judgment as to whether a young child needs his mother's constant care and attention is one that, in our society, traditionally belongs first of all to the mother. Society may intervene only when the child is in physical danger. In this instance, however, we are proposing to intervene in circumstances which relate not to danger but to poverty. Such a pattern of intervention may be appropriate in totalitarian countries. *It is not appropriate in America.*

In addition, some children can benefit from day care and some cannot. Many children may be damaged emotionally and physically by being taken from their homes and being placed in a setting with which they are not ready to cope. Day care professions are the last to urge day care for all children. They know that a prerequisite of a good program is a professionally administered, discriminating intake procedure. Such a process must work in consultation *with* the mother to determine the appropriateness of day care for her children.

Previous day care programs have always taken these facts into consideration. Yet there is nothing in this legislation to indicate that one of the criteria for determining whether it is "appropriate" for a mother to accept training or employment is whether the placing of her children in day care is in their best interest. In this connection we refer you to section 523 (1) (B) of the Social Security Act which provides that the States must formulate "(iii) * * * such safeguards as may be necessary to assure provision of day care * * * only in cases in which it is determined * * * that a need for such care exists;" Although this provision of the law was developed in a somewhat different context, it demonstrates an appreciation by Congress of the kind of standards to which any *good* day care program must conform. Simillar language must be explicitly applied to the day care provided for in H.R. 12080 if we are to have any hope that the resulting programs will work for, rather than against, the children covered.

The second serious problem with the bill is its failure to set any standards for day care services or even to indicate that such standards should be set. This is a deficiency which, in our view, must be corrected.

A federally funded day care program assumes tremendous responsibility, by virtue of the fact that it intrudes into a sphere normally reserved for the family. Fully to discharge the responsibilty of caring for hundreds of thousands, perhaps several million, children, this program will have to live up to very high standards. The Secretary of Health, Education, and Welfare should be explicitly directed to formulate guidelines for day care programs within which local communities must operate. Such guidelines should guarantee that day care facilities, staff and programs meet standards of quality sufficient to insure the welfare of participating children.

A licensing provision similar to that already applicable to the day care programs funded after the child welfare provisions of the Act should also be written into the program.

Such directives relating to standards should be a part of any legislation pertaining to day care. In the context of this particular program, however, they are absolutely essential. Since receipt of so much of their other money will be tied to the provision of day care, the States will be under tremendous pressure to get day care programs operating quickly. In a situation where speed is important, standards of quality are always threatened.

Congress should also give consideration to changing the formula under which the day care part of the program will operate. If the formula for State contributions was the same as that required for community action programs, so that the State's share was 10% instead of 15 and 25% (and payable in services and facilities as well as in money) better day care would be provided in those States which would find the present provisions financially impossible.

Our recent experience with the Headstart Program indicates that there must be provision of funds for the building and renovation of facilities. Lacking this it will be impossible to start a large scale program in many cities, and, even more, in rural area. In addition there must be provision for the training of teachers and other staff, and for the provision of health and guidance services, unless what is contemplated is a purely custodial "baby sitting" service. If this latter is the case, our country will be in the anomalous position of giving some children a headstart, while giving others a push backward. If what is contemplated is a system of meting out punishment to the children of AFDC mothers, such a custodial program would be eminently qualified to succeed.

We believe that the mandatory work provisions, the lack of a minimum wage scale for working mothers, the incentives offered to States to remove illegitimate children from their homes, and the implicit pressure on unemployed fathers to leave their families may lead to wholesale migration from areas where the law is enforced too literally, into areas which appear to be more liberal and therefore safer. If this leads to increased migration on any large scale into cities which cannot afford to absorb additional low income families, nor to provide the space, staff or funds to meet the additional need for day care, we predict a period of misery, frustration, and backbreaking problems for our already over burdened cities.

Before closing this statement, we feel that we must add our voice to those who have objected to other provisions of the bill which seem more likely to punish the poor than to end dependency. In particular, we would hope that the Committee would see fit to eliminate the freeze on AFDC recipients, transform the work training program into one that is mandatory upon the States but voluntary for recipients, liberalize the eligibility rules for unemployed parents, and eliminate any incentive for removing children from their families.

We look to the distinguished and thoughtful members of the Senate Finance Committee and to the Senate as a whole to amend this bill so that it will become a worthy part of the country's war on poverty, instead of the beginning of a new war designed to fight the poor.

THE ARTHRITIS FOUNDATION, INC.,
NEW YORK CHAPTER,
New York, N.Y., September 13, 1967.

Senator RUSSELL B. LONG,
Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: Since the inception of the New York Chapter of the Arthritis Foundation, we have given information and assistance to many thousands of arthritics in Southern New York State. Because of our close relationship with many of the chronically ill and disabled in the community, we have been able to learn of their needs on a first hand basis. Our awareness of community problems compels us to tell you of our concern with certain portions of the new Social Security legislation recently passed by the House of Representatives, H.R. 12080.

H.R. 12080 in its entirety contains many beneficial provisions that have been long sought by the Arthritis Foundation and other health and welfare organizations. They include: an increase in Federal financing for such social services as family counseling, day care, family planning, foster care, and other protective child welfare services; for demonstration and other research projects; for the special costs associated with work and training programs; for the training of social workers and their aides; and provision for an incentive exemption of earned income. However, we question the effectiveness of these new policies if they must be carried out under the shadow of certain repressive items in the bill.

These reprehensible items in H.R. 12080 do not maintain the original spirit and intent of the Social Security Act of 1935. Instead, these sections will force the United States back to medieval punishment for poverty and away from the preservation of human dignity. We refer specifically to:

Title I, Part 1

We reluctantly supported the recommendation for a 15% increase in cash benefits, as proposed in the Administration Bill. We felt it was a step in the right direction, but very inadequate to achieve the original intent of Congress in the 1935 Social Security Act. In 1935 the Congress visualized a social insurance system which would maintain for senior citizens a decent American standard of living.

The 12.5% increase in H.R. 12080 is so small that it will have a negligible impact on the needs of the senior citizens of America.

Title I, Part 3

We laud the inclusion of in-patient pathology and diagnostic radiology in Part A of Medicare. We feel, however, that it is imperative that hospital outpatient benefits be continued under Part A rather than Part B of Medicare. For many patients the placing of these services under Part B will be restrictive because they will be subject to deductibles and coinsurance. Thus, even fewer patients will be able to avail themselves of these services.

In addition, it is essential that Home Health Services be included in the list of mandatory services. Home Health Services would extend medical care to many ill persons. It would drastically lower the occupancy of hospital and nursing home beds. It would also serve to cut the high cost of in-patient care.

Unfortunately, the House did not decide to extend Medicare to disabled persons under age 65. As a voluntary health agency we are particularly sensitive to the unmet needs of this disadvantaged group for whom we have provided varied service programs. We urge you to support this item.

Title II, Part 1

The fixed ratio for AFDC children of January 1, 1967 could drastically affect the children who need services the most if that percentage of the population increases. We do not believe that the use of ratios is ethically justified in meeting the needs of deprived children.

We are further concerned about compulsory employment and training programs for children over age 16, unemployed fathers, and mothers with dependent children. The drastic switch of emphasis of H.R. 12080 makes the Social Security legislation a compulsory job training and employment recruitment program rather than a means of strengthening family life. We are certain that you are aware that coercive measures will not rectify the consequences of generations of injustice, poverty and disease.

We propose that Congress should incorporate the following five recommendations:

1. Set nationwide minimum welfare grants which would require all states to raise all welfare grants at least to the federal low income poverty line ($4,000 for a family of 4).
2. Require the AFDC unemployed parent program in all states and make it a permanent part of the Social Security Act.
3. Establish work incentives for AFDC and other welfare recipients allowing welfare families to keep all money they earn until their family income reaches the federal income poverty line.
4. Transfer the administration of community work training programs to the Department of Labor.
5. Eliminate all other coercive elements of the bill that may ultimately deprive thousands of dependent children of the bare subsistence they now receive.

Title II, Part 2

Under the new eligibility criteria for proposed changes in Medicaid, Title XIX, those medically indigent people who are in the upper income brackets would be cut off. The broad range of services would also be narrowed. We at the Arthritis Foundation have witnessed the beneficial effects of this program which has begun to move health care services forward to levels befitting a modern industrialized society. We urge that Title XIX not be circumscribed.

We recommend that more adequate social insurance benefits and policies be provided in Title I in order to reduce assistance levels and costs by assuring other sources of adequate income and helath care. We feel that the Public Welfare Advisory Council's proposal of a comprehensive program of assistance and service based on Federal standards and financing be implemented as an alternative to the regressive policies in the bill.

We look to your progressive leadership in the Senate to remove the aforementioned punitive items and to develop a legislative document that is logically consistent and ethically acceptable.

Sincerely yours,

CHARLES B. HARDING, *President.*

THE AMERICAN NATIONAL RED CROSS,
Washington, D.C., September 14, 1967.

Mr. TOM VAIL,
Chief Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. VAIL: This will respond to your letter of September 7 asking for information we might provide concerning the amendment included in H.R. 12080 which would require greater replacement of blood by Medicare patients than is required under existing law. We understand that you also would like to have an expression of our views on the proposed amendment.

As you suggested, the American National Red Cross has had rather extensive experience in the blood banking field. It has engaged in some form of such activity continuously since 1937. The present program is the largest single program in the United States and probably the largest in the world. It includes 56 regional centers serving areas that include about 114,000,000 people and it collected over 3,000,000 units of blood during the fiscal year ending June 30, 1967.

All the blood collected by the Red Cross is donated on a completely voluntary basis and the blood thus collected is provided to hospitals without charge for the blood itself. In most instances, the hospitals reimburse the Red Cross centers for a *portion* of the costs involved in collecting, processing, and distributing the blood delivered to the hospitals. In other instances, the entire cost is borne by the Red Cross. Additionally, the participation of thousands of volunteers in all stages of the program minimizes the expense incurred.

Most of the blood collected by the Red Cross is donated by members of civic groups, labor unions, church congregations, and employees of industrial and commercial concerns. If a certain percentage—usually about 20%—of each participating group donates blood once a year, the Red Cross is ordinarily able to meet the annual blood needs of the donors and their families—including the parents and grandparents of the donors—provided that the Red Cross is not required to provide more than one unit of blood for each unit actually transfused. And it is the general policy of the Red Cross to provide blood replacement only on such a one-for-one basis.

Under the above-mentioned amendment, for purposes of the three pint deductible, a Medicare patient would be responsible for replacing two pints of blood for the first pint of blood received rather than one pint as provided for in the present law. Not only would this requirement produce extra income for the blood bank or hospital—which presumably would be free to sell the extra pint to other patients—it would place additional burdens on the donor group replacing the blood. But, more importantly, it would seem to penalize a group of people who are least able to replace the blood used in their treatment. Both from the information we have compiled within the Red Cross and from the results of surveys made by other organizations, it seems that approximately one-third of all blood transfused in hospitals is given to persons 65 years of age or older. As you probably know, the medical standards adopted by the Red Cross and most responsible blood banks do not permit the donation of blood by persons 60 years of age and older. Thus, the Medicare patients and their contemporaries are ineligible to donate blood and necessarily have to rely on donations by younger members of their families or of the donor groups that can be of assistance.

Accordingly, the American National Red Cross does not believe that the proposed amendment would be in the best interests of the intended beneficiaries of Medicare legislation nor that such amendment would contribute to the successful operation of the Red Cross' Blood Program.

We are grateful for the opportunity afforded us to present the foregoing information and views.

Sincerely yours,

FREDERIC S. LAISE, *Vice President.*

NATIONAL CONFERENCE OF STATE SOCIAL SECURITY ADMINISTRATORS,
September 22, 1967.

Hon. TOM VAIL,
General Counsel, Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR MR. VAIL: At a recent meeting of the National Conference of State Social Security Administrators much thought and discussion was given to the many difficulties each State experiences in connection with erroneous reporting of social security taxes by State and local governmental employees to Internal Revenue Service.

Each State Administrator is anxious for employees of his respective State to retain all wage credits he or she has earned. However, for a State to assume many years of unknown tax liability places a State in a most difficult position and one that many States cannot possibly comply. However, in order for each State to be able to assist its employees we are requesting that Section 218 of the Social Security law be amended.

I, as Chairman of the Legislative Committee, requested technical assistance from the Bureau on the proper statutory language on this particular subject. Of course, the fact such technical assistance was rendered does not mean that this represents the position of the Social Security Administration.

The enclosed draft language provides that a State, at the time it extends coverage to a coverage group, may elect to deem those employees who had been members of the coverage group, erroneously reported to Internal Revenue Service and for whom no refund has been made, to be members of the coverage group on the date designated pursuant to section 218(f)(2). This would mean that the

State, in providing coverage by regular modification, with any effective date of coverage permissible under section 218(f)(1), could include in the coverage group the employees who meet the above requirements.

Continuity of coverage, with no deletion of reported wage accounts, can occur when retroactive coverage is provided by the State for periods open to correction. To the extent that this is not done, no coverage exists for prior periods and the wage amounts must be removed for the periods open to correction.

In no event would the draft language provide coverage for those individuals who although reported to the Internal Revenue Service are not members of the coverage group. In this instance, wage amounts for periods open to correction will be removed.

We are transmitting ample copies for each member of the Committee, as well as a supply for any action you deem appropriate.

Assuring you of my personal appreciation as well as each member of the Legisative Committee and each State Administrator for your assistnace, I am

Sincerely,

EDNA M. REEVES, *Legislative Chairman.*

Section 218(f) is hereby amended by adding the following:

"(f)(3) Notwithstanding the provisions of paragraph (2) of this subsection, in the case of services performed by individuals as members of any coverage group to which an agreement under this section is made applicable, and with respect to which there were timely paid in good faith to the Secretary of the Treasury amounts equivalent to the sum of the taxes which would have been imposed by Sections 3101 and 3111 of the Internal Revenue Code of 1954, if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed, and with respect to which refunds were not obtained, such individuals may, if so requested by the State, be deemed to be members of such coverage group on the date designated pursuant to such paragraph (2)."

STATEMENT OF WILLIAM L. TAYLOR, STAFF DIRECTOR OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS IN CONNECTION WITH TITLE II OF H.R. 12080

The United States Commission on Civil Rights is an independent, bipartisan agency established by the Congress in 1957 and directed, among other things, to appraise Federal laws and policies with respect to equal protection of the laws and to submit reports, findings, and recommendations to the President and the Congress.

Under this mandate, the Commission and its State Advisory Committees have devoted considerable attention to problems concerning the public assistance program of aid to families with dependent children (AFDC). In 1966, the Commission issued a report entitled "Children in Need" following its investigation of the AFDC program in Cleveland, Ohio. In addition, Commission State Advisory Committees in Indiana, in Mississippi, in New Jersey, and elsewhere have carried on their own investigations of the AFDC program, as well as other public assistance programs, and have apprised the Commission of their findings and recommendations. As a result of these investigations, the Commission has been made aware of many of the deficiencies and inequities in the existing AFDC program and of the clear need for changes to permit the program to operate more effectively. It is a matter of basic importance that the AFDC program, in accordance with its statutory goals, enable the families it serves to achieve positions of self-sufficiency and economic independence.

We believe that several of the provisions contained in Title II of H.R. 12080 would provide salutary changes to existing law. We are deeply concerned, however, about other provisions of Title II which, in our view, would intensify the problems to which they are addressed rather than alleviate them. Our comments are addressed to the following five sections of Part 1 of Title II of the bill: Sections 202, 203, 204, 206 and 208.

Section 202—Earnings Exemption for Recipients of Aid to Families with Dependent Children

Under existing law, States may disregard the earnings of children under the ADFC program up to $50 a month per child, with a family maximum of $150. In addition, the earnings or any other income of an AFDC family may be set aside for the future identifiable needs of children in the family. Adults in AFDC, however, are allowed no earned income exemption under the Social Security Act.

We support, therefore, the objective of Section 202 which, by permitting employed parents to retain part of their earnings, would provide real incentives to AFDC adults to work. Under this provision, the first $30 of the monthly earnings of an adult or of a child, over the age of 16 and under 21 and not attending school, would be exempted as well as one-third of earnings above that amount. Earnings of children under 16 and of those 16 to 21 who are attending school full time would be fully exempt. We urge, however, that the exemption be raised at least to the level provided for in the Administration Bill, H.R. 5710, namely $50 per month of earned income for each parent and child over 18, with a $150 monthly family maximum.

We also support the provision which would make the income exemption for both adults and children mandatory on the States. Under existing law, States are not required to allow any income exemptions. Currently only 25 States offer the incentives to AFDC families that are permitted under Federal law.

We believe that by broadening the income exemptions and making such exemptions mandatory on the States, Section 202 can make a substantial contribution toward the goal of enabling AFDC families to achieve economic self-sufficiency.

Section 203—Dependent Children of Unemployed Fathers

In 1961, Congress established, on a temporary and optional basis, the program of benefits for the dependent children of unemployed parents, (AFDC-UP). This was an important step toward providing for the care and support of children who are dependent not as a result of the absence of a parent from the home, but as a result of the unemployment of the parent. We support Section 203, insofar as it would place the AFDC-UP program on a permanent basis.

But we also urge the Committee to amend Section 203, to make adoption of the AFDC-UP program mandatory to the States. In the six years since the program was enacted, fewer than half the States have adopted the program. The Commission has received considerable testimony concerning the effect on families who must rely on the AFDC program to survive in States which have failed to adopt this program. In Gary, Indiana, for example, where this program is not in effect, a caseworker for the Lake County Department of Welfare told the Indiana State Advisory Committee:

"Our State AFDC program puts a premium on the broken home * * *. Unemployed fathers, faced with the choice of staying with their families and being unable to provide for them or leaving and enabling them to collect AFDC benefits, frequently leave."

In Newark, New Jersey, another jurisdiction that has failed to adopt the AFDC-UP program, a former caseworker told the Advisory Committee of the advice he had to give to a father who could not find employment:

"It was my very sad duty to have to tell him that if he remained in the home * * * the family would be taken off [AFDC] and, off the record, I informally suggested to him that it might be better if he left the home in order for his family to be taken care of."

The Commission is convinced that if the integrity of family life is to be maintained among families dependent upon public assistance, adoption of the AFDC-UP program must be made mandatory.

The Commission supports the provision in Section 203 by which the term unemployment would be defined under standards prescribed by the Secretary rather than the States. In the 22 States which have adopted the AFDC-UP program, there are wide variations in definitions of unemployment. In some, such as Arizona, the terms has been defined so narrowly that the program has been unable to operate on more than a token level. Therefore, the Commission agrees that there is a need for a Federal standard which would apply uniformly throughout the States.

The Commission is concerned, however, about the provision which would unduly restrict this definition by requiring the father to have had a specified amount of recent employment. This provision, by excluding fathers with no work experience and those who have suffered unemployment for prolonged periods, would have a discriminatory effect on Negroes and other minority group members who as a result of past employment discrimination and unequal training opportunities might not be able to qualify as previously employed fathers under the limitations of the bill.

Section 204—Community Work and Training Programs

The House bill would make it mandatory for the States to provide for community work and training programs. Adults in AFDC families and children over 16 and under 21 who are not in school would be considered with respect to their appropriateness for participation in such programs. If they cannot show "good cause," any appropriate child or relative who refused to accept a work or training assignment, or refused to accept employment by the State employment service or by any employers, would have his assistance discontinued. The Commission strongly opposes this provision.

The Commission favors the establishment and expansion of programs which will provide training, meaningful work experience and remedial education designed to counteract the adverse affects of years of inadequate education, employment and training discrimination, and related denials of opportunity to which millions of Negroes and other minority group members have for so long been subjected. We endorse measures which will replace dependency with greater economic and social opportunity and which will enable disadvantaged people to attain their individual potential.

We seriously question, however, whether these desirable objectives can be achieved within a framework of compulsion and under the constant threat of denials of assistance. We support Section 204 to the extent that it would require the States to *offer* programs of work and training. But we urge the Committee to amend that Section to make it clear that the *acceptance* of the offer of work or training is voluntary.

The Commission has found in the course of its investigations that many mothers of dependent children are anxious to work and actively seek opportunities for training and employment. For these mothers the bill can be of considerable help by providing for meaningful work and training experience and by providing for adequate day care services. We also have found, however, that many mothers of dependent children feel it is more important for them to stay at home and care for their children. We believe it would be a serious mistake for the bill, by permitting the State to determine which mothers are "appropriate" for work, to deprive these mothers of the choice which rightfully should be theirs to make.

Moreover, experience has shown that the coercive approach represented by this provision not only fails to produce the desired result—economic independence and self-sufficiency—but it invites abuse, discriminatory treatment, and threats of reprisal against those who would assert their rights. The Commission's Mississippi State Advisory Committee heard testimony concerning incidents in which local welfare officials used their authority to remove needy families from the rolls as a means of preventing Negroes from exercising basic constitutional rights. Section 204 could provide such officials with even greater power over the lives of needy families.

We also recommend that Section 204 be amended to provide expressly that the training offered to any individual shall not be below the skill level of his last regular occupation. A similar provision has been established by the Secretary of Labor in connection with the Manpower, Development and Training programs. We recommend further that adequate safeguards be provided to assure adherence to appropriate training standards. The Commission's Mississippi State Advisory Committee has learned of several instances of exploitation of trainees in the work experience and training program offered under the auspices of that State's welfare department. In one instance, a woman testified that although she was supposedly being trained to learn the florist business she was required to spread gravel and later found herself assigned to work as a domestic in her employer's house. Another woman who sought training as a dietician told the Advisory Committee that she was put to work washing dishes and mopping floors in the local school. These incidents strongly suggest the dangers of exploitation and the possibility of inadequate training and meaningless work experiences unless appropriate standards are provided.

Section 206—Emergency Assistance for Certain Needy Families with Dependent Children

The Commission endorses the principle underlying Section 206 of the House bill which, for the first time, would authorize Federal participation in emergency assistance payments to certain needy families with children. As the House Ways and Means Committee noted in its report, this provision will permit the degree of flexibility necessary to provide for destitute children and their families whose needs cannot be met through the ordinary channels and procedures of public assistance.

One group of Americans who often are in need of emergency assistance are the thousands of migrant worker families who usually are unable to meet residence requirements for public assistance. Commission State Advisory Committees in South Bend, Indiana, San Antonio, Texas, and Los Angeles, California, have heard accounts of the poverty, deplorable housing conditions, and health hazards to which migrant workers and their families often are subjected. We believe the provision for Federal matching funds for emergency assistance payments contained in Section 206 could be of considerable help to this group of Americans as well as to many other families who require immediate assistance to meet emergency situations.

We urge the Committee, however, to liberalize Section 206 by extending the time period in which emergency assistance would be provided, from the maximum of 30 days in any 12-month period, as called for in the bill, to a period of at least 60 days.

In addition, we strongly recommend that Federal matching for this program be sufficiently high to provide a realistic inducement to the States to avail themselves of this new opportunity. The 50 percent matching provided for in the House bill would not furnish such inducement to most States and would place the program beyond the financial reach of many States. Experience has shown that many programs of Federal assistance to States are inadequately utilized because the States are unable to provide the funds necessary to earn Federal dollars. This has occurred in programs in which Federal funding has been as high as 75 percent or more. We recommend that the Federal share under Setcion 206 be increased so that this new feature of the Social Security Act will be able to compete succesfully with other Federal aid programs and gain acceptance by the States.

Section 208—Limitation on Number of Children with Respect to Whom Federal Payments May Be Made

The Commission strongly opposes the provision in the House bill which would, in effect, freeze the number of dependent children deprived of parental support by reason of a parent's absence from the home who can be assisted under the AFDC program, to the proportion of such children to the State's entire child population as of January 1967.

We oppose this provision, first of all, because it is arbitrary and punitive. In some States, whose populations tend to remain stable, this provision undoubtedly would have only a minimal impact. In others, however, those to which impoverished Americans—many of them minority group members—have migrated in increasing numbers, seeking better opportunities, this provision will force the States into making a cruel choice: that of ether bearng the entire cost of assisting the increased number of destitute families or standing aside and ignoring their needs.

We also oppose this provision because, while it addresses itself to a very real problem, it deals only with symptoms and not with causes. The House Committee on Ways and Means indicated its concern, in its report on H.R. 12080, over the growth of the AFDC program in recent years, and over the rapidly increasing cost to the taxpayer. The Committee also is concerned that the 1962 amendments to the public assistance laws did not succeed in reversing these trends. We share these concerns that the program is not meeting its objectives.

The Committee concluded that additional steps were necessary to reduce the AFDC rolls by restoring more families to employment and self-reliance. This, we agree, is the course that legislation dealing with AFDC families should take—namely measures to promote self-sufficiency and economic independence of AFDC families. If such measures are adopted and are successful, the root causes of the problems to which Section 208 is addressed will have been met and Section 208 will be unnecessary. If, however, these causes are not successfully met, Section 208 can only have the effect of depriving those who already are deprived. We urge that this provision be rejected.

Requirement that States meet full need

Under existing Federal law, public assistance payments must be based on State estimates of the minimum amounts required for food, clothing, shelter, and other needs. Federal law recognized that conditions may vary among the States, and each State is permitted to determine its own need standards. The States are not required, however, to meet their own standards of need in the assistance payments which actually are made. Thus a major purpose in permitting States to determine their own need standards is defeated in that they also are allowed to disregard these very same standards. In many States, arbitrary ceilings are set on the amount of assistance that actually can be paid—ceilings which may be substantially lower than the minimum need as determined by the State. Although there are wide discrepancies between need standards and the maximum payments which actually are made in programs for the aged the blind, and the permanently and totally disabled, the greatest gap is found in the program of aid to families with dependent children—the programs which has the largest proportion of Negro and other minority group recipients.

Most State standards for a family of four on AFDC range between $150 and $250 a month. Nonetheless, in 20 States, the maximum that may be paid to assist a family of four is $150 a month. In seven States the ceiling is less than $100. The State of Mississippi places a maximum of $50 on the monthly payments to a family of four, only 28 percent of its $175.62 standard of need. In 1966, the average AFDC family in that State received less than $500 during the entire yera. In no State does the average payment per AFDC family exceed the poverty level and in virtually every State payments range far below the standard as defined by the Social Security Administration.

In Commission hearings and State Advisory Committee meetings, we have learned of the effect these low levels of AFDC payments have on impoverished families. In Cleveland, for example, the Commission learned that even with the bonus provided by the Food Stamp Program there was not enough money remaining from the AFDC check, after the payment of rent, to enable AFDC mothers to provide an adequate diet for their families. One AFDC mother was asked whether she had to cut corners in order to survive. She replied: "I haven't found a way to cut corners. I found a way to live without."

The Commission, in its report, "Children in Need," concluded that a national minimum standard for public assistance payments should be established, below which no State may fall and continue to receive Federal assistance. We also recommended that the Federal Government should provide additional assistance to help the States reach and maintain this standard. We believe the Administration proposal requiring the States to meet their own standards of need in providing assistance payments would be a salutary step in this direction and that, at a minimum, the bill should be amended to incorporate this important provision.

Mr. Chairman, the Commission is convinced that reforms are badly needed in the laws and administration of our public assistance program. The House bill, however, incorporates some basic misconceptions as to what those reforms should consist of. As the Commission pointed out in its study of the welfare program in Cleveland, Ohio:

"It is the Commission's belief that the great majority of ADC recipients do not view public welfare as a means for enabling them to live comfortable lives without working. Instead, they view the welfare program as a means to achieve self-support and independence. These are crucial points, apparently not well understood by many Americans—especially those who advocate keeping assistance payments low in order to discourage dependency."

We do not believe that the solution to the problems of continuing economic dependence and increasing public assistance costs lie in measures to force destitute families from the welfare rolls. The Commission does not concede that these problems have been proven to be so intractable that we must despair of resolving them through other than coercive means. In our view, several of the reforms contained in H.R. 12080, as well as the recommendations for affirmative measures proposed by this Commission and other groups and individuals, to assist disadvantaged families in becoming self-sufficient and independent are deserving of a thorough test before we are entitled to conclude that this approach cannot succeed.

We urge the Committee to adopt these recommendations and to reject those punitive portions of the bill which would serve only to deprive the poor even further of basic rights and remove from many the hope for full opportunity.

NATIONAL ASSOCIATION OF SOCIAL WORKERS,
UTAH CHAPTER,
Salt Lake City, Utah, September 19, 1967.

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

DEAR SENATOR LONG: I have been directed as President of the Utah Chapter of the National Association of Social Workers, by the Utah Chapter's membership as its spokesman, to protest certain provisions of the pending Social Security Act amendments of 1967 (H.R. 12080), now before the Senate Finance Committee. The Utah N.A.S.W. Chapter is made up of over 400 professionally trained social workers, representing over 100 Utah community service agencies. This is to say, that virtually all of the state's major social welfare leaders and leadership are represented through the activities and official voice of the Association.

The proposed amendments have been under study for several weeks by both the Family and Children's Council of the Chapter, and the Division of Social Policy and Action. Josephine Scott Patterson, Director of L.D.S. Relief Society Social Services and Chairman of the N.A.S.W. Family and Children's Council, had petitioned for a public N.A.S.W. stand against certain aspects of the Social Security amendments on behalf of the Council. A meeting of the Chapter's general membership has vigorously supported the conclusions of the Council, the Division of Social Policy and Action, the Chapter's Board of Directors, and the release of this statement to Utah's congressional delegation and to the public news media.

You have before you the statements of the Honorable Dr. John W. Gardner, Secretary of Health, Education, and Welfare, and Dr. Wilbur J. Cohen, Under-Secretary of Health, Education and Welfare, given before the Senate Finance Committee on August 22, 1967. You also have the August 31, 1967 testimony of Mitchell I. Ginsberg, Commissioner of the New York City Department of Social Services, who is Chairman of the National Association of Social Worker's National Division of Social Policy and Action, and Dr. Daniel Thursz, Dean of the University of Maryland School of Social Work.

We are familiar with the statements of these persons, as well as with the official position of the Child Welfare League of America, and the Utah State Division of Welfare. (Which you now have). All of these statements, we have found, speak as one voice with respect to both positive and negative features of the amendments from the professional social work point of view.

The membership of the Utah N.A.S.W. Chapter has taken no exception to the points expressed in these important materials. Where protests have been made, we protest; where commendation has been given, we commend; where questions have been raised, we question; and where alarm and concern has been shown, we show alarm and concern.

In the interest of your valuable time and the needlessness of our written duplication of what has been so expertly stated by the foregoing persons and groups, it is our official position that we concur with these statements and recommend them to you as a representative voice of those in Utah, who have over past years demonstrated a high degree of professional competency in social welfare leadership and administration.

We do desire, however, to specifically cite two provisions of the Public Welfare provisions (Title II) of the amendments as creating coercive, punitive, and discriminatory conditions, hostile to the welfare of Utah's needy children, and the promotion of sound family life. They are:

1. The provision requiring all mothers (with limited exception) on state welfare programs to seek employment or job training as a condition for receiving public assistance.
2. The provision which would limit the numer of one-parent families on welfare to their proportion of a state's child population in January 1967.

These provisions appear to be excessively harsh and punitive towards children. Children living in poverty conditions, who have have no fathers in the home need the constant presence, love and attention of their mothers. To deprive this underprivileged and especially vulnerable group of children of the care of their mothers, is to unjustly punish them for circumstances beyond their control. Furthermore, to say to a destitute child that funds and services are not available for meeting his needs solely on the basis of his case having fallen into the wrong "percentage" of destitute children is to blame and punish a child for the circumstances of his birth or the desertion, death or disability of his father.

The attitude towards poverty, illegitimacy and desertion as expressed in these two provisions of H.R. 12080 militates heavily against the positive aspects of the bill. They should be amended out.

We feel so strongly concerning the erroneousness of this attitude that we would like to deal with it at length.

Probably the most often repreated story about public welfare's Aid to Families With Dependent Children Program is that it encourages illegitimacy. Welfare caseworkers hear the accusation made time and time again, and the story has gained stature by being propounded in reputable publications, often by reputable personalities.

"There are a lot of women who feel the world owes them a living, and they find AFDC just the ticket," say some critics. Others believe that many women actually go into the "business" of having illegitimate children as a profitable means of increasing their welfare allotments.

Many can't think of public welfare programs without feeling most of them should be abolished. One indignant writer to the editor of a Salt Lake City newspaper pleads, "Why should decent, hard-working people be taxed to keep such trash? It is families of this type (unwed mothers with illegitimate children) who are now receiving government help to the third and fourth generation and will continue to do so for generations to come. The government should get busy and pass legislation that would prohibit such women from receiving any welfare benefits after their second illegitimate child."

State welfare authorities are also alarmed over the rising rate of illegitimacy—3% of all live births in Utah during 1966—but are quick to refute the statement that public welfare programs are an encouragement of illegitimacy.

In associating welfare with illegitimacy the public's indignant belief far exceeds its actual knowledge. Recent surveys of the state's AFDC caseload point out that 87% of all children on welfare were born legitimately.

Of the 13% born illegitimately, the large majority or up to 90% of these children were born before application for public assistance was made. A large portion of the remaining 10% of the illegitimate births were conceived before application for public assistance. Actually, the Welfare Division only paid medical costs for about 90 illegitimate births during all of 1966.

This is an insignificant number when compared to the 5,600 families on the AFDC Welfare Program and over 23,000 total live births in Utah during 1966.

It would be impossible to prove that the possibility of future financial aid influences the unwed mother at the time of her child's conception.

There are, of course, some exceptions. It's the few cases of this type which bring criticism on the entire AFDC Program.

Most welfare caseworkers who deal with unwed mothers on public assistance regard the "business" of illegitimate children for more welfare money a myth that makes little sense—especially to the mother on welfare. In Utah, a recipient mother with two children receives a total assistance payment of $5.48 a day. ($163.00 per month)

Based upon consumer price index studies, and studies conducted by the U.S. Department of Agriculture this amount falls far below the level of income considered necessary for a minimum standard of living for three persons. The $5.43 must purchase rent ($41.00 per month) food ($57.00 per month) clothing, personal care, utilities and household supplies, school needs, furniture, recreation, and all other necessities of life.

For an additional child the mother receives an additional $.70 per day and will receive less than this for a fourth, fifth, or sixth child.

Obviously, the increase in assistance money is not the motive behind having illegitimate children. Emotional insecurity and instability plus inadequate home training and poor personal judgment lie at the root of the growing rate of illegitimacy. Out-of-wedlock births are no respector of any economic or social levels, it's a problem experienced by all income and cultural groups in our society. Welfare authorities point out that the State Welfare Program ultimately becomes involved with only a small percentage—one out of every eight—of the state's illegitimate births.

The problem is one which belongs to the whole community—to all individuals and families, all social agencies, schools, churches, professions.

Most important, every legislator should try to understand the factors that can lead to illegitimacy. Nobody, of course, can put his finger on one specific cause.

But legislators should keep in mind certain points: Young people are growing up in a cold-war world that has little stability. Their unease is a reflection of world-wide unrest. Youth has never found it harder to acquire a sense of personal security. Both the home and the community are losing the ability to provide this sense of security.

Americans are radically becoming a mobile people, moving their families from town to town, from one end of the country to another. This cuts ties with relatives who might give moral and other supportive help as was more common in past decades. And, again, it tends to deprive a child of the security that comes from steadiness.

Movies, television, and magazines that emphasize sex and aggression tend to stimulate young people and place lowered moral codes before them. They are not taught the importance of accepting frustrations, and the long-term rewards of developing self-control.

One approach to the problem is in a stronger parent-child relationship and in the return to our old standards of family ties and family feelings.

In line with this, there is the problem of reaching families before trouble happens and working with parents who are not able to give their children security and affection. The proportion of this type of parent in ratio to population far exceeds the average person's estimate.

Extended parent counseling services would help, but would probably make only a small dent in the problem. Inadequate parents are difficult to reach; only a few will go to agencies for counseling or accept another person's guidance.

We have to start with the child. We should be doing much more in the schools, in public welfare programs, and in our church programs to detect maladjustment which is the danger signal of a potential illegitimacy problem. We must come to know the child and his home situation on an intimate level. Detection is needed to prevent social ills, just as it is needed with physical ills, just as it is needed with cancer.

N.A.S.W. therefore recommends more personal and family guidance resources in and available through schools, public welfare, and churches—more trained persons who could pick out potential unwed mothers and provide professional preventive and corrective casework services. Perhaps even before this, is a more basic need—the need to discover all of the "whys" of the problem. We need far more answers than we now have.

Most unwed mothers do not need public assistance and do not seek aid, either financial or professional counseling services. But the minority who do, the State Division of Welfare has a serious responsibility. If the responsibility is not met, the problem doesn't disappear, it becomes greater.

An unwed mother is a lonely unhappy person. She usually is condemned by the community for her pregnancy. Often she has no one to turn to for help, although she greatly needs help and comfort. The physical needs of an unwed mother are the same as those of the married mother—she needs shelter, food, clothing, medical care, and moral support. The married woman receives these, but the unmarried mother's needs are often met only grudgingly and usually partially so.

The married mother looks forward to the birth of her child joyously while the mother with an illegitimately conceived child is frightened and depressed. She may vacillate between the desire to keep her baby and the thought that the baby would have a better life if given away for adoption. There is a great deal of suffering for the mother without a husband. And there are those who believe she should suffer because she has done wrong; she is "bad."

No person, however harshly he might treat unwed mothers, would believe their children should be punished for the circumstances of their birth. They must be cared for on the same basis as other needy children.

The Aid to Families With Dependent Children Program is one way citizens of the state help an unwed mother and her illegitimate child. The program focuses on the welfare of the child—to keep the child with the mother on the theory that a mother's love is preferable to life in an institution or a substitute home. Only a few children in the AFDC Program have been born illegitimately. (About 13%.) County welfare offices are usually requested to help the expectant unwed mother after the fact; they work with the mother's immediate needs and do what they can to prevent further pregnancies.

The purpose of the AFDC Program is to help care for needy children in their own homes who are deprived of the support of a parent because of death, divorce, desertion, separation, or because the family breadwinner is unemployed, physically handicapped, or in an institution such as a hospital or a prison.

It is of particular importance that a mother provide a suitable and wholesome home for her children. Welfare caseworkers feel strongly about this. They are aware of the emotional damage that can result when a child is removed from his family, and a caseworker will do everything possible to help a mother correct a child neglect problem.

When a neglect situation demands it, a family may be referred to the Juvenile Court and there is the possibility that the court will order a foster care placement for the children. It's in this category that the critics of AFDC have a heyday. They will point to one mother who entertains men and throws booze parties when the AFDC check comes in and condemn the entire program.

Welfare caseworkers are the first to admit that families of this nature are not unknown. But they flatly deny that it is a common practice. These few cases are those who receive public attention, and this builds up a false image of all AFDC mothers. The president of a bank may abscond with all of the bank's money, but it doesn't mean we should think all bank presidents are crooks.

AFDC laws require caseworkers to make regular home visits and make other contacts with families. They must determine individual social problems and move professionally to correct them. Caseworkers contact schools to determine whether a child is attending regularly and inquire about his school performance. They find out whether he appears well fed and properly clothed.

A neglectful mother finds it difficult to hide her neglect should she desire to do so. Neighbors or relatives call the Welfare Office, local officials hear about the problems; and if they are true, neighbors, relatives, and officials demand that some action be taken to correct the conditions. These incidents, however, are very rare in Utah.

In providing assistance for the unwed mother, caseworkers stress concern for the welfare of the child and respect for the dignity of the individual. It is by maintaining a mother's dignity and feeling of worth as a person that she can best be helped to help herself. To force her into the labor market when she believes a mother's place is at home by the side of her children is to destroy the dignity of motherhood in our communities.

Financial assistance is provided so that the mother and child can meet the necessary expense of living. Medical costs are met, and if the mother is in need of psychiatric help, she is referred to a clinic. Although financial aid is the most publicized part of the AFDC Program, casework and other social services is the cornerstone.

Some girls come to the Public Welfare Program in a pretty desperate condition. Their families and friends often reject them, and they don't have anywhere to turn but the Welfare Division. For most it is a last resource, since they have no other place to go for help.

Some of the practical things done by welfare caseworkers with an illegitimately pregnant girl are helping the parents and their pregnant daughter accept the reality of their situation with as little incrimination and self-blame as possible, helping the mother plan for the birth of her child, arranging for medical care, etc.

The mother may want to go to a family-care type of home pending the child's birth. She may wish to release her child for adoption, and the caseworker will help her to reach a decision and follow the necessary procedure. She may also need guidance on how to file legal action against her child's alleged father. HR 1280 would torpedo much of this basic service to a mother if she should happen to fall in the wrong "percentage" grouping.

While we don't condone the act that caused a girl's illegitimate pregnancy, we accept the unwed mother as a very hurt, troubled, unhappy and anxious girl who needs her family, her friends, and her community more than at any time in her past life. The last thing she and her unborn child needs at this point is to be personally judged and condemned for the difficulty they find themselves in. The proper development of the child will depend in a large measure upon the degree of its mother's stability as a human being. The punitive and coersive provisions of HR 1280 completely ignore this principle.

The AFDC Program provides for counseling when a mother is faced with daily problems too big for her to cope with. With the help of a skilled caseworker she may be saved from going into worse situations—and perhaps from becoming one of the "repeater" unwed mothers.

Families don't stay on the AFDC Program long. The average family receives assistance about 20 months. For the most part, welfare families find the means of self-support themselves and are glad to get off the welfare rolls. Many AFDC mothers marry, or seek employment as a matter of personal choice and desire.

Contrary to popular belief, only about 4% of all welfare cases in Utah represent second or third generation welfare recipients, and the percent of Utah's population on welfare rolls is at one of its lowest points. In 1940 over 9% of the population was on welfare. In 1950 it had dropped to 4.2%, and in 1966 the ratio stood at 3.6%.

During the 1965–66 fiscal year the Utah Division of Welfare opened 16,265 cases and closed 19,035 cases. Its program is rehabilitation and service oriented. HR 12080 would in its present form, throw the program into chaos. Agencies that help the unwed mother haven't caused the problem; they've inherited it. The Aid to Families With Dependent Children Program doesn't increase illegitimacy, it tries to provide for the fatherless children and families which are the result of something wrong in society.

The Utah NASW Chapter membership firmly believes that HR 1280, unless appropriated amended, is contrary to the best interests of the 18,000 Utah children now in AFDC recipient households. We understand that our State Delegation to the House of Representatives did not consult with Utah Division of Welfare leaders before voting in favor of HR 1280. We would hope that our U.S. Senators will feel it appropriate to do so.

Sincerely yours,

JAMES P. WHEELER, *President*.

SEPTEMBER 6, 1967.

Re petition to request two important changes in current Social Security bill provisions.

Senator RUSSELL B. LONG,
Chairman, U.S. Senate Committee on Finance,
New Senate Office Building, Washington, D.C.

DEAR SENATOR LONG: Now is the time for all good constituents to "take the bull by the horns" and properly present their rights of petition under the First Amendment.

While I cannot be properly classified as one of your area constituents, there is ample evidence you have demonstrated sincere consideration of citizens from states other than the good state of Louisiana.

I am herewith submitting a copy of my letter to California's Governor Reagan which contains an appeal for his approval of a bill by state Senator Stephen P. Teale which was then awaiting the Governor's signature.

It would provide that all "increases" in Social Security payments could not be regarded as "income" or deducted from Welfare grants. A careful reading of this letter copy will disclose the fact that it is pertinent to the present "Hearings" of your Committee.

In Governor Reagan's statement issued with his veto of this bill on September Fourth, he said: "The Old Age Assistance program is designed solely to meet the needs which cannot be provided by other income. To disregard Social Security Benefits, even to a minor extent, is improper."

Now it appears from this statement that the old and the poor cannot place any confidence or faith in a Republican Governor to help them adjust to the skyrocketing cost of living, even when it does not incur additional expense to such an administration or state.

(1.) First: Permit me to request your Committee On Finance to add a provision on the current Social Security bill,—now under their consideration,—which will make Social Security Benefit payments legally exempt from all other forms of retirement income, as advocated by Senator Jennings Randolph, according to the Press.

(2.) Secondly: I am also requesting improvement of regulations and rules in the provisions of the Kerr-Mills Act and those of Title Eighteen and Nineteen of the Social Security Act, to control better such drastic abuse in the use of Federal "Matching Funds" as now occurring in this state.

The "reckless action" of the present new administration in Sacramento, operating under the handicap of a shortage in Welfare Funds, has abrogated the intent and purpose of these statutes established for the necessary and proper care, protection and health of all recipients using such "Matching Funds."

These conditions can be easily verified by Mr. Jesse M. Unruh, Speaker of the California State Assembly, whose statement upon the matter is partially included in the attached news clipping from the Los Angeles Times of September Third. Further unfavorable comment,—and in some cases outright threats,—can be obtained from the Executives of California Dental, Chiropractic, Medical and Optical Association, or any Medical Doctor who has patients under California Medi-Cal or Federal Medicare programs.

I addressed this letter to you—Senator Long,—as I have hopes that you could possibly find a little of your busy time schedule to read it, for you have been so considerate of my previous correspondence.

I am sending a copy of it to Senator Dirksen, who happens to be the only Republican member among the other fine Committee Senators of whom I have knowledge.

Will you please file it with your Chief Counsel, Mr. Tom Vail, to enter in the record of Committee Hearings?

I want to reassure you of my admiration and respect once more, and I trust that some of my petition requests will receive approval by your Committee Members.

Most sincerely,

SIDNEY FORBES.

SEPTEMBER 1, 1967.

Re a bill by Senator Stephen P. Teale exempting social security "increased" payment from deduction by welfare.

Governor RONALD REAGAN,
State Capitol,
Sacramento, Calif.

DEAR GOVERNOR REAGAN: In these disturbing days it is time for more constituents to "take the bull by the horns" and present their cause or appeal to a fair and just "Leader" like yourself, instead of following a futile parade led by others of questionable success.

In reference to this bill by Senator Teale, which is now waiting your approval, I thought you might appreciate the attached Editorial from the Los Angeles Times of this date, in which this Republican paper has officially endorsed the bill and suggest that you sign it.

Obviously this increase in Social Security Benefits is intended to offset some of the skyrocketing cost of living, especially for that large segment of the old and the poor.

Many of these unfortunate recipients have health problems which prevent them from working, or are eliminated because of their advanced age, but they still will have to face the added burden of paying for their essential drug prescriptions under the new restrictions of the Medi-Cal program.

This bill of Senator Teale's will make it possible to give most of these old folks who need prescribed medication for some chronic illness, the necessary extra money to buy what the new Medi-Cal reductions deprives them of. That sounds like a fair "Exchange" to me.

Without your signature on this bill, California Welfare Funds will increase through the automatic reduction of present State Assistance payments, due to the increased deductible amounts of Social Security checks.

The State will then require a smaller amount in Federal "Matching Funds" for the ensuing period, and thus we arrive at a situation which is comparable to "Robbing Peter to pay Paul."

The comparison materializes when the Federal government takes money out of one pocket (Social Security Funds) merely to put that money back into another pocket (the Treasury General Fund) because the state involved did not require "Matching Funds" equal to, or proportionate with previous requests.

The sad part of all this trading is the glaring fact the poor old Beneficiary is left hanging in the same precarious position he occupied before this exchange of finances occurred.

I am sure you are aware of the fact there is not even a remote possibility the State can or will increase assistance payments to recipients of Welfare and Old Age Security.

Should this become feasible in the future, previous records of such increases fail to reveal any condition which will allow the State to equal the amount of this proposed Social Security increase, even over an extended period of years.

(Closing paragraph and signature omitted as nonessential.)

[From the Los Angeles Times, Sept. 1, 1967]

SOCIAL SECURITY PRECAUTION

The House-approved Social Security bill now before the Senate Finance Committee is a marked improvement over the Johnson Administration's original proposal.

The omnibus measure of more than 200 pages also proposes substantial changes in medical, public welfare and child health programs and full hearings will be necessary to ascertain workability and the impact on the various states.

A principal objective of the public welfare section is, in the words of Rep. Wilbur Mills (D-Ark.), chairman of the Ways and Means Committee, "to make taxpayers out of tax eaters."

To accomplish that the bill would, among other things, require the states to provide job training for able-bodied males receiving aid and establish day-care centers for children of recipient mothers deemed able to work or receive training.

California already has job training in 51 of the 58 counties, and both these requirements are favored by Reagan administration officials.

Spokesmen for the governor indicated that while the general tenor of the bill is in line with administration thinking, there are still certain critical areas which must be examined before decisions can be made. They did not specify the points at issue.

The Times suggests a particular area of concern in the Social Security program.

That section of the bill would grant a 12.5% increase to old age, survivors and disability recipients at an estimated first year cost of $3.2 billion. But a Senate subcommittee has already warned that the increase could once again trigger reductions in other forms of retirement income.

In a report released last week Sen. Jennings Randolph (D-W. Va.), the committee chairman, noted that few states have availed themselves of 1965 legislation to avoid cutting back old age assistance payments when Social Security benefits go up.

Randolph is convinced that sound provisions can be written into the new act "to assure that each dollar of Social Security produces an improvement in incomes of American elderly or at least results in no detriment to their income."

If such action is not taken in Congress, it is then doubly important that the states themselves avoid siphoning off benefits which Congress votes to the elderly.

A bill to afford just such protection is now awaiting Gov. Reagan's signature. Authored by Sen. Stephen P. Teale (D-West Point), it provides that Social Security payments shall be excluded in computing income for state assistance purposes.

Gov. Reagan should resist any temptation to veto this measure unless it can be guaranteed that any resultant savings to the state will be utilized to enrich other assistance programs for the elderly.

[From the Los Angeles Times, Sept. 1, 1967]

UNRUH CRITICIZES MEDI-CAL CUT AS "RECKLESS" ACTION

SACRAMENTO.—Assembly Speaker Jesse M. Unruh Saturday called the Reagan administration's Medi-Cal cuts a "reckless action."

The Inglewood Democrat said the $210 million slashes "will result in physical misery and suffering for over 500,000 children in California and for almost as many aged persons who have a right to comfort and decent medical help in the waning years of life."

His statement said the Medi-Cal program was not hastily conceived but was adopted in 1965 after more than 30 years of experience with the state's old welfare medical system.

Instead of forcing the poor to be treated in public hospitals by civil service employes, it provides some freedom of choice, Unruh said.

"The administration's cutbacks in vital health services are based on the most dubious estimates and accounting procedures," he charged.

LEGISLATURE BACKED BUDGET

"When the governor presented his budget to the Legislature only five months ago, we gave him every penny he requested to maintain the program * * *.

"We were forced to rely upon the governor's Department of Finance for the budget figures. Now we are told by these same people that a $210 million deficit has suddenly materialized."

Unruh believes that Gov. Reagan is attempting to finance 15 months of the program with only 12 months of revenue in "fiscal gimmickry" which will show a paper deficit but actually will produce a cash surplus which can be used to create an artificial image of economy.

The Assembly leader said caseload and cost projections are exaggerated and additional federal revenue of up to $20 million as a result of mental retardation and "Short-Doyle" programs is being ignored.

Short-Doyle is the name given to California's method of financing mental health services in local communities in contrast with mental services offered by state hospitals. The financing is shared 50-50 by county and state in some instances and 75% state and 25% county in other instances.

(The following letter with attachment was submitted to the committee by Hon. Carl Hayden, a U.S. Senator from the State of Arizona:)

EMPLOYMENT SECURITY COMMISSION OF ARIZONA,
Phoenix, Ariz., September 1, 1967.

Hon. CARL HAYDEN,
U.S. Senate,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR HAYDEN: Attached is a statement regarding the amendments to the Social Security Act. This legislation has been carefully studied by Mr. Charles A. Boyle, Administrator of the Arizona State Employment Service, and brought to the attention of the Employment Security Commission of Arizona. In previous discussions on this matter, the Commissioners have felt, as Mr. Boyle, a basic objection to the Welfare Administration duplicating facilities which are now present in the State Employment Services.

Apparently, nowhere in this legislation is any effort made to take advantage of the background and experience which has been built up over the years in the various State Employment Services. It would be extremely costly to establish a competitive, parallel employment service system under the Welfare Administration.

Please understand, the objection is not that some additional resources may be needed under the Welfare program in view of the many serious problems we face, but it appears there should be careful study of the area of duplication, expenses, and responsibility.

I urgently request that you give this matter careful consideration, and I hope that the Senate will be able to consider suitable amendments in this area of legislation.

Sincerely,

CHARLES J. MINNING, *Chairman.*

STATEMENT RE AMENDMENTS TO SOCIAL SECURITY ACT

This statement refers to amendments to the Social Security Act as proposed by H.R. 5710 (copy attached) and the modified version reported out by the House Ways and Means Committee on H.R. 12080 (copy attached).

The original proposal, which was encompassed in H.R. 5710, would have provided, in a new Section 410 beginning on page 116, for a comprehensive work and training program under the Secretary of Labor, including testing, counseling, training, job development, and placement, for welfare clients. Under this legislation it was contemplated that manpower programs for welfare clients could be established in any county in a State after a joint determination of need had been made by the Welfare Department and the Employment Service. The State Employment Service would take necessary steps to develop a manpower program to met the rehabilitation needs of the particular client group, making full use of all resources and techniques of the Manpower Administration in the Department of Labor. The operation of such a program would be the responsibility of the Employment Service. The availability of social services to the welfare client enrolled in the training program would continue. Effective program operations would require close cooperation and coordination between the two departments. Funds for operation of such manpower programs would come from the Social Security appropriation and would be on a 90-10% matching basis.

As reported out by the House Ways and Means Committee, Section 410 of H.R. 5710 has been dropped and the entire manpower rehabilitation effort has been written into Section 409 of H.R. 12080, under which the Welfare Administration in 11 States has been operating a small community work and training program on a 50-50%. Federal-State matching basis. In this revised section, participation by welfare clients is virtually mandatory and full control of manpower program action rests with the Welfare Administration; there is no language which directs this massive manpower training and placement effort in the direction of the existing Public Employment Service System presently established by the Congress in the Nation and the Manpower Administration within the Department of Labor. The only reference to this type of relationship is to an optional purchase of service arrangement from the Employment Service if the Welfare Administration requests it.

With the mandatory participation it is conceivable that each county Welfare Department in the United States might eventually have an Employment Service component to serve the clients of that county. This could include not only work experience and training capability, but also broader employment services.

Although the legislation contains no provision or ceiling in terms of numbers of participants, it has been estimated that close to 500,000 trainees may be involved in this program the first year. By comparison this is twice the size of the total MDTA program. This legislation, so enacted, would clearly be the first step in establishing a costly manpower system within HEW parallel to the existing Public Employment Service System. It could provide for duplicate employment service offices in every location where the State Employment Services are presently functioning and for additional offices where they are not. The legislation contains no caution or safeguard in relation to using existing facilities or services, nor does it make provision for financial inputs into these existing systems. The program decisions relating to manpower development under this legislation would rest not with the existing manpower development agencies, such as the State Employment Service, but rather with the welfare establishment which at the present time has very limited capability in this form of service.

There is little question relating to the need for the additional resources provided in the bill. There is a real question, however, relating to the method of developing and administering the resources which disregards the long years of manpower experience and know-how in the State Employment Service and which gives the responsibility to the welfare organization which lacks both.

I sincerely hope you will explore fully in the Senate the manpower provisions as originally proposed in Section 410 of H.R. 5710.

BOROUGH OF BETHEL PARK,
September 1, 1967.

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

DEAR SENATOR: In recent weeks there has been much speculation regarding numerous proposals relating to changes in the existing framework of our Social Security program. These changes, emanating in the House Ways & Means Committee, have passed the House by a resounding majority (414-3), which would seem to indicate an overwhelming response by Congress, not only to the needs of so many millions of citizens dependent on these funds for their very existence, but almost total approval of the measure as presented, both in form and size of allocation. If this is accurate, then it would seem that the proposed measures have fallen short, at least in spirit and intent; nowhere has the existing bill demonstrated the desire of our lawmakers to move beyond the realm of political expediency, or to initiate more than stop gap measures designed to create, at best, a sorry illusion in the eyes of so many of our Senior Citizens.

It is relatively easy to stop considering individuals, especially when so large a segment of our population is represented, and to begin substituting instead masses of figures, assigning them to a particular movement within a budgetary roll. What seems to have been lost sight of is the fact that in enacting any change in a law as personal as Social Security, one which determines the standard of living of so many millions of our citizens, the true test of its total benefit lies not in the ease of its passage or the simplification of its administration, but in the value that it holds for the recipient. If it ceases to serve the purpose for which it was intended, then it has failed before it has moved toward its ultimate goal, that of sustaining a decent standard of living and it has become a mockery of injustice bringing discredit on its authors and despair to those who look to it for hope.

Admittedly, it is a most difficult and exhausting task to formulate legislation which will offer the greatest possible benefit to the largest number of our people. In reviewing those areas of change under consideration in the proposed amendments to the existing Social Security Law, it is indeed a travesty of justice to see how one change in particular penalizes such a large portion of those twenty-five million Americans dependent upon the benefits of the law. That part of the law which places an unfair limitation on the earning capacity of the recipient able to supplement his or her income not only creates a personal hardship in most cases but severely limits the law in its original intent; that of offering an opportunity to build a sense of security without the destruction of the individual's initiative or self respect.

The existing set of amendments as passed by the House incorporates an increase in the amount that a recipient may earn before he forfeits some of his benefits. The present law establishes a limit of $1500.00, while the proposal would increase this amount to $1680.00. Both present and proposed measures are grossly inadequate and represent an almost unbelievable lack of concern; more important, they seem to have lost touch with the realities of financial life as they relate to our Senior Citizens. The presentation of this particular measure is nothing more than a further affront to the already long-suffering citizens laboring under the totally unsympathetic treatment of this law.

In an earlier message directed to Congressman Wilber Mills, Chairman, and Members of the House Ways & Means Committee, I outlined what appeared to be similar deficiencies in the existing law. In that message I explained how the present ceiling of $1500.00 now only placed an unfair burden on those recipients able to supplement their income and provide a decent standard of living, but that it essentially held no real position of value in the overall framework of the Social Security Law based on practical application. It was then, and it is still my firm conviction, based on the compilation of current data as presented by various governmental agencies, and on numerous discussions with many civic and industrial groups across the country that the lowest acceptable ceiling of a person's income could be no less than $4800.00.

Although the area of this ceiling on the amount one may earn without forfeiting his or her benefits is a most critical one, it is not the only part of this proposal that severely limits the ability of the recipient to improve their standard of living. *President Johnson, in his recommendations to our lawmakers, advised that a minimum cash increase of 20% in excess of the existing benefits be enacted. Congressman Wilbur Mills and his associates in the House Ways & Means Committee have seen fit to reduce that request to 12½%.* This counterproposal is not only *totally unacceptable* in light of the needs of our Senior Citizens, but represents an appallingly short-sighted approach to this area of concern.

It is elementary, even to the most unlettered among us, that each of our dollars, given a specified amount, will buy the same goods and services for one person as it will for another if they are spent in identical fashion. Our economy has no provision for allowing a greater purchasing power for those on fixed limited incomes than it does for those who can and do have access to greater and more variable incomes. A loaf of bread at the local chain store will cost a man earning $10,000.00 per year just as much, or as little, as it will the Senior Citizen receiving Social Security. Is it not just, then, to allow the Senior Citizen an equal opportunity to supplement his minimal income so that he may also have a better opportunity to provide, if not for the luxuries, at least for the necessities of life?

Statistics have proven that a large percentage of approximately twenty-five million citizens now receiving Social Security are attempting to bring their standards of living to an acceptable minimum by supplemental earnings. This is an indication that these people are neither content to rely upon total government subsidy for their existence, nor willing to allow their self respect to be compromised by a sub-standard offering. It is also well to remember that these citizens are not beggars—they ask only for what they have earned over the course of their years of productivity to their families, their employers and their country. Is it not foolish, then, to attempt to restrict their initiative and honor, which has served them and their country so well for so many years, by penalizing them for attempting to upgrade an obviously inadequate existence?

Any decision relating to a more realistic reappraisal of the existing $1500.00 penalty to at least $4800.00, must take into consideration several basic facts of any citizen's life. Initially, most recipients of Social Security are operating their finances on a very rigid and inflexible income; this income may have been adequate to cope with an economy in which prices were depressed or declining, but it falls pitifully short of the mark in the economic framework of today's spiralling cost of living. It is all too obvious that the dollar of 1967 will not purchase those goods or services that it did in 1937. It is also obvious that the fixed income of our Senior Citizens receiving Social Security has not kept pace with this rise. Economically, this group appears to represent a large segment of our population that has simply been left standing in the shadows of America's affluence, an affluence which they, to a large degree, helped to shape.

I would like to submit to the Members of the Senate, those to whom will fall the ultimate task of shaping a compassionate and forward looking legislation, that before they examine those measures with the ultimate goal of enacting them into law, they examine their own consciences in an attempt to better resolve the pressing needs of this dilemma. There is far too much at stake to consider lightly any one aspect of this measure. Man's ability to survive, and to ultimately persevere, has always included not only those factors relating to his physical existence, but to his intrinsic values of honor and self respect as well. Any legislation that takes into consideration anything less than the total well-being of the individual is not only doomed to fail as a positive measure, but can have only the most disasterous social and economic effects on those to whom it is directed. *True reform can come only from the hearts and minds of those dedicated to the cause of* furthering the highest worth of man, *without thought of personal gain* or political expediency. There can be no other course.

Sincerely,

PETER J. PAGE, *Mayor.*

(The following letter was submitted to the committee by Hon. William Proxmire, a U.S. Senator from the State of Wisconsin:)

WHITEHALL, WIS., *September 20, 1967.*

Hon. WILLIAM PROXMIRE,
Senate Office Building,
Washington, D.C.

DEAR SENATOR PROXMIRE: I am writing to you concerning the proposed amendments to the Social Security Act, H.R. 12080. As a social work supervisor overseeing the administration of the social security aid programs I have become aware of two potentially damaging aspects of the proposed amendments.

First. Title II, Section 208, page 140 of the bill limits the number of children who might receive assistance through Aid to Families with Dependent Children on the basis of the January 1967 ratio of such children to the total state child population.

This aspect of the bill could be a serious hazard to the citizens of the United States. Should an economic recession occur in a specific region of the country the proportion of children in need could easily outstrip the ratio method of calculating assistance to AFDC families. Those children not included in the ratio would then either not receive aid or be forced into sub-standard existence and subjected to a different standard of living than other AFDC families. Only the children will suffer if this portion of the bill is not removed.

Second. The second potentially damaging aspect of the proposed amendments is in Title II, Section 201, page 107FF, and Section 204, page 120 FF. Specifically I refer to the proposal which would require mothers on the AFDC program to engage in work training and employment as a condition to receiving assistance.

It is my feeling that this aspect of the proposed bill could be very damaging to the little pre-school children who need the identification with an adult. Generally AFDC is granted to homes where the father is gone for any number of reasons. Therefore, in AFDC homes there is only one parent for the child to identify with. If the mother is then forced into work training or employment, there will be no one to give the child comfort, re-assurance or love. It would be very likely that such a barren childhood would damage the mental health of these children.

If this aspect of the bill could be changed to exclude those mothers with pre-school children and those adults not physically fit, it would not be so objectionable.

As a person who has daily contact with the family situations this bill will effect I can only urge you to use the power of your office to delete the portion of the bill in Title II, Section 208, page 140 and alter that section of the bill which would require all adults, including AFDC mothers with pre-school children, to exclude those mothers with pre-school children.

I would appreciate it very much if you would insert my opinions in the hearing record of the Senate Finance Committee.

Sincerely yours,

RICHARD G. SHEPARD,
Social Work Supervisor.

REGO PARK, N.Y., *August 23, 1967.*

HON. RUSSELL B. LONG,
Chairman, Committee on Finance,
New Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: Your committee has under consideration at the present time certain amendments to the Social Security Act, as amended.

I hereby offer for your consideration the following suggestions which I believe would improve the existing Public Law:

1. The minimum payment of $44 a month under the present act should be raised to $75 a month.
2. A retired person could earn up to $145 a month without forfeiting any benefits.
3. Increase from $1500 to $1700 the amount a recipient under 72 could earn without loss of benefits.
4. Effective Jan 1968 increase all monthly benefits by 8% with the exception of the minimum payment as indicated above. Last effective monthly benefit scale adjust. in Jan. 1965. Cost of Living rise since that time I believe is in the neighborhood of 8%.
5. H.R. 12080 appears sound on 4.4 tax on employees and employers each for 1968 and 4.8 in 1969.
6. Using Jan. 1968 as effective date, I believe you will be able to synchronize increased benefits outgo, an increased withholdings on Wages, and new possible tax bill for general revenue requirements of this bill.
7. Federal Civilian employees to have coverage under the Social Security Act on a purely voluntary basis in addition to their coverage under the Federal Civil Service Retirement Act.
8. Retirement at age 60 on a reduced basis.
9. Investments in the Social Security Trust Funds to be other than U.S. Governments, perhaps U.S. government agency individual issues, as well as Private Industry Bonds and high grade equities for greater yields to offset higher costs of administration of the Act.

Thanking you in advance for your consideration of this matter,

Respectfully,

MORTON WEISS.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 25, 1967.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN. We, the undersigned members of the House of Representatives, strongly oppose the anti-welfare provisions of H.R. 12080, amending the Social Security Act. Since the bill contained improvements in the social security program but was brought before the House under a rule that prevented our offering amendments, we could neither vote against the bill nor amend those parts we believed to be injurious to the poorest people in our society, especially the children in needy families.

The failure of our society to provide decent jobs and adequate social facilities for its people results in many persons becoming unemployed and dependent through no fault of their own. Most of the poor (78%), although legally entitled to public welfare, survive on a hand-to-mouth basis without any public assistance. Of the remaining 22 percent, those who receive welfare, only about half are assisted on programs in which there is Federal matching money and consequently some effort to raise standards.

Of the 7.3 million persons who do receive public welfare, 2.1 million are 65 or older, 700,000 are severely handicapped, 3.5 million are children in needy families, and 1 million are the parents of these children, mostly mothers who need training for themselves and child care for their children if we expect them to seek jobs, if, indeed, they should.

Few persons on relief, therefore, are employable; and if jobs were available, there are millions already in the labor market who are not on welfare and are seeking employment.

H.R. 12080 does not recognize these and similar facts in its anti-welfare provisions. If passed, this bill would (1) freeze the number of children eligible to receive AFDC assistance as of January 1, 1967, (2) compel work assignment without spelling out safeguards, (3) change in purpose the AFDC program from one of protecting children to one of forcing mothers into the labor market without adequate protection for themselves or their children, (4) through its so-called work incentive provision, keep families in poverty in most states which offer low grants, and (5) fail entirely to assure minimum level standards or to provide that states must meet even the minimum needs they fix.

For these reasons we unite our efforts in seeking the cooperation of members of the Senate in rejecting anti-welfare provisions of the House-passed bill; and we further call on public-spirited citizens and organizations to mobilize public opposition to this part of H.R. 12080.

Respectfully yours,

Jonathan B. Bingham; Jeffery Cohelan; Don Edwards; Donald M. Fraser; Patsy T. Mink; Richard L. Ottinger; Benjamin S. Rosenthal; William F. Ryan; Charles C. Diggs, Jr.; George E. Brown, Jr.; John Conyers, Jr.; Leonard Farbstein; Augustus F. Hawkins; Robert W. Kastenmeier; Joseph Y. Resnick; Edward R. Roybal; John G. Dow; James H. Scheuer.

(The following letter was submitted to the committee by Hon. Ralph Yarborough and Hon. John G. Tower, U.S. Senators from the State of Texas, and Hon. Eligio de la Garza, a U.S. Representative in Congress from the State of Texas:)

STATE DEPARTMENT OF PUBLIC WELFARE,
Austin, Tex., August 21, 1967.

Re H.R. 12080, 90th Congress, 1967.

DEAR SIRS: On July 20, 1967 we called upon you for your assistance in resolving some of the problems the State of Texas was encountering in the implementation of its Title XIX Plan for Medical Assistance effective September 1, 1967. In our telegram of July 31, 1967 we advised you that we were about to work out an agreement with Mr. Joseph Meyers, Acting Commissioner, Welfare Administration, Department of Health, Education, and Welfare. At this time we wish to express our sincere appreciation to you for your assistance, and we are now asking your continued help in resolving some of the problems in connection with Title XIX and H.R. 12080, which we understand, will come up for consideration in the Senate early in the week of August 21, 1967.

We wish to make you aware that the resolution of our problem with the Department of Health, Education, and Welfare is entirely contingent upon the passage of *H.R. 12080* with the provision (Section 223) that a State may buy-in under Title XVIII and *with full Federal financial participation* without being required to provide for eligible individuals under the age of sixty-five (65) the same services and in the same amount, duration, and scope as is provided by Part B of Title XVIII to eligible individuals age sixty-five (65) or older.

The Department of Health, Education, and Welfare felt that there was no legal basis under which they could grant a waiver of the equality of service requirement in order to permit Texas to implement its Title XIX Program in accordance with the non-comparability of service amendment in H.R. 5710 at that time being considered by Congress; however, Mr. Meyers did agree to furnish a letter to Texas committing the Department of Health, Education, and Welfare to allow Texas to reduce its benefits to a non-comparability level of Medical Assistance under Title XIX after the enactment of H.R. 5710, including full Federal financial participation for the "buy-in", if Texas would initially implement a Title XIX Program with the comparability feature as is now required by law.

Since H.R. 12080 has been substituted for H.R. 5710 we are now concerned with the effect of H.R. 12080 upon all of the Public Welfare programs in the State of Texas including Title XIX Medical Assistance.

If *H.R. 12080* is passed as written, including Subsection (b) of Section 223, making this amendment applicable with respect to calendar quarters beginning after June 30, 1967, the problem of comparability would be completely resolved for Texas. We wish to point out, however, that it is absolutely essential for this non-comparability of services provision to be enacted into Law and with full Federal financial participation and for it to be made retroactive to July 1, 1967 if Texas is to operate its Title XIX Program effective September 1, 1967.

The State is in accord with the twelve (12) major changes in the Public Assistance Programs specifically in AFDC and the correlation of services required under the Program for Child Welfare. We believe that it will be advantageous to have Child Welfare services and services to AFDC administered under one organizational unit within a single State and local agency. This should enable the States to accomplish the highly desirable expectations of the Bill.

It is recognized, however, that although the States will get favorable Federal financial matching, this may and probably will pose some serious questions in the State of Texas and I am sure in many other States. The most serious is the *requirement* that portions of these programs be mandatory by *July 1, 1969.* In order to initiate some of these services, State legislation will probably be necessary. It may be possible to use some of the auxiliary Laws now in effect in the State of Texas as the necessary vehicle, whereby those Programs can be implemented; but if not, it is very unlikely that we could obtain legislation effective before July 1, 1969. The Regular Session of the legislature convenes in January 1969 and for legislation to be effective before July 1, 1969, the legislation would have to be an emergency measure and it is not always feasible to get emergency legislation enacted even though there is no special objection to it. Even if special legislation is not required to implement all of these services, the State does not have appropriated funds out of which the State could pay its share of the cost. The Departmental Appropriations Bill for the next biennium will be effective September 1, 1969, therefore, we urge that the Bill be amended so that the provision requiring the implementation of the work and training programs by July 1, 1969 and the requirement that the State obtain a separate organizational unit for combined AFDC and Child Welfare services by July 1, 1969 be amended so that the provision would be effective either July 1, 1969 or within 90 days after the adjournment of the first Regular Session of the State legislature, whichever is the later.

Although we are in accord that measures should be taken to rehabilitate families so that they may be self-sustaining and may be able to go off the assistance rolls, we are concerned with the provision that the unemployed father program be related to the labor market (had been employed and earning at least $50 within the last quarter in covered employment). This would limit the possibility of training and rehabilitating those who per chance had not been related to the labor market, and as you know, in Texas we do not as yet have complete coverage under Social Security.

We are also concerned with the provision that would limit the AFDC roll by precluding Federal financial participation in the AFDC Program if the proportion of all children under age 21 who were receiving aid in each State in January 1967 because of absence of the parent from the home is exceeded after 1967. This might result in eliminating from the rolls some children who would otherwise be eligible and who are desperately in need of the services. It seems that there should be some other means of enforcing the provisions designed to rehabilitate the families and to eventually make them self-sustaining.

H.R. 12080 has many desirable provisions, such as the non-comparability of services provision contained in Section 223; the provision in Section 222 permitting the States to buy-in for all people eligible for Medical Assistance, including those who do not receive money payments as well as those who do receive money payments; the provision permitting States to buy-in for all persons who first go on the Medical Assistance roll after 1967; and many others dealing with the Public Assistance provisions, the provisions relating to demonstration projects under Section 1115 of the Social Security Act, the extension of medical care, and the provision authorizing optional payments to patients under Medical Assistance, etc.

There are, however, a number of other provisions which may adversely affect the Medical Assistance Program and the Public Assistance money payments as provided under the Social Security Act:

(1) Section 222 provides that there is *no Federal matching* for the State's share of the premium for those people for whom the States buy-in who are eligible only for Medical Assistance, but are not receiving money payments. This poses an undue burden or penalty upon the States and is inconsistent with all other provisions of the Social Security Act. We urge, therefore, that *Federal matching of funds toward the State's share of the premium for the buy-in for people not receiving money payments under Medical Assistance will be made available.* It is desirable that this be on at least a fifty-fifty matching basis, but if this is not feasible then some matching formula wherein the Federal Government would share in this cost should be included. *We also urge that Federal matching funds be made available for the payment of any and all medical services which must be paid by the State;*

(2) Under Federal requirements the State must first apply the recipient's income (in most instances small Social Security benefits) toward meeting the personal needs before applying the income to their medical needs. As a result of this requirement, Texas is having to deny a minimum of 9,000 Old Age Assistance recipients who are presently living in nursing homes because their small income is sufficient to meet the personal need, although it does not meet the medical needs which up to the effective date of Title XIX had been partially included in the grant. All of these recipients and many others whose personal needs other than medical are small, will be ineligible for Public Assistance grants but eligible for Medical Assistance under Title XIX. Up to this time the Department has been paying the $3.00 premium under the Buy-In Agreement on behalf of these people and has been receiving Federal matching for the premium. With this Federal requirement, after September 1, 1967, it will mean that Texas will be paying *all* of the *buy-in premium* on these 9,000 people who are being denied as well as others coming within the same regulation. *We urge an Amendment to H.R. 12080 which will eliminate the requirement or regulation that makes the States first apply the small amount of income toward personal needs*, making him ineligible for money payments and thus, making the States responsible for the total cost of the buy-in for those individuals, or if the State does not buy-in for these individuals, *making the States pay the entire cost* of the *medical care* which the client could have received under Part B of Title XVIII had the State bought in, since these funds are also not matchable with Federal funds. *This amendment is most urgent.*

Effective September 1, 1967, the State of Texas (and I am sure many other States are experiencing the same problem) is paying Medical Assistance under Title XIX and assistance grants (money payments under Titles I, IV, X, and XVI) to patients in State institutions for mental diseases and in the hospital and nursing sections of the institutions for the mentally retarded.

For all those patients who have been adjudged mentally incompetent and for the patients who are mentally retarded, it is still an unresolved question as to whether or not these assistance payments (money grants) may be made payable to the superintendents of the institutions on behalf of these patients without the necessity of going through judicial proceedings to have legal guardians appointed. If the State is required to have legal guardians appointed for some 5,000 to 6,000 people, this will be a terrific additional expense and will flood the probate courts in the counties where the institutions are situated with routine guardianship applications, and will delay for at least 60 to 90 days the initiation of assistance grants to otherwise eligible people. This problem, of course, does not affect Medical Assistance payments, but is a real problem in connection with the money payments.

We urge that an amendment be added to H.R. 12080 which will permit the States to make money payments directly to the superintendents or their legally delegated representatives on behalf of all individuals eligible for money grants who are patients in the State hospitals for mental diseases and in the institutions for the mentally retarded. These superintendents and/or trust officers are required by law to keep accurate accounts of all monies received and expended on behalf of all patients in the institutions. They are bonded and audited under State Law; therefore, they are the logical people to receive and expend the assistance grants on behalf of the recipients in the institutions, and the appointment of such superintendents as legal guardians, does not give any more protection to the recipient, but only costs money for the appointment and causes delays in granting assistance.

Again, may we express our appreciation for your past assistance in this matter and for the future assistance we know we can anticipate from you in seeing that our Texas Program is protected by the passage of this legislation.

Sincerely yours,

BURTON G. HACKNEY.

ARLINGTON, VA.,
September 26, 1967.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: I read in the Washington Post of September 22 that you were "a bit amused" at Treasury Secretary Fowler's suggestion that desires of constituents should play second fiddle to opinions of selected experts. "After all, we represent the folks back home," you said. "We're their lawyers." Here you repeated a phrase you used just before the Senate passed the 1965 Social Security Amendments. You said then: "The worth of the Social Security Bill of 1965 cannot be measured solely in terms of dollars. It can better be judged by an economist than an actuary, better by a social worker than an accountant, and even better by our folks back home and the needs that are met, the fears that are dissolved, the wants that are satisfied by what we have wrought." (Congressional Record, July 9, 1965, page 15582).

There are plenty of actuaries and accountants working on Medicare, but hardly any economist or social worker. We need a better balance in the program and more regard, such as you called for, for costs in relation to benefits and not only to funds.

Today at the Finance Committee hearings I heard Senator Carl T. Curtis say to Social Security Commissioner Robert M. Ball that "reasonable cost rewards inefficiency." I raised the same question in a report I submitted in the Social Security Administration concerning which I wrote a letter to your predecessor as Chairman of this committee, which may be found in the record of the Hearings on H.R. 6675 (89th Congress, 1st Session, May 1965, pages 1123–5). It was pointed out in the recent report to the President on Medical Care Prices from the Gorham group in the H.E.W. department 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."

Those to whom I submitted my report in the Social Security Administration could not see the practical effect of the confusion of concepts to which I directed attention. This was despite the fact that I was only echoing criticism of the concepts misused by the American Hospital Association and Blue Cross which may be found in reports by the American Medical Association and the Public Health Service, to which I can direct attention to anyone interested. Today Mr. Robert M. Ball testified before your committee, in justifying his delay in coming to grips with the problems of health economics, that he was authorized by the House Ways and Means Committee to be guided by "Principles of Payment for Hospital Care" and "Cost Finding for Hospitals" recommended by the American Hospital Association. In fact, the House Ways and Means Committee and, formerly, the Senate Finance Committee, have relied excessively on the Executive branch, according to Senator Abraham Ribicoff's speech of February 17, 1967 in the Senate. He was a Secretary of Health, Education and Welfare himself. He said he did not want all the information and knowledge on the subject of Medicare to come out of the HEW Department because this made impossible what he called "independent judgment."

My letter to the Chairman of the House Ways and Means Committee, which may be found in the record of the Hearings on H.R. 5710 (Part 4, pages 2445–9) presents evidence of errors in Congressional committee reports due to excessive reliance upon the Social Security Administration. I quoted from a letter I received from the Chief Actuary of the Social Security Administration, dated August 10, 1966, in which he said it was not his responsibility to make economic judgments. Yet this is the burden being put upon him, again and again, in the deliberations of Congressional committees who are asking actuaries to make judgments beyond their province. I request you put into your record, together with this letter, an exchange of correspondence between me and the Chief Actuary, which is relevant to what follows. I ask, also, that you put into your record, a letter to me from Miss Lenore A. Epstein, Deputy Assistant Commissioner for Research and Statistics, Social Security Administration, together with "Some Data on Medical Care of Disabled Workers." These data, as stated on page 37 of the House Ways and Means Committee Report on H.R. 12080, caused the Chief Actuary to increase the cost estimates to bring the Social Security disabled beneficiaries into the Medicare programs (with new figures as shown on page 362 of your Hearings on H.R. 12080).

Where are the lawyers for the disabled under Social Security? President Johnson proposed (and I understand it is still urged verbally by Administration spokesmen) that they be granted the Medicare benefits which other Social Security constituents will get. Suddenly data, not made public (it took two weeks of pestering for me to get a "brief note" of summary), are cited as evidence that the disabled "cost" too much. The House Ways and Means Report on the 1967 Social Security Amendments (H.R. 12080) says that a "major factor" in the denial of benefits to the disabled under Social Security was based upon "data which first became available while the proposal was being considered" (page 37). These "data" are part of an unfinished (and apparently undigested) study by the Office of Research and Statistics of the Social Security Administration. (There is an interesting contrast here with the study of the Task Force on Nursing Homes which though completed cannot be seen by Congress.)

In his letter of August 10, 1966 to me, the Chief Actuary said that only in "formal presentations" of the Social Security Administration can we be sure of strictly correct use of terminology. (However, note page 69 of the Ways & Means Committee Report on H.R. 12080 where "future rates of increase in hospital costs" are shown without any indication that these are daily figures, nor that the "low costs" are shown without any indication that these are daily figures, nor that the "low cost" series, according to page 504 of the Ways & Means Committee Hearing record on H.R. 5710, refers only to room and board, excluding ancillary hospital costs. I don't know about the other two series shown in the latter respect.) Apparently the "brief note" of the alleged "data" used to raise the estimated cost for the Social Security disabled is not such a "formal presentation." The group studied does not in fact correspond to the disabled under Social Security, as explained in footnote #2. Footnote #1 refers to "possible confusion in the concept of disability" in one respect, but other confusions, for want of information not given, abound.

The "brief note" points to certain differences between the group to which it refers and Social Security disability beneficiaries which are not taken into account in certain rough figures provided to me by the Chief Actuary's office. I had asked for some account of the translation of your findings of the "data" into the actuarial cost estimates shown on page 362 of your Hearings on H.R. 12080, according to which we are going to save all kinds of money by letting the Social Security disabled shift for themselves instead of giving them the same helping hand in sickness we plan to give other Social Security beneficiaries. I request the Senate Finance Committee to get from the Chief Actuary a better account of this operation than I have been able to get.

The "open, explicit, verifiable, self-correcting process," which according to Mr. Alain C. Enthoven, Assistant Secretary of Defense, Systems Analysis, is the first step in "the method of science," is not found in the way cost estimates are presented to Congress in connection with the Social Security program. The very term, "cost" is ambiguous. I was told by a member of the Chief Actuary's staff that it is logical to expect the "disabled" to "cost" more to Medicare funds than the aged. Not that they have to pay more for the same services but that they need more of them. If he is right, then this is not dependent on any specific set of data but is a permanent fact of life. We get the topsy turvy result that precisely because they need these benefits more they should get them. By this reasoning, Medicare should not have been given to those over 65 years but to those under 65 years.

H.E.W. Secretary Gardner told you (page 214 of your Hearings on H.R. 12080) that "available data indicate substantially higher health costs for the disabled than for the aged. The data confirm the importance of covering the hospital costs of the disabled under Medicare." According to the Chief Actuary, this account of the "data" is not as accurate as the statement in the Ways & Means Committee Report (page 37) that "the per capita cost of providing health insurance for the disabled under medicare would be considerably higher than is the cost of providing the same coverage for the aged." (Some readers would mistake "coverage" for actual use of health services. This statement, though it does not mean the same as the Secretary's, remains unclear to the many who are not "experts" and just ordinarily intelligent but helpless in the hands of "experts.")

The conclusion from the "data" drawn by Secretary Gardner is more correct than that drawn by the Ways & Means Committee but I might say it is the weakest possible way of putting up a fight for the helpless disabled under Social Security. I have reason to believe that nobody in the Secretary's office took the trouble to ask for even the "brief note" until I came along and raised a fuss about it.

According to the Chief Actuary, the reduction of benefits is the only way to reduce costs. (I developed this point in my letter to your predecessor which may be found in the record of your Hearings in 1965 on H.R. 6675, pages 1123-5.) His main interest, and apparently that of Congress, too (which does not make it right) is in "actuarial soundness." No corresponding interest exists yet in the economic problem of getting the most for Medicare money. The national income accounts of the Commerce Department, with the approval of the Budget Bureau (which does not make it right), treat all Medicare payments as "transfer payments," as if the money were under the control of the beneficiaries when in fact it is the Government which is spending it for them, unlike other Social Security money. According to the Commerce Department's classification of what Section 1861, (v)(1) of Title 18 of the Social Security Law defines as a "service benefit" paid for in money by "other than the recipients," it is not a service benefit. Only cash benefits exist under Social Security. The Social Security Administration, negotiating for health services with providers thereof knows better but it passively approves of the Commerce classification which is contrary to fact and law.

But even worse. The Social Security Administration passively submits to unsound or not-adequately-studied reimbursement guidelines presented by the American Hospital Association and Blue Cross. "Principles of Payment for Hospital Care" put out by the American Hospital Association is a very confused document. A Report to your Committee by the Comptroller General, in the appendix of your Hearings of May 25, 1966, made certain distinctions between the "accounting" and the "economic" approaches of which many hospital people are not aware. The Comptroller General's report was a competent consideration of questions about legislative intent raised by your Committee staff and very competent reports have been given to your Committee on drug pricing, nursing home practices and other areas of concern. There is one gaping hole, which in my opinion, might well be filled by the General Accounting Office. This is a report on the economic principles of hospital pricing.

You asked the Blue Cross Association representative who appeared before your Committee to explain apparent discrepancies between their cost projections and those of the American Hospital Association. After Mr. James Ensign testified before you, I caught him in the lobby and asked him to send me a statement of the Blue Cross Association principles of payment for hospital care. I received from him the 1963 "Report of the Task Force on Principles of Payment for Hospital Care" by the American Hospital Association of which Part 2, "Equity in Financing" (page 27), was by Mr. Walter J. McNerney, President, Blue Cross Association. I have examined this section carefully and can find no evidence in it of concern for the final consumer, other than pious phrases.

This reminds me of how I was introduced to this subject by an assignment in the Social Security Administration. I was asked to prepare "a summary analysis" of the McNerney-University-of-Michigan Study of Hospital and Medical Economics. This consisted of 13 projects and involved an expense of over $380,000. The illumination from this study was used as a reason for others, including the Michigan Legislature, to wait with bated breath for its coming. It was completed in 1962, and led to a report to the Governor of Michigan, who turned out to be Governor Romney. To this day, I have seen no evidence that anybody is the wiser for it, although it is full of all kinds of statistical tables and something called "multivariate analysis." They forgot one detail. Governor Williams had included "cost reduction" without loss of "quality" as one of the objects of the study. This is not even mentioned once anywhere in the 13 projects.

My exchange of letters with Governor Romney about this appears in the record of the House Ways and Means Committee (88th Congress, 1964, Hearings on H.R. 3920, pp. 2501–2). He saw nothing wrong with this, especially since it was not Michigan state funds that were involved but that of a private foundation. I mention this now because of the recommendation by the Ways and Means Committee (Report on H.R. 12080, page 44) that the H.E.W. "Secretary may find it helpful to contract with research organizations, under existing authority, for the conduct of research designed to establish better methods of measuring hospital efficiency and output."

I wish to warn against reliance on an outside organization to do the basic thinking that must be done within the Social Security Administration, which has the responsibility not only of administering the Medicare program but the basic thinking "necessary before we start bending metal." (Defense Secretary McNamara's phrase.) I have had difficulty interesting Congressmen or Senators in the current absence of genuine economic analysis (as distinguished from "actuarial science") because they do not see what difference it makes in their voting. However, my efforts have not been entirely futile. Without any apparent stimulation from the Social Security Administration (but some from the Gorham Report to the President on Medical Care Prices, and the laudable action of Secretary Gardner in calling into session a National Conference on Medical Costs) the Social Security Bill (H.R. 12080), for the first time calls for true economic analysis in Title IV, Section 402, authorizing "experiments" and study of payments with "incentives" for cost reduction. A study of Social Security Administration Work Plans convinces me they will engage in this most reluctantly since they exaggerate the need for waiting for fuller data, statistical and actuarial, before economic analysis can begin. Title IV, Section 402 is a step in the right direction, finally putting a dent in the sacredness of that uneconomic "reasonable cost" concept now in the law. However, I hope the Finance Committee can find a better way of defining the problem than the House of Representatives found. Talking only of "experiments" and "incentives" fails to bring out sound economic analysis, already more solid than mere experimentation but already in operation in other parts of the Government and in private industry. The General Accounting Office, as evidenced by the very fine reports already submitted to your Committee by the Comptroller General, could with profit be brought into the picture.

I have just received a letter from a member of your Committee (whose name I do not give, not knowing whether he would desire it). He writes me: "Your study deserves considerable attention and in view of the fact that this is not only a philosophical discussion, but one that may lead to constructive criticism of our present system. I will attempt to study your suggestions in depth."

I hope this is not so "deep" that no practical suggestions can be seen in it. I shall appreciate having this placed in your record. Such past placement in Congressional Committee records has furthered public discussion.

Yours sincerely,

SIDNEY KORETZ.

[From the Washington Star, July 1966]

INCREASED BENEFITS

SIRS: On July 2, you published a letter from Miss Sarah Shafer which stated, in part, that Social Security benefits had depreciated over the years in terms of buying power. The basis of this statement was that in terms of 1964 dollars, the average benefit increased 54% from 1940 to 1964, whereas the cost-of-living index went up nearly 125 percent.

Unfortunately, Miss Shafer's analysis is completely incorrect, because she did not realize that the increase in the average benefit, in terms of 1964 dollars, had already taken into account the increase in the cost-of-living index! In other words, the purchasing value of the Social Security benefits actually increased by 54 percent, since the dollar size of the benefit increased by about 250 percent (from approximately $22 in 1940 to about $77 in 1964).

ROBERT J. MYERS,
Chief Actuary,
Social Security Administration.

[From the New York Herald Tribune, May 28, 1966]

PRICE INFLATION PINCH DIFFICULT TO MEASURE

(By Joseph R. Slevin)

The United States has been suffering from price inflation, but no one can say just how severe the inflation has been.

The government's closely watched Consumer Price Index says that spiraling prices have knocked 15 cents off the value of the dollar during the past decade. Each dollar buys 1½ cents less at the end of the year than it did at the beginning.

The difficulty is that it's far from clear that the price barometer takes proper account of improvements in quality.

Turkeys have bigger breasts but the C.P.I. only shows the cost of turkeys—not that consumers are getting better turkeys.

Better medicines and greater medical knowledge have combined to slash the average hospital stay. The C.P.I. shows that the average daily cost of a hospital stay has been soaring but it doesn't make allowance for the briefer periods that patients are confined.

BIGGEST FLAW

The loudest questions are being asked by a special committee of New York's National Bureau of Economic Research. It recently told Congress that economists and statisticians "in all probability" would overwhelmingly agree that the biggest flaw in the government's price barometers is their failure to take account of quality improvements.

The government agency that keeps track of prices is the Bureau of Labor Statistics and it thinks that the National Bureau is guilty of gross exaggeration.

"We don't say there's no upward bias, but we don't think it's very big," Robert J. Myers, deputy commissioner of labor statistics, said.

The chief National Bureau case in point is the price of automobiles. Its startling conclusion is that cars really cost less today than they did in 1950.

The National Bureau relies on a special study by economist Zvi Griliches. He decided that the prices of the "low-priced three" actually fell by 18 per cent from 1950 to 1959 if due weight is given to quality improvements. The more prosaic C.P.I. reports that the selling prices went up 31 per cent.

Mr. Griliches arrives at his prices by making adjustments for three quality changes—weight, horsepower, and overall length. He says all three are quality improvements and that today's cars aren't as expensive as they seem when it's recognized that they are heavier, longer and more powerful.

The B.L.S. has some sticky questions about Mr. Griliches techniques, but it has an even more fundamental complaint that any car owner can understand.

"How do we know that those are improvements?" Mr. Myers asked. "With the current trend toward smaller cars, they may not be improvements at all."

The B.L.S. does make a number of price adjustments for quality changes and automobiles are the best example.

Whenever there is a clearly measurable improvement, the B.L.S. tries to make appropriate adjustments in its index. To take one illustration, it knocks $650 off the average price of today's car against the average price of a 1937 model to adjust for quality improvements such as the shift from six-cylinder to eight-cylinder engines and from standard to automatic transmissions.

ARLINGTON VA.,
July 11, 1966.

MR. ROBERT J. MYERS,
Chief Actuary,
Social Security Administration,
Washington, D.C.

DEAR MR. MYERS: I am glad to see you drawing attention to what Social Security money buys, as well as to dollar amounts. This will take on a new significance with Medicare which will represent largely purchases of goods and services, while hitherto Social Security payments have been transfer payments.

I believe I was responsible for getting the Commerce Department to look twice at this. The Federal Budget, erroneously, I claim classified Medicare as a transfer payment. Apparently the "revolutionary" change represented by Medicare has been handled in a rather absent-minded manner.

Mr. Robert M. Ball told the Senate Finance Committee, on May 25 (and you were there) that the "cost of rendering hospital care has been rising at an average rate of roughly 6 percent a year." The usual figure given is 7%; the table you provided the Senate Finance and House Ways & Means Committees shows an average of 6.7% in the annual increases of "average daily hospitalization costs" in the years 1955–1963 inclusive.

How do you justify the continual reference to rising hospital costs by this amount without pointing out that it is a daily figure?

The statement is made that "hospital costs have been increasing at a faster rate than earnings." You mention a differential of 2.7%. In the table you provided, it appears that by "earnings" is meant "average wages in covered employment," but there is no support shown why the two series whose changes are compared are the appropriate ones for providing any kind of basis for determining economic feasibility of the program.

I would appreciate a clarification from you on this point.

Yours sincerely,

SIDNEY KORETZ.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., August 10, 1966.

Mr. SIDNEY KORETZ,
Arlington, Va.

DEAR MR. KORETZ: I am sorry to have delayed so long answering your letter of July 11, but I have been away on a 3-week vacation that ended just a few days ago.

I am always very much interested in the points that you make about the Social Security program and usually (but not always) find myself in close agreement with you.

You are quite correct that the various references that you have cited to "hospital costs" have, strictly speaking, been to "average daily hospitalization costs". I think that you will find that, in my various formal presentations, I have always used this terminology. However, in informal and spontaneous discussions, short-cut phrases have often been used, but I think that it is fair to state that, in these circumstances, the various parties knew what was being referred to. Certainly, in my actuarial cost estimates, the factor of duration of hospitalization has always played an equal role with average daily hospitalization costs. Although for all ages combined, the average duration of hospitalization has been decreasing slowly in recent years, it is not at all certain that this is the case for persons aged 65 and older. In fact, it appears that a considerable part of the overall decrease in average duration results from maternity cases (there has been a definite medical trend toward shorter stays) and changes in the age distribution of the population.

The earnings series that I used to compare changes in average daily hospitalization costs was derived from average earnings reported under the OASDI system for the first calendar quarter of each year (selected so as to minimize the effect of the maximum taxable earnings base). In my opinion, these 2 series are the proper ones for actuarial cost estimating purposes, because the earnings series reflects accurately changes in the general earnings level of the covered population. You raise a question as to whether these series are appropriate "for determining economic feasibility of the program"; it is not my responsibility for making the mentioned determination about the Medicare program so that I cannot answer your question as to whether these 2 statistical series are appropriate for such a purpose.

Sincerely yours,

ROBERT J. MYERS, F.S.A.,
Chief Actuary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., September 21, 1967.

Mr. SIDNEY KORETZ,
Arlington, Va.

DEAR MR. KORETZ: In response to your telephone request, I am enclosing a carbon copy of a brief note we have just prepared which summarizes data that were reviewed in connection with the proposal to extend Medicare to disabled beneficiaries.

I hope this meets your needs.

Sincerely yours,

LENORE A. EPSTEIN,
Deputy Assistant Commissioner
for Research and Statistics.

FROM LENORE A. EPSTEIN, DEPUTY ASSISTANT COMMISSIONER FOR RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION

SOME DATA ON MEDICAL CARE OF DISABLED WORKERS

Information on hospital and medical care utilization by the disabled will become available from the Social Security Administration's National Survey of Disabled Adults which is now under way, with comparative data for beneficiaries under the OASDHI program and disabled persons not receiving benefits. Data from the 1966 Survey of Disabled Adults in Households is now being processed; interviewing for the complementary 1967 Survey of Disabled Adults in Institutions is in process.

Pending the availability of these new data, special tabulations of National Health Survey (NHS) data were prepared for persons classified by age and activity limitation. The data for men provide some basis for judging the comparative levels of utilization by the disabled and the aged.[1] These are of special interest apropos of the proposal to extend Medicare to persons receiving OASDI benefits because of disability.

In brief, the available NHS data indicate that the level of hospital utilization, physician's visits, and personal medical expenses are higher, and health insurance coverage lower, for men aged 17–64 with health limitations on their ability to work than for men in the same age range who are not disabled or for men aged 65 and over. While these data are suggestive, they are limited to the noninstitutional population and do not necessarily reflect the level of health care utilization or the health insurance coverage of disabled worker beneficiaries under the OASDHI program. Some of the men classified as "unable to work" do not meet the work experience requirements for insured status; some beneficiaries may not consider themselves unable to work because they believe they have some residual capacity for work. Furthermore, a cross-section sample of the disabled would include more persons with a disability of very recent onset (i.e., during the previous year) than would a sample of disability beneficiaries, because of the 6-month waiting period. This would result in higher utilization rates than for a cross-section of disabled worker beneficiaries if it is true, as would be expected, that the recently disabled have received more intensive care at the time of, and shortly after the onset of disability, before the condition stabilizes, and before benefits are payable.

Utilization of Medical Care

According to a special tabulation of unpublished NHS data collected July 1964–June 1965,[2] the average annual number of days of care in short-stay

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[1] Corresponding data for women aged 17–64 have not been analyzed because of possible confusion in the concept of disability and possible misinterpretation of utilization data due to pregnancy.

[2] For general concepts, definitions and methods, see Public Health Service Publication No. 1000, Series 1—No. 2, *Health Survey Procedure* (May 1964). For earlier data on persons hospitalized, see Series 10—No. 20, *Persons Hospitalized* (June 1965).

hospitals per 1,000 men aged 17–64 was considerably higher for those unable to work than for those with lesser work limitations or without work limitations, as follows:

Days in short-stay hospitals per 1,000 men aged 17–64

Unable to work	9,535
Limited in amount or kind of work	3,850
Not limited	626
Total men aged 17–64	1,035

Men aged 17–64 who reported themselves unable to work (about 2 percent of the total aged 17–64) averaged almost four times as many days in short-stay hospitals as men aged 65 and over, who averaged 2,374 hospital days per 1,000.

The 1960 Survey of Disabled Worker Beneficiaries conducted in eight metropolitan areas,[3] also indicated a high level of short-stay hospital utilization among disabled beneficiaries (age 50–64) and freezes under age 50.

The relationship between number of physician visits and limitation in work ability is similar to that of hospital utilization. In the period July 1963–June 1964 the number of visits ranged from 3.2 per person per year for men without limitation to 7.6 for those limited as to kind or amount of work, and to 15.0 for those unable to work. Men 65 and over averaged 6.0 physician visits per year.[4]

Health Expenses

Personal health expenses during the 12 months ending July–December 1962 were more than twice as high for the men unable to work as for those who said they were limited ($537 versus $243). Their expenses were two and one-half times as high as for men aged 65 and over, and almost five times as high as for other men aged 17–64 (Table 1). These figures relate to the bills rendered, including amounts reimbursed or to be reimbursed by insurance, but excluding the value of any care provided without charge to the patient through such facilities as workmen's compensation, temporary disability insurance, the Veterans Administration, or public assistance agencies.

The allocation of personal health expenses by type of care confirms the impression gained from examining utilization rates that hospital stays impose a particularly severe cost burden on those unable to work. Short-stay hospital bills accounted for about 40 percent of their very large total medical bill. The average expense was one-third larger than that for physicians, while men with limited work ability and men aged 65 and over (not in institutions) spent 8 or 9 percent less for hospitals than for physicians in 1962. Drugs were also very important in absolute terms, $93 per year per person, though they represented a smaller proportion of the total than among the other groups of men.

Health Insurance[5]

The National Health Survey found in 1962–63 that about one-half as many of those unable to work had hospital insurance as those 17–64 who were not limited in their work ability. The proportion with health insurance coverage among the disabled 17–64 was lower than that among all men 65 and over. Of the males aged 17–64 who were unable to work 38 percent had hospital insurance. This compared with 59 percent among the men limited in the kind or amount of work they could do and 77 percent among those who were not limited in work activity. Of the men aged 65 and over 54 percent had hospital insurance.

In the 1960 Survey of Disabled Workers, 48 percent of the beneficiaries (aged 50–64) had health insurance. By comparison with the NHS figures on all severely disabled, it may be inferred that disability beneficiaries had better health insurance coverage than nonbeneficiaries. These comparisons are, of course, limited by the differences in population sample (restricted to eight metropolitan areas for the 1960 beneficiary study), the age differences and possible changes over time between the 1960 study and the NHS 1962–63 study.

It is possible that many workers who have private health insurance coverage at the onset of disability are unable to keep up their insurance after a prolonged

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[3] *The Disabled Worker Under OASDI*, Social Security Administration, Office of Research and Statistics, Research Report No. 6, October 1964.

[4] Public Health Service Publication No. 1000, Series 10—No. 18, *Volume of Physician Visits*. Table 9.

[5] For summary data, see Public Health Service Publication No. 1,000—Series 10—No. 11, *Health Insurance Coverage, July 1962–June 1963* (August 1964).

period of disability. Many will no longer be eligible for group rates and may find the cost of health insurance too heavy in the face of reduced income. Disability also occurs more often among those in the lower paid, less stable occupations, who are also least likely to receive health insurance as part of their fringe benefits. At the same time it is probable that men who can meet the extensive work experience requirements for OASDI insured status are more likely to have had health insurance when employed than men who could not meet the work requirements.

HEALTH EXPENSES PER PERSON PER YEAR BY MEN AGED 17-64 YEARS BY EXTENT OF WORK LIMITATION AND BY MEN AGED 65 AND OVER, JULY-DECEMBER 1962

Type of expense	Men aged 17-64				Men aged 65 and over
	All	Unable to work	Limited in amount or kind of work	Other	
Total (average annual expense in dollars)	129	527	243	111	203
Hospital	29	220	74	21	57
Doctor	42	164	83	36	62
Dentist	22	15	17	22	15
Medicine	24	93	48	21	48
Other	12	35	21	11	21
Total (percent)	100.0	100.0	100.0	100.0	100.0
Hospital	22.5	41.8	30.4	18.9	28.1
Doctor	32.6	31.1	34.2	32.4	30.5
Dentist	17.1	2.8	7.0	19.8	7.4
Medicine	18.6	17.7	19.8	18.9	23.6
Other	9.3	6.6	8.6	9.9	10.3

Source: National Center for Health Statistics. For definitions, see Public Health Service Publication No. 1,000, series 10, No. 27 (February 1966).

STATE OF MAINE,
OFFICE OF THE GOVERNOR,
Augusta, Maine, September 13, 1967.

Mr. CHARLES A. BYRLEY,
Director, National Governors' Conference,
Office of Federal-State Relations, Washington, D.C.

DEAR MR. BYRLEY: I am enclosing the response of my Department of Health and Welfare to the ten questions which you posed in your special notice of August 14.

I hope that this information will be helpful.

Sincerely,

KENNETH M. CURTIS, *Governor.*

DEPARTMENT OF HEALTH AND WELFARE,
STATE HOUSE,
Augusta, Maine, August 28, 1967.

To: Dean Fisher, M.D., Commissioner.
From: Stephen P. Simonds, Director, Bureau of Social Welfare.
Subject: Social Security Amendments of 1967—National Governors Conference Query.

My response to the 10 questions posed in the National Governors Conference memorandum is as follows:

1. The Federal government should continue to pay the full cost of state consulting services to assist hospitals and nursing homes to become eligible for medical programs. The well-established precedent for 100% funding of developmental activities is particularly appropriate in the Medicare program. The provision has been freely utilized in Maine and has helped us to develop and license home health agencies that would not otherwise exist.

2. The total number of children from broken homes receiving AFDC should not be limited. The House Ways and Means Committee report on H.R. 12080 points out that states may continue assisting children above the ceiling without

federal matching. This is unlikely since most states, particularly the lower income states, depend on federal matching to finance the bulk of the program; 75% in Maine. However, children in need must be helped, one way or another. We will not permit them to starve but the burden will fall on local government. Pressures on the municipal budget and the property tax are such that the Executive Secretary of the Maine Municipal Association, Mr. John Salisbury, has expressed official concern over this provision in H.R. 12080. He will be communicating the views of his organization to the Congressional delegation.

The proposed ceiling on the number of children who will be assisted by the Federal government is aimed at controlling the number of broken homes. The Congress is understandably alarmed over the increase in desertions and illegitimacy in some parts of the country, especially the urban ghettos of the northern cities; but to use the public assistance program as a means of controlling human behavior is fruitless and self-defeating. More than likely, it will compound the problem. One wonders what rules and regulations could be adopted to maintain such a ceiling and guarantee equal protection under the law. Constitutionality is open to serious question. From a practical standpoint, the most serious shortcoming in this ceiling proposal is that it does not allow for caseload increases resulting from industrial lay-offs, business down-turns or other economic causes of dependency. There is an urgent need, however, to get at the causes of social problems and other provisions in H.R. 12080, such as the strengthened Community Work and Training Programs, Day Care, Foster Care, Family Planning, and Homemaker Services are extremely useful, new rehabilitative tools and offer the best hope of controlling the side of caseloads.

3. No ceiling should be placed on the Federal share of the Medicaid program. A program as new as this is should provide maximum opportunity for experimentation and innovation at the state level. It is too early to impose ceilings on a national basis.

However, if ceilings are to be adopted, the technique proposed by Congress, an income standard related to the state's public assistance standards is the most equitable. The proposed 133⅓% of the average AFDC payment to a family will mean a very limited and restricted program in a state such as Maine, where the average assistance payment is very low. The average payment to a mother with 4 children in Maine is $150 a month. The proposed Medicaid formula means that a family with an income in excess of $2,400 per year would be ineligible for medical assistance. If the ceiling cannot be eliminated altogether, we recommend it be 150% of the average AFDC payment instead of the proposed 133⅓%.

4. The requirement for work training program for mothers receiving AFDC payments should apply only to mothers requesting the training instead of all AFDC mothers, as the bill proposes. It is both undesirable from the standpoint of public policy and totally unnecesary for practical reasons.

The effect of the bill's proposal is to put government in the position of deciding which mothers will work and which ones will not; which child will have the benefits of his own mother's care; which child will be cared for by parent substitutes. For very sound reasons, government has not taken upon itself the power to dictate such decisions. Furthermore, this element of compulsion is not needed, and is irrelevant. The fact is that the combined resources of our Work Experience and Training program, anti-poverty agencies, and other manpower training programs are unable now to provide all the necessary educational, training and work experience resources requested by AFDC mothers. We cannot take care of all those who want to work. The proposed Amendments would require us to set up elaborate administrative machinery, assure weekly registration with employment services, police "bona fide" job offers; costly procedures which serve only to divert our attention and resources from the work training programs we are now just getting underway. Moreover, a substantial percentage of the AFDC recipient groups are on the program relatively short periods of time and except for brief intervals are basically self-supporting. Their major need is money to get them through a crisis period and they quickly return to former or new jobs, when this is passed. In our present program, these families are identified and we do not spend time doing things for them which they are perfectly capable of doing for themselves. H.R. 12080 would force us to adopt unproductive and meaningless procedures for this group.

5. AFDC financial assistance for unemployed parents under the AFDC program should be required of all states. It no longer makes sense to exclude this group of needy children whose homes are still intact and where family breakup

can be prevented through timely and adequate assistance. We do not see the necessity for giving a financial bonus to the states adopting such programs. They all too often reward the richer states and penalize the poorer ones. Rather the state's share of these and other financial assistance programs should be determined by its relative ability to contribute with the Federal government contributing the difference between the state's fair contribution and an adequate subsistence standard.

6. The matching ratio on the new self-help programs to get people off the welfare rolls should be at least 75%–25%, and there should be a uniform matching ratio for all public welfare programs. The tendency for Congress to adopt varying ratios for different programs and functions makes for extremely difficult, time-consuming, and complex processes at the state level. They are sometimes self-defeating in that they discourage the adoption of new programs. States have long advocated a uniform matching ratio based on the state's ability to contribute to the program for *all* public welfare activities. The one exception might be 100% federal financing of educational and training programs.

7. We strongly recommend that the proposed exemption of earnings for the full-time student be extended to the part-time student. Part-time school arrangements, Work-Study programs, and the like, are serving more and more youth who cannot undertake a full-time school program. The income exemption provision for students misses the youth in greatest need if it excludes the part-time student.

8. The self-help programs provided for in H.R. 12080 are innovative and forward-looking. They offer states ample opportunity to enlarge and expand such programs. In our view, the decision by the House Ways and Means Committee to keep the Community Work and Training authority in public welfare and to strengthen the program was a wise one. It permits, indeed requires, the state agency to fully utilize educational, employment counseling, and job training programs offered by other state and federal agencies. When these resources are unavailable, however, public welfare has authority to develop programs specifically tailored to the welfare recipients' needs, individually or in groups. More important, these services can be "packaged" with all other health and social services needed to help a family get on to its feet.

Thus, for the first time in history, public welfare will have all the tools it needs to prevent dependency and restore employable individuals to self-support. This is a key feature in H.R. 12080 as it pertains to public welfare programs.

9. Yes. States should be required to make welfare payments at the level which the state itself determines to be necessary to maintain a level of health and decency. If the state contributes according to its relative ability to finance public welfare programs, the federal government should make up the difference between the state's contribution and a pre-determined level of adequacy.

10. Greater support is needed for the training of all personnel engaged in family counseling and health activities. Maternal and child health services, particularly with welfare recipients, are relatively ineffective without family caseworkers adequate both in numbers and skills. By the same token, family casework is unproductive if the necessary maternal and child health resources are lacking. Support for training is needed across the board in all health and welfare services at all skill levels, as these activities are interrelated, interdependent, and frequently indistinguishable.

REPLY FROM GOV. JOHN A. BURNS, HAWAII

SPECIAL NOTICE FROM NATIONAL GOVERNORS' CONFERENCE REGARDING SOCIAL SECURITY AMENDMENTS OF 1967 (H.R. 12080)

The following are our comments and recommendations with respect to the ten questions posed by the Federal-State Relations Office, National Governors' Conference:

1. Should the federal government continue to pay the full cost of state consulting services to assist hospitals and nursing homes to become eligible for medical programs or should the matching be 75/25 as proposed in HR 12080?

We believe the present provision in the law should remain under which the federal government pays the full cost of the consulting services. Under existing State law, the Department of Health is the licensing agency for hospitals and nursing homes and as the certifying authority under Title XVIII. It is, therefore, the logical agency to provide consultation. The proposed change would remove the consultant services from the State Health Department.

2. Should the total number of children from broken homes receiving AFDC benefits be limited?

The total number of children from broken homes receiving AFDC benefits should *not* be limited. Any child who is deprived of food and the necessities of life should be entitled to the benefits of this program, not excluded on the basis of an arbitrary quota.

3. Should there be a ceiling on the federal share of Medicaid? If so, should it be limited to 133⅓ percent of the highest AFDC payments to a family or should it be at a higher level?

We believe there should be a ceiling on the federal share of Medicaid. However, we believe that the ceiling should be based on an adequate national standard of assistance. The proposed ceiling of 133⅓ per cent of the highest AFDC payments in the State would result in a substandard ceiling of Medicaid in the states with substandard AFDC. This will easily compound the problem.

4. Should the requirement for work training programs for mothers receiving AFDC payments include only mothers requesting the training, mothers of children over 6 years of age, or all AFDC mothers as the bill proposes?

The requirement for work training programs should not be imposed on all AFDC mothers. Participation in such programs should be determined by the individual home situation and the needs of the family. Arbitrary criteria such as "only mothers requesting the training" or "mothers of children over 6 years of age" are not practical. A mother with a handicapped child over 6 or a large family may be vitally needed in the home to provide adequate care and supervision for her children.

5. Should the states with AFDC programs for unemployed parents receive a bonus—such as higher federal matching grants—in order to reward their progress and encourage the remaining states to adopt the program? Should AFDC program be required in all states?

AFDC programs for unemployed parents have initiated in states where there has been sufficient state and/or local funds appropriated to earn federal matching funds. To give such states bonuses would have little effect on solving the problem of inadequate state and local finances. Placing a requirement on states to establish an AFDC program for unemployed parents again does not meet the basic problem contributing to the state's failure to inaugurate such a program. We recommend some plan of graduated percentage matching for AFDC–UP programs in which the federal percentage would be higher for those states where the availability of the state and local share of financing is limited.

6. Should the matching ratio on the new self-help program to get people off the welfare rolls be 75/25, 90/10 or some other figure?

We recommend that the matching ratio for state and federal financial participation in self-help programs be made uniform irrespective of which federal agency the federal share is coming from. At the present time, there are a variety of matching ratios for such programs administered as on-going or as projects by state agencies with federal financing through the Office of Economic Opportunity Program, Office of Vocational Rehabilitation, Federal Department of Labor, etc. This tends to place a premium on developing self-help programs where the ratio of federal matching is the highest. We would recommend the ratio be no less than 75% federal and 25% state for administrative costs of services in federally financed welfare programs and that the federal matching be extended to child welfare services for non-needy children.

7. Should the exemption of the full earnings of full-time students as a work incentive under AFDC be extended to the full earning of part-time students?

We are in favor of extending the exemption time to the full earnings of part-time students to encourage use of educational opportunities.

8. Are the new self-help programs to be required for the states the proper types, number, and mixture, or should some be deleted and other added or left as in the current bill?

We believe the following requirements are constructive and should be included in the bill:

a. Evaluation of work potentials of recipients.
b. Establishment of work and training programs.
c. Exemption of earning of students.

d. Making available family planning services.

e. Establishment of day care centers for AFDC children as required.

f. Bringing to the attention of local court cases involving paternity establishment and support.

g. Coordination of services for needy and non-needy children through one state agency.

We recommend the deletion of the requirements that

a. States provide protective payments and vendor payments to protect the welfare of children.

If children are abused, neglected and exploited by parents, they should be provided with substitute parental care and supervision outside the parental home. Giving payment to a third party does not correct parental neglect.

b. Making participation in work-training programs for all AFDC mothers an eligibility requirement.

c. Limiting the number of children from broken homes who are eligible for AFDC.

We recommend that federal funds for matching of foster care payments for all children whose best interest are served by foster care placement be available irrespective of whether such a child is needy or non-needy.

While we believe each state welfare agency should provide services directed toward reducing the number of illegitimate births, we feel that this is a community problem and that illegitimacy should not be correlated with welfare payments. There is danger of developing a double standard of morality for unmarried mothers based on ability to support her child.

9. Should the bill call for the states to make welfare payments at the level of their definition of need? If so, should the federal share be increased to enable the state to meet the need?

We believe that the bill should call for states to make welfare payments at a level of need which represents a minimum standard of living compatible with decency and health. If states are unable to finance their share of welfare payments according to a definition of need which provide a minimum standard of living, then the federal share should be increased to enable states to meet full minimum need.

10. Do the states need greater support for maternal and child health or for training of welfare workers?

All states need professional trained social workers as well as Bachelors Degree workers with undergraduate preparation for the Maternal and Child Health programs and for welfare programs. The increased appropriation for graduate and undergraduate training would assist states to improve the quality and quantity of personnel to upgrade services in state programs. We recommend that the requirement that at least 50% of the living fund go to undergraduate programs be deleted until there is experience data to justify the need.

AUGUST 14, 1967.

HAWAII'S COMMENTS ON THE SUMMARY OF COMMITTEE DECISIONS FOR PURPOSES OF INTRODUCING CLEAN BILL, THE "SOCIAL SECURITY AMENDMENTS OF 1967"

I. HEALTH INSURANCE (MAJOR CHANGES)

Increase in Number of Covered Hospital Days

We favor this amendment. While the projected increase in the number of days of hospitalization would apply to a relatively small number of cases, these are the ones who may need it most. As an individual's medical bills extend to this period of time, the co-insurance becomes very expensive.

Payment to Physicians Under the Supplementary Medical Insurance Program

This appears to be a desirable change. Any relaxation of the provision in SMI concerning payment procedures will undoubtedly make the program more acceptable to the medical profession. In Hawaii, the most often heard complaint about Medicare is the amount of paper work generated in order to make it possible for the physician to collect his bill. The vast majority of physicians in Hawaii do not charge more than what would be considered reasonable and customary and for that reason would probably be willing to accept the carrier's determination of a reasonable charge.

Transfer of Out-Patient Hospital Services to the Supplementary Medical Insurance Program

The transfer of the hospital outpatient diagnostic services to Part B from Part A seems to us to be a logical change. The fact that they will then be covered under the deductible and co-insurance features in Part B will probably result in some liberalization from the patient's standpoint because his outpatient services will only be subject to one deductible instead of two.

II. HEALTH INSURANCE (MINOR CHANGES)

Most of these changes relate solely to the administration of the Medicare Program and strong feelings about these items generally. One paragraph under this section is of specific interest.

Experimentation with Hospital Reimbursement Methods

The payment of reasonable cost for inpatient hospital care has been criticized because no effort has been made to control poor, inefficient administration. The reasonable cost having now been extended to Title XIX programs for inpatient hospital care becomes doubly important for the Federal government as well as the various State governments to seek solutions for this problem.

We foresee increases in overall hospital costs during this fiscal year of as much as 20 per cent. Any brake that can be found to slow down the rising cost of hospital care will be helpful to all States.

III. AID TO FAMILIES WITH DEPENDENT CHILDREN AND CHILD WELFARE

Family Employment and Other Services

Responsibility is placed on State Welfare Departments for the initiation of programs, which may or may not be essential to meet the individual State's needs, and may be a duplication of services already available through other public or private agencies. We recommend that rather than include specific administrative direction on the type of programs and the methods of organization, the law require assurances that States will take administrative action best suited to meeting their individual problems toward helping families to become economically independent.

The requirement that States furnish Child Welfare Services which would contribute toward getting families off assistance rolls, seems inconsistent with the goals of Child Welfare Services and therefore needs further clarification. Child Welfare Services, as presently defined at the Federal and State levels, are those services in behalf of children which will insure that no child will be deprived of his own home and the care and supervision of his own parents because of financial need, and only if his own parents are unable because of factors other than financial need to provide proper care and supervision, shall substitute parental care either temporarily or permanently be made available. Child Welfare Services have never had as their objective getting families off assistance, but rather preservation of the family home for all children using financial assistance as one of the tools toward that goal in the best interest of the child.

We believe that Federal matching for the administrative costs of providing Child Welfare Services is long overdue. These services should be strengthened for all children regardless of economic need.

Community Work and Training Programs

The establishment of Community Work and Training Programs by public welfare agencies in every area of the State where a significant number of AFDC families live as a requirement appears to us as unsound.

The establishment of such programs should be coordinated with the Work Experience Projects and the work and training projects already in operation through other State and Federal departments, such as state departments of education, state and federal labor and vocational rehabilitation agencies, and private organizations. We recommend the legislation be limited to requiring the State to give assurances that adults and children over sixteen will be expected to use work and training resources available when use of such resource is appropriate.

Work Incentives

This amendment does not appear to be consistent with the other amendments to the Bill. It broadens the base of eligibility and thus would increase caseloads and costs. The statement that "a family would have to fall below the usual assistance levels to qualify initially for assistance and for earnings exemptions" appears to establish a differential eligibility standard for families with earn-potentials and those without. This amendment creates further inequities in relation to a basic standard of living to which families are entitled as it makes the standard of living dependent on whether the family members are able to obtain employment (physically, mentally, by age and skill) and on the labor market.

Children of Unemployed Fathers

This amendment appears undesirable as it could result in the elimination of federally matched assistance to children presently eligible on the basis of the unemployment of the breadwinner. The majority of the children who qualify under this condition have fathers who have not because of their loss of skills and education had "a substantial connection with the work force" nor "have had a year and a half of work during the three year period ending in the year before assistance is granted." The condition exists not because of their refusal to work but because the labor market does not have jobs for which they can qualify. Should this amendment go into effect in October 1967, most states with AFDC–UP programs would either have to meet the needs of these families and children from state and local funds or let them starve unless the father deserts, thus creating whole new sets of problems.

Federal Payments for Foster Home Cases of Dccendent Children

The present law and the administrative requirements with respect to federally matched payments for children in foster care under the AFDC programs have not been sufficient. Many states believe in the principle that foster care is a temporary measure for helping parents to improve their situation so that the children can be returned to their care and that recourse to the courts is a last resort. The amendment appears to perpetuate and expand a program that is not geared to the best interests of children and their right to their parents and their own homes.

It also encourages the development of foster care services for economically needy children, to the exclusion of non-needy children by providing matching Federal funds administrative costs of Child Welfare Services to needy children.

To tie Federal matching funds to a criteria which limits such funds to economically needy children perpetuates the inequities on the part of the Fedeal government in its financial responsibility for participation in the costs of services and foster care board payment for any child regardless of economic need for whom foster care is in his best interests.

Emergency Assistance for Needy Children

The objective of the amendment is unclear. From experience, however, most crisis situations in families occur as an end result of long time deprivation. Help for 30 days will not solve the problems of long standing which created the crisis. If the purpose of the amendment is to provide immediate help on the basis of presumptive eligibility with Federal matching for necessary vendor payments by purchase order, it is contrary to the present effort of providing for emergency needs with immediate cash payments. The limit of 30 days assistance defeats the purpose of AFDC as a rehabilitative program geared toward providing the necessary services to prevent crisis situations through strengthening family life and employment potentials.

Child Welfare Services

We believe that the requirement to provide AFDC services and Child Welfare Services through a single organizational unit in the State and local agencies is a sound one from the point of administration. However, the amendment only provides for matching Federal funds for personnel and administrative costs for services rendered to children in families qualifying for AFDC. The bill originally introduced by the late Congressman Fogarty and re-introduced by Congressman Burke (H.R. 5710) was designed to remedy the inequity in Federal funds for administrative costs as well as foster board payments for all children who required such services regardless of economic need. We strongly recommend that the newest amendment be revised to include Federal matching funds for administrative costs of providing protective and preventive child welfare services and for foster board payments for all children, not just those in AFDC families.

Limitation on Aid to Dependent Children Eligibles

We are not in agreement with the extent of the amendment, which limits the number of minor children deprived of parental support due to the absence of their father, eligible for federally matched assistance. No child should be deprived of food and the necessities of life on the basis that he does not fall within an arbitrarily established quota of children. The criteria for Federal matching funds should be based on the child's need for financial assistance, not the cause of the need.

The State of Hawaii has always accepted its responsibility for providing for the needs of dependent and neglected children through legislation and appropriations. Its participation with the Federal government in financing the programs for children has contributed immeasurably to the quality and quantity of these programs. We firmly believe that the only criteria which should be considered for eligibility either for funds or services is need for funds and/or services. We have advocated the elimination of categorical requirements for Federal financial participation in the cost of such programs. It would appear that the intent of these amendments is to place further restrictions on eligibility for Federal matching funds by the introduction of additional conditions of eligibility unrelated to need, and beyond the control of the applicants.

We are in full support of all efforts to maximize the potentials of recipients in needy families to become economically independent. However, such efforts will not achieve this objective unless equal recognition is given to the development of work opportunities in public and private enterprises so these individuals can be absorbed into the labor market in jobs commensurate with their skills and abilities.

IV. TITLE XIX AMENDMENTS

Limitation on Federal Participation in Medical Assistance

We are not entirely in favor of this amendment. We realize that some controls should be built into the law to hold the income eligibility standards to a reasonable level. However, controls which are built to limit these eligibility requirements on a nation-wide basis may operate to the serious disadvantage of some States whose money payments eligibility standards are extremely low. They would not be able to provide adequate amounts of medical assistance under the proposed amendment. This amendment would have no effect in Hawaii. Our income levels for eligibility are very conservative by comparison of the proposed requirements.

Maintenance of State Effort

We do feel that the proposed amendment is a progressive step in requiring all States to show forward movement in their programs covering Medical Assistance. As in the case of the previous amendment, Hawaii is very comfortable within the requirements of the present law. These requirements are set forth in the Handbook of Public Assistance Administration, Supplement "D", Section D-8524.

Coordination of Title XIX and the Supplementary Medical Insurance Program

Hawaii has given consideration to several alternate provisions in the existing law covering this subject and would like to continue to exercise an option. Certainly, we must take advantage of SMI as a resource. Whether this is done through buy-in, payment on behalf of, or by a cash payment to the recipient has been the subject of much discussion. It would be more convenient if the various States could be allowed the option of one of these three methods to accomplish the purpose of the amendment.

Modification of Comparability Provisions

We do not feel that this amendment is wise as it would allow a reduction of services by States which should be encouraged to increase the services which they are providing.

Required Services under State Medicaid Programs

We believe the present law is preferable. Perhaps there are States which need to be given the freedom to enter the Title XIX Program gradually. Hawaii is not one of them. We have been in advance of the requirements of the law in almost all instances, and as far as we can foresee will continue in that manner.

Extent of Federal Financial Participation in State Administrative Expenses

Hawaii has not used the services of professional personnel in the Department of Health in any other than advisory capacities to the Department of Social Services, the "single State agency" charged with administering the provisions of Title XIX. We do see the possibility of such usage in minor instances but do not feel that the additional Federal matching should be a criteria in any decision relating to the use of such personnel.

Advisory Council on Medical Assistance

Just as the several states are encouraged to use the services of advisory committees, so would it be wise for the Department of Health, Education and Welfare to employ the services of such a council.

Free Choice for Persons Eligible for Medicaid

This is a necessary and desirable provision in the eyes of Hawaii. Steps have already been taken to implement this in our State. While the cost of providing all services under Title XIX will be much greater, this seems to be another area in which we should follow the policies of Title XVIII. There is no sound reason why the needy and medically needy individuals should be treated any differently in this respect from other individuals.

Use of State Agencies to Assist Health Facilities to Participate in the Various Health Programs under the Social Security Act

We are unable to find in the literature on H.R. 5710 the amendment to which this heading refers. From the explanation given in the summary for committee decisions, it would seem that the amendment might have value to States which may be having difficulty in financing new health programs.

Payments for Services and Care by a Third Party

We do agree with the purpose of this amendment. Hawaii is already meeting the requirements of this provision. We require the use of all resources to assist in the payment of the medical expenses of either the needy or medically needy individual. Among these are Medicare, private and community health insurance, excess income of the medically needy individual and funds which may become available through liability insurance claims as a result of accident or other circumstances.

Direct Billing of Patients under Medicaid

We foresee strong objection from the various physicians' organizations to the portion of this amendment which allows us to reimburse the medically needy individual on the basis of an *unpaid* itemized bill for physician services. On the other hand, they would be greatly in favor of the amendment if it allowed such reimbursement after payment of the bill by the individual. This would have a direct reflection on the patient who is eligible for Medicare and also for assistance as a medically needy person under Title XIX. It would enable a physician to be paid for his deductibles under Part B without having to get and accept an assignment under Medicare. From the latter standpoint, Hawaii would support this amendment with the exclusion of the word *unpaid* from the amendment.

V. OTHER PUBLIC ASSISTANCE AMENDMENTS

Federal Payments for Repairs to Homes of Assistance Recipients

We agree with the intent of this amendment. However, we recommend that the matching fund be available for repairs of unsafe and hazardous conditions in the home whether it could be occupied or not, and 50% matching be considered on the total cost of such repairs rather than placing a monetary limit for matching.

Social Work Manpower and Training

We are in full agreement with the authorization for training grants but recommend that the limit on the appropriation to be used for undergraduate training be deleted until more experienced data is available on need.

Permanent Authority to Support Demonstration Projects

We fully support the funds for demonstration projects, and their permanent status.

STATE OF WASHINGTON,
OFFICE OF THE GOVERNOR,
Olympia, August 29, 1967.

Re Social Security Amendments of 1967 (H.R. 12080).

NATIONAL GOVERNORS' CONFERENCE,
Office of Federal-State Relations,
Washington, D.C.

GENTLEMEN: In response to your inquiry of August 14 concerning the proposed amendments to the Social Security Act, there are enclosed herewith answers to the ten questions which you posed and which represent the views of this office and of the interested operating departments in this state.

I do not plan to testify personally with respect to these amendments, but I do consider the proposed amendments to arise important questions and therefore will appreciate your reviewing carefully the position of this state as contained in our attached answers.

Sincerely,

DANIEL J. EVANS, *Governor.*

ANSWERS OF WASHINGTON STATE TO THE 10 QUESTIONS SUBMITTED UNDER DATE OF AUGUST 14, 1967, BY THE NATIONAL GOVERNORS' CONFERENCE, OFFICE OF FEDERAL-STATE RELATIONS

1. "Should the federal government continue to pay the full cost of state consulting services to assist hospitals and nursing homes to become eligible for medical programs or should the matching be 75/25 as proposed in H.R. 12080?"

Since Medicare is the prinicpal reason for state consulting services to assist hospitals and nursing homes, the federal government should continue to pay the full cost of these services rather than using a 75/25 matching formula.

2. "Should the total number of children from broken homes receiving AFDC benefits be limited?"

The main purpose of the AFDC program is to provide financial assistance to needy children deprived of parental support and care, with absence of a parent being one of the reasons for deprivation. Within a given State, any eligible child deprived by absence has the same right to assistance as any other eligible child deprived by absence. Setting a limit—either in absolute numbers or in relation to population or some other index—is inequitable, discriminatory and out of conformance with the purpose of the program.

Secondly, the administrative problems involved in setting and enforcing any such limit would be serious. Population estimates, for example, are not sufficiently refined or timely to be a convenient or accurate vehicle for such purposes. Such problems would be particularly troublesome in such rapidly expanding areas as the State of Washington.

Third, by setting any such limit, the States—and in particular the public welfare programs with the States—are being financially penalized for the existence of nationwide problems for which no public welfare agency as such can be held responsible. Although family breakup may be deplorable, the fact remains that divorce and separation are widespread in our society (and incidentally, not restricted to the economically marginal). Many of our social institutions—the church, the school, the mass media—share responsibility for the changes which have occurred and must also share responsibility for halting or reversing them. Arbitrary limitation of Federal funds is not a constructive solution to the problem.

Positive measures designed to limit the number of children *requiring* AFDC because of absence as opposed to children *receiving* AFDC because of absence are however, desirable. Certainly public welfare agencies can and should focus their efforts more clearly and imaginatively in this direction. For effective results, however, the cooperation and involvement of the total community is imperative.

Lastly, any proposed reduction in residence requirements under any of the public assistance titles would automatically increase the proportion of the population eligible for a Federally-aided program. Imposing a maximum related to proportions existing prior to the removal of such residence provisions would most certainly be inappropriate.

3. "Should there be a ceiling on the federal share of Medicaid? If so, should it be limited to 133⅓ percent of the highest AFDC payments to a family or should it be at a higher level?"

The ceiling on the Federal share of Medicaid proposed in H.R. 12080 would presumably affect only the medically needy in all states. Since the intent of the basic law is to provide public medical assistance only to the needy, it is reasonable to link the definition of a medically needy person to the standards used to determine need for cash assistance. On this basis, the 133⅓ percent ceiling proposed in this bill is appropriate.

4. "Should the requirement of work training programs for mothers receiving AFDC payments include only mothers requesting the training, mothers, of children over 6 years of age, or all AFDC mothers as the bill proposes?"

Work training programs should be available for all AFDC mothers who can benefit from them. Caseworkers should be required to evaluate the individual situation and to evolve an employability plan for each mother. Obviously adequate child care must be provided and reasonable objectives must be set. Since over 30 percent of mothers with the husband present are presently in the labor force it should not be assumed that a mother may simply elect to remain on public assistance until she "wants" to assume financial responsibility for her family. She should become a contributing part of the main economic stream as soon as is feasible. Planning for eventual support should begin as soon as she applies for welfare. This should result in not only lower AFDC rolls but in a more productive life for the mother and advantages not otherwise available to the children.

5. "Should the States with AFDC programs for unemployed parents receive a bonus—such as higher Federal matching grants—in order to reward their progress and encourage the remaining states to adopt the program? Should AFDC–UP program be required in all states?"

Since unemployment has been recognized by Congress as being as much a reason for deprivation of parental support and care as death, incapacity or absence, all states should be required to extend their AFDC program to needy children of the unemployed. Since such extension merely represents conformance with Congressional intent and equal treatment of deprived children regardless of reason for deprivation, no special bonus should be paid to states for implementing an AFDC–UP program.

6. "Should the matching ratio on the new self-help program to get people off the welfare rolls be 75/25, 90/10 or some other figure?"

Maximum Federal financial participation is of obvious advantage to the States in any area. However, given the extremely high cost of day care and the importance of AFDC mothers obtaining or retaining employment, it would be particularly desirable to have a high matching ratio for such services—certainly higher than 75/25. Even if the short-run costs should equal the gross short-run savings because of employment, financial benefits should accrue in the long run because of the acquisition and/or retention of skills by these working mothers.

7. "Should the exemption of the full earnings of full-time students as a work incentive under AFDC be extended to the full earnings of part-time students?"

The exemption of full earnings for full-time students should not be extended to part-time students. However, while H.R. 12080 liberalizes earnings exemptions for most children, its provisions do result in a reduction in exemptions for 17 and 18 year olds who are not in school full time and are earning between $30 and $90 per month. The State does not approve of this restrictive aspect of the bill.

8. "Are the new self-help programs to be required of the states the proper types, number, and mixture, or should some be deleted and others added or left as is in the the current bill?"

The required self-help programs, with the inclusion of AFDC mothers and unemployed children under 16, will cover virtually all employable or potentially employable persons in the federally-aided programs. However, if the AFDC program is to be held down to any reasonable level these self-help programs must be available to *all* employable or potentially employable assistance recipients whether in Federally-aided or General Assistance programs and whether they are single or in families.

Although the bill provides that, when "appropriate," testing, job training and counseling is given to each adult and child over 16 the term "appropriate" is not defined in HR 12080. If HEW were to interpret this narrowly the results may be disappointing. The AFDC mother who has only an 8th grade education, no work experience and three children under 5 years of age may seem inappropriate for training, but updating her education now, even through home correspondence courses, may shorten her time on assistance. To wait 10 years before any attempt is made to provide job training or to upgrade her education may significantly lessen her chances for eventual independence.

9. *"Should the bill call for the states to make welfare payments at the level of their definition of need? If so, should the Federal share be increased to enable the state to meet full need?"*

All things considered, it does not seem advisable to pass legislation requiring states to make welfare payments at the level of their definition of need. In the absence of well-defined standards for measuring need (e.g., a requirement that States use the standards recommended by various Federal agencies, such as the Department of Agriculture), States would be free to circumvent the intent of the legislation by arbitrarily changing their quantity-quality standards used in determining need. The real issue is whether States *should* be free to adjust the level of welfare payments. Unlike the Federal Government, the State of Washington does not operate with "open-end appropriations" and cannot finance public assistance by deficit spending. Thus, at least when an unforeseen budgetary shortage occurs, e.g., an unanticipated expansion of caseload. States must either be free to adjust the level of their grants (a percentage reduction against requirements—a "ratable"—being the easiest—though not necessarily the most equitable—way), or be able to obtain additional funds from the Federal Government. It would seem that the latter option would be a difficult procedure to administer—from a Federal point of view—for it would require some method of ascertaining just what expenditures were in fact unforeseen—and further, unavoidable.

The President's Advisory Council on Public Welfare proposed that the Federal Government set the level of each State's contribution to the welfare program, that the level be based upon per capita income and that the Federal Government then finance the remainder. While this method may be a solution to the problem states would encounter if complete standards were defined by the Federal Government and the meeting of full need was required, it would result in an encroachment upon the right of the states to decide how much they wish to tax and how they wish to divide the tax dollar among the many alternatives.

Unless one feels that the entire area of the decision as to who is to receive assistance and how much will be given should be removed to the Federal level, states must be free to adjust the level of grants. The question of meeting "full need", with the definition of full need open to adjustment, is of little consequence. The only effect such a requirement would have would be to force states to continually adjust their standards rather than to utilize other methods, such as a ratable. Application of a ratable—instead of adjusting standards arbitrarily—does have the advantage that while a ratable is in effect, it is obvious the need is not being met. Adjusting standards obscures this fact.

10. *"Do the states need greater support for maternal and child health or for training of welfare workers?"*

In its report on H.R. 12080, the Committee on Ways and Means expressed its belief that the basic responsibility for health services for mothers and children rests with the state. The basis for this belief was not stated but it is apparent that in many areas (e.g., dental care) the state has been unable to provide the ideal amount of services required. Additional Federal grants for maternity and child care for low-income families would aid the states in expanding the scope of care and services now available.

The shortage of trained social workers has been a perennial problem nationwide. With the increasing responsibility that the government and society at large are placing on social caseworkers to deal with and ameliorate the ever-intensifying economic, medical, and psychological problems encountered among the welfare clientele, the need for more and better-trained personnel is becoming more and more pronounced. While this state has for years had an exceptional inservice training program as well as a stipend program for graduate students in social work, these efforts have failed to keep pace with current requirements. More Federal aid for training would greatly assist the states in meeting the expectations expressed in recent public welfare legislation.

HILLCREST CHILDREN'S SERVICES,
Dubuque, Iowa, September 22, 1967.

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

DEAR SENATOR LONG: Enclosed is a Resolution adopted by the Board of Trustees of Hillcrest Children's Services, Dubuque, Iowa. As indicated, the board has expressed concern regarding several sections of Title II (Public Assistance Amendments) of H.R. 12080.

This concern centers around opposition to mandatory work and training for AFDC mothers as a "condition for receiving assistance." In addition, the board opposes the use of vendor payments, and the elimination of present safeguards for the use of "protective payments." The board also opposes any limitation on the number of children who may be eligible for federal financing of AFDC programs.

As an Associate of Child Welfare of America, we would concur with testimony offered by the League to the Senate Finance Committee on September 18, 1967.

We do share the concern of Congress concerning the rising incidence of illegitimacy in the U.S.A. As an agency offering comprehensive services to the unmarried parent (mother and father) we wish to emphasize that the problem is not confined to the low income, or public welfare recipient, or to any one racial minority group. This is a community problem, and we believe legislation aimed at the welfare client group is highly discriminatory.

We are certain that House members did not fully understand the implications of the bill, and are most hopeful that the members of the Senate Finance Committee, as well as the Senate as a whole, will look more objectively on this long range implication of this important legislation.

Thank you for your continued interest in sound child welfare legislation.

Sincerely yours,

DONALD R. OSBORNE, ACSW,
Executive Director.

RESOLUTION CONCERNING H.R. 12080

Whereas the Board of Trustees of Hillcrest Children's Services, Dubuque, Iowa, a licensed child welfare agency, under the auspices of the Iowa Area Conference of The Methodist Church, and

Whereas said Board in deliberation at its annual meeting, held at Dubuque, Iowa, on September 20, 1967, and

Whereas it has come to the attention of said Board that the 90th Congress, on August 17, 1967, passed H.R. 12080, known as the Social Security Amendment of 1967, and

Whereas it is the opinion of said Board that the several sections of the Act will benefit a large segment of our country's population, and

Whereas, on the other hand, several sections of Title II—Public Welfare Amendments, are punitive and regressive, specifically relating to AFDC eligibility—work and training, and reduction of the incidence on assistance rolls because of illegitimacy or desertion, and

Whereas the question is raised whether otherwise desirable services and policies can be carried out under the shadow of a coercive and regressive policy without being discredited and their effectiveness destroyed: Now therefore be it

Resolved, That the Board of Trustees of Hillcrest Children's Services expresses its extreme concern that H.R. 12080 was passed by the Congress without full and due regard to the unfortunate children who are victim of circumstances, and be it further

Resolved, That the Board of Trustees of Hillcrest Children's Services strongly urges The United States Senate through the Senate Finance Committee, to examine in depth the negative implications of the aforementioned Act and delete the regressive measures which would have an adverse effect on solving our Nation's child welfare problems, and be it further

Resolved, That a copy of this resolution be sent to Senator Russell B. Long, Chairman of the Senate Finance Committee; to Senator Bourke Hickenlooper, to Senator Jack Miller, to Representative John Culver, to The Honorable Harold

Hughes, Governor, State of Iowa, and to the State of Iowa Board of Social Welfare.

Dated this 20th day of September 1967, City of Dubuque, County of Dubuque, State of Iowa, by:

DONALD R. OSBORNE, ACSW,
Executive Director, Hillcrest Children's Services.

OFFICE OF THE GOVERNOR,
Springfield, August 21, 1967.

Hon. JOHN W. GARDNER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR SECRETARY GARDNER: After further review and study by various State staff, I am supplementing my recent letter to you regarding H.R. 12080, the 1967 Amendments to the Social Security Act.

If H.R. 12080 becomes law, these are the changes we consider as particularly good; they are in keeping with what we are doing—or have advocated—in Illinois for many years:

1. *Requires* that *all* States establish adult work and training programs, complete with day care for children when necessary, for ADC recipients—and *requires* that recipients accept employment or training as a condition of eligibility.

Illinois has had such a program operative for over five years; we consider this the major reason for the fact that in the last five years the ADC load in Illinois has decreased 5.6% whereas nationally it has increased 22.9%.

2. Provides for direct payments to vendors as an alternative method of handling the ADC "mismanagement" cases.

Illinois has advocated this for years, and has moved in this direction as far as use of State funds only will permit. Our position here is that if the *children* aren't receiving the maximum benefits from the ADC grant, then—to the extent indicated—the agency may pay directly to the landlord, utility company, grocer, school, etc.

3. Emphasizes the need for more services to ADC families to improve potential for self-support, including required attention to family planning program.

There are also some requirements that concern me a great deal, and which the Senate should amend if the States are to be expected to achieve those very program objectives which the Committee on Ways and Means endorses:

1. Restriction of the ADC program in its coverage of unemployed fathers.

Excluding from coverage fathers who do not have the required "attachment to the work force" would preclude the welfare agency from continuing the ADC program to some families as a means of holding the unit together and equipping both the father and the mother through the training programs for self-support.

A like contradiction of program objectives occurs in the proposals to deny aid unless the father has been unemployed for 30 days, and the exclusion of a father who is receiving Unemployment Compensation.

2. The proposed freeze on the absent parent segment of the ADC caseload.

We see no sense nor justification in eliminating from the program the very children who are most in need of the program's benefits. We believe that the States should have an opportunity to demonstrate what results can be achieved through other measures the Bill directs at the problem of the absent parent.

3. The basic fallacy is still present in the "maintenance of State effort" provision. This formula is an affront to the initiative of high standard States and an expression of a dubious public policy that all States should find ways to spend more money in the subject fields of public welfare . . . . by not giving recognition to decreasing caseloads that have resulted or could result from the initiative of States.

I am most grateful to you for asking the Governors of all the States to supply you with their comments and suggestions on these maters which are of such vital concern to us. Through such opportunities to participate in the final shaping of Federal laws and regulations, we can expect a healthier climate in Federal-State relationships and better preformance at all levels in achieving the national purpose.

Sincerely,

OTTO KERNER, *Governor.*

STATEMENT OF FAMILY AND CHILD SERVICES OF WASHINGTON, D.C., SUBMITTED BY MRS. DEFOREST VANSLYCK, PRESIDENT

Family and Child Services, on the basis of its 85 years experience as the largest voluntary family counseling and child welfare agency in Washington, D.C., is deeply concerned with what it believes to be several regressive, unsound, and harmful provisions of the proposed amendments to the Social Security Act.

We wish to submit for the record our general endorsement of the testimony of the Child Welfare League of America as presented by its President, Elmer Anderson, on September 18, as well as the statement of the Health and Welfare Council of the National Capital Area, and urge the Committee to consider very carefully the full implications in particular of Title II—The Child Welfare and Public Assistance Amendments.

We are especially concerned with the two major new restrictions affecting children dependent upon or eligible for public assistance under the AFDC program. In our view these proposals constitute a fundamental reversal of accepted principles of public policy.

Family and Child Services shares the legitimate concern of Congress with the disturbing increases in numbers of families needing this type of assistance and also in numbers of deserting parents and illegitimate births. On the other hand, the experience of our agency persuades us that such arbitrary and punitive restrictions as compulsory work or training requirements and a ceiling on the number of families eligible for federal assistance, irrespective of need, are not only inhumane but self-defeating and would not help to rehabilitate families and remove the causes of dependency.

The need for greatly expanded day care programs to permit parents, where appropriate, to seek employment is obvious. We have long supported this. But to require that all adults and older children have jobs in order to qualify for federal assistance ignores in our experience the fundamental importance of a mother's role, for example, in caring for and training young children and in maintaining stable and independent family units.

We urge the Committee to reject these two provisions.

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, D.C., September 15, 1967.

Hon. RUSSELL B. LONG,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Because of prior commitments, I am unable to appear before your Committee to present my views on a subject of the greatest importance to California and the nation. I refer to the need of extending medicare's hospital coverage to certain state and local employees. I have co-sponsored a proposal, S. 1071, also introduced as amendment #206 to H.R. 12080, which would provide for this additional coverage. Enclosed is a statement in support of this proposal. I respectfully request that it be placed in the record of hearings on H.R. 12080.

With kindest regards,

Sincerely yours,

THOMAS H. KUCHEL.

STATEMENT BY U.S. SENATOR THOMAS H. KUCHEL IN SUPPORT OF MEDICARE FOR STATE AND LOCAL EMPLOYEES

Mr. Chairman, I wish to address the members of the Finance Committee with regard to the need of allowing states, under Federal-State agreements, to provide hospital coverage under medicare for certain state and local employees whose services are not otherwise covered by Social Security. S. 1071, a proposal which I have co-sponsored and which was introduced by the distinguished Senator from Connecticut, Abraham Ribicoff, seeks to meet this need and end a severe inequity under our medicare laws.

On July 1, 1966, hospitalization coverage under medicare began for nearly 20 million Americans age 65 or over. Those who reach the age of 65 before 1968 will be similarly covered, whether they are eligible for Social Security retirement benefits or not. But, after January 1, 1968, a person must be covered by the Social Security retirement system to be eligible for medicare hospitalization insurance. Although generally equitable, these requirements create a severe problem for employees of state and local governments; a problem hopefully answered by the provisions of S. 1071.

As of January 1965, approximately 2.6 million positions in state and local employment were not covered by Social Security. The individuals in these positions will not be eligible for hospitalization insurance provisions of medicare unless they have attained Social Security coverage in other employment. These are employees who are not covered by Federal-State agreements bringing them under Social Security. In most cases, they are covered by their own form of retirement systems. These public employees, although members of state or local retirement systems, do not have programs similar to the hospital insurance program available to them. Many are willing to pay for such insurance, but under present law, are precluded from doing so unless the state brings them under the Social Security retirement system as well.

Among those public employees excluded from medicare's hospital coverage are over 689,000 public school teachers across the nation. These are teachers who have devoted their lives to educating the children of this nation; teachers located in a dozen states across the nation which have excellent retirement systems not related to Social Security. As a consequence, these dedicated servants will be excluded from medicare's hospital insurance.

In my own State of California, over 160,000 teachers are among the thousands of instructional personnel in the nation who will be denied the benefits of medicare unless the Social Security Act is amended to permit them and their employers to contribute to and receive the advantages of a separately financed insurance program. The reason for this is because California retirement and survivorship benefits are provided by a State Teachers Retirement System rather than by Social Security and the existing law makes no provisions for them to qualify for the coverage available to nearly 20 million citizens over age 65.

The bill which I have co-sponsored and which is now before you as amendment #296 to H.R. 12080, the Amendments to the Social Security Act, will provide that those state and local employees not now included under an agreement providing Social Security coverage may be covered by hospital insurance. They may elect to participate in the hospital insurance program as long as they pay their own way. The agreement provisions under which a state may make hospital insurance available in the referendum provisions to accomplish coverage are similar to those now in effect for Social Security retirement coverage of state and local employees. A majority of the employees in the coverage in question must vote for these benefits. The bill covers only those employee groups which may currently be subject to Federal-State agreements.

The employees and their employers will pay for the coverage of hospital insurance according to the schedule now set out in the law. Thus, these employees will be paying their own way and will not in any sense be getting a free ride. They and their employers will contribute to this fund. The payments would go into a separately established hospital insurance trust fund.

The enactment of this legislation will bring another large group of Americans under the protective provisions of the hospitalization insurance program. I respectfully request, therefore, that the distinguished members of your Committee give this proposal their close and favorable consideration. The enactment of such a program would be beneficial to medicare, to the deserving state and local employees, and to the health and welfare of the United States.

PREPARED STATEMENT OF THE NATIONAL COUNCIL OF JEWISH WOMEN, INC., NEW YORK, N.Y., SUBMITTED BY MRS. LEONARD H. WEINER, NATIONAL PRESIDENT

The National Council of Jewish Women, established in 1893, with a membership of over 100,000 members in local units throughout the United States, has pioneered in services to children and senior citizens, and has always strongly supported programs for such services.

When H.R. 5710 was before the House Ways and Means Committee, the National Council of Jewish Women supported the provisions of the legislation in the belief that it would provide much needed improvements in the various programs under our Social Security System. We are, therefore, deeply concerned and disturbed by some of the provisions of the measure reported by the Committee and subsequently adopted by the House of Representatives. Instead of improving the lot of those who are recipients of, in some instances, pitifully inadequate assistance, the measure, if it should become law, may rob them of this assistance altogether.

The drastic changes proposed under the Public Assistance title are contrary to a long-standing position of the National Council of Jewish Women of supporting "procedures which uphold the rights and dignity of recipients of welfare services." There is a serious question in our mind whether the dignity of an individual is upheld if he or she is forced to accept or keep a job as a condition of assistance, or the rights of a mother are upheld when she is forced to abandon her freedom of choice of caring for her children, or in some instances deprived of their custody.

Much has been said and written about family deterioration as one of the causes of our social problems. There is much in this pending legislation which will not help strengthen the family, on the contrary some of its harsh and punitive provisions will promote family disintegration, frustration and hopelessness.

The assumption that coercion will place individuals in jobs may prove to be erroneous. Our experience with young people in the Women's Job Corps indicates that a great deal of rehabilitation is required even before job training can be attempted, and even after training is completed there is no assurance that a job will be immediately available. Should the young people be deprived of sustenance and punished for conditions beyond their control?

The limitation of the number of children eligible for assistance adopted by the House as a means of encouraging the states to implement the more positive provisions of the pending bill may also prove to be more of a punishment of the children than an achievement of the desired goal. The "freeze" as of January 1, 1967, does not take into account the possibility of changing economic conditions in a given state; the in-migration which may occur; or the period of time required to develop the necessary programs for job training, job placement and day care services. The chief victims of this economy move will be the helpless children and society will not be the gainer.

As an organization dedicated to the promotion of the general welfare we are strongly in support of the provisions in the pending bill which increase Federal financing for family counselling, day care, family planning, foster care, protective child welfare services, and other needed programs for the training of personnel, and the provision for an incentive exemption of earned income. However, it is discouraging to find that the House Committee report places all the emphasis on the reduction of expenditures rather than on helping the people improve the quality of their life. At a time when such formidable efforts are being made to restore dignity and a sense of worth to the people in poverty, the attitude expressed in the House Committee report is not likely to support this effort.

The action taken by the House of Representatives in reducing even the modest increase in social security payments proposed in H.R. 5710 was very disappointing. The National Council of Jewish Women was one of the very early supporters of the Social Security System and a vigorous supporter of medicare. Because of the various services we sponsor for older Americans our members have personal knowledge of the plight of the older persons, whose sole income is the very inadequate social security payment. Our experience indicates that the present level of social security payments is not commensurate with the cost of living, our standard of living, and our concept of life with dignity.

In recognition of the inadequacy of income of social security recipients many of our local Sections sponsor employment programs for senior citizens. This program helped us to acquire an intimate knowledge of the precariousness of the economic status of these individuals. We will cite a couple of examples of workers of the Workshop for Senior Citizens sponsored by the New York Section of the National Council of Jewish Women.

Mrs. M. a 69 year old widow, born in Puerto Rico, lives alone. She worked as a laundress for 20 years and her only source of income at present is her Social Security payment of $70.40 per month, and the $40 per month she earns at the workshop. Mrs. M's only relative is her son who has been at the Manhattan State Hospital for 15 years. She visits him regularly once a week, and occasionally brings him home for holidays. She finds it extremely difficult to pay the carfare for these trips, and when she is obliged to buy her son clothing and small necessities, she frequently has to do without food and clothing for herself.

Mrs. O., 67 years old, lives alone in one room at a rental of $15 per week. She shares a bathroom and kitchenette with others on the floor. Her income of $32.30 per month in Social Security and the $40 per month she earns at the workshop are her only regular source of income. An 80 year old brother, who lives with his wife in Florida, occasionally sends her a little money, but because of a strained relationship, Mrs. O. is terrified at the prospect of this source of help being cut off. She is aware of the opportunity of securing public assistance, but coming from a background of moderate circumstances, she shares the middle class abhorrence of the humiliation of receiving public relief funds. Her economic plight caused her to develop hypertension and she lives in a state of fear and apprehension.

Both these individuals have an annual income of $1432.80 and $745.30 respectively. These incomes fall far short of even the accepted poverty level and emphasizes the miserable conditions under which these people subsist.

This country is engaged in a war on poverty and we are spending millions of dollars to help large groups in our population lift themselves out of poverty. A substantial increase in social security payments is probably the most effective way of advancing the economic status of millions of our senior citizens, and offer them an opportunity to lead a life with at least a minimum of dignity.

We hope that the Committee will weigh very carefully the consequences that might flow from some of the very harsh and punitive provisions of H.R. 12080, and adopt the modest improvements of the Public Assistance Program proposed in H.R. 5710. We also urge the Committee to give very serious consideration to a more realistic increase in social security payments so as to help older Americans enjoy the privileges to which a citizen of the most affluent country in the world is entitled.

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.,
Flint, Mich., September 20, 1967.

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

DEAR SENATOR LONG: The Flint Chapter of the National Association of Social Workers representing more than 80 workers of Genesee, Lapeer and Shiawassee counties wishes to engage your support and concern in the revision of the coercive and restrictive provisions of H.R. 12080 as it was recently passed in the House and now stands before the Senate Finance Committee.

In support of needed revisions, we enclose a brief position statement thereon, as prepared by our Committee on Social Policy and Action. This represents our analysis of the bill and its implications, as it now stands for Public Welfare in our three counties.

We hope that you are supporting this bill but we urge you to consider the changes we think are vital to the people of the State of Michigan.

Respectfully yours,

MURRAY M. EISEN, ACSW, *President.*

FLINT, MICH., CHAPTER OF NATIONAL ASSOCIATION OF SOCIAL WORK POSITION STATEMENT ON H.R. 12080

Translated into action on the local level, H.R. 12080 would, in effect, reverse the service emphasis of the 1962 Amendments. If, in effect, the purpose of its restrictive provisions is to reduce the welfare burden, then it is a self-defeating bill, with built-in provisions for failure. Coercion through reduction of assistance has been proven time and again to be ineffective as a method of rehabilitating family strength. The skilled social worker whose efforts must be devoted to policing eligibility requirements is rendered totally ineffective as an agent of rehabilitation.

Locally, the "freeze" on AFDC families as of January, 1967, would throw approximately 500 families of Genesee County alone, on the limited Direct Relief resources of the county. Conservatively, this would cost this county upwards of $1,000,000.00 yearly in local tax appropriations. Multiplied to include other counties in the state, it is apparent that our Federal-State-County fiscal balance in Michigan would—immediately following this year's perilously achieved fiscal reform measure—again place our economic structure in jeopardy. The alternative would be to reduce a large segment of our population to virtual starvation, an unthinkable situation in our affluent society.

The segment of population most affected by these punitive provisions, would be that portion of our society already suffering from severe deprivation.

This Chapter does recognize the importance of the expansion of the community work and training provisions of the bill with its many good features. We do urge, however, that the proposal of the Administration, transferring this program to the Department of Labor, be supported to effect better operations and the development of public service employment programs. We must, however, urge that the basic right of a mother to stay at home to rear her children, be preserved. The mental health of future generations of citizens dictates that children have basic needs for care given by their natural parents in their own homes. A mother of several children cannot provide full time mothering after an eight hour day. Foster care and day care costs are so expensive as to effectively reverse the economic gains of the employed mother.

This Chapter would further like to urge support at this time of an increase in social security benefits by twenty percent with $100.00 per month minimum for individuals and $150.00 minimum for couples, per month. This provision would be a key for moving the OASDI beneficiary from old age assistance. It does not seem necessary here to expand the positive features of this change.

We would further propose that this Bill include the disabled in Medicare as originally proposed by the administration, rather than study the situation, as the Bill currently provides.

STATEMENT OF THE MEDICAL ASSOCIATION OF GEORGIA, SUBMITTED BY J. FRANK WALKER, M.D., CHAIRMAN, MAG COMMITTEE ON NATIONAL LEGISLATION

Mr. Chairman, I appreciate this opportunity to submit a statement on behalf of the Medical Association of Georgia on H.R. 12080, the "Social Security Amendments of 1967." We are mindful of the crucial decisions and thoughtful deliberations incumbent upon this Committee in seeking to formulate legislation that will truly be in the best interest of the health and well being of all the people. This statement is submitted in the interest of assisting the Committee in this important function.

In a broad sense, the Medical Association of Georgia supports H.R. 12080 as it passed the House of Representatives. Notwithstanding our frank and open opposition to the original Act, P.L. 89-97, we enthusiastically support the majority of amendments to this Act as embodied in H.R. 12080. In our view, they represent significant improvements in the basic Medicare and Title XIX law. There are several aspects of H.R. 12080 to which we would like to give our particular support and there are two aspects that cause us great concern. These are:

SECTION 125—(ITEMIZED STATEMENT OF CHARGES)

This Section provides two new options to the present method of payment of a physician's statement of charges. The physician may submit his itemized bill direct to the carrier, in which case the carrier would be authorized to make payment equal to 80 percent of the reasonable charges (provided, of course, that the total charges are judged to be reasonable); or, the patient may submit the physician's itemized bill and be paid 80 percent of the reasonable charge. We believe this will eliminate a hardship for many under the program, and we therefore recommend enactment of this Section of the bill.

SECTION 140—(INCLUSION OF THE DISABLED)

As passed by the House this bill is commendable for something it did not do—that being that it did not extend Medicare (Title XVIII) benefits to the disabled of all ages as had previously been proposed. The original intent of Medicare was to provide a system of health care financing for people in their elder years on the assumption that a big medical or hospital expense at age 65 or beyond would pose a financial crisis from which they might never recover. Arbitrary inclusion of selected beneficiaries of all ages under Title XVIII would, in our opinion, subvert the intent of the original Act from a program designed for older people to one designed for people in selected categories of all ages. We believe that the House acted wisely by not including the disabled under the provisions of Medicare. We further believe that Title XIX should be utilized to assist the disabled.

We recommend enactment of Section 140 with the additional provision that the Council appointed by this Section to study the matter give careful consideration to the use of Title XIX as a source of available assistance to the disabled.

SECTION 141—(INCLUSION OF ADDITIONAL LICENSED PRACTITIONERS)

Section 141, directing the Secretary of Health, Education and Welfare to conduct studies to determine the need for the services of additional licensed practitioners under Part B of the program, causes us some concern. We do not oppose a study of any aspect of the Medicare program per se. Rather our concern results from considerable publicity given to the view that such study and subsequent report may expand the program to include as providers of service those limited license practitioners whose inadequate training and unscientific approach to medical practice may, in fact, do great harm to those in need of competent medical care.

Most specifically we are concerned over the possible expansion of the program to include the services of chiropractic. In the view of the medical profession chiropractic represents cultism in one of its most flagrant forms. The dogma of its irrational tenets actually resist scientific advances in the diagnosis and treatment of human disease. As a healing art it constitutes a hazard to good health care in the United States and should be resisted on the basis of its own lack of merit.

Accordingly, we recommend that the Committee reject any suggestion that chiropractors be included as providers of service under Medicare or Title XIX.

DRUG STANDARDS

The Medical Association of Georgia recently had occasion to file with the Monopoly Subcommittee of the Senate Select Committee on Small Business a statement setting forth its position on the question of compulsory generic prescribing of drugs; a question also before this committee in the form of an amendment to H.R. 12080. This statement read in part:

"The Medical Association of Georgia opposes compulsory prescribing of drugs by their generic name. It believes instead that the physician should be permitted to retain his traditional freedom in the selection of those medications known by him to produce the desired response in the patients under his care. To impose a system that circumscribes his best medical judgement would be a disservice to the patients. To suggest that the therapeutic effectiveness of a generic drug is necessarily equal to that of a brand drug, carefully selected for a particular patient, is to suggest that there are no distinguishing differences among patients.

The controversy over generic versus brand name drugs certainly should not be resolved on the basis of cost alone. To do so, one must first accept, in good conscience, the principle that brand name drugs have an absolute generic equivalent capable of achieving the same results. However, there is a glowing lack of scientific evidence to support such a contention. There is, in fact, considerable evidence to suggest that a marked difference exists even among generic drugs produced by different manufacturers.

In treating an ill or injured patient the physician must be able to maintain absolute control over the drugs prescribed. This is particularly true with regard to quality. In the instance of successive refills the physician would have no control unless a given drug were supplied by the same manufacturer and possessed the same varibles—coating, solubility, disintergration time, base—with each batch supplied to the pharmacist. We submit that this is possible only with brand name drugs; and is not and could not be possible in a generic drug supplied by several different manufacturers.

The Medical Association of Georgia adopted a resolution expressing its concern over the possible enactment of the compulsory generic principle in December 1966. At the time it viewed Title XVIII and Title XIX of the Social Security Act as the most probable avenues by which this principle might become established in Federal law. The Resolution is explicit in its opposition to this principle either in the Social Security Act or in any other civilian program in current operation or which may be forthcoming. We submit it for your thoughtful consideration."

RESOLUTION

Whereas, federal legislation to amend Title XVIII of the Social Security Act to require filling of prescriptions on a compulsory generic basis is an eminent possibility in the 90th Congress; and

Whereas, the establishment of any system, either by statute or regulation, to compel the pharmacists to substitute generic equivalents for brand name prescriptions would circumscribe the physician's choice of drugs and restrict the exercise of his best medical judgement; and

Whereas, the enactment of such legislation applicable to Title XVIII would be in obvious conflict with the intent of Congress as expressed in Section 1801 of Title XVIII; and

Whereas, prescription by compulsory generic formula makes the cost of drugs a higher priority consideration than the quality of drugs, which is unfair to the physician and potentially dangerous to the patient; and

Whereas, the enactment of such legislation would inevitably lead to the extension of this principle to other federal health programs: Now therefore be it

Resolved, That the Medical Association of Georgia does hereby go on record expressing its vigorous opposition to the enactment of legislation establishing the principle of compulsory generic prescribing or filling of drugs under Title XVIII or XIX or any government civilian program in current operation or which may be forthcoming.

We recommend therefore that the Committee not establish this principle in law nor permit it by regulation prior to an exhaustive study of all the factors, economic and therapeutic, which bear on this important question.

In conclusion we would like to say that the Medical Association of Georgia has reviewed the testimony presented to this Committee by the American Medical Association and concurs with it throughout. We have examined carefully to determine its impact at the local level and accordingly wish to give it our full support and endorsement.

STATEMENT OF DR. C. D. ROHLFFS, PRESIDENT OF UNITED BUSINESS SCHOOLS ASSOCIATION

Mr. Chairman and members of the committee, my name is C. D. Rohlffs. I am President of Nettleton Commercial College of Sioux Falls, South Dakota. For more than 35 years I have been associated with business education including service as a Commissioner on The Accrediting Commission for Business Schools.

I am presently serving as President of the *United Business Schools Association* which is the one association of educational institutions in which nearly 500 of the quality business schools and colleges of the Nation hold membership. Approximately 90% of these institutions are proprietary (i.e., "profit making"). The roots of UBSA go back more than half a century to 1912. However, many member institutions have been serving students for more than 100 years.

UBSA itself is an affiliate of the American Council on Education. At least one administrator in every UBSA school is a member of the American Vocational Association.

Also by way of background, the *Accrediting Commission for Business Schools;* a professionally independent body was founded in 1953 by UBSA. It was designated in 1956 pursuant to Chapter 33, Title 38, U.S. Code, and subsequent legislation as a "nationally recognized accrediting agency" by the U.S. Office of Education. In that capacity it has accredited more than 300 independent educational institutions after careful review and inspection.

STATEMENT OF POSITION

Our special interest in H.R. 12080 concerns the training programs authorized by the Public Welfare Amendments of Title II. The success of these training programs is directly related to the authority under the bill to utilize all available educational institutions and facilities to carry out the intent of the measure.

Our reading and understanding of the bill indicates that there is an adequacy of language to permit utilization of private profit-making business schools under contract in carrying out the purposes of the act. This interpretation of either version of the proposed Community Work and Training Program (i.e., H.R. 12080 or H.R. 5710) is supported by direct responses from both the Secretary of Health, Education, and Welfare and the Secretary of Labor to questions propounded by the Committee.

Confirmation of this interpretation is not surprising because of the host of other Federal training programs which utilize private proprietary (i.e., profit making and taxpaying) business schools under contract. There is a 47 year history of successful participation by these schools in the Vocational Rehabilitation Act. More recently the schools commenced contributing to the success of the Manpower Development and Training Act with increasing significance.

Some of the Federal training programs which authorize the use of proprietary schools under contract include:

1. *Vocational Rehabilitation Act* of June 2, 1920, as amended 29 U.S.C. 31 *et seq.*
2. *Manpower Development and Training Act of 1962;* as amended 42 U.S.C. 2571; P.L. 89–792.
3. *Indian Adult Vocational Education*; 25 U.S.C. 309, 452, 823(c)
4. *Economic Opportunity Act of 1964*, as amended, 42 U.S.C. 2701 *et seq.*; P.L. 89–794
5. *Government Employee's Training Program;* (P.L. 89–554) 5 U.S.C. 4101–4118
6. *Economic Development Administration* (P.L. 89–15) 42 U.S.C. 2583
7. *Veterans' Vocational Rehabilitation*, 38 U.S.C. 1501–1511
8. *Vocational Education Act of 1963;* P.L. 88–210 Sec. 8(1)

ALL RESOURCES NEEDED

The need to utilize every resource has been forcefully pointed out by Dr. Walter M. Arnold, Assistant Commissioner for Vocational and Technical education of the U.S. Office of Education who, in response to a question about the present state of inadequate facilities in vocational education, said:

> "* * * *I think you could say safely that if we utilized every resource in this country to its maximum, we wouldn't meet the needs in all these programs, and for all kinds of persons in the country, at different levels of schooling.*"[1]

INDIVIDUALIZED TRAINING AND COUNSELING NECESSARY

The proposed expansion of the Sec. 409 Community Work and Training Programs in H.R. 12080 calls for training which necessarily is of a somewhat individualized type because of the special problems of the trainees. The private business school has a successful history of conducting training programs for this type of individual. This is equally true for the counselor oriented Vocational Rehabilitation program and for the MDTA approach which uses both group training and the individual referral method.

To illustrate what is being accomplished in *other Federal-State vocational training programs* through the utilization of independent proprietary business schools "under contract," the below listed items are attached as exhibits:

Exhibit "A": Letter from the Oklahoma Rehabilitation Division dated September 12, 1966, detailing "the very fine working relationship with the private business schools." This is only one of some thirty letters from State Directors.

Exhibit "B": "Partnership In Training" by A. Lauren Rhude, *Employment Service Review*, May, 1966, USES–US Department of Labor. The story of MDTA trainees in a business school.

Exhibit "C": "The Climb to Rehabilitation" by Nancy Osgood, *St. Petersburg Times*, Thursday, May 5, 1966. The story of the vocational rehabilitation of a working mother in a business school.

Exhibit "D": "Computer Course Is Set Up For Blind" by Don Robinson, *The Washington Post*, Sunday, November 20, 1966. The story of training blind people for computer careers in a computer school.

Exhibit "E": "Mothers On Welfare Get Job Training" by Carol Honsa, *The Washington Post*, Tuesday, December 6, 1966. The story of job training for mothers who receive Aid to Families with Dependent Children (AFDC) through programs in local business schools.

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[1] Hearings before the General Subcommittee on Education of the Committee on Education and Labor, House of Representatives (89th Congress, 2d Session). Vocational Education Amendments of 1966, H.R. 1544 and H.R. 1545, June, 1966, at page 42.

Exhibit "F": Excerpt from a research report of the Stanford Research Institute under U. S. Office of Education Contract no. OE-5-85-068 detailing "Proprietary School Operations."

Exhibit "G": Article by Mary E. Switzer, Administrator of Social and Rehabilitation Service, HEW, entitled "Training Handicapped Students For Office Careers" from the *Balance Sheet*, October, 1964, pp. 62-63. The article points out how "men and women with handicaps can be expected to continue to go to business schools for training."

(The exhibits referred to above are made a part of the official files of the Committee.)

The AFDC story entitled, "Mothers on Welfare Get Job Training," of Exhibit "E" is particularly pertinent. What is now being done successfully in private business schools on a demonstration basis can be expanded and made permanent through the proposals of either H.R. 12080 or H.R. 5710.

These are just some of the exciting, innovative and successful programs now being conducted in independent business schools with joint Federal-State funds in other vocational programs.

1966 MANPOWER REPORTS OF HEW AND LABOR SECRETARIES

The Secretary of HEW in his 1966 Fourth Annual Report to Congress on MDTA noted the growth in the use of nonpublic facilities of Manpower training programs. The number of trainees in private schools increased from 948 in FY 1963 to 7,660 in FY 1965.

"The amendments of 1965 authorize a wider use of private facilities 'where such private institutions can provide equipment or services not available in public institutions, particularly for training in technical and subprofessional occupations, or where such institutions can, at reasonable cost, (1) provide substantially equivalent training, or (2) make possible an expanded use of the individual referral method, or (3) aid in reducing more quickly unemployment or current and prospective Manpower shortages.'" (p. 14)

In like manner, the 1966 Report of the Secretary of Labor on Manpower Research and Training under the MDTA repeatedly refers to the *wider use of private schools* for institutional training (page 170); for increased use of the *individual referral* method (page 162); and as a factor in *cost reduction* (page 58).

"The individual referral process was an early administrative measure designed to broaden training opportunities by supplementing class-group training programs through fuller use of existing facilities and to provide training on an individual basis for those for whom training in a class-group is impractical. The measure has been given full support by the Congress in the newly amended mandate of the MDTA directing an expansion in the use of the individual referral process. A relaxation of the provision for use of private training institutions also supports increased use of the individual referral process." (p. 161)

CONCLUSION

The proposed amendments to the Community Work and Training Program which will permit Federal financial participation in the costs of training when the State or local agency enters into agreements with employers, agencies and private proprietary schools are well founded on experience already gained in such other programs as Vocational Rehabilitation, MDTA and Title V of the Economic Opportunity Act.

The need for constant revision of organizational arrangements was pointed out by Secretary of Health, Education and Welfare, the Honorable John W. Gardner in his book, *Goals for Americans*, where he said at page 88:

"All the organizational arrangements, all the methods and procedures that characterize American education today were originally devised to help us accomplish our purposes. If they no longer help us, we must revise them. The arrangements and methods must serve us and not control us."

It is our position that the language of Title II authorizes the use of private proprietary schools under contract to carry out training programs. In support of this position we rely upon:

1. The same interpretation by both the Secretary of HEW and the Secretary of Labor,
2. The public policy which is manifest in the other training programs enumerated and discussed herein, and,
3. The successful results already obtained in such other long established training programs and under demonstration AFDC training programs.

No single concept, viewpoint or type of institution should have a monopoly on how best a Federal-State training program should be administered or structured. The training proposals of H.R. 12080 or H.R. 5710 offer a diversity of opportunity for the continual testing of the efficacy of innovative and imaginative approaches combined with an efficient implemention of proven methods.

I thank the Committee for the opportunity to express my views.

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION OF THE UNITED STATES, BY DR. JOHN M. LUMLEY, DIRECTOR OF THE DIVISION OF FEDERAL RELATIONS, IN SUPPORT OF AMENDMENT NO. 206 TO H.R. 12080

Because of the automatic coverage under Social Security of most employees throughout the United States, many people are surprised to learn that this coverage is not extended automatically to employees of state and local governmental units. Social Security calls for a tax upon both employee and employer. At the time of the original enactment of the Social Security law, Congress did not want to levy a tax upon local or state governments and so it excluded employees of such political units from automatic coverage. Subsequently the Congress has seen fit to remedy this situation by offering the opportunity for the employees of these units to affiliate with Social Security on the basis of the majority vote of those so employed. Public employees in thirteen states have chosen not to take advantage of this provision because they feared consequent weakening in retirement systems already in operation. These states are California, Colorado, Connecticut, Florida, Illinois, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Nevada, Ohio, and Rhode Island. Approximately 1,850,000 public employees are involved of which number about 700,000 are instructional personnel in the public schools. It is for this latter group primarily that we speak.

Although they have chosen not to take advantage of the Social Security system, the public employees enumerated in the preceding paragraph believe that they should not thereby be foreclosed from participation in the "Medicare" program. They are willing to pay the same fees for this protection as they would be called upon to pay if the assessment was being handled through Social Security deductions from their compensation. The thirteen states concerned would have to pass enabling legislation to permit this to be done and a plebiscite of the employees concerned would have to be held, but no difficulty is anticipated with regard to either of these aspects of the matter. Some states have enacted enabling legislation already.

The National Education Association therefore urges that the Senate Finance Committee add Amendment No. 206, introduced by Sen. Abraham Ribicoff on August 30, to H.R. 12080, the Social Security Act of 1967, now before it for consideration. This would enable employees of state and local governmental units to contribute directly to their coverage under "Medicare" without joining the Social Security system. The text of this amendment is identical with that of S. 1071, introduced by Sen. Ribicoff February 24, 1967, which the Association supports.

Your attention is directed to the statements of the California Teachers Association, the Connecticut Education Association, the Maine Teachers Association and the Massachusetts Teachers Association in support of Amendment No. 206 to H.R. 12080 which are attached hereto.

(The statement of the California Teachers Association appears at p. 1511.)

STATEMENT OF THE CONNECTICUT EDUCATION ASSOCIATION BEFORE THE SENATE FINANCE COMMITTEE ON AMENDMENT 206 TO H.R. 12080—PRESENTED BY WILFRED J. SHEEHAN, EXECUTIVE SECRETARY, CONNECTICUT EDUCATION ASSOCIATION

My name is Wilfred J. Sheehan, Executive Secretary of the Connecticut Education Association, and I speak in behalf of the Association and its 20,000 members in support of S. 1071 (Amendment No. 206 to H.R. 12080).

The teachers in Connecticut are privileged to have an excellent retirement plan, which also includes provisions for a survivorship and dependency program. Our retirement plan provides the benefits and protections necessary to guarantee the security required to have a teacher function well on the job. However, the one thing lacking is protection from the ever-rising medical bills faced by many soon after retirement.

Members of the Committee, purely and simply, we need the protection afforded to others through enactment of the Medicare provisions added to Social Security. The teachers in Connecticut have not chosen to be covered by Social Security in its entirety. They have elected to improve their own state retirement system rather than elect the choice of some type of integrated plan which would have eroded our system.

Economics and reality dictate the folly of any move to initiate a "Medicare" system on the state level. Our choice now is the proverbial Hobson's Choice, and the Committee has before it a reasonable and acceptable alternative, a provision whereby public employees in non-covered employment can be covered by the Medicare portion of Social Security. This, again purely and simply, solves the problems and needs of our teachers.

We have not been inactive at the state level. The 1967 Connecticut General Assembly has enacted enabling legislation in anticipation of favorable action at the federal level. This state action has been greeted with enthusiasm by our Connecticut teachers and now they are looking to you to provide the final remedy.

We support S. 1071 wholeheartedly and urge your immediate favorable report.

Thank you.

STATEMENT OF DR. JOHN H. MARVIN, EXECUTIVE SECRETARY OF THE MAINE TEACHERS ASSOCIATION IN SUPPORT OF AMENDMENT 206 TO H.R. 12080

I am John Marvin, Executive Secretary of the Maine Teachers Association, testifying in behalf of the MTA, an organization with slightly over 10,000 members and providing with this statement the full endorsement of the Maine State Employees' Association, an organization composed of over 8,500 state employees.

Somewhat more than 19,000 Maine state employees and public school teachers now participate in the Maine State Retirement System. This is a retirement plan that has quite generally operated to the satisfaction of the participants although constant efforts are being made to add improvements.

Repeated studies have been made over the course of the years about whether Maine state employees and teachers ought to go into the Social Security program. For the vast majority of teachers and state employees in Maine, to abandon the state program would be quite disadvantageous. The benefits from the state program exceed those available from Social Security. A detailed comparison of the Maine State Retirement Program with Social Security involves accounting for a large number of comparative factors, but in total the factors tend to work out in favor of the state program in terms of dollar cost and benefits. Certainly Maine teachers for the most part are not sufficiently well paid to be able to afford investing more than 10 percent of their salaries in a combination of the two programs.

Many of Maine's teachers are approaching retirement. Within 10 years half of the elementary teachers in the state will reach retirement age. For the most part those older teachers represent a large group that has endured for years inadequate and substandard salaries.

There is overwhelming sentiment among teachers and state employees in Maine in behalf of securing the option to enter the Medicare phase of Social Security on a fiscally sound basis. Maine does not ask that the Federal government subsidize these people, but simply that they be accorded the same privileges enjoyed by most other citizens.

The Maine legislature has accepted the principle in the form of five unanimous readings of enabling legislation for state employees and teachers to participate in the Medicare program if Congress passes the needed legislation. This bill has only to receive an appropriation at this time along with several other worthwhile programs. These will all be held up until the present fiscal crisis in state government financing is surmounted, but the initial action of the Legislature is indicative of the general public support for the position that those participating in state government retirement plans should be allowed to secure Medicare passage.

I am a relatively young executive secretary primarily interested in problems of moving the profession ahead. Retirement legislation is of secondary interest, but I have learned in recent months the tremendous impact that this amendment will have on the lives of a lot of citizens who have worked hard in behalf of education, the community, and the state. I am well able at this time to testify to the critical importance that this amendment plays in the lives of many who are attempting to plan retirement programs on extremely limited benefits.

Each month of delay in enacting this amendment will cause untold problems for many not now covered by Medicare. I hope that this legislation will receive favorable consideration from the Senate and untimately the full Congress.

MASSACHUSETTS TEACHERS ASSOCIATION,
Boston, Mass.

From: Executive Secretary William H. Hebert.
To: The Congress of the United States.
Subject: Medicare for teachers.

The Massachusetts Teachers Association wholeheartedly supports the proposal recommended by Senator Abraham Ribicoff of Connecticut, which would allow teachers in states not covered under the Social Security Act to purchase coverage under Medicare. Our Association has consistently supported the position that teachers in these states should be able to purchase said coverage without the necessity of being enrolled in the total Social Security program.

Massachusetts is one of the thirteen states affected by this bill. We have approximately 53,000 public school teachers in the Commonwealth of Massachusetts, and this Association represents these teachers in expressing this point of view.

The teachers of the Comomnwealth of Massachusetts are members of a contributory retirement system under which they contribute five per cent of gross annual income towards the support of the retirement plan. It is an excellent retirement system, and public employees as well as the State Legislature have consistently supported improvements in this plan. However, there is no possible way that teachers and other public employees in Massachusetts may take advantage of the coverage offered by Medicare without the enactment of the Ribicoff bill.

Therefore, on behalf of the Massachusetts Teachers Association, we urge the Congress to enact the above-mentioned bills so that the teachers and public employees throughout the nation may have the opportunity to participate in this excellent program.

Sincerely yours,

WILLIAM H. HEBERT, *Executive Secretary.*

THE STATE OF WISCONSIN,
COUNCIL FOR HOME AND FAMILY,
Madison, Wis., August 30, 1967.

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

DEAR SENATOR LONG: We understand that bill H.R. 12080 relating to Social Security Act amendments is presently in your committee and that you are holding hearings on this measure. You might be interested to know that the state of Wisconsin legislature at the recommendation of the state Council for Home and Family has adopted Senate Joint Resolution 9, copy of which is attached.

As far as we know, the problem of runaway fathers is not included in the above mentioned bill which was passed by the House of Representatives and we believe that this is a subejct that should be dealt with. On this point the 1967 Wisconsin legislature at the urging of our new state agency passed the above mentioned resolution asking that child abandonment be made a federal crime so that abandoning fathers could be more readily apprehended and made to support the legitimate or illegitimate children that they have brought into the world.

I am the chairman of the Council for Home and Family's consulting Committee on Enforcement of Support in Divorce Judgments and the above mentioned resolution originated in this committee. Our committee met again yesterday on this subject and directed me to ask whether one of the judicial representatives affiliated with our council could be afforded the opportunity to testify before your committee on this subject. We would like to leave no stone unturned to ask the United States Senate to incorporate the two objectives of the attached resolution in the revised version of H.R. 12080 which will be recommended by your committee.

Any accommodation which you might see fit to accord us in this matter will be greatly appreciated.

I am sending copy of this letter to our two Wisconsin senators, the Honorable William E. Proxmire and the Honorable Gaylord A. Nelson and also to Congressmen John W. Byrnes of Green Bay and Clement J. Zablocki of Milwaukee to ask for any possible support that they may be able to offer. I am also sending a copy of this letter to Wisconsin state Senator Allen J. Busby, chairman of the home and family council.

Very truly yours,

CLARENCE G. TRAEGER,
Dodge County Judge, Chairman of Support Enforcement Committee.

THE STATE OF WISCONSIN, 1967 SENATE JOINT RESOLUTION 9

ENROLLED JOINT RESOLUTION

Memorializing the Congress of the United States to amend the social security act in Title 42 of the United States Code so as to authorize release of needed information for inforcement of child support, and to enact a federal law against child abandonment.

Whereas, an appalling number of children are currently deprived of adequate living conditions due to the failure of their fathers to fulfill the obligation of their support; and

Whereas, family courts and county law enforcement officers do not presently have adequate means for tracing runaway fathers who have left the state where their children reside in an effort to avoid their legal obligation of child support; and

Whereas, social security records are a source through which the new locations and occupations of these runaway fathers can often be disclosed; and

Whereas, such records are now made available to county welfare departments only where the abandoned families are public assistance recipients, but are otherwise unavailable to family courts and county law enforcement officers primarily concerned with enforcing the obligation of family support; Now, therefore, be it

Resolved by the senate, the assembly concurring, That the legislature memorializes the Congress of the United States to amend the social security act so that information relating to the most recent address and place of employment of a missing parent who is under an obligation to support any minor child may be made available directly to the appropriate divorce or family courts and county law enforcement officers in the state where such child resides, upon written request therefor by any of them, to assist them in enforcing the obligation of support for such child; and, be it further

Resolved, That the legislature also urges the Congress to attack this problem, which causes grave social and economic repercussions, by the enactment of a law making it a federal crime for any person to cross a state line to avoid supporting his minor child or after having abandoned said child in order that federal law enforcement authorities can assist in apprehending any such person; and, be it further

Resolved, That copies of this resolution be transmitted to the Attorney General of the United States, the Director of the Federal Bureau of Investigation, the Director of the Family Services Division of the United States Department of Health, Education and Welfare and to the members of the United States Senate and House of Representatives from Wisconsin, Minnesota, Iowa, Illinois, Michigan, Indiana and Ohio, as well as to the presiding officer of each house of the legislatures of such states other than Wisconsin.

WILLIAM P. NUGENT,
Senate Chief Clerk.
HAROLD V. FROEHLICH,
Speaker of the Assembly.

THE STATE OF WISCONSIN,
COUNCIL FOR HOME AND FAMILY,
Madison, Wis., September 19, 1967.

Re Bill H.R. 12080, Social Security Amendments.

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

DEAR SENATOR LONG: Thank you for your letter of September 11th in which you indicate concurrence in that provision of Wisconsin Senate Joint Resolution 9 which relates to social security information availablity in tracing runaway fathers.

You also mentioned that you are having an amendment prepared to ferret out runaway fathers and collect an amount from them through the federal tax laws.

One other fact. We note that on page 6 of the committee print entitled "Summary of Provisions of H.R. 12080 The Social Security Amendments of 1967" it is stated: "Upon request, the Social Security Administration would furnish an appropriate court with the most recent address of a deserting father if the court wishes the information in connection with a support or maintenance order for a child." We would respectfully recommend that law enforcement officials be included in the provision mentioned. In this connection we would also urge you to give consideration to a further amendment patterned after Senator Ervin's bill, S. 2160 which would make it a federal crime for a man to cross state lines to abandon his children or his wife.

We appreciate your including my letter of August 30th in your hearings. However, we would like to prepare a more extended statement in the name of the Council for Home and Family to be included in the record if this is permissable. We expect to have this statement prepared and sent to you by the end of this week.

Again, thanks for your interest and cooperation in this matter.

Very truly yours,

CLARENCE G. TRAEGER,
Dodge County Judge, Chairman of Support Enforcement Committee.

THE STATE OF WISCONSIN,
COUNCIL FOR HOME AND FAMILY,
Madison, Wis., September 19, 1967.

Re Bill H.R. 12080, relating to Social Security Amendments.

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

DEAR SENATOR LONG: We are submitting herewith for inclusion in the record of your committee hearings on the above bill 30 copies of the attached written statement by our council, which is an agency of the Wisconsin legislature, in support of 1967 Wisconsin Senate Enrolled Joint Resolution 9. As we previously informed you, this resolution urges congress to amend the social security laws to make child abandonment a federal crime where the father fails to support his children and leaves the state of the children's residence. The text of this resolution is printed in the attached written statement.

Thank you kindly for your courtesy and accommodation in this matter.

Very truly yours,

ALLEN J. BUSBY,
State Senator, Council Chairman.
CLARENCE G. TRAEGER,
Dodge County Judge, Chairman of Support Enforcement Committee.

WELFARE COSTS RESULTING FROM DESERTION OF FAMILIES IN WISCONSIN

According to statistics of the Wisconsin State Department of Health and Social Serivces, desertion is one of the major causes of dependency for families receiving Aid to Families with Dependent Children assistance. During the three fiscal years 1963 to 1965, desertion was assigned as the cause of dependency in 15% of all AFDC families in Wisconsin. Of the total number of AFDC grants made during this period, 17.3% of the grants were made to families whose dependency was caused by desertion.

The following figures for recent years indicate the monetary dimensions of the problem in terms of welfare costs attributable to desertion in the state of Wisconsin.

(1) Total amount of grants to families whose dependency was caused by desertion:

1963-64	$3,781,875
1964-65	3,874,935
1965-66	3,951,452

(2) Total number of families receiving AFDC whose dependency was caused by desertion:

1963-64	2,243
1964-65	2,250
1965-66	2,233

(3) Average yearly grant per family, whose dependency was caused by desertion:

1963-64	$2,326.20
1964-65	2,374.80
1965-66	2,473.44

The above figures show the significant financial burden imposed upon the people of Wisconsin as a result of increasing welfare costs caused by family desertion. It has been pointed out that while family desertion is not often considered a major crime requiring urgent remedies, nevertheless, the effects of such desertion on a wife and her children are often devastating. The social, economic and human costs of the problem point up the need for federal legislation that would recognize and attack the criminal nature of desertion and open up new sources of information to aid in the apprehension of runaway parents.

[S. 2160, 90th Cong., first sess.]

A BILL To amend title 18, United States Code, to make a misdemeanor the flight, in interstate or foreign commerce, by any person who is the parent of a minor child or who is a married man, if such person so flees with the intent of evading his legal responsibilities with respect to the support or maintenance of his minor child or of his wife

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) chapter 49 of title 18, United States Code, is amended by adding at the end thereof the following new section:

"§ 1075. Flight by parent or husband to evade legal responsibility of maintenance or support of minor child or wife

"(a) Whoever, being the parent of a child under 18 years of age, or whoever, being a married man, moves or travels in interstate or foreign commerce with the intent of evading any obligation for the maintenance or support of such child of such person or of the wife of such person, which obligation is imposed by the law of the place from which such person flees, shall be fined not more than $1,000, or imprisoned not more than one year, or both.

"(b) Any person, who, at the time he moves or travels in interstate or foreign commerce, is the parent of a child under 18 years of age or is a married man, shall be presumed, for purposes of subsection (a), to have so moved or traveled in such commerce with the intent referred to in subsection (a) if—

"(1) as a result of such person's so moving or traveling in such commerce—

"(A) such person is outside the jurisdiction of the place the laws of which impose the obligation referred to in subsection (a).

"(B) such child, or the wife of such person, as the case may be, remains within the jurisdiction of such place,

"(2) at the time such person so moves or travels in such commerce, such child, or the wife of such person, as the case may be, is in destitute or necessitous circumstances, and

"(3) such person shall have failed, for more than one month after such person leaves the jurisdiction of such place, to notify such child or the wife of such person, as the case may be, of his whereabouts.

The presumption established by this subsection shall be rebuttable."

(b) The analysis of chapter 49 of such title is amended by adding at the end thereof the following:

"1075. Flight by parent or husband to evade legal responsibility of maintenance or support of minor child or wife."

STATE OF NEW YORK,
EXECUTIVE CHAMBER,
Albany, September 14, 1967.

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

DEAR SENATOR LONG: People in New York are deeply concerned with the implications of the Social Security Amendments before your Committee, and I'd like to express my views on the Amendments to you. Therefore, I'm taking the liberty of writing you frankly on the subject.

Parts of H.R. 12080, the Social Security Amendments of 1967, are intolerable because the bill discriminates against thousands of children and because it threatens thousands of the medically needy with the loss of benefits. It is wrong that some children and those who are medically needy should be denied the same opportunities that are available to others.

There are several flaws, as well as good points, in the bill, but its shortcomings are particularly acute on three major problem areas which are not in keeping with New York State's historical humanitarian concern.

First, the section limiting Federal participation in the Medicaid program of medical assistance to the needy would dangerously affect New York State's present program and its ability to provide its residents needed medical care. The program that New York State now has underway has emancipated the medically needy of the State from the fear of financial ruin and tragedy that often occurs with serious illness.

New York State acted in good faith to comply with Federal legislation establishing Medicaid. This legislation required that new Federal funds be used to expand existing State programs. It would be manifestly unfair for the Congress to penalize New York State at this time for complying with the original Federal legislation.

If this bill were to become law, at least ten per cent of those New York State residents who are receiving aid will lose their benefits, and at least ten per cent of those eligible will lose their eligibility. It would result in losses of Federal aid to New York State of at least $20,000,000 the first year, $40,000,000 the second, and $50,000,000 the third year.

A second undesirable part of this bill relates to children of unemployed fathers and permits Federal funds to be expended only for those families where the father has a recent employment history or has exhausted unemployment compensation benefits.

This is a distinct threat to family solidarity. In many cases fathers who lack a recent work history will be forced to desert their families so that the children can be aided. It is also unfair to the unfortunate children whose fathers for one reason or another do not meet the employment criteria specified in the bill. Why should these innocent children be forced to bear the brunt of the penalty!

Finally, a grievous error would be made if there is a freezing of the percentage of Federally aided children in any state based upon January 1967 figures.

Our estimates of the effect of the proposed limits on Federal participation in the Aid to Dependent Children program indicate that 25,000 needy children and their parents would be denied Federal aid by January 1968 if this proposal were to become law. The loss in Federal reimbursement would be approximately $10,000,000 during the last six months of the State's fiscal year. This again is discrimination against children that should not be tolerated.

No situation is without movement and change. How do we know, for example, what difficulties a period of high unemployment might bring, and how many more needy children might be its consequence? I believe that assistance to children under the Aid to Families with Dependent Children program should remain an open-ended appropriation, depending upon the circumstances existing at any given time, as have all welfare programs since their inception in 1935.

This is no time to equivocate with the future of our children, be they without need or be they poor. The times call for a social awareness that mingles compassion with understanding and a desire to rededicate ourselves to the dignity of all individuals, young and old alike.

Sincerely,

NELSON A. ROCKEFELLER.

STATE OF NEW YORK,
EXECUTIVE CHAMBER,
Albany, September 19, 1967.

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

DEAR SENATOR LONG: In my earlier letter dated September fourteenth, I pointed out a number of undesirable features contained in H.R. 12080 which would adversely affect New York State's present program of assistance to the medically needy.

I wish at this time to reiterate my strong support for flexibility in the program by allowing income eligibility for Medicaid to more accurately reflect the sometimes widely varying economic conditions in different parts of a state. The present provision of the Federal legislation, requiring a uniform statewide standard, has proved to be unrealistic. A rigid statewide standard fails to take into account that both health costs and income levels vary vastly in different areas of a state.

Accordingly, I urge your Committee to give favorable consideration to a provision to permit the State to set flexible income eligibility standards.

Sincerely yours,

NELSON A. ROCKEFELLER.

STATEMENT OF MALCOLM L. PETERSON, M.D., CHAIRMAN OF THE PHYSICIANS FORUM, NEW YORK, N.Y.

As Chairman of the Physicians Forum, I am pleased to present its point of view regarding H.R. 12080. I received my medical degree from the University of Washington in Seattle and my post-doctoral training in internal medicine at Philadelphia General Hospital, Barnes Hospital in St. Louis, and the New York Hospital. I am presently Director of the Division of Gastroenterology in the Department of Internal Medicine at Washington University School of Medicine in which capacity I am daily involved in the care of patients and the training of physicians.

The Physicians Forum is a national organization of physicians dedicated to the principle that everyone is entitled to good medical care as a fundamental right. By "good medical care" we mean a single class of medical care available to each citizen without any financial barriers and provided by a team of health workers concerned with rendering total care for the total person. Necessary to such medical care is an adequate supply and efficient utilization of physicians, allied personnel, and health facilities.

At this time of inevitable expansion of government-financed medical care, the Physicians Forum believes that the organization of medical services in the interest of economy, effectiveness, and quality is essential to assure a desirable health return on the public dollar spent.

It is with these concerns and interests in mind that the Physicians Forum submits comments on H.R. 12080.

TITLE XVIII

We believe that the principle of social insurance implied in Title XVIII, which results in the paid-up right to medical care and the avoidance of a means test or charity, is fundamentally correct. We regret the restrictions in the application of this principle by the imposition of deductibles and limitations of services.

A. We favor the increase in cash benefits but regret the reduction from the 15% recommended by the administration to a 12½% level specified in the bill. Likewise we favor the increase in the tax base but regret that this base was not raised to the schedule increase to $10,800 recommended by the administration, as we believe increasing the base is an equitable application of the progressive tax principle.

B. The PF recommends the elimination of deductibles now included in Title XVIII because we favor an unlimited application of the sound principle of the paid-up right to medical care. We also question the economic wisdom of such deductibles because:

1. The costs of administering such deductibles may cancel out the savings; particularly when separate agencies process charges rendered to a beneficiary in different states. At the end of the first fiscal year of Medicare, queries in regard to deductible status for payment of physician services under Part B reached a total of 16,677,414.

2. The beneficiary's delay in seeking medical care may result in an increase in the ultimate cost of treatment.

C. We favor the provision of alternate means of reimbursement for services rendered by physicians. We believe that reimbursement for many types of service on a per capita or salary basis would be preferable to fee-for-service. Where a fee for service is being applied, we feel that a fixed fee schedule with variations in different communities according to the current customary and usual charges is a reasonable basis for a relative value fee schedule.

D. We regret the transfer of all outpatient hospital services to the supplementary medical insurance program of Part B, Title XVIII and we recommend the inclusion of both hospital and physician outpatient services under Part A. Hospitals would then bill separately for hospital and physician services and hospitals would remunerate physicians. We approve the payment of full and reasonable charges for radiological and pathological services furnished by physicians to hospital patients, and we favor the provision for remuneration of such physicians by the hospitals rather than by direct fee-for-service payment.

E. We regret the more restrictive definition of disability in H.R. 12080 as compared with the present law, and we regret the failure to include disabled beneficiaries under Medicare as recommended by the administration.

F. We believe that significant cost of illness, namely the purchase of drugs, should be covered by the social insurance purchased by the beneficiaries. This cost is particularly high for the elderly who require continuing medication for chronic disease. We recommend that benefits under Title XVIII be expanded to cover costs of eye glasses, hearing aids and drugs prescribed by physicians for outpatients, the costs of drugs being kept at a minimum by prescription according to generic name.

TITLE XIX

Our main objection to Title XIX and therefore to the amendments to this section in H.R. 12080 is its continuation of traditional poor law legislation, limiting eligibility to those qualifying under means tests. We, therefore, disapprove the limitation on income eligibility that not only tends to freeze medical assistance eligibility levels but also lowers them in some states. The principal of social insurance providing medical care as a paid-up-right without a means test is superior to the provision of care according to a means test no matter how high the levels. We not only disapprove of a means test eligibility for individuals qualifying for cash benefits under the welfare provisions of social security, but we particularly disapprove of determination of "medical indigency" at the time of needed medical care.

We believe deletion of the present requirement that states provide at least inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physician services, and requirement that states provide only *any* 7 of the first 14 services outlined in section 1905 will critically weaken the Title XIX program. The five previously required services are basic and minimal to a satisfactory program and the provision of dental services is a "must."

TITLE II

The restriction of limited federal financial assistance to broken home families, eligible for AFDC at the caseload equivalent to the January 1967 ratio of such children to the total state child population, places a restriction that could exclude an unpredictable number of children from needed support.

The provision for an increase in Federal financing for such social services as family counseling, day care, family planning, foster care, and other protective child welfare projects; for demonstration and other research projects; for the special costs associated with work and training programs; for the training of social workers and their allies appear desirable. But we question whether such desirable services and policies can be carried out under the shadow of coercion and punishment without destroying their effectiveness.

We question the advisability and even the constitutionality of compulsory requirements of work or training. Certainly flexibility in such requirements must allow for the unavailability of appropriate employment, day care centers, and suitable training centers, and for family circumstances which dictate the necessity of the mother's presence in the home. We feel that the responsibility for the conduct of the expanded work and training programs should be in the Department of Labor rather than in the Department of HEW.

Cutting costs and improving quality of medical services

Much as we need to improve the financing and distribution of the cost of medical care by governmental insurance, doing so without correcting our current disorganized, fragmented and uncoordinated health services will jeopardize the quality and economy of U.S. medicine. Therefore, confronted with the inevitable extension of health insurance, the primary need is improving the organization of our health services along such lines as the following:

Every family or individual should obtain primary health care from a family physician especially educated, trained and respected as a specialist in this basic field of medicine. Such family physicians, instead of practicing from segregated private offices with overhead costs of 45 percent of earnings, should be members of community clinic group practice teams that include public health and visiting nurses, social workers and homemakers supported by laboratory facilities appropriate to meet some 70 percent of health and medical needs.

Nurses would do screening physical examinations in the clinic and the home, thus reducing expense and freeing physicians to do what only physicians are qualified to do. The expensive duplication by family pediatrician and internist in understanding family medical, social and economic problems and in making home visits would be an extravagance of the past. The family group practice teams would be the foundation of our health and medical care.

For the needs that the family group practice teams are not qualified to meet, specialists would be called as consultants to see the patient with the family physician in the family care clinic or patient's home, or, as circumstances require, in the hospital where needed specialist services are available.

Specialists other than psychiatrists and family physicians, should be members of hospital based group practices. As such they would be more readily available to their hopitalized patients than when private office based. The wasteful expenditure of physician time and energy in travel between hospitals and office several times a day would be eliminated. Needed supporting personnel, expensive diagnostic and therapeutic facilities and consultation with other specialists would be more readily and economically available to them and their patients.

Appropriately trained midwives or obstetrical assistants would reduce the cost of normal deliveries and the number of deliveries unattended by any obstetrically trained person. Obstetricians would then have more time to better serve patients who need their special care.

With progress in such basic organization of professional services, needed regional planning of hospitals and other health facilities according to location, size, ownership, adequacy of staff and equipment and coordination of facilities could be a *fait accompli* instead of the failure it now is. The costly and uneconomical segregation and duplication of hospitals according to religious denominations, patient economic status or government service could be reduced and ultimately eliminated. The institution of progressive health care by hospitalized patients and the development of hospital connected rehabilitation units, nursing homes and home care services would both improve the quality of care and reduce the current annual five billion dollar misuse of inpatient hospital facilities.

And last but not least such organization of services would promote consideration of ways of remunerating physicians that would correct the current disparity in fees for services requiring similar amounts of time and similar competence in respective fields of specialization, eliminate the loss of fees as a possible deterrent to referral of patients to colleagues specially qualified to meet specific needs, and lessen the administrative cost and paper work of physician remuneration by insurance plans.

Summary

The Physicians Form believes that the principle of social security insurance with the paid-up right to medical care is so basic to the goal of providing a single class of medical care to each citizen that we have recommended and recommend again that the coverage by TITLE XVIII be extended without deductibles or other limitation to the entire population. We deplore poor law legislation which provides unequal eligibility to citizens of different states and eligibility for medical indigency determined at the time of need.

A critical need in this time of expanding government financed medical care is the improvement in the organization of services in the interest of economy, effectiveness and quality. Without such, the poor health return on the public dollar spent and the drain on the treasury could be disastrous for both the health and economy of the nation.

BENNINGTON COLLEGE,
Bennington, Vt., September 1, 1967.

TOM VAIL,
Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. VAIL: Thank you for your prompt reply to my letter of August 25, requesting the right to testify before your Committee. I am, of course, grieved to learn that about such an important measure, affecting the lives of so many men, women, and children, you are curtailing public hearings, and will not be able to give me an audience. I am even more grieved that you should have confused my urgently-addressed request to testify about some of the most repressive welfare legislation since the New Deal with a request to testify about "tax increases." I am simply assuming that you have confused me with somebody else, and, because of the urgency of the case, responding to your invitation to submit a written statement which I would request be published in as close to nearly-complete form as possible.

My objections to the proposed welfare freeze, the employment of all those "employables" over 16, and the cut-off of such benefits as unemployment insurance for welfare recipients, as well as the provision that a man must have worked one and a half out of the last three years to collect welfare, is that these are unusual, inhuman, cruel acts. Some may hector you about the impracticality of administering laws to punish children for the mishaps of their parents by holding out the threat of starvation. Others may even point out, and with justice I think, that such provisions are surely violations of the equal protection clause of the Constitution, since they single out a particular group for the unusual treatment of being deprived of a public benefit. But, even these objections pale, I think, when placed alongside the very simpleminded objection that it is simply not common decency to treat any class of people in a democracy as malefactors simply because they have a history of poverty which that democracy has done little or nothing to alleviate.

The clear implication of the welfare amendments is that it is the fault of the mothers and fathers and children who are poor that they are poor. Else, why use every means to seek out defaulting fathers who are, of course, no less poor, although defaulting? Why punish children by depriving them of their only form of succor by withholding Federal reimbursements? Why punish a man for not working when the economy seems to proceed with great facility with a built-in pad of three percent unemployment, an unemployment which falls most heavily, I suspect, on black men and women?

The wisdom of legislation which seeks to get tough with the poor, as House Chairman Mills indicated, is truly to be doubted in this age of violence and insurrection.

Does the Committee (or the Congress entire) plan to do anything to get tough with the farmers in the South and elsewhere who, by putting their lands in soil bank, have set up their own nicely abundant welfare program, and driven hundreds of thousands of black and white tenant farming families off the lands and onto the welfare rolls in our cities? No! It is only the poor who are to be punished, as if they had fallen backwards into their poverty, rather than it having been their general condition for as long as they have been citizens of this Democracy?

And what of the children who are going to be enfeebled and humiliated by growing up once again, as still another generation, without proper sustenance and care which only mothers and fathers can provide when they have ample means?

Even if one agrees with the law's implicitly invidious characterizations of the parents (and the means that are necessary to deal with them) what is the decency of punishing the children? One would think that it would be incumbent upon an enlightened legislature, believing as it does, to take every measure that the children do not recapitulate their parents' histories. But the proposed amendments, which will not only create bitterness and more poverty, will also assure those children who happen to be born dependent on the State and fall above the January 1967 levels, that their only legacy is to be destitution, malnutrition, and a lack of the amenities of such proportions that their very ideas and vocabularies are warped and disordered to such a degree that they may never participate in the general middle class celebration which is American life today.

The evidence for some time has been clear that the States alone, even if they wished to do so, do not have the resources to provide sustenance to the growing numbers of poor children and their families. This legislation obligates the states to pick up the tab which the Federal government, out of some squeamishness, suddenly refuses to honor. What can be the effect of such an action except to create more of the very poverty among black and white people which the Nation through its executive and its will in the Congress has covenanted to eliminate?

I understand that the legislation which is so repressive for welfare families is part of an omnibus bill which provides modest increases for social security pensioners and some rehabilitational and day-care programs for poor families. I am not opposed to these provisions, of course, but they do seem to be a disguise for a flagrant punishment of the few by the many for not being so fortunate to have had prosperous fathers grow up before them, and I would ask this Committee to consider revising the amendments, applying insight, conscience, and the decency by which they would choose to be treated if they were in such straits; and then to decide whether America is to be a country for the weak as well as the strong, or whether it is to be a nation of increasingly privileged fat cats who cannot stand to share their affluence for the commonweal. Forgive me if I have been at all long-winded. Bear in mind, I am not an administrator, nor a social worker, only a writer who spent two years of his life living and talking with those whom poverty had outraged in New York. Thus, I cannot offer you any convenient nostrums or panaceas to decrease the public expense for poor relief. It is little enough that the people now get. As we prosper, they are further impoverished, for they must buy in the same marketplaces, eat the same foods, wear the same clothes, at the prevailing cost. The result is that they are assured only that they and their children shall be poor. The current legislation goes one step further: It assures them that they are to be singled out, treated as malefactors, virtually reduced to State slavery (which often turns out to be State subsidy of venal employers) for the simple reason that they are poor and have always been poor.

To the British Parliament which proposed to do something about the starving condition of the Irish poor, the poet Swift proposed that cottage industries be established to dress, truss, eviscerate and prepare Irish children for sale on the English market as table meats. One wishes that the presently proposed legislation evidenced even this much perverted social sense. But our Congress does not intend to fatten but to starve, not to eliminate a problem but to make even more painful the lives of those who already bear the burden of that problem. If there were even decently maintained State establishments where the present generations of poor children might be removed from the harmful milieu of poverty, some of the persecutions of the parents, although no less callous and cruel, might make a certain amount of social sense. But what we have to offer is a life in the rural or urban slums or a Dickensian alms-house incarceration at great State expense but without hope, comfort, or possibilities for the future. So I hope you will forgive my indignation, if it seems excessive, and ask yourselves if you wish to be decent men and if that is the way you believe that decent men should act toward those who are, unhappily, the poor.

Yours sincerely,

RICHARD M. ELMAN,
Author, "The Poorhouse State: The American Way of Life on Public Assistance."

STATEMENT OF GREATER PHILADELPHIA COMMITTEE FOR MEDICAL-PHARMACEUTICAL SCIENCES TO THE SENATE FINANCE COMMITTEE ON S. 2299 AND S. 17—PROPOSED AMENDMENTS TO THE SOCIAL SECURITY BILL, H.R. 12080, SUBMITTED BY THOMAS M. DURANT, M.D., CHAIRMAN, TEMPLE UNIVERSITY SCHOOL OF MEDICINE

SUMMARY AND RECOMMENDATIONS

The Greater Philadelphia Committee for Medical-Pharmaceutical Sciences wishes to commend this Senate Committee and its Chairman for their interest in an objective of the greatest importance to every American—assuring that the nation's drug supply will be of highest possible quality and that drugs will be available, to all who need them, on the most economic basis consistent with high quality and safe and effective use. Our Committee, made up of five medical schools, two schools of pharmacy, and five pharmaceutical houses, is in complete unanimity on the importance of this objective.

We doubt, however, that the provisions of S. 2200 will in fact advance our country toward that measure's goal of assuring "the orderly, efficient, proper, and economical provision of drugs . . ." for the following basic reasons:

First of all, this bill provides for the creation of a government committee who shall have the responsibility to publish a Federal Formulary. The task facing such a committee, in view of the provisions of the bill, would be insurmountable at the present time.

Second, the freedom of the physician to prescribe the drug product of his choice would be seriously impaired.

Third, the economic consequences to the pharmaceutical industry, our entire drug distribution system and, more importantly, the consumer, have not been explored. For example, the method by which prices would be controlled would diminish the motivation of the industry to risk investment in research and development of new drugs.

Fourth, it seems a certainty that the savings purported to be effected by this legislative proposal would be more than wiped out by the various additional costs which would be experienced in fulfilling the requirements of the bill.

Fifth, it removes the incentive for the industry to push forward in the development of better quality drug products. It places too much reliance on government controls to insure uniform quality of drug production rather than creating incentives for the individual company to exceed required minimal standards.

* * * * * * *

We believe that, in part, the goals of S. 2200 would be best accomplished by giving consideration to the following recommendations:

Recommendation No. 1.—The Food and Drug Administration, under the Kefauver-Harris Drug Act of 1962, has the broadest authority to inspect drug plants and conduct laboratory analyses of drug products. But the fact is that the Agency is unable to fully enforce the regulations at the present time because it lacks the necessary resources. Therefore, we believe the Congress should provide FDA with the technological manpower and related resources to fully implement the requirements of the 1962 Act.

Recommendation No. 2.—The FDA's new program of increased sampling and laboratory analysis of finished drug products of all manufacturers at all levels of distribution should be expanded as promptly as possible to the extent required to provide the highest degree of assurance that the nation's entire drug supply conforms with all USP, NF, and other statutory standards. Congress should supply all necessary funds for rapid expansion of FDA's test facilities at the New National Center for Drug Analysis at St. Louis, and elsewhere. The health professions and pharmaceutical industry should support appropriation of the necessary funds.

Recommendation No. 3.—The absence of USP and NF standards specifically relating to biological performance limits meaningful conclusions on the therapeutic effectiveness of a drug product that meets USP or NF specifications. The USP has set up a committee to investigate establishment of clinical performance standards for a number of drugs in the USP. The USP, NF, and comparable standards should be kept abreast of advances in science and technology. We urge, therefore, that government, health sciences and the pharmaceutical industry encourage and support such improvements in these standards.

Recommendation No. 4.—The professional organizations of medicine and of medical education should develop a program to impress upon physicians that they should be mindful of the economic consequences of the treatment they prescribe.

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S. 17—The Montoya bill

Additionally, the Greater Philadelphia Committee endorses the equally praiseworthy objectives of S. 17, which provide for the coverage of prescribed drugs in the voluntary insurance portion of the Medicare program. However, we feel that insuring, as S. 17 would, the availability of drugs for Medicare beneficiaries, principally those over 65, when they are outside of hospitals and nursing homes, is not necessarily the best or only answer.

The Greater Philadelphia Committee believes that none, regardless of age, should be denied prescription drugs because he cannot pay. We feel that the biggest burden is borne by those persons, young and old, who suffer from chronic illness, require long-term drug therapy, and who are not eligible for present government programs. Those who have this need should be identified. We urge that the health professions and all other interested parties join in a cooperative effort to measure such need, and then seek means to solve the over-all problem.

DISCUSSION

The Formulary Committee and its responsibility

S. 2299 would establish a nine-member Formulary Committee in the HEW Department with responsibility over drugs in the department's expanding health and welfare programs. It would require that committee to make, for all prescription drugs and biologicals, subtle judgments about relative drug effectiveness and distinctive therapeutic characteristics that no official body of U.S. medical science—in government—has ever before attempted or been asked to attempt.

The committee would then publish a "Formulary of the U.S." identifying the drug products that would be paid for by the government, and the HEW Secretary would establish "reasonable cost ranges." For such a Formulary to serve its intended cost-control purposes, many safe and effective drugs would have to be excluded. Thus, the formulary and related provisions would seriously interfere with the care of patients in HEW health and welfare programs and could ultimately impinge on aid to the sick everywhere. It seems to this committee that the prime objective of this official U.S. Government listing of approved drugs is cost reduction, not excellence of medical care.

How can any government committee be sure that some admittedly safe and effective, but "unnecessary" or "duplicative" drug—the Formulary would bar such—will not be needed by one or many Medicare or welfare patients?

A few years ago, for example, Congress gave extensive consideration to the complexities of evaluating drug efficacy and safety. After study that went on more than two years, Congress wisely rejected the concept that to be eligible for federal licensing a new drug should be relatively more effective than existing drugs prescribed for the same condition. Thus, the 1962 Kefauver-Harris Act requires a showing of safety and effectiveness, but without comparison to any other therapy.

Federal agency officials, the medical profession, the pharmaceutical industry, and members of Senate and House agreed that no showing of relatively greater effectiveness should be required as a condition for obtaining FDA approval of a new drug.

For all practical purposes, so far as the HEW Department's health and welfare programs are concerned, S. 2299 would effectively undermine the "new drug" provisions of the Federal Food, Drug, and Cosmetic Act under which the U.S. Food and Drug Administration requires the submission of substantial evidence of the safety and effectiveness of any new drug before it permits such a drug to be placed on the market.

The HEW Department expressed essentially the same view in a recent report to this Committee on the policy and procedural problems under S. 2299.

We strongly urge this Committee, therefore, not to recommend to the Senate that a Federal Formularly Committee be empowered and required to make judgments on relative effectiveness of medicines simply because these medicines are to be used in federally-financed health programs.

Interference with patient care

Evaluations of drug efficacy by panels of committees of experts might produce such conclusions as:

—Drug *A* has been shown in clinical trials to be effective in the treatment of 75% of the patients ill with a given disease.

—Drug *B* was shown to be effective in treatment of only 60% of patients with the same condition.

With appropriate evidence of relative safety, both Drug *A* and Drug *B* would be approvable under FDA's "new drug" provisions. And so they should be. But a Federal Formulary Committee of the kind contemplated by S. 2299 might conclude that Drug *B* is "unnecessary" or "therapeutically duplicate" because it is only 60% "effective" compared to Drug *A*'s 75%. However, the 60% successfully treated with Drug *B* might include some or all of the 25% who did not respond to Drug *A*. Is this statistically less effective medicine "unnecessary" or "duplicative" for those sick men or women?

Evaluating committees, no matter how exalted their credentials, deal with averages. The practicing physician deals with individual patients. No safe and effective drug should be denied to the medical profession or to the beneficiaries of federal-state health and welfare programs by federal edict on economic grounds alone. Though less effective—on the average—than some other product, the less effective drug may be "just what the doctor ordered" for certain "non-average" patients. Only their attending physicians can determine this.

This discussion of relative effectiveness has dealt primarily, to this point, with the comparative evaluation of different drugs for use in treating the same or similar diseases. But there is another, perhaps equally serious problem on the relative safety and effectiveness, for *individual patients*, of drugs containing the same active ingredient or ingredients produced by different manufacturers in a variety of dosage forms according to varying formulas. Drug products containing the same active therapeutic agent can and do have different inactive ingredients and excipients, different vehicles and bases. The active ingredient can be released at differing rates of speed.

Remember, Mr. Chairman, we have the problem of drug allergy. No drug was ever made that someone was not allergic to. The well-known problem of penicillin sensitivity supplies a good example. Allergic reactions to this life-saving drug range from minor skin eruptions to sometimes fatal anaphylacti shock. Patients can react not only to the active therapeutic agent, but they can also be allergic to the inactive ingredients in a tablet or capsule or other dosage form. Thus, it might be highly important, at times, for physicians to have available, for particular patients, one or more drug products that had been left out of the Formulary of the U.S. under S. 2299 as "unnecessary" or "therapeutically duplicative" or whose price was beyond the HEW Secretary's "reasonable cost range."

The U.S. Public Health Service, in a commentary on S. 1303—the predecessor to the legislation now under consideration, S. 2299—touched on many of these points. We understand that the PHS statement was submitted to your Committee by the HEW Department. It said in part:

"In the absence of a substantial amount of biopharmaceutical research relating to the relative clinical effectiveness of vast numbers of drugs and combinations of drugs, we fail to see how the proposed Formulary Committee can possibly make supportable value judgments as to the *relative therapeutic value* of one drug over another in carrying out its responsibilities under the proposed bill.

"Moreover, the matter of determining whether a drug is 'unnecessary or therapeutically duplicative' poses potential problems of professional prerogatives and judgment and could seriously interfere with the practices of private physicians.

"Drug allergies, which occur in up to 10% of the population and are of severe or even fatal nature, frequently require alternative preparations which may be therapeutically duplicative."

This brief PHS commentary sums up succinctly the problem of determining relative efficacy as well as how such determinations might effect the practice of medicine.

Economic consequences of S. 2299

There is another reason why the public interest could be hurt by a nine-member government committee with power to bar safe and effective drugs, on relative effectivenesss grounds, from an official U.S. Formulary.

It is widely accepted as a fact that expansions of federal and federal-state health and welfare programs, and of health insurance programs of industry, labor unions, private carriers, Blue Cross/Blue Shield and the like, will find so-called "third parties" (government agencies, insurance companies, etc.)—and not individual patients—paying the bill for one-third to one-half of all prescriptions within the next few years.

The Formulary of the U.S. and HEW's "reasonable cost ranges" would almost inevitably be followed by most other third party payers. We recognize that S. 2299 would not *explicitly bar from use* in HEW health and welfare programs drugs not listed in the Formulary of the U.S. Nor would it *explicitly bar from use* drugs whose cost exceeds the "reasonable cost ranges" established by the HEW Secretary. Drugs furnished to a patient by an accredited hospital which uses its own acceptable formulary system would also be paid for from federal funds.

But S. 2299 would *bar federal payment* unless the drug were in either the U.S. Formulary or an accredited hospital's formulary. And it would *bar federal payment in excess of the "reasonable cost range,"* or, where applicable, "reasonable charges." The patient or the state would have to pay.

The purposes of these provisions—and their effects—shoud be obvious. One result would be effective denial to the physician of necessary freedom to prescribe, for one-third to one-half of our people, to the serious detriment of good patient care. And a research-oriented industry, whose economic health is vital to the public health and well-being of this country and to medical-pharmaceutical progress, could be denied access for many products, both new and old to one-third to one-half of its present market.

The research and development of innovating companies who now spend $400 million annually for this purpose would be seriously curtailed. Consider, for a moment, what might happen. Under the requirements of the 1962 Kefauver-Harris Act, it may cost as much as $4 million or $5 million or more, and take six or seven years, to carry out necessary chemical, pre-clinical and clinical research on a new drug product and to get approval for marketing from the FDA.

This drug product might have unique values for some individuals or categories of patients, even though it was not universally more effective than already available medication. But, under the provisions of S. 2299, such a drug product might not be approved for the Formulary. This possibility would discourage the investment of large sums of risk capital by the industry in research and development.

In addition, from the economic viewpoint, the competitive pressure of another entry in the medical marketplace would be lost. The HEW report to your Committee on policy and procedural problems under S. 2299 was emphatic on this issue. It declared:

"The exclusion of competitive therapeutically duplicative drugs may tend to eliminate competition among manufacturers.

"The advantage to a manufacturer of having his drug in the Formulary, while possibly equally good drugs are excluded, provides an economic advantage not related either to quality or to the market place."

As to over-all R&D policy—it would be a real tragedy for the public welfare if an Act of Congress which was intended to reduce the cost to government of welfare drugs—medicines for the needy and aged—should erect a roadblock to new drug development.

The relative efficacy, formulary, and "reasonable cost" provisions of S. 2299 would force price competition among standard drug products, but at what cost to competition in pharmaceutical R&D; in the loss of new medicines; and in general depressant effect on the innovating pharmaceutical houses? HEW's reasonable cost ranges, imposing limits on federal payments for drugs prescribed for beneficiaries of federal-state health and welfare programs, would become effective price controls, too, in the private insurance plans. Ultimately, the effect of these price controls would be felt wherever medicine is practiced and prescribed drugs are bought and sold.

S. 2299 gives no consideration to the economics of an essential and productive industry—that segment of the drug industry that conceives and develops new drugs. Consequently, if S. 2299 were passed by the Congress, it is likely that the research productivity of a vital industry would be seriously impaired and medical and pharmaceutical progress would suffer.

Let us remind you of the words of HEW Secretary John Gardner when he appointed a Task Force on Prescription Drugs to examine these difficult problems. Secretary Gardner said:

"In all of its work, I have asked the Task Force to measure the value of possible solutions not only in terms of dollars to be saved, but in the quality of health care to be delivered."

The Greater Philadelphia Committee for Medical-Pharmaceutical Sciences urges this Committee to measure its objectives with the same sound yardstick.

Quality control considerations and their cost

The sponsors of S. 2299, seeking to assure the quality of drugs prescribed in federal health and welfare programs, directed the proposed Formulary Committee to prohibit the use of drugs it found to be of "unacceptable quality." Their bill authorizes the Formulary Committee to establish test procedures, and to have tests conducted so as to determine drug quality. In conjunction with the Formulary Committee, the HEW Secretary is called on to make inspections and follow other tests and procedures to ensure that drugs eligible for use in federal health and welfare programs are not misbranded or adulterated. The only limitation S. 2299 would place on the Formulary Committee and the Secretary in establishing test procedures would, it appears, be their own discretion.

The effectiveness of these quality assurance provisions would be doubtful, if not illusory. Under present law, the HEW Department and the Food and Drug Administration already have the broadest authority to perform drug plant inspections and analyze drugs in their laboratories.

It is beyond FDA's present capabilities to carry out a program limited to the narrow purpose of making sure that all drugs conform to USP, NF, or other applicable standards that specify, for example, the purity of chemicals used as drugs and how much active ingredient a product should contain.

The FDA itself acknowledges that it lacks the manpower and laboratory and related resources needed to provide even this limited assurance of drug product safety and effectiveness. How can the proposed Formulary Committee do this job if the FDA cannot?

The quality of the nation's drug supply has long been a subject of general discussion in the regulatory agency, in Committees of the Congress, and in the pharmaceutical industry. Two regulatory techniques that have been mentioned more than once are: (1) Certification of every batch of every drug produced by every manufacturer, and (2) The stationing of resident FDA inspectors in every drug manufacturing plant.

The first technique would compare to the kind of batch certification that now is required under the Flood, Drug and Cosmetic Act for: (1) Antibiotics for human use, and (2) Insulin. The second would be modeled after federal programs for continuous inspection of meat and poultry processing plants.

Testifying on August 10, 1967, before the Monopoly Subcommittee of the Senate Small Business Committee, Dr. James L. Goddard, Commissioner of FDA, estimated that batch certification of all drugs would cost about $90 million a year. There have been estimates that it would cost another $50 million annually to station resident FDA inspectors in every drug plant.

During your Committee's hearings on this legislation on August 31, 1967, the Chairman of the Senate Finance Committee stated: "My drug bill (S. 2299) would save $100 million a year and drugs would be of better quality than now . . ."

But batch certification and continuous FDA inspection, two frequently mentioned quality assurance techniques, would cost an estimated $140 million a year. And even if cost is ignored, neither measure can guarantee quality. The FDA Weekly Recall Report recently included recalls of three certified antibiotic products which had become subpotent.

No resident FDA inspector (no matter how experienced and capable—and these are essential qualifications) can personally monitor the diverse quality control activities that are performed by hundreds of employees at widely scattered locations in every quality-oriented pharmaceutical house to assure batch safety and effectiveness.

Therefore, even with batch certification and resident inspection, the proposed Formulary Committee would not have a "fool-proof" basis for deciding what drug products are of "unacceptable quality," or, for that matter, of "acceptable quality." And, in any event, on a cost basis alone, would not the $100 million saving be wiped out?

Is it not clear, Mr. Chairman, that these difficult problems of drug quality, effectiveness, and safety have not yet been given the kind of careful examination by Congress that they require?

Other administrative costs of S. 2299

Forgetting the high cost of "quality controls," there is good reason to believe that the cost to HEW and the states of administering S. 2299's restrictive *Formulary/cost-control system* would alone be greater than the savings possible from drug price fixing.

About 70 million welfare drug prescriptions were involved last year in federal-state programs, and the number may soon rise to 100 million or more a year as additional states take advantage of Title XIX (Medicaid).

Under S. 2299, each welfare drug prescription submitted for payment would have to be checked to: 1) Identify the drug dispensed, 2) Make sure it's a "qualified drug," and 3) Determine that the payment is within the "reasonable cost range."

We can conceive of the creation of vast auditing bureaus in the state and federal government, at staggering expense.

The Greater Philadelphia Committee, representing academic medicine, pharmacy, and drug manufacturing, cannot accurately estimate these costs. Therefore, we urge your Committee, if you have not already done so, to have detailed estimates developed by experts at HEW. Such estimates might well show a net dollar loss to the public from S. 2299 because of Administration cost alone.

S. 17—The Montoya bill

Also before you at this time is S. 17. This measure contains Formulary and "cost control" provisions similar in many respects to those in S. 2299. In addition, it would expand the voluntary insurance portion of the Medicare Act (Part B of Title XVIII) to include prescription drugs.

Our comments on the Formulary, quality and cost-control provisions of S. 2299 apply with equal force to the comparable provisions of S. 17 which should be given much further study.

As stated earlier, we endorse this bill's laudable objective of ensuring that our senior citizens will be able to obtain the drugs they need as outpatients—outside of hospitals or nursing homes where Medicare already covers drugs. Congress has, however, enacted the Medicaid program, which is intended to provide medical care, including drugs, for those classed as "medically indigent."

The Greater Philadelphia Committee has a deep concern for those who do not qualify for Medicaid and find the purchase of prescribed drugs a burden. All of these persons, young and old, should be identified. The degree of their need should be determined. We urge that the health professions and all other interested parties join in a cooperative effort to measure such need, and then seek means to solve the over-all problem. Perhaps the HEW Task Force Study, undertaken at the direction of the President, will point out some ways in which this can be accomplished.

HEALTH & WELFARE COUNCIL
OF METROPOLITAN ST. LOUIS, INC.,
St. Louis, Mo., September 26, 1967.

HON. RUSSELL LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: The enclosed statement on H.R. 12080 was unanimously approved by the Board of Directors of the Health and Welfare Council of Metropolitan St. Louis. The Health and Welfare Council is a voluntary organization of 200 health, welfare and recreation agencies in the St. Louis area.

We respectfully request that you and your committee take into consideration the views expressed in the enclosed statement.

Sincerely yours,

RICHARD S. JONES, *President.*

STATEMENT ON H.R. 12080

The Board of Directors of the Health and Welfare Council of Metropolitan St. Louis wishes to comment on certain provisions of Titles II, III and IV of HR 12080 (The Social Security Amendments of 1967).

This bill contains many desirable provisions long sought by the social welfare community. These include:

1. An increase in federal financing for a variety of social services such as family counseling, day care, family planning, foster care and other protective child welfare services; for demonstration and other research projects; for the special costs associated with work and training programs and for training of social workers and their aides.

2. Earnings exemption for recipients of Aid to Families with Dependent Children.

3. Emergency assistance for certain needy families with dependent children.

4. Federal payments for repairs to homes owned by recipients of aid or assistance.

We endorse the inclusion of these provisions and urge the Congress to retain them in the final version of this bill.

There are however other provisions in this bill which give us deep concern and we are opposed to their inclusion in the bill in their present form. These are:

1. *Limitation on the number of certain dependent children for whom federal AFDC payments may be made.*—This provision results in unequal treatment of children in need; potentially, increases the fiscal burden on state and local units of government or spreads already inadequate assistance payments over a

larger number of children; and eliminates a state's ability to respond promptly to situations arising out of economic recessions.

2. *The compulsory nature of the community work and training program requiring that an AFDC mother or other adult or child over 16 years of age must engage in work and training (unless specifically exempted) as a condition of receiving assistance.*—Employment and training programs are important resources for public assistance recipients. Their value is however diminished when they are made a condition of assistance. This provision will be expensive to administer and will further drain off already scarce social work personnel into inappropriate roles.

3. *Limitation of 75 percent federal matching funds for child welfare services to AFDC children rather than granting this to all children in need of such services.*—Child welfare services should be available to all children who need them. States should be encouraged to provide such services regardless of the families' need for financial assistance. This provision because of its more favorable matching formula for AFDC children will tend to retard the development of child welfare services for all who can benefit from such services.

4. *Vendor payments for dependent children.*—The purpose of public assistance programs is to assist families in a dignified and constructive manner. "Voucher" payments are reminiscent of company stores and are likely to increase a family's dependency.

5. *Elimination of the five percent limitation on the number of AFDC recipients for whom protective payments may be made.*—We recognize that there are a limited number of families who are either incompetent or otherwise unable to handle money wisely and, therefore, "protective payments" are necessary. The present requirement of the law that such payments be limited to no more than five percent of each state's AFDC recipients provides assurance that it will not be misused. We urge retention of the five percent limitation.

6. *Revisions in the Aid to Families with Dependent Children—Unemployed Parent Segment which tie the definition of unemployment to an attachment to the labor force.*—In 1961 the Congress attempted to correct one of the major shortcomings of the AFDC program by permitting states to provide assistance to dependent children one of whose parents is employable but unemployed. We urge that this section of the law which is now temporary be made a permanent part of the Social Security Act. At the same time, however, we believe that the revision proposed in HR 12080 tying the definition of unemployment to an attachment to the labor force is unwise. The need for assistance is as great in families where fathers have no work experience as in those where they do. We urge that the present language of the law be retained.

7. *Elimination of the Title XIX requirements that states must provide five specific basic services.*—We favor retention of this requirement.

8. *The definition of medical indigency set at 33⅓% percent above the highest amount paid to a family of the same size in the form of money payments under AFDC.*—We urge the adoption of the definition contained in HR 5710, namely 50 percent above the highest amount paid to the family of the same size under AFDC.

Any public welfare program in order to be effective must emphasize the dignity of human beings. The provisions of HR 12080 enumerated above, tend to destroy the dignity of people and increase rather than decrease their feeling of dependency and worthlessness.

The proposed amendments do not address themselves to one of the basic inadequacies and inequities of our public welfare laws—namely, the inadequacy of all public assistance grants in many of our states and the inequities of the formulae for federal support between the AFDC category and the adult categories.

We urge the Senate to eliminate those provisions of HR 12080 which are destructive of human dignity and we further urge the Senate to restore the public assistance requirement originally contained in HR 5710 that states "meet their own minimum standards." We believe however that states will only be able to implement such a provision if additional federal financial assistance is made available. In our own State of Missouri, we only provide 77.3 percent of the budgetary need for old age assistance recipients and a shockingly low 41.7 percent for AFDC families.

STATEMENT OF THE PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, SUBMITTED BY THOMAS W. GEORGES, JR., M.D.

SOME COMMENTS ON H.R. 12080

We are concerned about some of the provisions in H.R. 12080 now being considered in the Senate. While many aspects of the amendments are desirable including the service provisions for increased and improved day care, foster care, homemaker services, constructive work incentives, more useful work and training programs, rehabilitation plans for each family, extra funds for family planning, and money for social work education, we feel the necessity to comment on those aspects of the bill about which we have serious question. In addition, we do have some suggestions.

Section 101. Increase in old-age survivors and disability insurance benefits

The bill provides for a benefit increase of 12½% across-the-board with a $50 a month minimum. We support the administration's recommendation of a 15% benefit increase and a $70 a month minimum benefit. The present bill would remove from poverty approximately 800,000 people while the recommended increase would remove approximately 2,000,000 people from poverty. It would afford a substantial number of old age assistance recipients in Pennsylvania to become independent of that assistance.

We further recommend a special minimum benefit of $100 per month for persons who have worked at least 25 years in jobs covered by Social Security.

Under the present bill, benefits for disabled widows are provided beginning at age 50, reducing the amounts they would get if they retired at age 62 without disability. We believe that disabled widows at any age should receive full widow's benefits.

The House bill did not include the recommendation that disabled Social Security beneficiaries should be included under Medicare. This affects Pennsylvania by making it necessary for us to provide health care under Title XIX. Since available data reveals that health costs for the disabled are higher than for the aged, we support modifying the bill to extend the protection of hospital insurance to the disabled group.

Section 202. Earnings exemption for recipients of aid to families with dependent children.

This section of the bill provides incentives and various social services for aid to families with dependent children. These provisions in and of themselves are good, however the legislation attempts to impose socially accepted behavior and to force mothers to work. This kind of legislation invites coercion approaches by the states.

We disagree that work for AFDC mothers should be made mandatory because:

(1) Each American mother has the right to decide whether or not she will remain home and raise her young children.

(2) In Pennsylvania the average number of persons on AFDC in a year has been reduced between 1963 and 1967, from 316,090 to 246,679. During those years 117,834 cases came on the rolls because they left employment; 106,316 left the rolls because they went to employment. We believe this record is based on a program which provided a wide variety of opportunities and aids—training, specialized rehabilitative, educational and employment services; unusually fine cooperative activity among departments of government; a healthy economy with industry, business and government doing everything possible to provide jobs.

While we continue, as does the rest of the country, to have unemployment among certain groups (particularly youth and especially Negro youth), we are vigorously carrying out MDTA, Title V (OEO), Neighborhood Youth Corps (OEO), New Careers (OEO), and many specialized employment programs of our own to meet the problems head on.

Public Assistance clients are not essentially different from other Americans. Most of the able-bodied want to work if jobs are provided. But we emphasize that mothers of young children should have a choice.

(3) The mandate reverses the thrust of the original Social Security Act itself which was to keep mother and child together. There is no coercion, for instance, in the survivor's benefit program. Many mothers of children receiving OASDI benefits work. Many do not.

(4) The Congress of the United States, by passing the mandatory work provisions would be establishing securely in law that AFDC mothers, purely because of their poverty, are second class citizens and should receive coercive treatment.

(5) We believe society does not gain if it forces a mother to leave her young children and go to work. Contrary to usual opinion about the AFDC program, Pennsylvania, like most other states, has always insisted that women with grown children be self-supporting. Where a woman has young children, we offer her a choice.

The House neglected to consider that foster care, day care, and homemaker costs might be as high as the assistance cost. Most AFDC mothers go into low-paid employment and will not be able to contribute a great deal for these services. In addition, we must consider the social as well as the higher economic cost of homes that may break up when mothers of young children work. Foster care costs are four times the cost of assistance and there has not been comparable federal matching.

It should be noted, too, that the incentive plan adds another formula to an already diverse and complicated set. Federal law and regulation provides for *different* incentive deductions for old age assistance, for the blind. The proposal to exempt the first $30 and one-third of the difference for an AFDC wage earner is an improvement over the present situation which allows no work deductions for AFDC recipients, except children. It apparently replaces the mandated higher deductions allowed for several Federal employment programs.

The proposed incentive is lower than is allowed for the aged, the blind, and the Federal employment programs. It should be increased.

The incentive plan, if used positively, will encourage public assistance recipients to seek and keep employment.

The incentive provisions excludes persons already employed and at the same earnings level of working persons on assistance receiving the work exemption.

This appears inequitable. In effect, it gives a person on assistance a bonus denied to a person with equal earnings.

The incentive provision would cost Pennsylvania $3,197,500. About one-third of this cost arises because of Pennsylvania's general assistance program which is entirely state financed.

Section 203. Dependent children of unemployed fathers.

Federal funds are presently available for AFDC payments to families where the breadwinner is unemployed. Pennsylvania has made excellent use of this program. The bill provides that fathers would be required to have had a "substantial connection" with the work force to be eligible. They must have either exhausted their unemployment compensation rights or have had a year and a half of work during a three-year period ending in the year before assistance is granted. The assistance would not be available if the father was currently receiving unemployment compensation.

This restriction of eligibility to fathers who have a connection with "work force" or who are not receiving unemployment compensation would cost Pennsylvania $273,000. However, if there is an increase in unemployment, there would be a significant increase in state costs. This provision greatly restricts our AFDC program by:

(1) Relating the employment status solely to the father, not, as now, to either parent;

(2) Requiring a work history of six quarters;

(3) Requiring a work and training program be established (July 1, 1969) and assignment of the unemployed father within thirty days after receipt of aid;

(4) Denying AFDC to cases where the father received unemployment compensation.

Young married couples with children in which the father has not been in the work force long enough to have six quarters of coverage and needs public assistance will be denied.

Persons receiving unemployment compensation payments are today eligible for supplementary public assistance in Pennsylvania.

The *maximum* weekly unemployment compensation rate is $45 per week in Pennsylvania. The family whose needs exceed that amount, will be denied assistance under the new bill.

These restrictions on eligibility are regressive. Public assistance has always been a backup to Unemployment Compensation, Social Security, Veteran's Benefits, and other income maintained and insurance programs whose provisions do not take size of family and need into consideration. The provision, because of Pennsylvania's general assistance program, would not eliminate these persons from the caseload. It would put the entire burden on the state.

Such a complicated eligibility provision would also add substantially to our administrative cost and workload.

Section 204. Community work and training programs.

The provision for 75% matching (85% until July 1, 1969) for "training, supervision, and material" is attractive. Pennsylvania could use a variety of services in a sound work and training program. However, the mandatory requirement that a CWT program be established in all areas where there is a "significant number" of AFDC recipients age 16 and over ignores the fact that the CWT program by itself, can be used to conduct work relief projects which have a dead end. In effect, the person in a CWT program would work only for his assistance grant.

We have real question as to whether such programs are geared to providing stable, realistic jobs. They seem rather to satisfy the belief that poor people should work for what they get. It is not a respectable way of getting people to work. It does not get people back into the labor market as self-supporting. It tends to continue dependency. It is not a substitute for either public employment or private employment expansion efforts.

We wonder, in these days of almost unlimited training programs with government support, if there is any reason for public welfare to operate a work relief program? Pennsylvania has had such a program for many years. Our own experience is that the more recently created Work-Training programs (Title V. EOA, MDTA, Neighborhood Youth Corps, New Careers Program, etc.), with built-in incentives are more productive.

We propose that there should be a Federally supported work and training program. It should be equal in its incentives and benefits to the MDTA, Neighborhood Youth Corps, New Careers, and Title V (Economic Opportunity Act Program).

Our best experience convinces us that the public assistance rôle is to prepare the hard core of unemployed to enter the labor market. Our greatest success has proven that literacy training is fundamental to any work and training program if it is to enhance lasting upward mobility. Therefore, the program should be keyed to training rather than a mandatory work training program alone. For literacy and related training, the incentives should be the same as for work training.

Section 205. Federal participation and payment for foster care of certain dependent children.

This section of the bill is a liberalization of an existing program that has been little used. It provides that Federal payment for foster care of children coming from AFDC families be increased to about $56.00 per person instead of about $22.00. However, the restriction that the AFDC child must be placed in foster care by action of court both restricts the number of children affected and is contrary to current foster home placement practices where dependent children are placed by voluntary action of parents. We agree that neglect and abuse cases should go through court. But these are a minority of our placement situations. The required court action undoubtedly represents the main reason why the program has been so little used.

We believe the stipulation for court action as a prerequisite for AFDC funds to pay for or contribute to cost of foster care of AFDC children should be eliminated.

The potential financial gain to Pennsylvania is $1,500,000. If the court provision is left in, however, the program will be little used.

Section 207. Protective payments and vendor payments with respect to dependent children.

In our opinion, the provision for vendor payments is in and of itself a regressive step.

At present, only about 1% or 1½% of public assistance recipients nationwide are having protective payments made for them under present law. One of the difficulties is that persons cannot be found to act as protector. In light of the fact that the bill leaves wide open the items for which vendor payments can be made, we feel that some safeguards need to be built in. It is not unlikely, in light of the punitive nature of these amendments, that someone will suggest that all public assistance cases be put on a vendor payment system. Therefore, we suggest that a limitation of 5% of the caseload be established as the maximum for vendor payments.

We agree that some families need protective payments. We hope that they would not be used in a negative manner. Opening vendor payments on any large scale could make state legislature and Departments of Public Welfare subject to heavy pressures from lobbies of vendors and the result could be an undignified system of relief in kind which encourages dependency.

Section 208. Limitation on number of children with respect to whom Federal payments may be made.

This provision is inequitable and particularly hurtful to many children. It states that Federal participation will be limited to "The proportion of all children under age 21 who were receiving aid to families with dependent children (AFDC) in each state in January, 1967, on the basis that a parent was absent from the home. . . ."

The estimated number of eligible ADC children receiving assistance because of absent fathers in January, 1967 constituted 2.5% of the population. The cost to the State for the quarter July-September, 1967 would be $375,000. In a year, if the caseload and population remained stable, the yearly cost would be over one million dollars.

It is impossible to accurately predict the future dollar effects. Because the law required a quarterly adjustment, extensive reporting and coding would be necessary, adding further complications to an already administratively overburdened system which we are trying to simplify.

We believe this provision of the bill is offensive to American children. It is class legislation and places the burden of society on innocent children.

It is offensive because:

(1) it is negative and restrictive. It is a masked attack on the Negro AFDC population.

(2) it states, in effect, that those children above the percentage of such children in the population as of January 1, 1967 whose fathers absented themselves, must suffer for the inadequacies of their parents.

(3) It could invite restrictive practices by some states. Pennsylvania, because of its humane statewide, state-financed general assistance program, will take on the additional burden without Federal aid. This is unfair.

In addition, this limitation assumes:

(1) A stable economy and a set employment rate

(2) That the poor will stay poor

(3) That the birth rates among the poor will be coercively reduced

(4) That training and education must produce unrealistically rapid results in getting people off the rolls. It blames the assistance system for unemployment.

(5) That Congress can force reduction in caseloads by using pressures on the poor.

Not one of these assumptions appears to be valid.

Another factor which apparently was not considered is that the provision could reflect unfairly on states with a high percentage of families whose personal or religious convictions forbid them from restricting the size of their families. H.R. 12080 is contradictory on this point since elsewhere in the bill allowances are made for such convictions.

Section 220. Limitation on Federal participation in medical assistance (title XIX).

A major restriction is placed on the level of Federal eligibility for Medical Assistance for persons not receiving cash grants. Pennsylvania has received 55% Federal matching for its federally eligible Medical Assistance costs since entering the program January, 1966. In July, 1967, the State extended its coverage to conform with Federal provisions. The additional cost for the 1967–68 fiscal year will be—Total $46,400,000; Federal $19,700,000; and State $27,700,000. The entire 1967–68 cost will be—Total $123,400,000; Federal $56,900,000; and State $66,500,000.

Pennsylvania's income eligibility for non-cash grant persons is based on $2,000 for a single person, $2,500 for a couple, with $750 for each dependent. Persons are eligible if they use ½ of their excess income over these amounts for medical expenses.

The new provisions say that eligibility levels may not be more than one and one-third higher than a similar family group would have received in cash assistance. For states in the program, including Pennsylvania, a transitional maximum of 150% and 140% are provided.

If Pennsylvania maintains present medical assistance eligibility levels and retains its present grant levels, this provision would cost the state yearly:

At 150 percent (July 1, 1968 to Jan. 1, 1969)	$3,200,000
At 140 percent (Jan. 1, 1969 to Jan. 1, 1970)	4,400,000
At 133⅓ percent (after Jan. 1, 1970)	5,200,000

because the state would have to bear the costs in excess of the Federal percentage participation level.

If Pennsylvania were to reduce its medical assistance levels so that the present grant level relationship conformed to the proposed percentages, the medical assistance levels would have to be reduced as follows:

MAXIMUM ALLOWANCE INCOME STANDARD

	Percent of average maximum allowance			
	Current	133⅓ percent	140 percent	150 percent
Size of family:				
1	$2,000	$1,380	$1,450	$1,550
2	2,500	2,030	2,130	2,280
3	3,250	2,510	2,640	2,830
4	4,000	3,030	3,180	3,410
5	4,750	3,535	3,710	3,980
6	5,500	3,910	4,110	4,400

Reduction of present medical assistance eligibility levels would place a burden on hospitals which would have to care for more persons without state aid. This would tend to increase hospital insurance costs for private subscribers since the hospitals would need a method to finance any additional free care load.

If Pennsylvania maintained its present Title XIX eligibility standards and raised the AFDC grants to make the percentages conform as proposed in the law, it would cost the state:

133⅓ percent of average maximum allowance	$14,200,000
140 percent of average maximum allowance	17,630,000
150 percent of average maximum allowance	10,400,000

We agree that there should be a Federal ceiling on medical assistance levels. We have some question about whether relating them to the assistance grant levels in this fashion is sound. However, in the absence of Federal standards for public assistance grants, the proposal is useful. We would like to see the program pegged at 150% and the states given until 1975 to conform.

Pennsylvania's medical assistance standards are based on studied opinion that families and persons below these levels cannot afford to buy health insurance. We believe that a better approach would allow the health insurance system to be expanded to cover as many persons as possible (the disabled, the blind), and that other eligibility be based on a cost of living determined ability to purchase health insurance.

We are now convinced there should be Federal standards for public assistance grants based on local cost of living standards. These should stand alone for their own value.

The Title XIX provisions also eliminate the present requirement that states provide the five basic types of service specified in the present law. They could select from a number of formerly optional and less fundamental types of care. This is a regressive provision. A state, for instance, could have a program without physicians or hospital services. Among other consequences, this is inconsistent with the bill's mandate that all states provide family planning services without a physician program, there could be no family planning program.

For persons over 65 the states would not be authorized to provide services which could have been provided under part B of Medicare. They would no longer be required to provide comparable service for persons under 65. This could reduce or delimit care for families and children if a state so desired.

We are adamant that persons receiving Medical Assistance must be assured free choice of practitioners and facilities. This is a fundamental part of the Pennsylvania program already.

The bill provides that the medically indigent may receive cash payments against their bills rather than direct payment by the state to the physician. The physician would make the choice of payment method. Aside from the complex administrative payment problems that would result, many experts believe that such a system could result in exploitation of patients and in a lower quality of care.

The best way to reduce assistance levels and costs is to assure other sources of adequate income and health care. These would include improved social insurance benefits and a comprehensive program of assistance and services based on Federal standards of adequacy supported by a new and more adequate pattern of Federal financing.

Section 235. Inclusion of child welfare services in title IV.

If the intent of this provision is to separate services from the money payment in public assistance and combine them with the services of child welfare, it is a positive move, in spite of the difficulties it would present to Pennsylvania because of our structure. (Our public assistance is state-administered and our child welfare services are county-administered.) In fact, it might be more sound to move the Title IV services to Title V. This could allow for clear provision that financial eligibility procedures and services be separated, as they should.

If child welfare services would be used to force mothers of young children to work, we would be opposed to this move. We assume that they are made in the spirit of improving services for all needy children.

In balance the provision is sound. We should keep clearly in mind that its passage would require fundamental change in Pennsylvania's public welfare delivery system and governmental responsibility structure. Theoretically, the present financial structure could be maintained. But either the county would have to administer public assistance, at least the AFDC service part, or the state would have to assume responsibility for conducting child welfare programs presently under county auspices.

There could, of course, be a system which would provide several patterns. Or we could create, as was suggested by the Pennsylvania State and Local Welfare Commission, a new pattern, not unlike the school district arrangement.

HEALTH & WELFARE COUNCIL OF NASSAU COUNTY, INC.,
Garden City, N.Y., September 22, 1967.

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

DEAR SENATOR LONG: The Board of Directors of the Health and Welfare Council of Nassau County met on September 20 and authorized the release of the attached statement indicating our grave concern about Title II of HR 12080, the Social Security Amendments of 1967.

We urge you, as Chairman of the Senate Finance Committee, to give serious consideration to the objections listed in this statement since they are shared by individuals and organzations throughout the country who know, from long experience in the fields of human services, that this legislation is regressive and can only lead to serious problems in our attempts to help people lead a more decent life.

Sincerely yours,

JOHN A. GAMBLING, *President.*

HEALTH AND WELFARE COUNCIL OF NASSAU COUNTY, INC., GARDEN CITY, N.Y.

STATEMENT REGARDING IMPLICATIONS OF TITLE II OF H.R. 12080 APPROVED BY THE BOARD OF DIRECTORS, SEPTEMBER 20, 1967

The Board of the Health and Welfare Council of Nassau County has reviewed with deep concern Title II of the Social Security Bill HR 12080 which is now being considered by the Senate Finance Committee. The membership of the Council includes 130 Nassau County organizations and agencies and 400 individuals active in the fields of health and welfare. In the opinion of the Board, the purpose of Title II as stated in the House Ways and Means Committee report of "reducing AFDC rolls by restoring more families to employment and self-reliance" is commendable. Other desirable features of Title II include provisions for increased federal financing for day care, foster care, demonstration projects and training of social workers, and provision for retention by a welfare recipient of a portion of his earned income.

However, Title II of HR 12080 includes provisions for carrying out its objectives that are so punitive and coercive that the net result of this legislation can easily be the compounding rather than the solution of the problems of the families affected.

Undesirable provisions in Title II include:

1. Freezing at the January 1967 level the number of children in each state eligible for AFDC funds regardless of the number of children requiring such funds;
2. Forcing mothers of AFDC families to accept training or employing away from home even when they are the only adult family member, by threatening them with such penalties as removal from AFDC rolls and the possibility of court ordered removal of their children from their homes;
3. Limiting federal funds for child welfare services to AFDC families and further limiting day care funds to children of working AFDC mothers without regard to the needs of the children of non-working AFDC mothers and the children of mothers who require these services to keep the jobs that enable them to support their families;
4. Limiting aid to children of unemployed fathers to those who have had recent employment thereby forcing fathers who have been unemployed over a long period of time to leave home in order to make their families eligible for AFDC funds;
5. Permitting the hiring of AFDC participants at sub-minimum wage level.

It has been the experience of Health and Welfare Council members in that their own work and that of the Nassau County Anti-Poverty Program that assurance of proper care for families, adequate and appropriate education, training and work opportunity, and the right to keep a portion of their earnings to materially improve their family's financial situation are far more powerful incentives for welfare recipients to become self-supporting than threats or punishment. It is also noteworthy that it is in the best interest of some families that the mother remain at home with her children. Also, continued absence of a father from a home usually promotes family insecurity and instability.

The Board of the Health and Welfare Council recommends that HR 12080 be amended to assure the availability of federal child welfare funds to all children requiring supportive services, eliminate coercive and punitive measures for forcing mothers to accept employment, include assistance to children of unemployed fathers without requiring their absence from home and to authorize the appropriation of enough federal funds to permit the establishment of sufficient day care, training and other services to meet the actual need.

STATE OF COLORADO, DEPARTMENT OF PUBLIC WELFARE,
Denver, Colo., September 21, 1967.

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

DEAR SENATOR LONG: As chairman of the Advisory Committee to the Division of Children and Youth, State Department of Public Welfare, I wrote to the Honorable Wilbur Mills, Chairman, Ways and Means Committee, in support of H.R. 1977, which provided for comprehensive child welfare legislation so badly needed by Colorado as well as by other states. H.R. 1977 has been supplanted by H.R. 12080 now in your Committee.

We are deeply concerned that this bill, although it does provide a considerable increase in amount authorized for child welfare, will restrict the benefits given to children dependent upon public welfare programs. Section 235 of H.R. 12080 moves the existing child welfare program from Part 3, Title V of the Social Security Act (Child Welfare) to Title IV (AFDC), but does *not* provide for seventy-five per cent federal matching for child welfare services given to non-AFDC children, nor does it provide the same "open end" financing.

In effect this means that dependent children not members of an AFDC family cannot receive the same benefits available to children of AFDC families. The same is true in the provisions for day care—75% federal matching is limited to personnel working with AFDC working mothers, but not to personnel working with children not members of an AFDC family. Take for example the 3,406 children in foster care in May 1967. Of this number only 85 were from

AFDC families eligible under present law. Under the broadened eligibility provisions for foster care of AFDC children, only a small number of the remaining 3,321 children would have been included. These non-AFDC cases include children who are dependent, emotionally disturbed, mentally retarded, neglected or abused, children waiting for adoption, etc. Under the provisions of H.R. 12080 these children would not receive the same federal support afforded AFDC cases.

Colorado received $2,403,700 from the Legislature this year, $96,000 less than requested, and the counties budgeted $875,000. This is for foster care alone. We received only $487,432 from the Children's Bureau, Title V, Part 3 of the Social Security Act. Twenty of our counties are already at, or over, the maximum amount budgeted for welfare. This means some Colorado counties will have to close the foster care program. The State is running in the red over $20,000 each month for foster care.

The 1962 Amendments to the Social Security Act require the states to have a comprehensive child welfare program throughout all political subdivisions by 1975, and to show progress toward this goal each year. Without the federal matching formula provided for in H.R. 1977, the goal set forth by the 1962 Amendments is simply unattainable.

We urge you to remove from H.R. 12080 the restricting provisions which limit 75 per cent federal matching and "open end" financing to children of AFDC families.

Sincerely yours,

James G. Hudson,
Chairman, Advisory Committee to the Division of Children and Youth.

Family Service of Montgomery County, Pa.,
Norristown, Pa., September 25, 1967.

Hon. Russell B. Long,
*New Senate Office Building,
Washington, D.C.*

Dear Senator Long: We are writing you concerning H.R. 12080 directly following our first Board Meeting of the year. The entire Board, plus our Agency staff are vitally concerned about the new changes in philosophy relating to child welfare provisions. We applaud Section 401 of Title IV but are against anything that is discriminatory and could lower the already inadequate help for parents alone with children. Until now, our Aid to Dependent Children Program has been based on keeping children at home with their mothers and enabling mothers to be better parents in a natural home setting. This Program is so under-financed now, the parent never has enough and this situation could often encourage vices, rather than prevent or cure them. This, in turn, causes more abandonment of children and the problem of placement is greater all the time, not to mention the consequent increased cost of foster homes, if available, or institutes.

On the Amendment about work and training for all mothers and out of school youth over 16, we feel it would be far more practical if job opportunities were offered, not forced. Some mothers are not capable of doing two things at once and would break emotionally. It does not allow for individual differences. An overall must is dangerous, for example, if a child is disturbed and the mother has to take him out of the home, this makes the problem worse and your future citizens misfits who cannot contribute constructively to society when they grow to adulthood.

If your Bill eliminates the provision making it mandatory upon the State to pay full need as defined by each State itself, to public assistance recipients and to reprice such standards each year, won't you defeat your purpose by adding fuel to the fire of discontent in future riots plaguing our cities and also hurting our image abroad of a thriving democracy giving all a fair chance. We do not believe your Committee has realized the full impact of these Amendments and that a sober second thought will make clearer the terrible dangers to the health of our society.

Sincerely,

William R. Cooper II,
President of the Board.

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., September 25, 1967.

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

DEAR SENATOR LONG: The nation's Governors voice strong general support for the Social Security Amendments of 1967 but express concern for specific points in this vital legislation now before your committee.

The National Governors' Conference Office of Federal-State Relations polled the Governors on H.R. 12080. This summary is too short to cover every shade of view on each point they make but presents the general tone of their replies.

The responding Governors without exception oppose limiting the number of children in each state eligible to receive AFDC benefits. They claim this would be penalizing the children for sins of others and would in no way correct the situation of illegitimacy but merely shift onto the state the entire burden of caring for the additional children.

The Governors, however, find the other approaches to the illegitimacy problem helpful. They have great praise for the self help programs, particularly the idea of work training for mothers on AFDC. Most Governors do not think this should be compulsory across the board. Some suggest that the states be required to offer such a program but mandatory participation be handled on a case-by-case basis to make sure mothers who should be with their children are not forced to leave them during the day.

The Governors favor enhancement and encouragement of the AFDC for Unemployed Parents program. Some suggest higher matching, extention to every state by requirement or bonuses for states participating in the program. Opposition was expressed to new requirements in the bill.

The Governors would like to see the proposed ceiling on Medicaid removed or raised at least to 150 percent.

Many Governors feel the state should meet their minimum definition of need—*but they stress that this can only be done if the federal government increases its share of the matching.* Several Governors call for a uniform matching formula for all welfare programs to preclude participation in higher federal-share programs to the detriment of those with lower matching. In general, the Governors favor extending the exemption on the salaries of full-time students to part-time students.

Thank you so much for giving the Governors this opportunity to express their views on this important legislation. Because you are aware of their intimate knowledge of the execution of these important social and welfare programs, we are sure you will give their views great consideration.

Sincerely,

CHARLES A. BYRLEY, *Director.*

NATIONAL TUBERCULOSIS ASSOCIATION,
New York, N.Y., August 18, 1967.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Congress,
Washington, D.C.

DEAR SENATOR LONG: The National Tuberculosis Association wishes to bring to the attention of you and your Committee a provision of Title 18 which we believe is in need of re-evaluation, specifically, Section 1812(c) which applies to beneficiaries who are in tuberculosis (or psychiatric) hospitals on the first day of the first month in which they become entitled to Medicare benefits. This section provides that the 90 days of hospital benefits ordinarily available in the beneficiary's first spell of illness will be reduced by the number of days he has been in such a hospital during the 90-day period immediately preceding that first day.

It is our opinion that deletion of that part of Section 1812(c) which relates to tuberculosis hospitals is the only sound solution to rectifying an unfortunate restriction of benefits for patients who must receive treatment in these institutions.

Section 1812(c) is a restriction on tuberculosis *hospitals* and affects patients with tuberculosis only to the extent that they receive treatment in such institutions. Patients who are receiving treatment for tuberculosis in general hospitals at the time they become 65 are not subject to this restriction.

The restriction might impose no handicap for tuberculosis patients if they were always able to receive treatment in general hospitals. However, many general hospitals have retained a reluctance to care for tuberculosis patients in spite of the potency of drugs in eliminating infectiousness of the condition. In addition, the pressure on general hospital beds is so heavy in many communities that treatment for tuberculosis in such hospitals is not encouraged when a tuberculosis hospital exists in the area. When the tuberculosis patient has no alternative to receiving his care in a tuberculosis hospital, he is obviously at a disadvantage with the patient in another community who receives Medicare benefits in a general hospital with no consequent reduction in reimbursable days.

In most states, patients are required to pay for care in tuberculosis hospitals even though these are mainly tax-supported institutions. Reduction of Medicare benefits to the aged in these institutions can represent a considerable financial burden on them at a time in life when their resources are limited.

The purpose of Section 1812(c) is to prevent use of Medicare funds for custodial care. As such, it has no justification in view of modern tuberculosis treatment. Present length of stay of tuberculosis patients is often no longer than that of many other chronic disease patients due to the efficacy of antituberculosis drugs.

The provision is also illogical in view of recent trends towards treatment of non-tuberculous conditions in tuberculosis hospitals. In some tuberculosis hospitals, half the patient population are persons with other conditions. This fact was recognized by the Social Security Counsel in his ruling of June 24, 1966 to allow Medicare payments for patients in tuberculosis hospitals regardless of diagnosis.

Arbitrary provisions applying only to persons in tuberculosis hospitals are rooted in an historic distinction between tuberculosis and other diseases which no longer applies. The type of discrimination which Section 1812(c) imposes seems contrary to the intent of the insurance program, which is to help all aged persons meet the burden of hospital and medical costs. Certainly it is contrary to the spirit of the December 1963 report of the Surgeon General's Task Force on Tuberculosis Control which recommended an accelerated campaign to eradicate the disease.

It is our sincere hope that the Committee concurs that the situation described is in need of legislative action, best met by deletion of that part of Section 1812 (c) which relates to tuberculosis hospitals.

The NTA also wishes to express its approval of Section 132 of H.R. 12080 which allows purchase of durable medical equipment under the Medicare program instead of only rental, as is now the case. We are eager to see this amendment adopted because it will allow elderly patients with chronic obstructive pulmonary disease to own inhalation therapy equipment. Such patients, particularly those with emphysema, need to use this type of equipment at frequent intervals over long periods of time, sometimes for the rest of their lives. We believe the amendment is a rational and economical approach to long term provision of needed medical equipment for Medicare beneficiaries.

We would appreciate your making this communication a part of your committee's hearings on the Social Security Act.

Sincerely yours,

JAMES E. PERKINS,
Managing Director.

THE STATE OF WISCONSIN,
DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
Madison, August 8, 1967.

To: Paul E. Hassett, Office of Governor Knowles.
From: Wilbur J. Schmidt, Secretary, Department of Health and Social Services.
Subject: Social Security Amendments of 1967—H.R. 5710.

We have given a brief look at the items contained in the summary of the new bill called "Social Security Amendments of 1967" which is now being presented by the House Ways and Means Committee and which was sent to you by Under Secretary Wilbur Cohen, Department of Health, Education, and Welfare, for the interest of Governor Knowles and the other governors of the country. We have some reactions to record, although one is limited in making an examination of these proposals by the brevity of the summary which is in your hands and of which we have a copy.

As to social security benefits there are provisions which seek to increase benefits to eligible persons by approximately 12½% with other extensions and other added features which will somewhat up-date the benefit structure in terms of current price levels and the economic need of the individuals. Included among the added benefits is an increase from 90 to 120 days for hospital care under medicare, with the provision that during the added 30 days there will be a co-insurance feature requiring the beneficiary to meet one-half the daily cost for those additional days. In order to finance these changes it is proposed that earnings subject to social securtiy tax be increased from the present level of $6,600 per year to $7,600 per year, effective January 1, 1968.

Other features dealing with social security are technical in nature and appear to be aimed at making the program more comprehensive and at solving problems of definition.

In general we would regard the changes as desirable in order to keep the schedule of benefits in social security up to date which, by the way, will also result in some reduced demand upon the state's public assistance and medical assistance programs, since there will be additional benefits available to eligible persons before it becomes necessary for them to rely upon state programs.

As to features of this bill dealing with public assistance and child welfare, the following comments are submitted.

The provision for requiring states to establish community work and training programs and to see that all eligible persons have such opportunities seems to be very desirable. We have already made a start in Wisconsin and would look forward to an enlargement of this program under the terms of this legislation which, incidentally, would increase federal matching for supervision of such activities to 85% until July 1, 1969, and 75% thereafter.

The bill provides for increased earnings exemptions for breadwinners in aid to families with dependent children and as well for older children who are not attending school. This, in our opinion, is a very desirable feature and, in fact, one in which your office and our own Wisconsin Legislature have shown great interest in the past. It is hoped that by increased work incentives in this fashion there will be more desire on the part of these individuals to prepare themselves for employment.

Provisions of this bill dealing with children of unemployed fathers include more restriction than now as to federal financial participation. The principal provisions which bring about these limitations are (1) a requirement that an individual receiving aid under this program must have exhausted his unemployment compensation rights or must have had a year and a half of work during a 3-year period ending in the year before assistance is granted and (2) there would be no provision for supplementing unemployment compensation during the time the father would be receiving the same.

The Wisconsin program goes further, as has been allowed by the federal government in the past, in that we only require that the individual now unemployed and who has applied show that he has in fact been actively engaged in the labor market or has been seeking employment, but he is not forced to show a work experience of an exact number of months and, secondly, if need requires there may be supplementation of unemployment compensation during the time the same is being received. We have felt that need should be the principal consideration and that we can avoid a "runaway" program by careful supervision even with the more liberal definitions of eligibility which appear in our law and which I have just stated. If it would develop that we who have a program already started would be required to meet this new restriction by July 1, 1969, and thus would find some individuals who would need to be removed from our rolls and yet would appear to be in need of help, we would find ourselves paying for the same out of our general relief programs which, of course, would be locally administered and financed. I think we in the Department would prefer our present standard and would like to see it retained, although the impact of the provision proposed in the subject bill may not be very great in our instance.

There are some liberalizations in the bill as to federal financial participation in foster home care of dependent children. As far as this provision reaches, we would favor the same. Our interest, of course, would be in a still greater extension of federal financial participation in the costs of foster home care.

A new provision is one providing emergency assistance for needy children, which would appear to be the first federal effort to share, even in a small way, the cost of public assistance to families who encounter emergencies for which no immediate help is currently available. The limit as to time for such emergency assistance would be a 30-day period. This could have the effect of reducing our state cost in the program of state dependents, as this would appear to create an elegibility for federal financial participation during a 30-day period, which now would be a state cost.

We endorse the extension of child welfare services to families who are receiving aid under the aid to families with dependent children program as another means of sharpening the rehabilitative effort which goes into a total program of public assistance. There would be limitations placed on a number of cases which would be allowed for federal financial participation within the aid to families with dependent children program. The summary states that "the proportion of all children under age 21 who were receiving aid to families with dependent children in each state in January 1967 on the basis that the father was absent from the home could not be exceeded after 1967." Our first reaction to this is one of whether such a statement of limitation could produce inequity in federal financial participation between states. We have never seen a proposal like this before, consequently are not certain as to how this would effect a state like ours, as well as the other states of the country, as we would presume that the issues would be different in states where there would be a high degree of family movement in and out, and other states where the population tends to remain more stable. This is an obvious effort to control the aid to families with dependent children program so as to place some kind of limit upon the federal funding. While it may serve this purpose, the fact is that if a family is found to be needy, it would appear to be someone's responsibility to see that help is given, and if this help should happen to exceed the proportion which is fixed by this provision, the fiscal responsibility would obviously fall to the state or local units of government. Our first reaction is one of concern without being sure as to whether this provision should be opposed.

There is a limitation placed on the income level for eligibility for medical assistance which, for states like ours who are already in business, would allow an income not exceeding 150% of our needs level for families receiving aid to families with dependent children until July 1, 1968, after which time this would need to be reduced to 140% by January 1, 1969, and finally to 133⅓% by 1970. Our present definition of eligibility as to income would fall within the 150% provision that could be used for the present time, but would exceed the 133⅓% called for by 1970, unless during the time the average aid to families with dependent children grant also increased. Very likely there would be some increase seen in the aid to families with dependent children grant so that our allowed income for eligibility would probably not be upset by this provision.

We hope that these general observations will be of some value to you as you go about preparing the Governor's view as to this measure.

WILBUR J. SCHMIDT, *Secretary*.

SEPTEMBER 28, 1967.

To Senate Finance Committee:

Mr. Chairman, I very much appreciate this opportunity to testify in behalf of supplementary Finance Legislation concerning Medical Benefits for persons over the age of 65 or medically indigent. I am hopeful that your committee will look favorably upon what I have to say, in the context in which it is said.

At the present time, I am functioning as Chief of Staff of a somewhat less than 100 bed general hospital and as Medical Director of a 118 bed extended care facility. I have had a chance to observe first hand the impact and workings of Title 18. Initially in the hospital, from the hospital's point of view as well as the physician's point of view, and since January 1, 1967, the impact of this legislation upon the functioning of the extended care facilities and the inter reactions of the extended care facilities and the acute hospitals. With all the ramifications of implementing new legislation in a relatively short period of time, I have been quite impressed with the value of the legislation and the earnestness with which all parties have attempted to make it function smoothly and effectively. Certain areas have, however, appeared to me to be functioning inadequately or with great difficulty. In some cases this problem was on the basis of some questions or problems with the original legislation. Others had to do with its implementation and interpretation by the Social Security Administration. With your permission, I would like to detail some of these problems and explain their impact. In addition to making the acute hospital's job more difficult, they have added to the expenses of the operation. More significantly, however, it has caused considerable concern and anguish among the recipients, the over 65 individuals, and the greatest destructive impact have been on the indigent over 65 patients.

One of the earliest major problems had to do with the deductible portions. The $40.00 hospital deductible and $50.00 physician deductible very frequently placed a hardship on the medically indigent over 65 patients. While it is my understanding that this lack of payment may be reimbursible expense if it is delinquent, a considerable number of these people could create quite a financial burden for the hospital to bear for the initial twelve month period. In addition, there has been considerable confusion and anguish when patients, on leaving the hospital, are asked to pay their bill and in addition to the $40.00 deductible, have to pay the B deductible for hospital based medical specialists. It is my opinion that the abolition of any deductible would lead to enhance abuse of the program. However, I feel that there should be only one deductible covering both plans A and B, and that patients carrying a valid State Public Welfare card testifying to their indigency, or medical indigency should have their deductible waived. I also think to establish greater financial stability for the plan, that there should be a graduated benefit schedule much as our present Social Security payment schedule calls for—the higher the income or financial solvency, the less will be their need for Title 18 or Title 19 coverage. I feel that by putting a clause of this type into the program, the paper work would be shortened; the program could function more efficiently and more rapidly.

This also has been my understanding that the program has essentially been functioning near the proposed budget, with the exception of the patient benefits in extended care facilities which are running at approximately 500% at the budget cost. I believe I have one explanation for why the program is not functioning as tightly as possible. Physicians have traditionally had only one major roll to play; that is to minister to their patients ills. They have now been given an added responsibility—that of certifying as to their claims against their insurance carrier. Even the physicians that are willing to assume this burden are faced with the dilemma as follows: If the attending physician refuses to certify the patient, or if the Utilization Review Committee finds that the patient's care has become custodial rather than rehabilitative, as the law calls for, and then deprives the patient of his benefits, we physicians feel that there is a moral obligation and it is my opinion that, as the law is presently written, a legal obligation of the patient to start to regenerate his benefits under the sixty-day clause as provided for in the law. However, this is not the way the law is being interpreted at the present time.

If I may present the following example: Under present interpretation, if an elderly patient fractures a hip, is hospitalized for a period of ninety days, during which time she is operated on, convalesces, gets rehabilitative physiotherapy and at the end of her ninety_day stay in the hospital, is considered to be in need of no further acute or extended care; however, the family feels that they are unable to care for this patient and that the patient is unable to care for herself, propose to place her in a nursing home that she may spend her remaining days in a suitable environment with the understanding that they are to pay for all the costs incurred. They do so for a period in excess of one year. At the end of one year this unfortunate patient has another disabling illness, such as a myocardial infarction and is then returned to the hospital. At that time she will be told that she has no further Medicare benefits in the hospital as her spell of illness had never ceased since she was in a facility giving nursing care, even though the facility may not have been a qualified or approved extended care facility under the Medicare Law. This, I believe you can see, appears to be patently a denial of the patient's needs and would appear she would be entitled to. It is the awareness of these inequities and how the law is presently functioning that has led to some abuse of this particular facet of the program. Another difficulty with regard to utilization review concerns the legal status of the physicians functioning on the utilization review committee as to their liability. Attorneys have agreed with me that since we are physicians functioning in a medical capacity, albeit for the hospital, our determination that the change of a patient status from acute to custodial would constitute a medical judgment and since the patient was not examined, would be the basis of a suit for malpractice. If, on the other hand, the patient were to be examined, this could result in a suit for assault and battery.

It is, therefore, my opinion that to get the utilization review committee functioning more adequate, the members of such committees should be made immune from liability while functioning on behalf of said committee. If the definition in the law of a spell of illness were made either more precisely or recommendations that a more appropriate interpretation of this facet of the law were made, I believe that there would be a far greater willingness of the physicians and paramedical personnel in this country to make this law work effectively. Another facet of the law that is creating problems is the fourteen day period of transfer, from an acute hospital to an extended care facility. At the present time, if a patient is transferred from an acute hospital to a brand new, just built, extended care facility, they will not be covered under Medicare because it is physically impossible for the extended care facility to apply for and receive certification within a fourteen day period. I would recommend that new facilities, which are constructed, and will give extended care benefits, should have their effective date of certification made retroactive to their date of application, if they apply within sixty days of receiving state approval and if they meet the requirements of the law for certification.

With the advent of as major a piece of legislation as the Medicare Bill, many patients over the age of 65 who could not, or would not, seek medical care prior to this legislation and consequently would have suffered disabling or fatal illnesses are now receiving the medical care they need. This in turn is keeping a greater number of our elderly population alive and in relatively good health for their age, but still not at a productive level. I, therefore, would urgently recommend the committee to consider measures to give these patients some support at a lower level of personal care or custodial care. I do not feel that such legislation should cover the entire cost of such a procedure, but should be made contingent upon state and local community support. I also feel that these patients should be prohibited from receiving equivalent care as in extended care facilities. This would enable the patients to receive personal care in a physical plant with a lower cost of operation.

The last point that I would like to make is that at the present time the Medicare law requires three separate types of facilities and approval: namely, acute hospitals, extended care facilities, and home health care agencies. In many of the smaller communities it is very frequently difficult, if not impossible, to arrange for the separation of these three facilities. I would like to recommend that either an acute hospital or an extended care facility be permitted to establish a home health care agency with the approval of the Social Security Administration. As the rule now reads, this may be done so, but only if the State licenses home health care agencies. If the State does not license home health care agencies, these facilities may only be approved if they are non-tax paying as opposed to being permitted to be established by tax paying facilities.

I would welcome the opportunity to offer whatever services I could in the future to this committee should you so request. Thank you for this opportunity.

MURRAY J. MILLER, M.D.

STATE OF IOWA,
OFFICE OF THE GOVERNOR,
Des Moines, September 20, 1967.

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

DEAR SENATOR LONG: My staff and I have reviewed the Social Security Amendments of 1967, H.R. 12080. Although there is much merit in the bill, I cannot give it my unqualified support. I regret that circumstances prevent me from being in Washington to testify before your Committee. However, I should like to present my views on some of the more important points of the bill.

I am very much opposed to those provisions of the legislation which place limits on the number of children from broken homes who may receive AFDC. The children receiving such assistance are already the victims of circumstances beyond their control. Any denial of benefits would serve to compound the injustices to the child, further weaken the stability of the family, and increase the long-range problems of the community.

Should action be taken, as proposed, limiting the total number of children from borken homes receiving AFDC benefits, the state would, in my opinion, have an obligation to provide assistance from our own funds without federal matching. This step would, of necessity, reduce the total level of payments in the entire AFDC program. These payments are not adequate at present, making any further reduction an exceedingly harsh action on innocent children. Placing an inflexible limit on the total number of children does not have much validity in a very flexible economy.

I also strongly oppose, as unsound economy, the provisions of the bill relating to required work training programs for mothers receiving AFDC payments. The original philosophy behind the bill was that society and children would benefit from maintaining the family unit. This basic philosophy is still valid. The savings that can be made now through these provisions will prove extremely costly as these children grow into adulthood without the additional parental guidance which the nonworking mother could provide.

There should, in my opinion, be no blanket requirement that all AFDC mothers undergo work training, nor should mothers be arbitrarily required to go to work. The policy adopted should be based on the approach that a mother would be required to accept training and employment only when it is established that—

1. The age of the children, the circumstances of the family, or other factors do not require her continued presence in the home.
2. She is mentally and educationally capable of assimilating the training.
3. A job of the type for which she has been trained is reasonably available in the community or nearby.
4. The mother's acceptance of work training will serve to promote the family unit and increase the value of the over-all home experience.

In order to administer this program, we will need more and better trained case workers than are now available.

I very strongly support measures designed to encourage children from AFDC families to find jobs and move out of the welfare cycle. In view of this, I support extending the exemption, under the AFDC program, of the full earnings of full-time students, as proposed by H.R. 12080, to include the full earnings of part-time students.

I agree with the wisdom of requiring all states to establish community work and training programs in every area of the state where a significant number of AFDC families live. Such a requirement should, however, be made only when we have—

1. A sufficiently high rate of federal matching;
2. A limit on the period of eligibility rising from this cause which is uniform among the states; and,
3. A close administrative tie in arrangements among agencies dealing with the general problems of the unemployed.

For the next few years, I think it is vitally important that the matching rate should be at least 90/10 for any new self-help program designed to get people off the welfare rolls. These programs have not yet been sufficiently tested that we can demonstrate any cost benefit analysis. We will need such reference in justifying the program to state legislators if we are to get in excess of ten percent state funds. In the last session of the Iowa General Assembly, the only way to obtain funds at even the ten percent level was to switch from the regular ADC program. In time, if there is worth to the program, there should be a reduction in ADC expenditures assuming the number of recipients remains stable and the cost of living is not greatly accelerated. At that time, the states could be expected to assume a more proper share in financing the program.

The self-help program as outlined in the Social Security Amendments could, I feel, be benefited by greater emphasis on the role of statewide planning for program development. The ultimate result would be better if we allowed the states to develop their own individual plans for training of persons currently receiving social welfare assistance. Such plans would then be a state responsibility.

On a temporary basis, I feel that a ceiling on the federal share of medicaid would result in a more equitable distribution of federal funds to the states. At the present time, we may only estimate what the total expenditures on this program will be. Such a step would preclude the possibility of those states with higher per capita incomes and ability to obtain larger state appropriations claiming a disproportionate share of the federal funds. On a long time basis, I think the state should be encouraged to work toward adequate programs in light of their individual needs by the adoption of at least a 150 percent figure.

The proposal in H.R. 12080 that changes be made in the mode of providing and paying for consulting services to assist hospitals and nursing homes, to become eligible for medical programs, poses several problems. The major problem is the possible administrative division with inspections being placed under the Department of Health and consultative services under a division of welfare. The legislation would appear to present problems at the state level in terms of organizational structure. Perhaps an alternative method for providing payment o Health Department services granted under Title XIX, covering both surve and consultation activities that are not currently eligible under Title XVII should be developed.

It is natural for the states to urge retention of support at the 100 percent leve leaving state funds free for other equally urgent purposes. The consultation wit nursing homes does seem, at least in part, a state responsibility, and therefore, proper subject for state financial participation.

I would also urge the Committee to consider requiring states to make assistance payments on the basis of actual need. The level of state contribution coul be set on the basis of that state's position with relation to other states, takin into consideration the income levels within all of the states. The federal shar should be increased subsantially to a major portion enabling the state to mee full needs.

If we are to move in the area of social welfare from simply maintaining people in the status quo toward rehabilitation of them as a useful component of society then we shall obviously need, not only more social workers, but far better traine personnel in this vital area of government. I support the provisions of the bi that offer a partial remedy for this need.

I hope these comments will be of assistance to you.

Very truly yours,

HAROLD E. HUGHES.

NEIGHBORHOOD LEGAL SERVICES PROJECT,
OFFICE OF THE DIRECTOR,
Washington, D.C., September 28, 1967.

Re H.R. 12080, An Act to Amend the Social Security Act.

TOM VAIL,
Chief Counsel, Committee on Finance, U.S. Senate, New Senate Office Building, Washington, D.C.

DEAR MR. VAIL: The Neighborhood Legal Services Project of Washington, D.C., funded by the Office of Economic Opportunity, provides free legal services to the indigent people of Washington. Through our ten neighborhood offices during 1966 we handled 9,023 cases in the areas of consumer, landlord and tenant, criminal, domestic relations, juvenile, and administrative law. Approximately 500 of these cases involved problems of welfare law. During the last fiscal year we have also represented plaintiff recipients in attacking the validity of regulations and statutes enforced by the Department of Public Welfare, including suits to establish the illegality of the District of Columbia "substitute parent" rule and to declare unconstitutional the one-year durational residency requirement for public assistance eligibility.

Thus, the cumulative experience of our attorneys with respect to the operations and regulations of the District of Columbia Department of Public Welfare has been substantial. It is this cumulative experience and knowledge which I would like to bring to bear upon the provisions of H.R. 12080, a Bill entitled An Act to Amend the Social Security Act, now under consideration by the Senate Finance Committee. Title II of this Bill, the Public Welfare Amendments of 1967, contains provisions which would wreak substantial damage not only to the economic subsistence of recipients and innocent children but to their legal rights. I refer particularly to the revised standards of eligibility with respect to availability for employment and with respect to the proposed AFDC "freeze" and also to the threats to the legal rights of recipients with respect to their rights to "self-determination" in their struggles to achieve self-subsistence, self-care, and maintenance of their family's integrity. I wish to focus upon H.R. 12080's dangers to the legal rights of recipients and applicants in the District of Columbia. In this connection, I wish to direct your attention to the excellent interpretation and criticism of H.R. 12080 prepared for the Senate Finance Committee by Professor Edward V. Sparer of Yale Law School, a nationally known expert in the field of welfare law. His comments analyze the sweeping effects of H.R. 12080 on the administration of public assistance programs throughout the country, and they apply likewise to the changes that would occur in the District of Columbia as a result of passage of the amendments in their present form.

Proposed Section 201 of H.R. 12080 provides for development of programs for the reduction of illegitimacy among children on the AFDC rolls and for assuring entrance into the labor force and acceptance of employment by AFDC recipients.

With respect to the latter objective, virtually all of the welfare recipients we have encountered want to be off welfare and enter the labor market, wherever possible. Those AFDC mothers, of course, with small children may not prefer to work or cannot do so because they are needed at home to stay with their children. The provisions of H.R. 12080 are replete with a basic assumption that public welfare recipients do not want to work and will not work if given the opportunity, and that therefore they should be forced to work. This assumption, which is assuredly incorrect and unwarranted, must be examined in the light of the built-in disincentives to seeking employment incorporated into our public assistance laws at both the local and federal level. Let us focus upon the AFDC program since it is presumably here that the drafters of the Bill envision "free-loading" and reluctance to enter the labor market. Without regard to the lack of skills and education suffered by AFDC mothers which virtually makes them unemployable, let us examine the economic disincentives to employment which permeate the law applicable to AFDC families.

42 U.S.C. 602(7)(A) now provides that a state program must take into account all resources of the family, including all income from employment, except that the state may disregard not more than $50 per month of earned income of each dependent child under the age of 18 but not in excess of $150 per month of earned income for all dependent children in the home. The Social Security Act currently provides no authorization to the states to ignore or disregard income earned by AFDC mothers. Therefore, with the exception of those AFDC mothers who might be employed in programs funded under Title I or Title II of the Economic Opportunity Act, whose income would be disregarded as to the first $85 per month and one half the excess over $85 earned per month, there is no exemption for any income earned by an AFDC mother. Each dollar of income earned is subtracted from her family's grant, and she has nothing to be gained by seeking employment.

Moreover, in the District of Columbia, pursuant to EL 6.1 of the Public Assistance Handbook of Policies and Procedures, a mother who becomes employed full time in competitive employment is ineligible for any supplementation from the Department. Moreover, an AFDC mother who is deemed by the Department to be employable, without regard to her bona fide but unsuccessful efforts to get a job or the current state of the labor market, is deemed ineligible to receive continued assistance under District of Columbia law. Thus, a mother who may work full time as a domestic, but who does not make as much working full time as she might receive on assistance, is ineligible for supplementation from the Department of Public Welfare in order to bring her net income up to the minimal needs standards (based on figures more than a decade old) established by the Commissioners of the District of Columbia for families on public assistance. A mother could therefore end up penalizing her family with respect to income available for basic needs for the children by actively seeking work and becoming employed in a sector of the economy which pays substandard wages.

It should further be noted that a 13% increase in public assistance payments in the District of Columbia, authorized by Congress to be effectice January 1, 1967, has been implemented in such a manner as to penalize any recipient who has an outside source of income, including income from employment. An AFDC mother who works part-time and who is therefore eligible for supplementation of her wages from the Department ends up getting less than the mother who remains on AFDC without working. The 13% increase was implemented so as to be applied only to the actual cash payment from the Department. An AFDC mother, therefore, eligible for $200 per month for her family before the 13% increase, would receive $226 per month after the increase if she has no other source of income. An AFDC mother whose family was eligible for the same amount but who earns $100 per month in part-time employment, would receive $113 from the Department. Her net increase would be $13 instead of the $26 that would be received if there were no outside source of income. In effect, she would have been penalized for seeking part-time employment.

With such strictures in effect, with the complex web of negative incentives built into the framework of the Social Security Act and state programs, it is no wonder that AFDC recipients may, under some circumstances, have some reservations about entering the labor market. Nevertheless, it has been the experience of our attorneys that their welfare recipient clients have virtually unanimously and sincerely expressed an interest in getting off welfare. They feel trapped in a system which spies on them, harasses them, and violates their privacy and dignity as human beings. They would only be too glad to leave it, if it did not mean deprivation of need parental care for their children and financial sacrifices. It is our position that the emphasis throughout the proposed amendments of forcing recipients to work, depriving them of benefits if they do not accept work, and otherwise depriving them of independence with respect to the payments made to their families, is misplaced and unnecessary. First the financial disincentives to employment must be removed.

Proposed Section 202 somewhat mitigates the lack of incentive to work described *supra* and the punitive provisions of the Bill with respect to refusal to accept employment by providing that earned income of dependent children in AFDC families and AFDC mothers or guardians must be disregarded by the states in computing need with respect to the first $30 of the total of such earned income for the month plus one third of the remainder of such income for such month. While it would appear that this section would be quite desirable in removing some of the disincentives built into the system, described earlier, in making such disregard of income mandatory instead of optional upon the states, and in not imposing a ceiling on disregarded income, it is to be noted that 202(d) appears to abolish the existing exemption for income earned under Title I and II of the Economic Opportunity Act. Thus, those individuals receiving assistance who are employed during their first year in community action programs and whose first $85 earned per month and one half of the excess over that amount is disregarded for purposes of determining need would no longer benefit from such exemption and would be confined to the amount specified in 202(b). The $30 per month exemption plus one third of the excess earned above that amount, however, is a mere pittance compared to the real needs of such families; it would appear essential to initially disregard a more substantial sum of money, at least equal to that exemption currently provided for in Title I or Title II programs of the Economic Opportunity Act.

Another substantive change proposed appears to provide for endorsement of such rules as the District of Columbia's "substitute parent" rule. This rule, embodied, in EL 4.5, IV, C of the District of Columbia Department of Public Welfare Handbook of Public Assistance Policies and Procedures, provides that a recipient who maintains a continuing relationship with a man is no longer eligible for public assistance if that "continuing relationship" has certain characteristics outlined in the regulations, such as substantial interest in the children, joining in shopping expeditions with the recipient family, or availability in emergencies. The rule further provides that if the Agency believes that a man is living in the recipient's home, even though he is not father of any of the AFDC children and is not contributing to the support of the AFDC mother or her children, the family is not eligible for public assistance since it is presumed that the man is caring for and supporting the AFDC children. This rule, similar to rules in other jurisdictions, creates needless hardship and deprivation to innocent children who are deprived of subsistence needs because of their mother's alleged relationship with a man. This rule, which is under court test in both the District of Columbia (*Robinson* v. *Board of Commissioners*, CA 3399-66, District Court for the District of Columbia) and Alabama (*Smith* v. *King*, District Court, Middle District of Alabama, 2495-N), has never been explicitly countenanced under the Social Security Act, amendments thereto, or regulations of the Department of Health, Education, and Welfare. Yet Section 202(b) of the proposed Bill appears to sanction state, "substitute parent" plans by providing that the "State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, *or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid.*" This may mean that State agencies like the Department of Public Welfare of the District of Columbia, under the terms of 202(b), are permitted to consider the income and resources of a man living in the home of a recipient who is not an adoptive or even natural parent of any of the recipient's children, who has no enforceable duty of support to such children, and who has in most cases not undertaken to support such children. Further, this section appears to invalidate standards promulgated by the Department of Health, Education and Welfare in Section 3120 of the Federal Handbook of Public Assistance Administration (Part IV) which provides that "income must not be considered where it is not, in fact, currently available to the needy individual; e.g., support payments ordered by the court but which are not, in fact, made; contributions which relatives have been determined able to make but which are not, in fact, made; and income from employment assumed to be available in the community when, in fact, the individual is not working. Assistance payments must be based on need in the light of currently available income and resources." Section 202(b) would appear to sanction state agency consideration of income which in fact is not available to the children-beneficiaries of AFDC and would thus sanction and reinforce restrictive eligibility provisions such as the District of Columbia's "substitute parent" policy.

I would further like to comment on two other aspects of H.R. 12080. Both of these aspects present ominous and tremendously significant changes in public welfare law. First, Sections 207, 201(a), and 204(a) provide for a liberalized and increased use of the protective payment provisions of Section 406(b)(2) of the Social Security Act. As originally envisoned the protective payments provisions were to apply only when there was a determination by the State agency that the relative of the child with respect to whom such payments are made has "such inability to manage funds that making payments to him would be contrary to the welfare of the child." The protective payments provisions were to be narrowly restricted since it was considered that one of the objectives of the Social Security Act had been to guarantee the right of the recipient to make his own judgments about how money would be spent. Section 5120 of the Federal Handbook of Public Assistance Administration summarizes authoritatively the purposes of the money payment principle:

The provision that assistance shall be in the form of money payments is one of several provisions in the act designed to carry out the basic principle that assistance comes to needy persons as a right. The right carries with it the individual's freedom to manage his affairs; to decide what use of his assistance check will best serve his interest; *and to make his purchases through the normal channels of exchange, enjoying the same rights and discharging the same responsibilities as do friends, neighbors, and other members of the community. The Social Security Administration's interpretation of "money payments" recognizes that a recipient of assistance does not, because he is in need, lose his capacity to select how, when, and whether each of his needs is to be met.*

Considerable inroads into this principle have been made by revised Section 402(a)(20) (Section 204(a) of H.R. 12080), which provides that if an AFDC mother decides that she does not want to accept employment (perhaps it being her judgment that she is needed at home with her children and that the child care plan provided by the Agency is inadequate or does not meet the special needs of her children), she not only will be removed from the AFDC grant as to her own needs, but that aid to her children will be paid under the restrictive payment sections of Section 406(b), as amended. This would mean that the AFDC mother who refuses employment would no longer be free to provide for the needs of her children as she sees fit in accordance with her judgment as mother of the children. The judgment of the AFDC mother with respect to the needs of her children would be supplanted by an Agency evaluation of such needs. Nor would it be her prerogative, under the work training sections of H.R. 12080, to decide whether she might be more needed at home with her family than working. An AFDC mother who legitimately feels she must be with her children on the basis of their special needs may not only expose herself to the threat of being removed from the public assistance grant but she may also be placing herself in the position of depriving herself of the freedom to make such decisions about providing for her family that any mother not on public assistance is free to make.

Until now I have reserved comment concerning what is the most distressing proposal in H.R. 12080. Section 208 amends Section 403 of the Social Security Act so as to freeze the proportion of AFDC children on public assistance to the general population of children in the state at the level reached on January 1, 1967. Numerous witnesses before this Committee, including Professor Sparer, have stressed the deleterious impact of this provision upon poor people throughout the country. As for the District of Columbia, caught in a demographic trend which has seen an increasing percentage of poor people inhabiting the inner city and a large scale outmigration into the suburbs, such a freeze of the proportions at the January 1, 1967 level would be a disaster of monumental proportions, ultimately thrusting back upon Congress the necessity of increased appropriations for the General Public Assistance (locally funded) program of the District of Columbia Department of Public Welfare. It is difficult to project or estimate the number of innocent children who might be harmed by the freeze, but it is certain that the numbers would be substantial and the effects of such policy traceable in another marked increment in the population of Junior Village, the District's institution for abandoned, dependent and neglected children.

As lawyers for the poor, however, we wish to emphasize another aspect of Section 208 which is particularly distressing. The experience of welfare recipients before the Agency which controls their lives and their very subsistence has generally been the stance of a passive beneficiary of statutory benefits. Recipients have been often treated by the Agency in arbitrary and capricious ways. Individuals have been summarily cut off assistance without a hearing under an erroneous construction of Agency rules relating to eligibility. It has been the role of Neighborhood Legal Services Attorneys as advocates for the poor to provide an effective voice to recipients in their dealings with the Agency. We have attempted to ensure, through our representation of recipients, that the Agency abides by its own rules and regulations and that it acts, pursuant to its legal obligations under the Social Security Act, in a predictable, consistent and legal manner. Implementation of Section 208 paves the way for a regression in the attempts to establish a meaningful rule of law with respect to Agency conduct.

In order to carry out the Congressional mandate to freeze the proportion of AFDC children on the rolls as of January 1, 1967, it will be necessary for the District of Columbia to promulgate restrictive eligibility standards which would result in the elimination of some AFDC children to make way for new applicants. It is likely that the substitute parent rule—already the source of cutoffs of assistance in situations where innocent children are needlessly and cruelly affected—would be more rigorously and ruthlessly enforced. It is also likely that the Department's employable mother rule, which provides that all AFDC mothers physically able to work are presumptively employable and ineligible for continued assistance regardless of their skills, education, and the state of the labor market, would be more rigorously enforced. In short, vigorous enforcement of eligibility standards, whose relation to the purposes of the AFDC program ("to help maintain and strengthen family life") is already questionable, would be necessitated; and in order to prevent an increase of caseload the Department would be required to use these rules, possibly in a capricious manner, to eliminate some children from the rolls in order to make way for others. The mandate of Section 402(a)(9) of the Social Security Act—that "all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall be furnished with reasonable promptness to all eligible individuals" will have been rendered nugatory by proposed Section 208.

Poverty in our nation has long been a concern of Congress, and understandably so. Just three years ago comprehensive legislation (Economic Opportunity Act) was enacted to provide new remedies. Our public assistance programs have supported some of our most destitute Americans for decades and most informed commentators, of all political persuasions, agree that welfare provisions have not succeeded in either adequately providing subsistence or a means to become self-sufficient. It may be that a new system should be devised but meanwhile millions of persons are dependent upon publicly supplied assistance. H.R. 12080 should be rejected, for it presents no solutions to our present problems and is in fact a retrogression to punitive notions reminiscent of the English poor laws. The proposals submitted by the Administration in H.R. 5710 should be considered anew in the light of the few positive features of H.R. 12080, along with recommendations submitted by the Advisory Council on Public Welware in 1966 (*Having the Power, We Have the Duty*).

Sincerely,

DAVID H. MARLIN,
Deputy Director, Law Reform.

AMERICAN PUBLIC WELFARE ASSOCIATION,
Washington, D.C., September 27, 1967.

Mr. TOM VAIL,
Chief Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. VAIL: In the formal statement which we submitted to the Finance Committee on H.R. 12080 we expressed approval of the proposal for the exemption of a portion of earned income in determining the amount of assistance to be paid under the AFDC program. We also commented that the amount of income subject to income exemptions should be increased.

As we have thought further about this matter we have felt some concern that this proposal, if adopted, would require monthly checking of the families who are earning some income, and probably a recomputation of the budget and a change in the amount of assistance as well. This would have the disadvantage of adding even further to the very extensive paperwork requirements in the administration of this program.

We are therefore submitting for the consideration of the Committee an alternative proposal for the earnings incentive provision of the bill. The attached material is offered as an amendment to Sec. 202 of H.R. 12080.

This proposal would require states to establish a "poverty standard" and to disregard earned income, prior support payments, and contributions until these have amounted during the 12 month period following application, together with what the state would pay in assistance, to an income equal to the "poverty standard." Also, provision would be made for disregarding on a diminishing scale in steps of $100, of the next $1,000 of additional income from such sources.

For example, if the poverty standard in the state was $2,500 for a family of four and the assistance the state could otherwise give was $2,000 in a year, income from earnings, child support, and contributions during the 12 months following application would be totally disregarded until it aggregated more than $500.00.

The provisions of the proposal are:

1. To give mass encouragement to self-effort and to develop sources of support other than public assistance.

2. To increase the possibility of sustained independence.

3. To eliminate the expense of frequent month by month grant changes which are required by the present system and that now is contained in H.R. 12080, (such grant adjustments multiply as the sources and amounts of income vary under the present system. It has been estimated that each change costs from $10.00 to $20.00 and there may be up to 12 changes a year if the family is earning.)

4. To eliminate any necessary bureaucratic involvement to those states where such resources have substantial long term significance.

We also suggest the deletion of the word "earned" on page 116, line 24, of the bill.

If it is possible we would appreciate the inclusion of this letter and attached material in the record. In any case we offer it for the consideration of the Committee.

Sincerely,

HAROLD HAGEN,
Washington Representative.

SUGGESTED AMENDMENTS TO H.R. 12080

SECTION 202(a)[1]

I. Introduction

The provision in H.R. 12080 for incentive income in A.F.D.C. is a distinct conceptual improvement over the present arrangement.

A. It establishes a firm principle.

B. It liberalizes existing provisions for people not covered by the extraneous exemptions under O.E.O., etc.

It has some undesirable implications and likely consequences:

A. It at least does not decrease the existing paper work involved in recomputation and may actually increase it.

B. It fails to set limits of any significant degree within which the family can know clearly the total income consequences of its own actions and move without bureaucratic involvement.

C. It fails to recognize significantly the existing variations among states as to the adequacy of aid standards in relation to accepted measures of poverty, or to relate the results comparatively to the expenditure limits which apply to the average citizen.

D. It includes penalty sections which are contradictory to the principle of incentive and which belie the positive thrust the provisions should have.

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[1] If constructed as an amendment to the Social Security Act, separate from H.R. 12080, this wording would replace that now in Section 402(a)(7) (A), (B) and (C), and would include the preceding wording in H.R. 12080 beginning with the words "the State Agency" in line 12, p. 116.

The following revision of the H.R. 12080 version is suggested as carrying the concepts forward into a much simpler operating framework at the first line level—strengthening even further the psychological incentives, and providing the bridge into achievement and opportunity potentials customary for the general society. If enacted, such a substitute would:

1. Eliminate all of the paper work and red tape connected with variable, intermittent income except where it would begin to be enough to pose major dilemmas in comparison to self-supporting families at the lowest levels above the poverty line.
2. Permit families to know decisively and immediately the specific economic limits within which they can function to their own advantage without conflict with concepts of fraud and without bureaucratic complications.
3. Provide a base which would encourage and relate voluntary family support payments and other private contributions to significant long-term improvement of family conditions and rehabilitation.
4. Divorce incentive provisions from the limitations imposed by unrealistic state assistance standards.
5. Recognize relative differences among states based on general income and cost of living differences.
6. Eliminate the "added tax" imposed upon aid recipients for the support of other poor people.

II. Suggested Amendments

A. Eliminate all the wording in the present bill:

(1) On page 117, lines 4 through 25, inclusive; and

(2) On page 118, lines 1 through 15, inclusive; and

B. Substitute the following:

"determination, (I) all of the income from earnings of such persons, from family support payments made by an absent parent, and from contributions from any other source, and which, during each twelve-month period following the date of application, total less than the amount established in accordance with paragraph (B), and, (II) a percentage of up to $1,000 per 12 month period, of income excluding the amount established in accordance with paragraph (B) beginning with 90% of the first $100 and declining progressively by 10% for each $100 thereafter; and

"(B) shall, for purposes of determining the amount to be disregarded under (A) (ii) (I), determine the difference between

"(i) twelve times the monthly amount of aid that would be paid under the State agency's assistance standards if no income from the sources described in (A) (ii) (I) were available, and

(ii) the poverty level established by the State agency for a family of the same size;

"provided that the poverty level so established may not be less, for a family of four persons, than $3,150 adjusted in the same ratio as the average per capita personal income in the State bears to the average per capita personal income in the United States; nor, for a family of less than four persons, less than the same adjusted figure decreased by 15% for each person fewer than four; nor, for families of more than four person, less than the same adjusted figure increased by 10% for each person exceeding four;"

POSSIBLE VARIATIONS

1. Put paragraph (A) (ii) on the basis of a quarter or half year—with appropriate ajustments under pargaraph (B).
2. Reduce or eliminate pargaraph (A) (ii) (II).
3. Increase or decrease percentages in paragraph (B) (ii) or establish other percentages based on national accretions to the State agency's standards for a single person in the adult catgeories.
4. Instead of $3,150 use a percentage, (i.e., 95 or 90) assuming average provision of some assistance provided recipients in kind (i.e., medical care) and not similarly available to nonrecipients.
5. Put a maximum on the accretions (paragraph (B)(i)) due to size of family—for example, not to exceed a total of 8 person in a family.

IV. Hypothetical Examples of Use of Proposed Amendment[1]

	Nationwide	State A	State B	State C
1. Average personal income per capita	$2,724	$1,566	$2,007	$3,196
2. Average personal income per capita as percent of national average	100	58	74	117
3. Poverty level for family of 4	3,150	1,827	2,331	3,685
4. Estimated State assistance standard for family of 4 (per year)	....	473	1,466	2,196
5. Amount of income exempt under proposed revised sec. 402(b) par. (8)(A)(ii)(I)	....	1,354	865	1,489

[1] Based on incomplete data for 1965.

STATEMENT SUBMITTED ON BEHALF OF THE BOARD OF DIRECTORS OF THE TRAVELERS AID SOCIETY OF WASHINGTON, D.C., BY THE SERVICE COMMITTEE OF THE BOARD OF DIRECTORS, MRS. POTTER STEWART, CHAIRMAN

The Travelers Aid Society of Washington, D.C., an agency which works entirely with people away from home and in need, wishes to express its concern about provisions in the proposed amendments to the Social Security Act submitted as Bill H.R. 12080.

Our concerns are for the possible restrictive effects of many of the provisions of this bill as well as for some essential services which were omitted. Although we have also some concerns about the social security provisions the nature of our responsibility is more directly related to the proposed welfare amendments. Therefore we shall limit our comments to those sections of the bill which have special reference to welfare. Certain of these have serious potential impact on the families and individuals known to Travelers Aid.

The imposition of a financial penalty limiting federal assistance to the states to the ratio of dependent children to the number of children in the total child population of the state as existed in January 1967 would most penalize children of families resettling from one community to another. Relocating families as known to Travelers Aid, attempt to relocate in an effort to better their educational and employment opportunities or to join other family members. The Travelers Aid Society of the District of Columbia in its twenty-six years of service has yet to find a family which has delocated in order to become a public charge. However, many families who have lived in poverty or marginal subsistence in one community may gain a toehold toward independence in another; but if any circumstances such as illness, loss of job or other crises arises in their lives they are unable to maintain their beginning equilibrium and again find themselves in need.

In Connecticut and Delaware the courts have already adjudged durational residence requirements as unconstitutional on the grounds that they jeopardise the freedom of travel and the right to settle according to individual choice. The proposed ceiling on available funds for Aid to Dependent Children as it may affect in-migrant families threatens the same constitutional rights.

We recognize that the requirement to cooperate with law enforcement agencies in locating missing fathers may have the intent to protect the maintenance of the family as an intact unit. We question whether this proposed provision may not actually have the opposite effect. Travelers Aid has evidence that fathers unable to find employment and adequately maintain their families tend to desert in order that the family can receive essential maintenance through Aid to Families with dependent children. Once a man has left his family we daily see the results in progressive deterioration, loss of productivity among the men and a mounting number of wandering vagrants. With the additional pressures of involvement of law enforcement authorities such fathers will even more quickly than now disappear because of fear and deliberately sever all possible ties with family members.

Travelers Aid stands for a strong and effective public welfare program which is directed to meeting basic human needs, and aims at the social and economic rehabilitation of all of our citizens. Several of the other provisions in HR 12080 seem to us to move in the opposite direction. For example the compulsion that all adults and youth over 16 years of age not in school must accept work or work training, waiving minimum wage requirements, seems to us to be a most serious step backward. Adults should be given opportunity and encouragement toward work but must have the right to decide that other family considerations, notably the welfare of children, should take precedence. We see the requirement of work for youth as contributing to non-pursuit of education and working against recently developing efforts to have school dropout youth resume their education.

We see the imposition of disregard for minimum wage standards as a material threat to families and individuals who are seeking to enter the job market and to achieve economic independence. The families known to Travelers Aid who are moving in order to find employment all have less and less chance to realize their socially constructive goal of self-management if such a provision becomes law.

Finally, in relation to the assistance provisions, Travelers Aid strongly urges Congressional support for the elimination of durational residence requirements as a basis for public assistance throughout the United States and the substitution of assistance according to need as a supplement toward positive rehabilitation.

The proposed modifications of Title XIX (Medicaid) seems to us to be seriously repressive. First, the proposed restriction on the level of eligibility would mean that many families below the "poverty line" would not qualify for such assistance. Second, we cannot imagine a meaningful health care program which is not mandatorily based on provision of these five fundamental services now in the act, namely; inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physician services. Third, the fact that states would no longer be required to provide services to persons under 65 years of age drastically reduces the possibility of adequate medical care for growing children whose future depends on their capacity to function. Travelers Aid has seen too many children from the disadvantaged sections of our country, listless, malnourished, almost uneducable because of poor health. Fourth, we foresee increased public cost for the maintenance care of adults who cannot qualify and so cannot be restored to physical health when with adequate care they could be restored to gainful employment. Finally, for most of our citizens all possibility for preventive medical care would be lost.

One of the most positive and helpful provisions of H.R. 12080, we believe, is that for support of social work education and training. Not only are vastly increased numbers of competent and qualified social workers urgently needed throughout the spectrum of health and welfare programs but particularly are they needed for local public welfare programs if our country is to realize the goal of effective rehabilitation to self-sufficiency for those in need. Many of these local programs are presently suffering severe shortages, causing heavy caseloads for those dedicated workers now working in local departments, making it impossible for them to provide the kind of restorative help which they and all of us know is needed if we, as a society, are to break their chains of dependency. Work programs alone will not do it.

Unfortunately, we predict that if the several repressive and regressive provisions proposed in this bill are enacted into law the increase in numbers of social workers made possible by the social work education provisions of this bill will not choose positions in P.A. Instead, they will join other established and emerging programs where their skills are urgently needed and are supported by laws, regulations or policy. Qualified social workers will know as we do, that people cannot be motivated and moved to dignity and self-direction through punishment, compulsion and servility but rather through opportunity and social justice coupled with competent guidance and direction.

We urge the Senate Finance Committee to safeguard the spirit and preserve the integrity of the Social Security Act as it now stands and help to move the program forward, not backward. We need to undergird the best that we know.

TESTIMONY ON THE INSUFFICIENCY OF PUBLIC WELFARE ALLOWANCES

Petitioner: The undersigned, (Rev. Horace B. McKenna, S.J.) is a parish priest, now with eight years experience among the Washington poor, after twenty years of work with rural poor and six years in Philadelphia's inner-city.

SUMMARY

1st point: The rule forbidding Welfare to a family with a resident Father is an invasion of the marriage contract and rights, a fiscal blunder, and a civic disruption.

2nd point: Welfare payments in the nation, twenty to fifty percent below the poverty level, maintain a serfdom and a peonage that is a discredit and a disease in the United States.

Gentlemen:

STATEMENT

1st point: The rule forbidding Welfare payments to a family with a resident unemployed father violates the rights which the parents have vowed to one another. The social disruption gives rise to heart-rending suspicions. The civic situation calls for more policemen on the street to care for and advise unsupervised teen-age sons than there are fathers exiled from their homes. Washington had seventy "investigators" to enforce this rule, perhaps more than one for each absentee father.

The "Work-Training Program" put in by Senator Robert Byrd as a substitute for "Aid to families with resident fathers" was shown by Senator Ribicoff in August 1966, to have only a three percent result in jobs. In May I consulted the statistician of the program who told me that 5700 were enrolled, 1600 trained, and a few more than 500 got jobs. I would call a program only ten percent productive a failure, a disappointment, something like a hoax.

2nd point: The Washington Post, for Sat. June 24, had two articles on Welfare. One showed Sen. Byrd's picture. In it Miss Thompson, Welfare Director, said "housing allowance for family of five is $46.00 below monthly rental". A second article announcing the coming "Welfare Recipients' Rally" said "the national average for payments is $1760." And of course the poverty level for a family of four is $3150.

Hence Welfare is a legalized peonage and a serfdom festering in the heart of the world's most affluent society. Its injustice, its human agonies, its family tensions, its educational disappointments, its occupational hopelessness, these make a mine-field of the Nation.

Can we *not* do better than keep our Brother in want and misery at least in his family home?

Respectfully submitted.

(Rev.) HORACE B. MCKENNA, S.J.,
St. Aloysius Church, Washington, D.C.

STATEMENT OF WHITNEY M. YOUNG, JR., EXECUTIVE DIRECTOR, NATIONAL URBAN LEAGUE

Mr. Chairman, Members of the Committee, my name is Whitney M. Young, Jr. I am the executive director of the National Urban League.

The National Urban League is a non-profit, charitable and educational organization founded in 1910 to secure equal opportunities for Negro citizens and the members of other minority groups. It is non-partisan and interracial in its leadership and staff.

The National Urban League has affiliates in 83 cities, in 34 states and the District of Columbia. It maintains National Headquarters in New York City, regional offices in Akron, Atlanta, Los Angeles, New York and St. Louis, and a Washington, D.C., bureau.

A professional staff of 800 trained in the techniques and disciplines of social work, conducts the day-to-day activities of the Urban League throughout the country, aided by more than 8,000 volunteers who bring expert knowledge and experience to racial matters.

The National Urban League is deeply grateful for your invitation to submit a statement for inclusion in the record of the hearings before this Committee in order to add to your body of knowledge the information and evidence we have accumulated over the years as experts in the area and on the subject now before you.

H.R. 12080, reported out of the House Ways and Means Committee, passed by the House of Representatives, and now under consideration by this Committee, includes important provisions long sought by responsible welfare organizations, but in the view of the National Urban League these provisions have been embodied in a bill which contains other features which are so regressive, so coercive and so repressive, that they raise the question whether we, as a nation, can afford what is good in this bill if we are required to tolerate what is bad in it.

The desirable and exceedingly important features of H.R. 12080 include an increase in Federal financing for a variety of social services such as family counselling, day care, family planning, foster care and other protective welfare services; for demonstration and other research projects; for the special costs associated with work and training programs; for the training of social workers and their aides; and provision for an incentive exemption of earned income.

But other provisions are of such a regressive and punitive nature that there is an overriding question as to whether they will not, in the final analysis, destroy the effectiveness of those provisions which are both good and necessary.

The most severe changes are those affecting children dependent upon or eligible for public assistance and their parents. H.R. 12080 would impose a freeze on the percentage of children for whom welfare support is provided and limit the percentages to the level of January, 1967. It requires that all adults on the rolls, including mothers and out-of-school youth over 16, engage in work and training as a condition of receiving assistance, without regard to the impact of such work and training on family life, the availability of jobs at the end of the training period, or even an insistence upon receipt of established minimum wages. It contains provisions whereby children could be removed from the home by court order on terms that are highly questionable and which would serve to discourage mothers from applying for assistance regardless of the desperation of her need. It requires programs of family planning in the effort to reduce illegitimacy in terms that invite coercive approaches and have the effect of punishing illegitimacy by punishing the guiltless child.

H.R. 12080 requires cooperation with law enforcement agencies in determining paternity and locating absent fathers as a condition of assistance. It gives Congressional sanction to a version of the "man-in-the-house" rule recently outlawed by HEW regulations. It requires that in order to qualify for assistance, the parent must have had a substantial connection with the labor force, a provision which will eliminate many men who have never had an opportunity for steady employment and will only succeed in forcing more families to break up and more fathers to leave home in order to obtain support for their children.

States would be empowered to withhold cash payments to families when welfare authorities decide that adults are "misusing" the money, resulting in voucher payment or payment by a third party, which violates the right of cash payment and the right to exercise judgment in the spending and handling of money.

The purpose of this bill is clear. Its goal is the ruthless reduction of caseloads and welfare costs; its attitude is to "get tough" with welfare recipients; and its methodology is reminiscent of medieval poor laws and the alms house. The essence of the measure is the deliberate use of federally aided assistance and services to coercively impose acceptable middle-class behavior patterns on families whose welfare requires public assistance.

These undesirable elements in H.R. 12080 are at complete variance with the recommendations of the President's Advisory Council on Public Welfare, with the recommendations of earlier Presidential advisory groups, and with the recommendations of all reputable voluntary organizations in the labor, religious, civil rights, civil liberties, welfare and related fields.

In light of urban and racial unrest in this country, adoption of H.R. 12080 can only prove inflammatory in a situation already inflamed. It could well have the effect of stimulating riots and further escalating the warfare in American cities.

I am well aware of the considerations which motivated members of the House Ways and Means Committee. They are concerned—as we all are concerned—with breaking the cycle that is making public welfare a way of life for generations of families, with interrupting the cycle of public dependency. Their concern is well placed, but the job can only be done by adopting positive measures to create full opportunity. It cannot be accomplished through the withdrawal of opportunities embodied in repressive measures. It will serve no useful purpose to force people into training programs for jobs that do not exist and, in the process requiring mothers to forsake the home. Nor can we continue to place higher and higher premiums on broken homes as the condition for public assistance.

Because of its regressive features, H.R. 12080 will create more, rather than less, poverty, first, by reducing the number of children eligible for assistance, second, by discriminating especially against those children who are dependent on the care of only one parent, and, third, by reducing the amount of federal money available to share in the support of all dependent children. There is no basis for a belief that the number of children needing assistance will decrease or that the amount of money necessary to any family to maintain a minimum standard of living will diminish. The cycle of poverty and the cycle of public dependency can only be broken through long years of concerted social effort to rehabilitate families and individuals through humanely conceived and administered programs designed to combat the handicaps under which they suffer.

To proceed otherwise can only increase the sense of alienation, worthlessness, self-hatred, and hopelessness which at best perpetuate dependency and at worst result in riots. Threats, undeserved punishment, deprivation of rights and resources, curtailment of funds do not reverse dependency. They only create fear, bitterness and apathy, which reinforce the dynamics of dependency.

Given the disproportionate number of Negroes on the AFDC rolls, H.R. 12080 can only be discriminatory in its effect. It is designed to impose social controls rather than to arrive at social solutions to our most urgent domestic problem, unconscionable poverty in a land of prosperity and affluence.

H.R. 5710, although of a limited nature in relation to the overriding needs for overall reform of the present welfare system, contains none of the coercive elements or moral preachments of H.R. 12080. Of particular importance is the fact that it requires the states to bring their actual welfare payments up to the minimum levels established by the states themselves.

We in the National Urban League strongly urge the Senate to reconsider H.R. 5710 in place of H.R. 12080, urge that you strengthen it in accordance with the recommendations of the President's Advisory Council on Public Welfare, and that you include within it all the desirable features that now reside within H.R. 12080.

Adoption of the bill before you, with all its regressive, coercive and punitive features, will not suceed in breaking the cycle of poverty or altering the cycle of dependency. It will only visit further punishment on the poor and serve to escalate the crisis of our cities.

STATEMENT OF THE NATIONAL FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS, INC., SUBMITTED BY COLLIER, SHANNON, AND RILL

The National Federation of Business and Professional Women's Clubs, Inc., hereinafter referred to as BPW, submits this statement on the Social Security Amendments of 1967. BPW was founded in 1919, and its total membership now exceeds 177,000. BPW clubs are in operation in every state, the District of Columbia, Puerto Rico and the Virgin Islands. Membership is open to any working woman. As a result, the Federation's membership includes assembly line workers, clerks, lawyers, saleswomen, and, in short, women engaged in virtually every job description imaginable.

BPW considers the Social Security bill now before this Committee as one with several good features. However, we believe the Committee should give full consideration to all the following points.

First, under the present system, working couples often receive smaller benefits than couples with the identical income if only the husband worked. Specifically, let us assume that John Jones, a retired worker, was employed at an average yearly salary of $4,800. Upon retirement, Jones receives a monthly check of $123.00 plus $61.50 for his wife, despite the fact that she never worked.

In contrast, consider Mr. and Mrs. Brown, both of whom worked, each of whom earned an average yearly salary of $2,400. Their combined income equals the income of the Jonese. Yet, when the Browns retire, their combined benefits would equal $180 per month—$16.50 a month less than the Joneses receive.

The disparity becomes more acute if both husbands predecease their wives. Mrs. Jones, who never worked on contributed to the social security system, would receive $105 per month. Mrs. Brown, who did work, and who did contribute to the fund, would receive only $84 per month. Thus, a widow who never worked would receive larger payments than a widow who did and whose income, combined with the income of her deceased husband, equaled the income of the first couple. The inequity results from the failure of the social security system to permit working couples to pool their incomes for purposes of determining social security benefits. Although for tax purposes, the wife's income is treated identically with her husband's for social security purposes, the wife's income does not yield the same amount of benefits as the identical income of her husband. These inequities can be corrected by amending § 202 of the Social Security Act, 42 U.S.C. § 402 (1964), to permit working couples to pool their social security credits and draw benefits on the basis of combined incomes.

Under the present system, benefits would be reduced if a widow returns to work despite the fact that suspension of payments would, in most cases, nullify at least in part, the purpose for returning to work. Most widows must return to work so that they may earn more money in order to provide the essentials of life for themselves and their families. Unless the difference between the amount received before and after work begins is significant, there is no real incentive for returning to work. By reducing the payments, Congress lessens the incentive for returning to work and encourages women to remain unemployed by relying on social security. By continuing the payments, it would encourage more widows to seek employment and would provide increased benefits for those whose circumstances require additional assistance.

The present system also provides for "mother's insurance benefit," payable to widows with surviving children. 42 U.S.C. § 402(g) (1964). No provision, however, is made for payments to male widowers with surviving children, despite the fact that the considerations which require payment in the former case seem to apply with equal relevance to the latter as well. This discrepancy can be remedied by explicitly authorizing Fathers' as well as Mothers' Insurance Benefits.

Under present law, currently insured status (coverage in six out of the last 13 quarters ending with death, retirement or disability) is required in order for a child to be deemed dependent upon his mother and thus able to receive benefits under the Act. Under the bill passed by the House of Representatives which is now before this Committee a child would be deemed dependent on his mother under the same conditions that, under present law, a child is deemed dependent on his father. We believe that aid to dependent children should be the same whether the dependency is on a mother or father. If this bill is enacted, an estimated 175,000 children would become entitled to benefits beginning with the second month after the month in which the bill is enacted. This figure itself portrays the essence of the problem.

In our view, the points raised herein are a logical and equitable extension of the principles established in Title VII of the Civil Rights Act of 1964. The Act prohibited discrimination in employment based on race, religion, sex or national origin. Its basic purpose was to enact into law the fundamental principle that every person should be judged as an individual and should be able to secure those jobs and those employment benefits which his or her ability and perseverance will permit. The extension of Title VII to cover sex discrimination must be construed as a Congressional determination that discrimination based on sex is just as inconsistent with the principle of equal opportunity as racial or religious discrimination would be.

H.R. 12080 represents an initial step in attempting to apply this basic principle to the social security system. The principles discussed herein would, if adopted, eradicate discrimination by placing men and women on an equal footing—by making social security benefits commensurate with the contributions made by an individual. The present system determines benefits by applying the preconceived and often erroneous assumption that women are the subsidiary wage-earners in the family. If our principles are adopted, the law could be molded to fit the changing realities of American economic life.

In 1935, women comprised only 23 percent of the work force. Today, the percentage has risen dramatically to approximately 33 percent.[1] In 1935, approximately 35 percent of the working women were married. By 1962, this percentage has risen to 62 percent.[2] One-tenth of all family heads are women.[3] Additionally, "given the rising divorce rate and the high cost of living, most women are no longer in the labor market to supplement their husband's income but primarily in order to provide the necessities of life for their families."[4]

H.R. 12080 partially remedies the injustices and discrimination which have accompanied administration of the social insurance system. We, therefore, urge consideration and adoption of all the points raised herein.

In addition, BPW wishes to express its support for the welfare provisions of H.R. 12080. This bill will, if enacted, stem the growth in the number of families receiving aid to families with dependent children (AFDC). In 1962 legislation was passed which allowed Federal financial participation in a wide range of

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[1] President's Commission on the Status of Women, American Women 28 (1963).

[2] *Id.* at 29.

[3] *Reynolds* v. *Mountain States Telephone and Telegraph Co.*, Case No. 17-12E (Arizona Civil Rights Commission 1966).

[4] *Id.*

services to AFDC families. The intended results of that legislation—independence and self-support—have not been achieved. If the welfare provision of H.R. 12080 are adopted, BPW believes the AFDC rolls will be reduced by restoring more families to employment and self reliance. Federal financial involvement in the program would be accordingly reduced.

The significant provisions which we support are as follows:

(1) A requirement that all States establish a program for each appropriate AFDC adult and older child not attending school with a view to getting each of them equipped for work and placed in jobs. Those members of the family who refuse without good cause to accept training or employment would be taken off the rolls. Benefits for children, however, would not be affected.

(2) A requirement that all States establish community work and training programs throughout the State by July 1, 1960.

(3) A requirement that all States furnish day-care services and other services to make it possible for adult mmebers of the family to take training and employment. Family planning services would be offered to all appropriate recipients. Other services would also be required which would help make the family self-supporting.

BPW believes that if the welfare provisions of this bill are encated States would be required to develop a program for each appropriate relative and dependent child which would assure, to the maximum extent possible, that each individual would enter the labor force in order to become self-sufficient. Tto accomplish this, the States would have to assure that each adult in the family and each child over age 16 who is not attending school is given employment counseling, testing and job training. The States would also have to provide day care services needed for the children of mothers who are determined to be able to work or take training, and to provide such other services for children which would contribute toward making the family self-sustaining.

BPW believes the welfare provisions of this bill are steps in the right direction in that they acknoweldge that welfare alone is not the proper approach. We submit that by encouraging women currently receiving welfare benefits to be trained, and by providing care for their children while they are trained and while they are employed, the bill will give rise to a general increase in the self-respect of women now unemployed and receiving welfare benefits. It would be possible under this bill for a mother to be employed and still retain a portion of her welfare payment. Furthermore, the same mother could be secure in the knowledge that her children are being cared for while she is at work.

BPW, therefore, this Committee to vote in favor of the welfare provisions of H.R. 12080.

STATEMENT OF THE UNITED STATES TRADEMARK ASSOCIATION SUBMITTED BY FRANK E. FOOTE, PRESIDENT

The United States Trademark Association submits this statement to the United States Senate Committee on Finance concerning S. 2299, a bill relating to drug products to be supplied to individuals entitled thereto under certain programs established by or pursuant to the Social Security Act. The statement relates to those proposed amendments which have some impact upon the field of trademarks. The Association's position is limited to what might be termed the trademark aspects of the amendments, and failure to comment upon other aspects is not to be construed as approval of them.

The United States Trademark Association is eighty-nine years old, having been founded in 1878. It is a membership corporation organized under the laws of the State of New York, with offices at 6 East 45th Street in the City of New York. Its membership comprises regular or voting members who are owners of trademarks and associate members who are lawyers, advertising firms, publishers and others interested in trademark law, trademark practice and trademark protection. The associate membership is composed of members from many countries. Of the three hundred ninety-seven regular, or voting members, approximately thirty-one are pharmaceutical manufacturers; and of the thirty-five members of the Board of Directors, six are representatives of pharmaceutical manufacturers.

The purpose of the Association, generally stated, is to aid in the dissemination of information pertaining to trademarks and to afford a means of cooperative activity in protecting them. It publishes The Trademark Reporter, a monthly journal containing judicial opinions in litigated cases and articles of research and commentary. The Association has worked for uniform State trademark legislation, which has been adopted in many States.

At the outset it may be well to point out that trademarks in this country are competitive tools in an economy which is based on industrial and commercial competition. The basis of the protection of trademarks is to protect the public from confusion, mistake and deception, to foster fair competition and to secure to the business community the advantages of reputation and goodwill by preventing their diversion from those who have created them to those who have not. The function of a trademark is not merely to identify the source of a product but also to identify the goods of one manufacturer or merchant and distinguish them from those of others. In addition, it should be pointed out that when trademarks, or brand names, are protected by the Courts, it is not only the word or symbol, as such, which is protected, but it is the reputation for degree of quality of goods and business goodwill symbolized by the mark which are protected. Relief in trademark suits is directed toward protecting the public's right to be free from confusion, mistake and deception and the businessman's right to the fruits of his investment of time, energy and money in creating a better product and building public confidence in that product.

With this preface we turn to Section 2002 of the bill which authorizes a Formulary Committee to compile, publish and make available a Formulary of the United States Drugs and biologicals listed in the Formulary are to be listed by their established name with the exception concerning trademarked products set forth in Section 2002(b)(2)(C). It is with this section that the Association is particularly concerned. Section 2002(b)(2)(C) provides that certain drug or combination drug products may be included in the Formulary by trademark designation, but only if they meet certain criteria. These are:

(1) if such products have distinct demonstrated therapeutic characteristics not otherwise available,

(2) if such products are available at a lower cost than like products available by established name, or

(3) if such products generally available and primarily sold under trademark designation, are the only such products of a quality acceptable to the Formulary Committee.

The practical effect of the provisions will be to exclude from the Formulary many excellent drug products marketed by trademark name. In this respect these provisions are arbitrary and discriminatory and should be deleted. The Association is not unmindful of the fact that the purpose of bill S. 2299 is to limit the liability of the Government for reimbursement of the cost of drugs furnished under the Social Security Act to a "reasonable charge" as this term is defined in the Act. However, this purpose should be achieved without excluding trademarked products from the Formulary. The result of such exclusion is to dilute the effectiveness of trademarks as instruments of product identification and to impair their value and validity as means which provide freedom of choice among prescribers and buyers.

Some witnesses who have appeared before this subcommittee, and the Chairman himself, have suggested that conditions might be better if drugs were prescribed only by established name. This position overlooks the fact that such procedure could destroy the incentive of drug manufacturers to make better products, and more importantly, it would deprive the physician of his right to rely upon his experience with a specific product. Drugs, like automobile tires or detergents or motor oils and myriad other products, may fall within a given genus, but this does not mean that all drugs in the genus are identical either as to all ingredients or effects. All people do not react to all things in the same way—whether it be drugs, foods or fabrics. The drug trademark provides the means whereby the physician can prescribe the product with which he is familiar, which has given satisfaction in the past and upon which he can rely.

Furthermore, the impact and importance of the Formulary envisioned in S. 2299 will extend far beyond its use with reference to the Social Security Act. The Formulary will undoubtedly have great influence in the field of medicine generally and in the prescribing of drugs in particular. Certainly a Formulary which is to be designated a "Formulary of the United States" and which will bear the imprimatur of the United States Government should not preclude from listing therein trademarked drugs which are of acceptable quality by Government standards. The brand name is the badge of the manufacturer's reputation and good reputation is generally based upon quality which exceeds the average.

For the reasons mentioned the Association urges that the arbitrary and discriminatory provisions of Section 2002(b)(2)(C) (1), (2) and (3) be eliminated from S. 2299 and that the bill provide for the listing in the Formulary of all trademarked products which are of a quality acceptable to the Formulary Committee.

STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS,
Providence, September 20, 1967.

Re H.R. 12080, 1967 proposed amendments to Social Security Act.

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

DEAR SENATOR LONG: I am terribly disturbed over H.R. 12080 as it has been amended in the House and is presently before your committee. Under separate cover I have sent to the Clerk of your committee the position statement of our Department of Social Welfare on this bill. However, there are two principal points I would like to bring to your attention:

1. The freeze on AFDC caseload as of June 1, 1967. This would have an extremely damaging effect upon our ability to take care of children who have to be taken care of. It would not, by itself, reduce the caseload, but would just reduce our ability to do a decent job.

2. The linking of the Medical Assistance eligibility standards with public assistance standards. When we went into the Medicare program in 1964, we were encouraged by the federal officials to have as liberal standards as possible, and never was there a suggestion that the rules would be changed in the middle of the game. So we did adopt a liberal program, and now it is proposed that this cannot be in excess of 150% of the public assistance standards. Without any federal encouragement whatsoever, we have five times in the past three years increased our public assistance standards. Yet the proposed legislation would cost our State very substantial sums of money because we followed the federal government's original urgings in the Medicare program.

Under the Child Welfare Services provisions, I hope that there will be the adequate appropriations to match the authorizations, something that does not now occur, and I wish that the matching program would not solely apply to personnel serving AFDC children in foster care or day care. We have many non-AFDC children that are in these programs.

I support the work or training requirements for adult recipients, the day care proposals, and the income disregard provisions, although I wish it was $50 instead of the first $30.

Any support you could give to these proposals would certainly be appreciated.

Sincerely yours,

JOHN H. CHAFEE, *Governor.*

RHODE ISLAND DEPARTMENT OF SOCIAL WELFARE, PROVIDENCE, R.I.

POSITION STATEMENT

H.R. 12080, 1967 PROPOSED AMENDMENTS TO SOCIAL SECURITY ACT

OVERVIEW

The House of Representatives has passed Bill HR 12080 as reported out from the Committee on Ways and Means to amend the Social Security Act to provide increases in Social Security provisions and to improve Public Assistance and Child Welfare Programs. The Senate Finance Committee is now holding Hearings on the Bill through September 22, 1967 and will then go into closed session.

According to the House Report "the Committee is recommending the enactment of a series of amendments to carry out its firm intent of reducing the AFDC rolls by restoring more families to employment and self-reliance, thus reducing the Federal financial involvement in the Program." While we concur with this overall objective, employment is not a realistic goal in many cases. The House Report itself notes that the major reason for opening cases is need due to broken homes resulting in one-parent cases where the mother in many cases is not available for employment.

From the point of view of this state agency there is much that is constructive about the proposals especially the provisions for Federal participation in work training programs with a program for each appropriate adult and older child. There is also a provision for incentive to work by a disregard of a portion of the earnings. This is in keeping with Governor John Chafee's recommendation to the Rhode Island General Assembly that a work incentive program is a high priority. A requirement that Day Care Services and other services must be established to make it possible for recipients to take training and employment is significant. There are other positive factors which will be referred to below.

There are negative aspects to the Bill which are very significant. It is proposed that a freeze be placed on AFDC cases where the parent is absent from the home based upon the caseload of January, 1967.

The plan provides that the Medical Assistance eligibility level which in Rhode Island is $2500 for a single person, $3500 for two persons and $400 for each additional person may not be more than 150% of the Public Assistance budget for a money payment case effective July 1, 1968, 140% effective January 1, 1969, and 133⅓% January 1, 1970. This could mean a substantial increase in Public Assistance money payment standards for the most part with state funds, or a decrease in the MA eligibility levels.

Some of the provisions have great merit and some are unrealistically restrictive and almost punitive. The intent of the House Ways and Means Committee is to reverse the present national trend in the growth of the AFDC caseload. The provisions of the legislation will be helpful, but it certainly is not a panacea. The increase in dependent families cannot be strictly tied to the economy. There are factors which have a more profound effect on dependence or independence of families. These are problems of the changing fabric of our society; the alarming breakdown in family solidarity; the diminishing influence in traditional mores; and the technological displacement of substantial numbers of the labor force. These are problems which are not touched by this legislation. The serious problems of our cities with particular reference to the adequacy of housing, education, and economic opportunity for minority groups are basic areas affecting Public Assistance caseloads which will not be influenced in any substantial degree by this legislation.

The Public Assistance caseload is a reflection of community social problems, and although improvements can be made to modify caseloads, until solutions for some of the causative factors in the community are found, numbers of people will continue to need Public Assistance payments and social services.

In 1962, the Congress revised the Public Assistance Program with the expectation that caseloads would diminish. The Committee Report states that "while the goals set for the Programs in 1962 were essentially sound, those amendments have not had the result which those in the administration who sponsored the amendments predicted." "Your Committee has studied these problems very carefully and is now recommending several coordinating steps which it expects, over time, will reverse the trend toward higher and higher Federal financial commitments in the AFDC Program."

As stated earlier, these proposals which contain many improvements are not a panacea any more than the 1962 amendments were. If they become law, it should not be expected that Public Assistance costs will decline substantially particularly when there is so much need and ferment in our cities today.

POSITION ON SPECIFIC AMENDMENTS

1. Work or Training Requirements for each Adult Recipient; Day Care, and Training Projects

The Bill requires that all states establish a Program for each AFDC adult and child over 16 years not attending school with a view to getting each of them equipped for work and placed in jobs. Federal participation has not been available in community work and training programs until now. Through the use of 100% OEO funds under Title V the Rhode Island Public Assistance Agency has had a training program for the last three years. This has been limited and the funds available have been reduced over the three-year period. The new Program will permit an expansion with 85% participation up to July 1, 1969 and 75% thereafter. An increased state cost will result through the establishment of a sound program.

In implementing this concept, it will be mandatory to develop criteria as to who would appropriately be employable; to establish Day Care Services which if adequate would be costly; to facilitate the development of on-going educational opportunities which are not presently available; to develop work training sites and on-the-job training which are available now only to a limited degree; and to be willing to finance the cost of vocational and other training. In order to provide the structure and personnel for this kind of operation the state would be incurring fairly substantial expenditures even though the Federal Government would be reimbursing 75 to 85%.

2. Incentives for Employment

The amendments require the states to establish incentives for employment. Up to now the states have been required to disregard work expenses in earning the wage, but the disregard of earnings has only been permitted for children except for those adults who have been involved in Economic Opportunity Act Programs, or MDTA. The Bill provides that the first $30 of earned family income plus one-third of the earnings above that amount would be retained by the family. This is a positive step, but many feel that a plan at $50 per family and one-half of the balance of earnings would be a greater incentive. Actually the money being disregarded is money earned by the recipient and is not money which is being given by the agency.

According to the amendments, in a family receiving a Public Assistance grant of $200 a month, if the mother went to work and earned $30 per week, or $120 per month, the family would get the $120 of earnings plus $140 of grant (⅔ of the earnings above $30 would have been deducted) for a total of $260 as a total budget. If the rule of $50 and a half of the balance would be permitted, the mother would retain $120 of her earnings plus $165 of grant (one-half of the earnings above $50 would have been deducted) or a total of $285.

It is estimated that about 850 AFDC families in Rhode Island have earnings with 450 in training in our Three-R Program and about 400 in OEO Programs throughout the state. A substantial increase in these numbers could be anticipated. We believe that additional funds will help motivate people to obtain training and employment. However, a review of the brief history of work incentives will demonstrate the fact that this concept has tended to increase caseloads. Many people who ordinarily would become ineligible for an assistance payment continue to receive a maintenance check when portions of their income are not recognized. On the other hand, more people are stimulated to seek work and to develop work habits and may be enabled to move ultimately from the rolls. Despite the problems inherent in work incentives as envisaged by the Bill, we strongly support the concept.

3. Caseload Level Freeze

The Bill proposes to freeze the AFDC caseloads where the parent is absent from the home as of January 1, 1967. Under the Bill the proportion of all children under age 21 who were receiving aid on the basis that a parent was absent from the home could not exceed the January 1967 level for Federal participation.

In Rhode Island from January 1967 through July 1967 there had been an increase in the number of children receiving regular AFDC from 18,004 to 19,418, an increase of 1,414 children. Most of these children would be in one-parent cases and would be a 100% state charge. For this fiscal year the estimated increase in state costs would be $600,000, and in the next fiscal year, $1,200,000. There must be vociferous objection to this proposal which will deprive children of help from the Federal Government in the money payment program. Such children would suffer simply because of the lack of a parent, a matter over which they have no control.

4. Medical Assistance Eligibility Levels

The next area of objection must be to the proposal to relate the Medical Assistance standard to the Public Assistance money payment standard. Rhode Island has one of the higher permitted income plans for Medical Assistance. It would be required to increase the money payment standard so that the Medical Assistance eligibility criteria would not be any greater than 150% of it effective July 1, 1968, 140% effective January 1, 1969, and 133⅓% January 1, 1970. In this year, Rhode Island has increased its Public Assistance standards by $1,100,000, in 1966–1967 by $1,270,000, in 1964–1965 by $400,000. There has been progressive increase in the standards of assistance in recent years without reference to the Medical Assistance Program without a Federal mandate. It is not reasonable for the Federal plan to be changed after the states have set up their Medical Assistance Programs in good faith.

The obviously unreasonable alternative is a reduction in the income limits permitted in Medical Assistance.

Using the most realistic Public Assistance case budget for an individual, the MA eligibility limit is 56% over the money payment plan; for a Medical Assistance Unit of two at $3500, 52% over the money payment plan: for a Medical Assistance Unit of three at $3900, 37% over; and a Medical Assistance Unit of four at $4300, 26% in excess. Therefore, there would be a problem with the standards for one and two person cases which would mean either reducing the Medical Assistance eligibility limit or increasing the Public Assistance payments. It should be noted that the administration recommended in HR 5710 that the states be required to meet 100% of the Public Assistance standards which they have established. Many of the states meet only a percentage of their established standard. It would seem much more feasible if the Congress had adopted this proposal rather than attempting to curtail Medical Assistance or impose restrictions on the number of children for which there would be Federal participation.

5. *AFDC Unemployed Parents Segment*

There must be an objection to the plan to restrict the Program of AFDC because of unemployment. Rhode Island was the first of 22 states to adopt this plan in 1961 since it has always been felt that the agency is in a better position to rehabilitate a family if both parents are present. It has not been necessary for a parent to be absent in order for a family to get help in Rhode Island, but prior to 1961, this assistance was rendered through General Public Assistance with state and local funds. Such reliance on GPA with total state funds now may again be necessary if this provision is enacted.

The AFDC Program for unemployed parents and children has been our smallest program and has responded very well to job opportunities. The Bill excludes any father who is receiving unemployment compensation. It is also required that to be eligible a father must have had one year and a half of work during a three-year period prior to the application for assistance.

The proposal to restrict this Program is almost contradictory. A reasonable definition of an unemployed person would be someone who is unemployed and available for full-time work. The proposal would be difficult to administer and would emasculate our present program which has been most effective in meeting the need of such families permitting parents to remain together and a program in which there has been 100% turnover in each of the past two years.

In the last fiscal year, 585 cases were accepted and 587 cases were closed to employment. The average monthly caseload was 295.

CHILD WELFARE SERVICES PROVISIONS—TITLE II

Certain provisions in Title II of HR 12080 contain sound additions to the present law. However, there are other provisions in this Bill that are retrogressive or continue to emphasize the disparity that now exists between Federal financial participation for programs in child welfare and the public assistance categories.

The Department strongly supports the *increase in authorization* for public child welfare services from $55 million and $60 million for fiscal 1969 and 1970 respectively to $100 million for fiscal 1969 and $110 million for each fiscal year thereafter. While this is progressive and will strengthen public child welfare programs, state by state, it is significant to point out that never has the *appropriation* for child welfare services equaled the *authorization*. The Department continues to endorse for public child welfare services the same kind of Federal-state financial partnership that now exists between the state and federal governments in financing the categorical public assistance programs. A significant provision in the Bill provides for *75% matching for child welfare personnel serving AFDC children in foster care.* Why this same percentage of matching is not available for the same child welfare services to now AFDC children is difficult to comprehend.

Although the intent of the increased authorization for child welfare services is to help the states in the financing of foster care, a full array of child welfare services with emphasis on services to children in their own homes is needed in today's society to appropriately serve the variety of complex needs of children and their families who come to the attention of public child welfare agencies. The Bill emphasizes disproportionately the use of foster care as a kind of child welfare service with insufficient recognition of the importance of broad scale preventive child welfare services. It is, therefore, strongly urged that there be provision in this Bill for (1) 75% Federal matching for all child welfare personnel without distinction as to the caseload they serve, and (2) Federal financial participation in the cost of all types of child welfare services including the cost of foster care for children.

Again, while there is provision for *75% matching for day care*, the limitation of day care for children of AFDC working mothers only must be opposed. Why non-AFDC children, many of whom may come from marginal income families, should be denied equal opportunity for day care when needed is most difficult to understand. Further, the Bill makes no provision for Federal funds for the *construction of day care facilities*. Unless there is considerable Federal financial participation in this area, there cannot be a real expansion in the development of day care centers to the extent needed to accommodate the numbers of children of working mothers or mothers in training anticipated in the House Committee Report. While programs to train mothers and to make them employable and eventually financially independent are sound for some parents, the tenet must be reiterated that children have a basic right to develop and grow under the guidance of their natural family. While work and training programs should be available and used to the maximum, a *differential planning* for AFDC mothers must be the keynote. If states are to be mandated to develop sound work and training programs, their acceptance by the client should be voluntary with strong consideration given to the particular need of *some* children for their parents on a full-time basis.

The matching provisions for foster care to AFDC children living in conditions contrary to their welfare, as proposed, can only become available when a child is placed in *foster care by court order*. Rhode Island has adopted as sound child welfare practice the placement of children in foster care by voluntary agreement with the parent when it is determined, based on a sound social plan, that the child does not require the protection of the court and that a judicial determination to remove the child is thus not indicated. It is hoped, therefore, that although the time limitations concerning court action and placement have been extended in the current Bill, this aspect of the legislation could be further changed to make available Federal matching for AFDC children who are placed in foster care by the public child welfare agency *without court action* when their own home is not able to provide for thier basic child care needs.

While the proposal to have AFDC programs and Child Welfare programs under the same administrative agency at the state level may seem to provide for greater coordination of AFDC and Child Welfare Services, it must be underscored that Child Welfare Services should be available to all children in need regardless of socio-economic status. With the Bill's strong emphasis on AFDC such an administrative merger could result in a disservice to the many, many children not known to the AFDC Program. The administrative pattern for these services should be left to the prerogative of the state to determine rather than the Federal Government.

While it was noted earlier that the Rhode Island Department of Social Welfare supports the increased authorization for Child Welfare Services contained in this Bill, Rhode Island has worked hard to obtain legislation such as the Fogarty and Burke Bills. It is firmly believed that only through more comprehensive financing and greater Federal financial participation can there be a further strengthening of family life and protection of children in inadequate families. Full participation of the Federal Government in the cost for *all* child welfare services, not limited to foster care only, but preventive and rehabilitative services to children in their own homes to prevent unnecessary placement, is urgently needed. The states have long carried the major burden in the extension of child welfare services. The Federal Government must additionally help to share this burden if the "American dream" is to become a reality for the many unfortunate and disadvantaged children who deserve and need this nation's spotlight of concern.

MEDICAL ASSISTANCE—PROPOSED AMENDMENTS TO TITLE XIX

The Committee Report notes that intent of Congress in 1965 in authorizing grants to states under Title XIX of the Social Security Act as an extension of the 1960 medical assistance to the aged legislation, commonly called the Kerr-Mills Act. Designed to assist low income persons unable to pay the cost of medical care, the Programs in the some 35 jurisdictions presently operating concern the Committee in a number of areas including eligibility levels, impact on Title XVIIIB and maintenance of state effort requirements.

With the exception of the Committee's proposal concerning eligibility levels which is treated in Item No. 4 of this Position Statement, Rhode Island can be in general accord with the Committee's proposals. Indeed a number of the proposals embody the philosophy and practice which has prevailed in the administration of the state's medical care program in Public Assistance since 1952.

1. Maintenance of State Effort

The Committee suggests the present maintenance of state effort measurement criteria may cause states to expand their Medical Assistance Programs more rapidly than may be sound and proper.

To prevent this possibility, the legislation authorizes the States to meet the maintenance of effort requirement by counting only their expenditure for financial assistance, not including medical care, and permitting the inclusion of expenditures for child welfare services.

This provision is sound in concept in that it enables states to move perhaps more soundly in progressing to the comprehensive medical care program required in the basic 1965 legislation.

2. Title XIX and Title XVIIIB

The Committee believes it is very much to the advantage of of the states to "buy in" for all eligible recipients of medical assistance in order to secure for them the benefits provided under XVIIIB, the supplementary Medical Insurance Program.

Some twenty-five jurisdictions have bought in for their cash assistance recipients. Other states, including Rhode Island, have considered it but rejected buying in for various reasons which the Committee's Bill proposes to remedy.

Seen together, the provisions in the Committee Bill making it more attractive to buy in strike a "carrot and stick" note. Greater and significant flexibility and attractiveness is provided to the states concerning decisions to buy in or not, but if not, the state forfeits participation in the cost of XIX benefits available in XVIIIB; also if the state buys in for the medically needy aged, no participation in the premium cost is provided.

Despite this approach, the proposed modifications would assist Rhode Island in re-evaluating its decision not to buy in. It should be noted that the Rhode Island medical assistance aged population believes Title XVIIIB is valuable as more than 80% of the group has purchased this coverage, the non-Social Security money payment group with the agency providing the premium.

3. Additional Provisions

Payment for medical service by a *legally liable third party* (long a practice in Rhode Island) would be required; and permission for states to provide *7 of the 14 services* possible for inclusion in medical assistance programs would be authorized. These are sound proposals which Rhode Island supports. Further, the provision for an *Advisory Council on Medical Assistance* is to be applauded provided it would not function as a Council serving to "intimidate" the states, affecting whatever originality and flexibility the state might employ in the organization and implementation of its Title XIX Program.

Free choice of medical services is provided for in the Bill. This is in accord with long standing Rhode Island practice. The state has always stressed the importance of free choice of providers of medical services. In supporting this provision, however, the state cautions that it must continue to be permitted to provide payment only for those services it deems desirable and essential to include within is scope of service to insure the high quality medical care of its recipients.

Payment to Recipients of physicians' bills is authorized by the Committee's proposed amendment to the legislation. At present Federal participation in Title XIX is limited to the vendor payment method. Rhode Island feels that such a proposal would represent retrogression to the period prior to 1932 when payments for medical care for our Public Assistance recipients were made through the money grant with the recipient expected to pay the provider of service long after the service was rendered. While we recognize the provision would relate only to the medically needy at this time, the Department feels strongly that a very difficult management problem would be created. To establish controls to permit the administration of dual method of payment for physicians' services would, to this state, pose administrative problems far more severe than any benefits gained by certain providers of service through such a method.

ADDITIONAL AMENDMENTS

There are a variety of other amendments which should help strengthen the Program. Some of these are: Federal participation in *foster home care of AFDC children* up to $100 per month; 50% participation in *emergency assistance* when a family needs sudden help such as in the event of eviction, when utilities have been turned off, when food is not available, etc. This emergency assistance could be available to persons not already receiving AFDC. It is limited to one period of thirty days in any twelve month period. This type of emergency has previously been rendered through General Public Assistance.

There is a provision for strengthening of family life through *increased social services* and a mandatory requirement on offering *family planning services* to recipients. The intent of this policy is not fully clear. It may mean that Rhode Island although it provides for the referral of persons for family planning on request, may have to require its social workers to advise persons of these facilities when indicated and not contrary to an individual client's religion or conscience.

There is a requirement that states must establish units to *determine paternity* in cases of illegitimacy. This is a matter being handled by local government at present but only in Providence to any substantial degree. This would mean an expansion of our present state legal services program in a difficult area which needs attention. It has been found that the courts will not make a decision in paternity matters unless there is substantial evidence beyond question of a doubt. This is most difficult to establish.

The Bill further requires court action to obtain *support from absent fathers.* It appears that the present Rhode Island plan would meet this requirement fully.

The Bill provides for agreements with courts to remove children from AFDC families when it seems that some children would be better off in foster homes or in institutions due to poor home environment and child upbringing in homes with low standards including multiple instances of illegitimacy. It is our experience that the Rhode Island Family Court does not remove children from their parents for these reasons but rather applies a more rigid legal measurement of neglect.

There is a provision which mandates *protective payments* when the money payment is being abused by a parent. It is recommended that the Congress place some percentage limit, perhaps 10% of the caseload, on this provision in order to lessen the pressures which will result from vendors for direct payments, a mechanism which could become complicated and expensive and would lead to the agency beginning to take over the affairs of numerous families.

The Bill significantly provides for payments to colleges and universities to help with the social work manpower problem by training students at the undergraduate and graduate levels for work in the field. It also provides for sharing on a dollar for dollar rate in repairs to homes owned by recipients up to a $500 expenditure per case. The Congress is thus appropriately attempting to encourage families to home ownership and to encourage them in the retention of their homes.

The Committee encourages the states to adopt a $5 a month disregard for any income in order to eliminate the problem of reducing payments when there has been a Social Security increase which is anticipated this year. We believe this is sound and we anticipate adopting this policy concurrent with our work incentive policy.

ALABAMA HOSPITAL ASSOCIATION,
GEORGE H. LANIER MEMORIAL HOSPITAL,
Langdale, Ala., September 14, 1967.

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

DEAR SENATOR LONG: The Senate Finance and Taxation Committee is now hearing testimony on H.R. 12080, Social Security Amendments of 1967. The matters in this bill pertaining to Medicare and Medicaid Program are of vital concern to the hospitals in Alabama.

Section 131 would give hospitals an option of billing for radiology and pathology on their present SSA Form 1453 without having to bother with SSA 1554 unless they so desired. This greatly simplifies the whole claim process, since the professional component would be left in the hospital cost and at the end of the year, the transfer with one bookkeeping entry could be made for the professional component to Part B insurance. This is a step in the right direction and we would like to see this section to remain as it is. The bill also permits those who wish, to bill as they have in the past or for the radiologist or pathologist to bill for his own professional component. Under Title 130, the $20.00 deductible for outpatient service is eliminated. Again, this is an improvement, and we urge you to consider this favorably. One of the most confusing benefits to the beneficiary is the outpatient benefits and it is next to impossible to explain.

I would like to request that these sections be given your favorable consideration. Thank you very much.

Sincerely yours,

HAROLD W. STEADHAM,
President.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION,
Washington, D.C. September 29, 1967.

HON. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: During my appearance before your Committee on September 21, you indicated that you had in mind some revision in the language of S. 2299. The discussion on this point appears on pages 1572–1574 of the transcript of the September 21 hearing.

While we have not seen the precise language of the revision you have in mind, we understand from a later discussion with Committee staff that you have in mind the following two changes:

(*a*) The effective date of most provisions of the bill would be July 1, 1970, rather than July 1, 1969.

(*b*) A prescription in the personal handwriting of a physician giving the generic name of a drug plus the name of a specific manufacturer of the final dosage form would be entitled to reimbursement without regard to the restrictive provisions of the proposed formulary and cost range guide. Otherwise, the restrictions of the formulary and cost range guide would be applicable.

I have given very careful thought to this possible change since my appearance before your Committee, and I would like to submit these comments for the consideration of the Senate Finance Committee.

We strongly feel that this possible change would not, by any means, cure the very serious defects of S. 2299. We have reached this conclusion for the following reasons:

(1) The proposal would still be based on the erroneous assumption of therapeutic equivalence of drug products.

(2) The proposed government formulary committee would still be given the power to declare drugs "unnecessary and therapeutically duplicative" even though the drugs had previously been cleared by the FDA as safe and useful; thus, the impact of a restrictive formulary would still be present.

(3) The price fixing or price regulation impact would still be effective under this proposal, as the Secretary of HEW would still be required to publish a cost guide line under the terms of S. 2299.

(4) Under your revised approach, HEW would still be given an extraordinary, and in our view, completely unjustified authority to cause a drug product to be removed from the market—by amending the present FDA statutes. As I stated in my previous testimony, "we simply cannot understand why there should now be proposed this extraordinary procedure for taking a drug product off the market without the right of an administrative hearing or even without a court order based on a determination of eminent hazard to the public health."

In summary, we would be strongly opposed to S. 2299, even with the modification you have suggested. We also believe it would be desirable for the Department of Health, Education and Welfare to complete its study and report on this subject before any changes in present laws are made. Therefore, we earnestly hope that you and other members of the Senate Finance Committee will be able to conclude that S. 2299 should not be approved by the Senate Finance Committeee as an amendment to H.R. 12080.

May I express to you again my personal appreciation for the courtesies you have accorded me and the industry in giving consideration to our views on this proposal.

Sincerely,

C. JOSEPH STETLER,
President.

BIRMINGHAM BAPTIST HOSPITALS,
OFFICE OF THE EXECUTIVE DIRECTOR,
Birmingham, Ala., September 14, 1967.

HON. RUSSELL LONG,
Chairman, Finance and Taxation Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: I am writing at the request of our fifteen-member Board of Trustees to urgently request your favorable consideration of Sections 130 and 131 of H.R. 12080 (Social Security Amendment of 1967—Medicare and Medicaid Program), which is now under consideration in the Senate Finance and Taxation Committee.

These two titles will greatly improve the efficiency and effectiveness of the Medicare and Medicaid programs. I am confident that you are aware of the nation-wide dissatisfaction with the complicated and inefficient administration of the Medicare program to date. We certainly hope that you will see fit to support Sections 130 and 131 of H.R. 12080 since this seems to be the first step in improving the cumbersome and bureaucratic administration of these important health programs.

Yours very truly,

L. D. JORDAN, *Executive Director.*

(The following was submitted in response to questions asked by Senator Curtis:)

SEPTEMBER 25, 1967.

Memorandum From: Robert J. Myers, Chief Actuary, Social Security Administration.

Subject: Actuarial cost information on hospital insurance cost estimates.

This memorandum is in response to a request for information on "the basic utilization and cost information which underlie, and form the basis, for the proposed revisions in the HI tax rates contained in H.R. 12080".

The actuarial assumptions as to the inpatient hospital benefits consist of three separate basic elements—the population exposed to risk, the hospital utilization rate, and the average daily cost of hospitalization. These will be discussed in turn, as follows:

(1) *Population Exposed to Risk.*—This element is obtained from the detailed cost estimates for the OASDI system, by considering not only the beneficiaries aged 65 and over in current payment status, but also insured persons and their eligible dependents of this age who are not receiving benefits because of the earnings test.

(2) *Hospital Utilization Rates.*—For present law, an average utilization rate of 3.16 days per eligible person per year was assumed. This is based on the assumptions that, in the course of a year, 21.7% of the eligible persons will be hospitalized and that the average duration of hospitalization for those hospitalized will be 14.56 days (not counting any days in excess of the maximum number that are counted as being eligible under HI). The utilization rate is properly adjusted to reflect the cost effects of the higher maximum number of days provided by H.R. 12080 and, in the case of both present law and H.R. 12080, to take into account the deductible and coinsurance provisions. In carrying out the detailed computations, separate utilization rates by age groups and sex are used (rather than merely the average rate cited previously), so as to reflect the effect of the changing age-sex composition of the eligible group over time. The basic assumptions for this element are the same as in the original estimates for the HI program when it was enacted in 1965; the experience data for the first 6 months of operation (July–December 1966), although not yet complete, seem to indicate reasonably close agreement with these assumptions. It is assumed that these utilization rates (by age and sex) remain unchanged in the future.

(3) *Average Daily Cost of Hospitalization.*—The average daily cost of hospitalization to the program is estimated at $38.50 for July–December 1966 (note that this is not comparable with the index of the American Hospital Association, which is based on data for persons of all ages and which includes certain

expenses not considered by HI). The actual experience for this period, which cannot yet be fully analysed, seems to be reasonably close to this figure. This figure is projected for future years by assuming annual increases of 15% for 1967, 15% for 1968, 10% for 1969, 6% for 1970, and then gradually decreasing amounts until for 1975 and after an annual increase of 3% is assumed. These assumed increases are significantly higher than those used in the original cost estimates (so as to reflect the actual recent experience and the predictions of AHA and Blue Cross officials). At the same time, the general earnings level (which, after taking into account the maximum taxable earnings base, is of importance in determining contribution income) is assumed to have an annual rate of increase of 3% ultimately. For the House version of H.R. 12080, the maximum taxable earnings base is, nonetheless, assumed to remain fixed at $7,600 in all future years in the 25-year period considered in the cost estimates; this is a very conservative assumption because, if wages rise as assumed, the earnings base will surely be increased, at some time in the future, and more contribution income will be obtained.

The actuarial cost estimate for the extended care facility (ECF) benefits was not initially made on as detailed a basis as was that for the inpatient hospital benefits. This was the case because there were few instances where insurance programs provided this type of benefit, and so no experience data were available. The initial estimate made was that, in the first full year of operation, the total cost of the ECF benefit would be $25 to $50 million; it was assumed that any increase in this cost in the future would be offset by decreased cost for the inpatient hospital benefits (i.e. that the larger number of low-cost ECF days would be offset by a decrease in the number of high-cost hospital days). The $25 to $50 million figure was based on an average daily cost (before considering the coinsurance provision) of about $10 and on average daily bed utilization by HI eligibles of about 10,000 to 20,000 (out of an estimated ECF bed capacity of about 55,000).

The decision to provide a $20 coinsurance amount (initially) under the provision of the House version of H.R. 12080 that extends the maximum on inpatient hospital days per spell of illness from 90 days to 120 days was not an actuarial decision, but rather a policy decision. The House Committee on Ways and Means explained this provision as follows (page 44 of House Report No. 544):

"The coinsurance feature would mean that hospital care would generally not be less expensive to the patient than would continued care in the extended care facility, thus avoiding any incentive to return to the hospital solely for the purpose of reducing the patient's share of the cost."

The cost of covering the disabled beneficiaries under the HI program was estimated at $695 million in the first full year of operation and increasing amounts thereafter (see page 862 of the Hearings). This cost estimate was derived from: (a) the estimated number of eligible persons, from the OASDI cost estimates; (b) the average daily cost of hospitalization used for beneficiaries aged 65 and over; (c) an average utilization rate that is 3 times that for beneficiaries aged 65 and over; and (d) costs for the auxiliary benefits (ECF and home health services) on a proportionate basis to that for beneficiaries aged 65 and over. The "3 times" assumption for utilization is based on data from the National Health Survey and on preliminary data from the SSA 1966 National Survey of Disabled Adults.