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Social Security and Welfare Reform

Summary of the Principal Provisions of H.R. 1 as Determined by the Committee on Finance

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COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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INTRODUCTION

This summary describes briefly, in general terms, the significant features of the provisions of H.R. 1, the Social Security Amendments of 1971 as ordered reported to the Senate by the Committee on Finance. The description of minor and technical amendments included in the bill may not be contained here but will be reflected in the text of the Committee bill and will be explained in the Committee report accompanying the bill.

As ordered reported by the Committee, H.R. 1 represents the most massive revision of the Social Security laws Congress has ever undertaken. The bill would increase benefits by $17.6 billion over the estimated costs if present law were continued. The social security cash benefits alone will increase by $7 billion in 1973 ($7.4 billion in 1974) largely because of the 10-percent increase in benefits approved by the Committee. Medicare benefits will rise by $3 billion by 1974 as the new program for coverage of the disabled and for the provision of drugs become effective.

But perhaps the most significant features of the bill are those seeking to reform the welfare laws. In addition to upgrading the level of benefits for needy old age, blind, and disabled Americans (at an added cost of $2.2 billion in 1974) the Committee bill offers a bold, new approach to the problem of increasing dependency under the program of Aid to Families With Dependent Children. Specifically, where the youngest child in an AFDC family has reached school age (or where the family is headed by a male) the family would no longer be eligible for welfare as it is today, but instead the head of the family would be offered a guaranteed job opportunity. He, or she, would be given an opportunity to become independent through employment and sufficient financial incentives are provided by the bill to encourage him or her to prefer employment in the private economy to work in the guaranteed job. Moreover, unlike today, the Federal Government's incentive to help these families locate suitable jobs would be enhanced because under the Committee plan the entire cost of the employment program would be borne by the Federal Government whereas AFDC costs are shared with the States. The cost of this new system of employment opportunity is estimated at $4.5 billion in 1974, with virtually all the expense incurred to increase the income of the poor who work.

The Social Security, Medicare, and Medicaid Programs

SOCIAL SECURITY CASH BENEFITS

As passed by the House, H.R. 1 would increase social security cash benefits by $3.9 billion in 1973 and $4.3 billion in 1974. A little over half of this increase is related to the 5-percent across-the-board benefit increase in the House bill.

The Committee bill would increase social security cash benefit payments by $7.4 billion in 1974. The major item of cost relates to the 10 percent benefit increase in the Committee bill, twice the amount of the increase in the House bill.

Another major feature of the Committee bill would provide a special minimum benefit to low-wage workers with long-time attachment to employment covered under social security. A retired worker with at least 30 years of covered employment would be guaranteed a benefit of at least $200 (if the worker is married, the couple would receive a benefit of at least $300).

The individual provisions of the Committee bill are described below.

1. PROVISIONS OF THE HOUSE BILL CHANGED AND NEW PROVISIONS ADDED BY THE COMMITTEE

Increase in Social Security Benefits

The Committee bill provides for a general 10-percent increase in social security benefits in place of the 5-percent increase in the House-passed bill. The increase would be effective with the benefit checks that will be delivered July 3.

However, it seems unlikely that Congress could take final action on the bill in time for the higher amounts to show up in the July checks. The increase, therefore, will be paid retroactively after the bill is enacted.

Under the Committee bill about 27.8 million social security beneficiaries will receive higher benefits and about $4.3 billion in additional benefits will be paid in 1974 as a result of the 10 percent benefit increase. The average retirement benefit would rise from an estimated $133 to $147 a month, rather than to $141 as under the House bill. The average benefits for aged couples would increase from an estimated $223 to $247 a month, rather than to $234 a month under the House-passed bill. A worker with maximum earnings creditable under social security who retired at age 65 this year would get a monthly benefit of $237.80 rather than $216.10 as under present law. If he and his wife both become entitled to benefits at age 65, they would get $356.70 rather than $324.20 under present law.

The minimum benefit would be increased by 5 percent from $70.40 to $74.00, as in the House-passed bill.

Special benefits for people age 72 and over who are not insured for regular benefits would be increased by 5 percent, as in the House-passed bill, from $18.30 to $50.80 for individuals and from $72.50 to $76.20 for couples.

Special Minimum Benefits

The House-passed bill would provide a special minimum benefit of $5 multiplied by the number of years in covered employment up to thirty years, producing a benefit of at least $150 a month for a worker who has been employed for 30 years under social security coverage. The Committee bill replaces this with a provision for a special minimum benefit under the social security program which would provide a payment of $200 per month ($300 for a couple) for persons who have been employed in covered employment for thirty years. This benefit would be paid as an alternative to the regular benefits in cases where a higher benefit would result.

Specifically, the Committee bill would provide a special minimum of $10 per year for each year in covered employment in excess of ten years (for purposes of this special minimum, there would be no credit for the first ten years of employment). Under this provision, the new higher minimum benefit would become payable to people with 18 or more years of employment; at that point, the special minimum benefit—$80—would be more than the regular minimum. A worker with twenty years of employment under social security would thus be guaranteed a benefit of at least $100; one with twenty-five years would be guaranteed at least $150, while one with thirty years would receive at least $200 a month. Minimum payments to a couple would be one and one-half times these amounts.

The level of payments under the present law, the House bill, and the Committee bill are shown in the following table:

TABLE 1.—COMPARISON OF MONTHLY BENEFITS UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL

Average monthly earnings	Years of employment under social security	Retirement benefit for an individual under—		
		Present law	House Bill	Committee Bill
$200	20	$128.60	$135.10	$141.50
$200	25	128.60	135.10	150.00
$200	30 or more	128.60	150.00	200.00
$250	20	145.60	152.90	160.20
$250	25	145.60	152.90	160.20
$250	30 or more	145.60	152.90	200.00
$300	20	160.90	169.00	177.00
$300	25	160.90	169.00	177.00
$300	30 or more	160.90	169.00	200.00

Effective date.—January 1973.

Number of people affected and dollar payments.—1.3 million people would get increased benefits on the effective date and $300 million in additional benefits would be paid in 1974.

Automatic Increases in Benefits, the Tax Base, and the Earnings Test

The Committee bill retains the provisions in the House bill providing for automatic annual increases in social security benefits as the cost of living rises. These increases would go into effect each January whenever the Consumer Price Index goes up by at least 3 percent. However, the Committee did change the method of financing the additional benefits paid under the automatic mechanism. Under the Committee bill, the financing would be directly related to the amount of the additional benefits and one-half would be provided from an increase in the tax rate and one-half from an increase in earnings (presently $9,000 and increasing to $10,200 beginning January 1973 under the Committee bill) subject to the social security tax. Under the House-passed bill, the financing mechanism would not be related to the cost of the automatic benefit increase, but rather to changes in wage rates. Under the House bill, the increased benefits would be financed entirely through an increase in the taxable wage base.

Effective date.—The first cost-of-living increase would be possible for January 1975.

Increased Benefits for Those Who Delay Retirement Beyond Age 65

The Committee bill includes the provisions in the House bill which would provide for an increase in social security benefits of one percent for each year after age 65 that the individual delays his retirement. However, the committee modified the provision so that the additional benefit would apply to persons already retired, rather than only to those coming on the social security rolls after the bill's enactment.

Effective date.—January 1973.

Number of people affected and dollar payment.—5 million people would get increased benefits on the effective date and $180 million in additional benefits would be paid in 1974.

Reduction in Waiting Period for Disability Benefits

Under the House bill, the present 6-month period throughout which a person must be disabled before he can be paid disability benefits would be reduced by one month (to 5 months). Under the committee bill, the waiting period would be reduced 2 months to a 4-month period.

Effective date.—January 1973.

Number of people affected and dollar payments.—950,000 beneficiaries would become entitled to higher benefit payments on the effective date and 8,000 additional people would become entitled to benefits. About $250 million in additional benefits would be paid in 1974.

Benefits for a Child Based on the Earnings Record of a Grandparent

Under the House bill, coverage would be extended to grandchildren not adopted by their grandparents if their parents have died and if the grandchildren were living with a grandparent at the time the grandparent qualified for benefits. The Committee approved the House provision but extended it to instances where the grandchild's parents either are totally disabled or have died, and the grandchild is living with a grandparent.

Effective date.—January 1973.

Refund of Social Security Tax to Members of Certain Religious Faiths Opposed to Insurance

Under present law, members of certain religious sects who have conscientious objections to social security by reason of their adherence to the established teachings of the sect may be exempt from the social security self-employment tax provided they also waive their eligibility for social security benefits. This exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

The Committee bill would extend the exemption (by a refund or credit against income taxes at year end) from social security taxes to members of the sect who are "employees" covered by the Social Security Act as well as the "self-employed" members of the sect. The employee would have to file an application for exemption from the tax and waive his eligibility for social security and medicare benefits just as the self-employed members must presently do. Although a qualified individual would be exempt from the tax, his employer would continue to deduct the tax from his pay and to pay the employer tax. Later the employee could claim a refund or a tax credit. However, the provision specifically provides that there would be no forgiveness of the employer portion of the social security tax as the Committee believes this would create an undesirable situation in which an employer would have a tax incentive to hire people of one religious belief in preference to those of other religious beliefs.

Effective date.—January 1973.

Sister's and Brother's Benefits

The Committee bill includes a provision (not contained in the House bill) to extend social security coverage to dependent sisters and to dependent disabled brothers.

Effective date.—January 1973.

Number of people affected and dollar payments.—50 000 additional people would become eligible for benefits on the effective date and $70 million in additional benefits would be paid in 1974.

Disability Benefits for Individuals Who Are Blind

The Committee bill includes provisions (not contained in the House-passed bill): (a) making disability benefits payable to blind persons

who have six quarters of coverage earned at any time; (b) changing the definition of disability for the blind to permit them to qualify for benefits regardless of their capacity to work and whether they work; (c) permitting the blind to receive disability benefits beyond age 65 without regard to the retirement test; and (d) excluding the blind from the requirement that disability benefits be suspended when a beneficiary refuses without good cause to accept vocational rehabilitation.

Effective date.—January 1973.

Number of people affected and dollar payments.—250,000 additional people would become eligible for benefits on the effective date and $200 million in additional benefits would be paid in 1974.

Issuance of Social Security Numbers and Penalty for Furnishing False Information to Obtain a Number

The Committee bill includes a number of provisions (not contained in the House bill) dealing with the method of issuing social security account numbers. Under present law, numbers are issued upon application, often by mail, upon the individual's motion.

Under a Committee amendment, numbers in the future generally would be issued at the time an individual enters the school system; for most persons, this would be the first grade. In the case of noncitizens entering the country under conditions which would permit them to work, numbers would be issued at the time they enter the country or in the case of a person who may not legally work at the time he is admitted to the United States, the number would be issued at the time his status changes. In addition to these general rules, numbers would be issued to persons who do not have them at the time they apply for benefits under any federally financed program.

As a corollary to this more orderly system of issuing social security account numbers, the Committee bill would provide criminal penalties for (1) knowingly and willfully using a social security number that was obtained with false information for any purpose or (2) using someone else's social security number or other use of a social security number to conceal one's true identity (such as by counterfeiting a social security number) for such purposes. The penalties provided would be a fine of up to $1,000 or imprisonment for up to one year or both. These criminal penalties perfect and improve upon features of the House bill relating to false information with respect to social security numbers.

Treatment of Income From Sale of Certain Literary or Artistic Items

The Committee bill includes a provision (not contained in the House bill) to exclude income from sale of certain literary or artistic items created before age 65 from income for purposes of determining the amount of benefits to be withheld under the social security earnings test. Under existing law, such income is not counted if the literary work was copyrighted before age 65. Under the amendment, the time of copyright is immaterial so long as the work which produced the literary or artistic item was performed before age 65.

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Underpayments

The Committee bill includes a provision (not contained in the House bill) under which additional relatives (by blood, marriage, or adoption) would be added to the present categories of persons listed in the law who may receive social security cash payments due but unpaid to a deceased beneficiary.

Payments by an Employer to Disability Beneficiaries or to the Survivor or Estate of a Former Employee

Under the House bill amounts earned by an employee which are paid after the year of his death to his survivors or his estate would be excluded from coverage. The Committee bill would extend the provision to payments made to disability insurance beneficiaries. Under present law, such wages are covered and social security taxes must be paid on these wages but the wages cannot be used to determine eligibility for or the amount of social security benefits.

Death Benefits Where Body Is Unavailable

Under Public Law 92-223, expenses of memorial services can be counted as funeral expenses for the purpose of the social security lump sum death payment, even though the body is unavailable for burial or cremation. The provision applies only with respect to deaths after December 29, 1971. The Committee bill would cover deaths occurring after 1960, thus spanning the entire period of the Vietnam action.

2. PROVISIONS OF THE HOUSE BILL THAT WERE NOT CHANGED BY THE COMMITTEE

Increase in Widow's and Widower's Insurance Benefits

Under present law, when benefits begin at or after age 62 the benefit for a widow (or dependent widower) is equal to 82½ percent of the amount the deceased worker would have received if his benefit had started when he was age 65. A widow can get a benefit at age 60 reduced to take account of the additional 2 years in which she would be getting benefits.

Both the House bill and the Committee bill would provide benefits for a widow equal to the benefit her deceased husband would have received if he were still living. Under the bill, a widow whose benefits start at age 65, or after, would receive either 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement at age 65) or, if his benefits began before age 65, an amount equal to the reduced benefit he would have been receiving if he were alive.

Under the bill, the benefit for a widow (or widower) who comes on the rolls between 60 and 65 would be reduced (in a way similar to the way in which widows' benefits are reduced under present law when they begin drawing benefits between ages 60 and 62) to take account of the longer period over which the benefit would be paid

Effective date.—January 1973.

Number of people affected and dollar payments.—3.8 million people would get increased benefits on the effective date and $1 billion in additional benefits would be paid in 1974.

Age 62 Computation Point for Men

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men but only up to age 62 for women. Under both the House bill and the Committee bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

Effective date.—The new provision would become effective, starting January 1973, over a 3-year transition period.

Liberalization of the Retirement Test

The amount that a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $1,680 to $2,000. Under present law, benefits are reduced by $1 for each $2 of earnings between $1,680 and $2,800 and for each $1 of earnings above $2,880. The bill would provide for a $1 reduction for each $2 of all earnings above $2,000; there would be no $1-for-$1 reduction as under present law. Also, in the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included, as under present law, in determining his total earnings for the year.

Effective date.—January 1973.

Number of people affected and dollar payments.—1.1 million beneficiaries would become entitled to higher benefit payments on the effective date and 400,000 additional people would become entitled to benefits. About $650 million in additional benefits would be paid in 1974.

Childhood Disability Benefits

Childhood disability benefits would be paid to the disabled child of an insured retired, deceased, or disabled worker, if the disability began before age 22, rather than before 18 as under present law. In addition, a person who was entitled to childhood disability benefits could become re-entitled to childhood disability benefits if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

Effective date.—January 1973.

Number of people affected and dollar payments.—13,000 additional people would become eligible for benefits on the effective date and $16 million in additional benefits would be paid in 1974.

Continuation of Child's Benefits Through the End of a Semester

Payment of benefits to a child attending school would continue through the end of the semester or quarter in which the student (including a student in a vocational school) attains age 22 (rather

than the month before he attains age 22) if he has not received, or completed the requirements for, a bachelor's degree from a college or university.

Effective date.—January 1973.

Number of people affected and dollar payments.—55,000 present beneficiaries would have their benefits continued and 6,000 additional people would become eligible for benefits on the effective date and $18 million in additional benefits would be paid in 1974.

Eligibility of a Child Adopted by an Old-Age or Disability Insurance Beneficiary

The provisions of present law relating to eligibility requirements for child's benefits in the case of adoption by an old-age insurance beneficiary or by disability insurance beneficiaries would be modified to make the requirements uniform in both cases. A child adopted after a retired or disabled worker becomes entitled to benefits would be eligible for child's benefits based on the worker's earnings if the child is the natural child or stepchild of the worker or if (1) the adoption was decreed by a court of competent jurisdiction within the United States, (2) the child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit, (3) the child received at least one-half of his support from the worker for that year, and (4) the child was under age 18 at the time he began living with the worker.

Effective date.—January 1973.

Nontermination of Child's Benefits by Reason of Adoption

A child's benefit would no longer stop when the child is adopted.

Effective date.—January 1973.

Disability Benefits Affected by the Receipt of Workmen's Compensation

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable if the combined payments exceed 80 percent of the worker's average current earnings before disablement. Average current earnings for this purpose can be computed on two different bases and the larger amount will be used. The bills add a third alternative base, under which a worker's average current earnings can be based on the one year of his highest earnings in a period consisting of the year of disablement and the five preceding years.

Effective date.—January 1973.

Dependent Widower's Benefits at Age 60

Widowers under age 62 could be paid reduced benefits (on the same basis as widows under present law) starting as early as age 60.

Effective date.—January 1973.

Waiver of Duration-of-Marriage Requirement in Case of Remarriage

The duration-of-marriage requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild—that is, the period of not less than nine months immediately prior to the day on which the worker died that is now required (except where death was accidental or in the line of duty in the uniformed service, in which case the period is three months)—would be waived in cases where the worker and his spouse were previously married, divorced, and remarried, if they were married at the time of the worker's death and if the duration-of-marriage requirement would have been met at the time of the divorce had the worker died then.

Effective date.—January 1973.

Wage Credits for Members of the Uniformed Services

Present law provides for a social security noncontributory wage credit of up to $300, in addition to contributory credit for basic pay, for each calendar quarter of military service after 1967. Under the bill, the additional noncontributory wage credits would also be provided for service during the period January 1957 (when military service came under contributory social security coverage) through December 1967.

Disability Insurance Benefits Applications Filed After Death

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) would be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the worker's death, or within 3 months after enactment of this provision for deaths occurring after 1969.

Coverage of Members of Religious Orders Who Are Under a Vow of Poverty

Social security coverage would be made available to members of religious orders who have taken a vow of poverty, if the order makes an irrevocable election to cover these members as employees of the order.

Self-Employment Income of Certain Individuals Living Temporarily Outside the United States

Under present law, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for approximately 17 months out of 18 consecutive months, must exclude the first $20,000 of his earned income in computing his taxable income for social security and income tax purposes. The bill would provide the U.S. citizens who are self-employed outside the United States and who retain their residence in the United States would not exclude the first $20,000 of earned income for social security purposes and would compute their earnings from self-employment for social security pur-

poses in the same way as those who are self-employed in the United States.

Trust Fund Expenditures for Rehabilitation Services

Provides an increase in the amount of social security trust fund moneys that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits (as under present law) to 1¼ percent for fiscal year 1972 and to 1½ percent for fiscal year 1973 and subsequent years.

3. OTHER CASH BENEFIT AMENDMENTS

Other amendments included in the Committee's bill relate to the executive pay level of the Commissioner of Social Security; the coverage of U.S. missionaries working outside the U.S.; retroactive benefits for certain disabled persons; social security benefits for a child entitled on the earnings of more than one person; filing of disability applications; social security coverage for students employed at State operated schools; and social security coverage of Registrars of Voters in Louisiana; coverage of certain policemen and firemen in West Virginia; and wage credits for Americans of Japanese ancestry who were interned by the U.S. Government during World War II.

In addition, in order to pay for a portion of the long-range costs associated with the 10-percent across-the-board benefit increase, the Committee deleted the House-passed amendments relating to actuarially reduced benefits in one category not being made applicable to certain benefits in other categories; the computation of benefits based on combined earnings of a married couple; and to the dropping of additional years of low earnings from the computation of average earnings.

PRINCIPAL MEDICARE-MEDICAID PROVISIONS

1. PROVISIONS OF HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY COMMITTEE

Medicare Coverage for Disabled Beneficiaries

(Section 201)

Problem

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. In addition, disabled persons are often unable to obtain private health insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, a social security disability beneficiary would be covered under Medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled widows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.5 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is $1.5 billion for hospital insurance and $350 million for supplementary medical coverage.

Hospital Insurance for the Uninsured

(Section 202)

Problem

A substantial number of people reaching or presently over age 65 are ineligible for Social Security and thus cannot secure Part A (hospital insurance) coverage under Medicare. These people have difficulty in securing private health insurance coverage with benefits as extensive as those of Medicare.

Finance Committee Amendment

The Committee bill will permit persons age 65 or over who are ineligible for Part A of Medicare to voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially estimated at $31 monthly and to be recalculated annually). Where the Secretary of HEW finds it administratively feasible, those State and other public employee groups which have, in the past, voluntarily elected *not* to participate in the Social Security program could opt

for and pay the Part A premium costs for their retired or active employees age 65 or over.

The Finance Committee amendment requires enrollment in Part B of Medicare as a condition of buying into Part A.

Part B Premium Charges

(Section 203)

Problem

During the first 5 years of the program it has been necessary to increase the Part B premium almost 100 percent—from $3.00 monthly per person in July 1966 to a scheduled $5.80 rate in July 1972. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate.

Finance Committee Amendment

The Committee bill will limit Part B premium increase to not more than the percentage by which the Social Security cash benefits had been generally increased since the last Part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching.

Automatic Enrollment for Part B

(Section 206)

Problem

Under present law, eligible individuals must initiate action to enroll in Part B of Medicare. Nearly 96 percent of eligible older people so enroll. Some eligibles, however, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, the change provides for automatic enrollment under Part B for the elderly and the disabled as they become eligible for Part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

Relationship Between Medicare and Federal Employees' Benefits

(Section 210)

Problem

Federal retirees and older employees have been required to take full coverage and pay full premiums for Federal employee coverage despite the fact that the Federal Employees' Programs *will not pay* any benefits for services covered under Medicare. Thus the retiree, who also

has earned entitlement to Medicare, is paying a portion of his premium to F.E.P. for coverage for which no benefits will be paid him. This is particularly true in the case of hospitalization. The F.E.P. does not presently offer such employees or retirees with dual eligibility the option of electing a lower-cost policy or one which supplements rather than duplicates Medicare benefits.

Finance Committee Amendment

Effective January 1, 1975, Medicare would not pay a beneficiary, who is also a Federal retiree or employee, for services covered under his Federal Employee's health insurance policy which are also covered under Medicare unless he has had an option of selecting a policy *supplementing* Medicare benefits. If a suplemental policy is not made available, the F.E.P. would then have to pay first on any items of care which were covered under both the F.E.P. program and Medicare.

Limitation on Federal Payments for Disapproved Capital Expenditure

(Section 221)

Problem

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local health care facilities planning council and still be reimbursed by Medicare and Medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

Finance Committee Amendment

The Committee bill will prohibit reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of $100,000 or more which are specifically determined to be inconsistent with State or local health facility plans.

Experiments in Prospective Reimbursement and Peer Review

(Section 222)

Problem

Reimbursement on the present reasonable costs basis contains little incentive to decrease costs or to improve efficiency, and retrospective cost-finding and auditing have caused lengthy delays and confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, under prospective payment providers might press for a rate less favorable to the Government than the present cost method, and they might cut back on the quality, range and frequency of necessary services so as to reduce costs and maximize return.

Finance Committee Amendment

The Committee bill instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments. In view of its adoption of the Professional Standards Review amendment, the Committee deleted the portion of this section authorizing peer review experimentation.

Limitations on Coverage of Costs

(Section 223)

Problem

Certain institutions may incur excessive costs, relative to comparable facilities in the same area, as a result of inefficiency or "the provision of amenities in plush surroundings." Such excessive costs are now reimbursed under Medicare.

Finance Committee Amendment

The Committee bill authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except that he may not be charged for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of costs determined as not "necessary" to efficient patient care.

In cases where emergency care is involved, however, patients would not be liable for any differential in costs related to the emergency care.

Limitation on Prevailing Charge Levels

(Section 224)

Problem

Under the present reasonable charge policy, Medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase Medicare payments and costs.

Finance Committee Amendment

The Committee bill recognizes as reasonable, for Medicare reimbursement purposes only, those charges which fall within the 75th percentile. Starting in 1973, increases in physicians' fees allowable for Medicare purposes, would be limited by a factor which takes into account increased costs of practice and the increase in earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the amendment would provide for recognizing only the lower charges at which supplies of similar quality are widely available.

Payment for Physicians' Services in the Teaching Setting

(Section 227)

Problem

Physicians in private practice are generally reimbursed on a fee-for-service basis for care provided to their bona fide private patients. Difficulties have arisen in determining how and whether payments should be made in teaching hospitals where the actual care is often

rendered by interns and residents under the direction (sometimes nominal) of an attending physician who is assigned to (but not selected by) the Medicare patient.

The issue relates to the compensation of the attending physician often termed the supervisory or teaching physician. The salaries of interns and residents are now covered in full as a Part A hospital cost. In general, patients were not billed for the services of teaching physicians prior to Medicare and, since Medicare, billings have been essentially limited to Medicare and Medicaid patients. The proceeds are most frequently used to finance and subsidize medical education rather than being paid directly to the teaching doctor. While charges have often been billed on a basis comparable to those charged by a private physician to his private patients the services provided are often less.

Finance Committee Amendment

The Committee bill provides that services of teaching physicians would be reimbursed on a costs basis unless:

(A) The patient is bona fide private or;

(B) The hospital has charged all patients and collected from a majority on a fee-for-service basis.

For donated services of teaching physicians, a salary cost would be imputed equal to the prorated usual costs of full-time salaried physicians. Any such payment would be made to a special fund designated by the medical staff to be used for charitable or educational purposes.

Advance Approval of ECF and Home Health Coverage

(Section 228)

Problem

Uncertainty about determinations of eligibility for care in an extended care facility or home health program following hospitalization have created major difficulties for intermediaries, institutions and beneficiaries. The essential problem is in determining whether the patient is in need of skilled nursing and medical services or in fact, needs a lesser level of care. Retroactive claims denials resulting from determinations that skilled care was not required, while often justified, have created substantial friction and ill will.

Finance Committee Amendment

The Committee bill authorizes the Secretary to establish, by diagnosis, minimum periods during which the post-hospital patient would be presumed to be eligible for benefits.

Termination of Payment to Suppliers of Service

(Section 229)

Problem

Present law does not provide authority for the Secretary to withhold future payments for services rendered by an institution or physician who abuse the program, although payments for past claims may be withheld on an individual basis where the services were not reasonable or necessary.

Finance Committee Amendment

The Secretary would be authorized to suspend or terminate Medicare payments to a provider found to have abused the program. Further, there would be no Federal participation in Medicaid payments which might be made subsequently to this provider. Program review teams would be established in each State to furnish the Secretary with professional advice in discharging this authority.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Program

(Section 230)

Problem

The Medicaid program has been a significant burden on State finances. Section 1903(e) of Title 19 requires each State to show that it is making efforts in the direction of broadening the scope of services in its Medicaid program and liberalizing eligibility requirements for medical assistance. These required expansions of Medicaid programs have been forcing States to either cut back on other programs or to consider dropping Medicaid. The original date for attainment of those objectives was 1975. The Finance Committee, the Senate and the House approved an amendment in 1969 postponing the date to 1977.

Finance Committee Amendment

The Committee bill would repeal section 1903(e).

Relationship Between Medicaid and Comprehensive Health Programs

(Section 240)

Problem

State agencies often cannot make pre-payment arrangement which might result in more efficient and economical delivery of health services to Medicaid recipients because such arrangements might violate present Title 19 requirements that the same range and level of services be available to all recipients throughout the State.

Finance Committee Amendment

The Committee bill would permit States to waive Federal statewideness and comparability requirements with approval of the Secretary if a State contracts with an organization which has agreed to provide health services in excess of the State plan to eligible recipients who reside in the area served by the organization and who elect to receive services from such organization. Payment to such organizations could not be higher on a per-capita basis than the per-capita medicaid expenditures in the same general area.

Program for Determining Qualifications for Certain Health Care Personnel

(Section 241)

Problem

There is a shortage of qualified manpower in the health care field and many facilities have difficulty hiring sufficient qualified personnel.

At the same time there are persons available who do not meet full licensing or Medicare educational requirements, but who have had years of experience and have been granted "waivered" status (for example, waivered licensed practical nurses).

Finance Committee Amendment

The Committee bill would require the Secretary to develop and apply appropriate means of determining the proficiency of health personnel who are disqualified or restricted in responsibility under present regulations because of lack of formal training or educational requirements.

In order to encourage young people to complete required training, all health personnel initially licensed after Dec. 31, 1975 would be expected to meet otherwise required formal educational and training criteria.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(Section 242)

Problem

Present penalty provisions applicable to Medicare do not specifically include as fraud such practices as kickbacks and bribes. There is no criminal penalty provision applicable to Medicaid. Additionally, there are no penalties at present for false reporting with respect to health and safety conditions in participating institutions.

Finance Committee Amendment

The Committee bill would establish penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefits with intent to defraud, or for converting benefit payments to improper use, of up to one year's imprisonment and a $10,000 fine or both. Concealing knowledge of events affecting a person's right to benefits with intent to defraud, and converting benefits to improper use would also be a Federal crime subject to the same penalty. Additionally, the bill establishes false reporting of a material fact as to conditions or operations of a health care facility as a misdemeanor subject to up to 6 months' imprisonment, a fine of $2,000, or both.

Prosthetic Lenses Furnished by Optometrists Under Part B

(Section 264)

Problem

Medicare will pay for prosthetic lenses furnished by an optometrist, provided that the medical necessity for such lenses has been determined by a physician.

Optometrists contend that to require their patients to obtain a physician's order for prosthetic lenses is unfair to both the patient and the optometrist. Moreover, because the physician who furnishes the order is generally an opthalmologist, the requirement may serve to encourage patients to use an ophthalmologist in preference to an optometrist.

Finance Committee Amendment

The Committee bill provides that, for the purposes of the medicare program, an optometrist be recognized as a "physician" under section 1861(r) of the Act, but only with respect to establishing the medical necessity of prosthetic lenses for medicare beneficiaries. An optometrist would not be recognized as a "physician" for any other purposes under medicare and no additional services performed by optometrists would be covered by the proposal.

2. PROVISIONS OF HOUSE BILL SUBSTANTIALLY MODIFIED BY COMMITTEE

Failure by States To Undertake Required Institutional Care Review Activities

(Section 207)

Problem

Both the General Accounting Office and the HEW Audit Agency have found substantial unnecessary and overutilization of costly institutional care under Medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care. There is no provision in present law which places affirmative responsibility upon States to assure proper patient placement. As a practical matter, the Department of HEW has seldom if ever, recovered from a State amounts improperly spent for non-covered care or services.

House Bill

1. Unless a State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization of nursing home care, effective January 1, 1973, the House bill provides for a one-third reduction in the Federal Medicaid matching share for stays in a fiscal year which exceed 60 days in a skilled nursing home.

2. Federal matching would be available, in any year, for only: (a) 60 days of care in a general or TB hospital, and (b) 90 days in a mental hospital (except that an additional 30 days would be allowed in a mental hospital if the State shows that the patient will benefit). There would be no Federal matching for care in a mental hospital beyond 120 days in any year. In addition, there would be no Federal matching for care in a mental hospital after 365 days of such care during a patient's lifetime.

3. The House bill would also provide for an increase of 25% (up to a maximum of 95%) in the Federal Medicaid matching formula for amounts paid by States under contracts with Health Maintenance Organizations or other comprehensive health care facilities.

4. The bill would provide authority for the Secretary to assure that average Statewide reimbursement for intermediate care in a State is reasonably lower than average payments for higher level skilled nursing home care in that State.

Finance Committee Changes

1. In addition to the utilization review requirement, States must also conduct the independent professional audits of patients as required

by present law which are intended to assure that the patient is getting the right care in the right place.

2. Where a State makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of hospital and mental hospital care: (a) the 60-day limitation in general and TB hospitals, and (b) the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals, would not apply. If proper procedures assure that the patient needs the care and is benefiting from it, it seemed inappropriate to cut off Federal matching utilizing arbitrary limitations.

3. The Committee deleted the House provision calling for a 25% increase in matching for amounts paid to HMO's, since if HMO's deliver services more efficiently, and economically, it would be in the States' interest to deal with HMO's without an increase in matching.

4. Intermediate care services would also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appeared appropriate in view of the shift of intermediate care to Medicaid in legislation enacted subsequent to House consideration of H.R. 1.

5. Finally, the Secretary's validation of State utilization controls would be made on site in the States and such findings would be a matter of public record. The purpose here is to assure actual—rather than paper—compliance with the proposed statutory requirements.

Cost Sharing Under Medicaid

(Section 208)

Problem

Under present law, States may require payment by the medically indigent of premiums, deductibles and co-payment amounts with respect to Medicaid services provided them but such amounts must be "reasonably related to the recipient's income." However, States cannot require cash assistance recipients to pay any deductibles or co-payments.

House Bill

This section contains 3 provisions:

1. It requires States which cover the medically indigent to impose monthly premium charges. The premium would be graduated by income in accordance with standards prescribed by the Secretary and details regarding the operation of the premium would be left to the Secretary's discretion. The House Committee report indicates that it would be expected that premiums would be fixed on a state-by-state basis at whatever level would be required to result in a savings under the medically indigent program of approximately 6 percent.

2. States could, at their option, require payment by the medically-indigent of deductibles and co-payment amounts which would not have to vary by level of income.

3. With respect to cash assistance recipients, nominal deductible and co-payment requirements, while prohibited for the six mandatory services required under Federal law (inpatient hospital services; outpatient hospital services; other X-ray and laboratory services; skilled nursing home services; physicians' services; and home health services),

would be permitted with respect to optional Medicaid services such as prescribed drugs, hearing aids, etc.

Finance Committee changes

The provision would be modified by the Committee bill as follows:

1. The House bill permits States to impose co-payments and deductibles on the medically-indigent. The change limits such amounts to co-payments on patient-initiated elective services only, such as the initial office visits to physicians and dentists.

2. The House bill also allows States to impose co-payments and deductibles on the indigent for optional Medicaid services. The committee deleted this provision, as the savings ($5 million) would most probably be exceeded by the administrative costs.

Mandatory Medicaid Deductible for Families With Earnings

(Section 209)

Problem

Under present law, AFDC families with earnings can, at a certain earnings point lose eligibility for Medicaid. This has been called the "Medicaid Notch". This notch is believed to act as a potential work disincentive, since at a certain income level a family may precipitously lose Medicaid eligibility if it has additional earnings.

House Bill

Section 209 would remove this "notch" by requiring AFDC families with earnings to pay a Medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over $720. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. This approach eliminates any sudden loss of Medicaid eligibility. However, although eligible for Medicaid, every dollar of a recipient's retained earnings raises his Medicaid deductible by one dollar.

In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this point, however, his Medicaid deductible would increase dollar for dollar with his retained earnings.

Finance Committee Changes

Although the House provision eliminates any sudden loss of eligibility for Medicaid, the provision acts as a substantial work disincentive, since the Medicaid deductible increases dollar for dollar with retained earnings.

In order to avoid establishing a substantial work disincentive the Committee amended Section 209 to deal with the "Medicaid Notch" by allowing Work Program families otherwise eligible for Medicaid, who would ordinarily lose eligibility as a result of earnings from employment, to remain eligible for Medicaid for one year. At the expiration of that year, such families could elect to continue in Medicaid by paying a premium of 20 percent of income in excess of $2,400 annually (excluding work bonus amounts). Additionally, other families participating in the Work Program (see Title IV) which are otherwise ineligible for Medicaid in a State could also vol-

untarily elect to participate by paying a premium of 20 percent of income (excluding work bonus) above $2,400. Costs of coverage for those families on a premium basis would be subsidized by the Federal Government to the extent premium income did not cover the costs of benefits for those families.

The Committee retained that portion of Section 209 of the House bill which gives States the option of covering under Medicaid aged, blind and disabled persons made newly eligible as a result of the increases in payment levels to these persons proposed by the Committee.

Medicare Benefits for Border Residents

(Section 211)

Problem

At present, coverage for care in a foreign hospital near the U.S. border is available only where an emergency occurs *within* the United States and where the foreign institution is the closest adequate facility. This limitation creates difficulty in securing necessary non-emergency care by border residents who ordinarily do and would use the nearest hospital suited to their medical needs, which may be a foreign hospital.

House Bill

Authorizes use of a foreign hospital by a U.S. resident where such hospital was closer to his residence or more accessible than the nearest suitable United States hospital. Such hospitals must be approved under an appropriate hospital approval program.

In addition, the provision authorizes Part B payments for necessary physicians' services furnished in conjunction with such hospitalization.

Finance Committee Changes

The Committee approved the House provisions; it also authorized Medicare payments for emergency hospital and physician services needed by beneficiaries in transit between Alaska and the other continental States.

Payments to Health Maintenance Organizations

(Section 226)

Problem

Certain large medical care organizations seem to make the delivery of medical care more efficient and economical than the medical care community at large.

Medicare does not currently pay these comprehensive programs on an incentive capitation basis, and consequently any financial incentives to economical operation in such programs have not been incorporated in Medicare.

Two areas of potential concern arise in dealing with HMO's. The first area of concern involves the quality of care which the HMOs will deliver. Most existing large HMOs provide care which is generally accepted as being as of professional quality. However, if the Government begins on a widespread basis, to pay a set sum in advance to an organization in return for the delivery of all necessary care to

a group of people, there must be effective means of assuring that such organizations will not be tempted to cut corners on the quality of their care (e.g., by using marginal facilities or by not providing necessary care and services) in order to maximize their return or "profit." Under present reimbursement arrangements, although there may be no incentive for efficiency, neither is there an incentive to profit through underservicing and other corner-cutting.

The second problem area involves the reimbursement of HMO's. If an HMO were to enroll relatively good risks (i.e., the younger and healthier Medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large "windfalls" for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than Medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO.

House Bill

The House bill authorizes Medicare to make a single combined Part A and B payment, prospectively on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present Parts A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing prepaid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Finance Committee Changes

Agreeing with the desirability of authorizing reasonable per capita payments to organizations which have demonstrated a capacity to provide quality health care, and recognizing the above problems, the Committee authorized the following approach as a modification of the HMO provision in the house bill:

ELIGIBILITY FOR INCENTIVE REIMBURSEMENT

The Secretary would be authorized to contract on an incentive capitation basis for Medicare services with substantial, established HMO's: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined Part A-Part B capitation rate.

General Requirements

Such reimbursement would be authorized for HMOs which: (1) have been in operation for at least two years, and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over.

Exception

The Secretary would be authorized to make exceptions to the minimum enrollment requirement in the case of HMOs in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation, capacity to provide health care services of proper quality on a prepaid basis and which have at least 5,000 members.

Reimbursement

The combined Part A-Part B per capita payment would be determined and administered as follows:

1. An eligible HMO approved by the Secretary for per capita reimbursement would submit, at least 90 days prior to the beginning of a prospective Medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding Medicare costs in the HMO's area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost" (as defined below).

2. At the beginning of the contract period, the HMO would be paid monthly, in advance, the interim per capita prepayment for the Medicare beneficiaries actually enrolled. The HMO would submit interim cost estimates on a quarterly basis and the interim payment could be adjusted as indicated in such estimates, subject however to the limitations set forth below.

3. The HMO would submit, annually, independently certified financial statements, including certified costs statements allocating HMO operating costs to the Medicare population in proportion to utilization of HMO resources. Allocations may use statistical, demographic and utilization data collection and analysis methods acceptable to the Secretary in lieu of fee-for-service or cost-per-service methods in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance with Medicare accounting principles but not necessarily on the basis of actual case-by-case patient services. All HMO's would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General (and the Inspector General for Health Care administration).

4. The Secretary would retroactively determine on an actuarial basis what the per capita costs for Part A and Part B services for the HMOs' Medicare population would have been if the population had been served through other health care arrangements in the same general area and not enrolled in the HMO. That is to say there would be a calculation, on the basis of experience in the same or similar geographical areas, of the cost for the non-HMO group of similar size, age distribution, sex, race, institutional status, disability status, cost experi-

ence for the Medicare contract year in question, and other factors deemed by the actuaries to be relevant and material such as unusual usage of low-cost hospitals and non-usage of specialists. This figure defined as "adjusted average per capita cost" would be determined as promptly as practical after the end of a contract period. Many of the difficulties and uncertainties of previously suggested methods of rate determination are minimized or eliminated by making this determination after the fact. For example, the makeup of the enrolled population and Medicare cost experiences—within and outside of the HMO—would be known, rather than merely estimated.

5. If the HMO's costs for the types of expenses reimbursable under medicare are less than the adjusted average per capita cost the difference, called "net savings" would be divided and allocated as follows:

Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 percent and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80 percent level would be allocated entirely to the Government.

Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would receive a share equal to 7½ percent of the adjusted average per capita costs and the Government would retain 12½ percent of those costs.

6. At the option of the HMO, it could apply any amount of its share of the saving toward improved benefits, reduced supplemental premium rates, or other advantages for beneficiaries or retain the money. It could not, however, make cash refunds to beneficiaries.

7. If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would be allocated between the government and the HMO in the following manner:

Any amount of excess between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 25 percent by the HMO and 75 percent by the Government. Costs in excess of 120 percent would be borne entirely by the Government. Any losses incurred would carry forward and be recovered, proportionally, by the HMO and the Government in the future. Any losses by the Government would have to be recovered in full before any "savings" could be paid to an HMO in future years.

Reductions in Care and Services Under Medicaid Program

(Section 231)

Problem

The Medicaid program has been a significant burden on State finances. In an effort to reduce financial pressure upon States, Section 1902(d) of Title 19 provides that a State may reduce the range, duration or frequency of the services it provides under its Medicaid program, but it cannot reduce its aggregate expenditures for Medicaid from one year to the next. This maintenance of effort requirement has forced a few States to either cut back on other programs or to consider dropping Medicaid.

House Bill

The House bill provides for a continuance of the maintenance of effort clause with respect to the six mandatory health care services. The provision would, however, amend section 1902(d) by restricting the maintenance of effort requirement to those six basic services. The State would be able to modify the scope, extent and expenditures for optional services provided, such as drugs, dental care and eyeglasses.

Finance Committee Changes

The Committee substituted for the House provision an amendment repealing Section 1902(d)—entirely. This action is consistent with Committee and Senate action on H.R. 17550 in 1970.

Payments to States Under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems

(Section 235)

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them. Their recourse today is to contract with private companies for their data processing.

House Bill

1. Authorizes 90 percent Federal matching payments toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

2. Authorizes 90% matching for 2 years (up to a total of $150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Finance Committee Changes

The Committee deleted the first part of the House provision retaining, however, the part authorizing funds for cost-determination systems.

Provider Reimbursement Review Board

(Section 243)

Problem

Under present law, there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination, although administrative procedures exist to assist providers and intermediaries to reach reasonable settlement on disputed items.

House Bill

The House bill establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is $10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final

unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

The House provision is similar to a Senate amendment to H.R. 17550 in 1970. The House did not include those portions of the earlier Senate amendment which would allow providers, as a group, to appeal aggregate amounts of $10,000 on a common issue; and which would allow appeals to the Board by a provider where the intermediary fails to make timely final costs determinations.

Finance Committee Changes

The Committee substituted the 1970 Senate language and added language requiring the Secretary to report to the legislative committees at the end of the first year of operation of the provision concerning its capacity to function effectively and equitably as well as any suggestions he might have for improvement of the process.

Physical Therapy Services and Other Services Under Medicare

(Section 251)

Problem

Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office.

An additional problem relating to physical therapy is that a patient can exhaust his inpatient benefits and continue to receive payment for treatment *only* if the facility can arrange with another facility to furnish the therapy as an outpatient service. For example, a hospitalized patient would receive necessary physical therapy as a Part A benefit during his 90 days of coverage. But, if his hospital stay exceeded 90 days, he would be required to secure such services under Part B from a Home Health Agency—even though the hospital, itself, was capable of providing the needed therapy conveniently.

Another problem is the rapidly increasing cost of physical therapy services and findings of abuse of the benefit.

House Bill

The House bill would include as covered services under Part B, physical therapy provided in the therapist's office under such licensing as the Secretary may require and pursuant to a physician's written plan of treatment.

It would also authorize a hospital or extended care facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his Part B benefits after his inpatient benefits have expired.

Finally, it would control physical therapy costs by limiting total payments in one year for services by an independent practitioner in his office or the patient's home to $100, and by limiting reimbursement for services provided by physical and other therapists in an institutional setting to a reasonable salary-related basis rather than fee-for-service basis.

Finance Committee Changes

The Committee modified the House provision by adopting language to assure that factors, such as travel time, be included in the calculation of salary-related reimbursement and deleting the provision that would have established a new and separate benefit of up to $100 annually for services provided by an independent physical therapist in his office or in a patient's home.

Additionally, the Committee will include in its Report instructions to the Secretary designed to assure that reasonable arrangements may be undertaken in rural and smaller population centers to enhance availability of physical therapy in those areas.

Waiver of Registered Nurse in Rural Skilled Nursing Facility

(Section 267)

Problem

There are some rural nursing homes which can obtain a registered nurse to work one shift 5 days a week, but which are unable to obtain the services of an additional registered nurse to work on the other 2 days, generally the weekend.

House Bill

The House bill would allow a complete waiver of the requirement for a registered nurse in a rural nursing home, if there is no other skilled nursing home in the area to meet patient needs. Under the bill a skilled nursing home could function without any skilled nurse at all.

Finance Committee Changes

The Committee modified the provision granting waivers for certain rural skilled nursing facilities which are unable to assure the presence of a full-time registered nurse in such facilities 7 days a week. The Committee modification would allow a rural skilled nursing home, which has one full-time registered nurse and is making good faith efforts to obtain another, a special waiver of the nursing requirement with respect to not more than two shifts, such as over a weekend. This special waiver would be authorized if the facility had only patients whose physicians indicated that each such patient could be without a registered nurse's services for a 48-hour period. If the facility had any patients for whom physicians had indicated a need for daily skilled nursing services, the facility would have to make arrangements for a registered nurse or a physician to spend such time as was necessary at the facility on the uncovered day to provide the skilled services needed.

Coverage of Chiropractic Services

Problem

Chiropractors are not currently eligible to participate as physicians in the Medicare program.

House Bill

The House Bill calls for a study regarding the coverage of chiropractors.

Finance Committee Changes

The Committee on Finance deleted the study of chiropractic services called for in the House bill and substituted a provision providing for the coverage under Medicare of services involving treatment by means of manual manipulation of the spine by a licensed chiropractor who meets certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services applicable to Medicare would also pertain to States providing such care under Medicaid.

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

Establishment of Professional Standards Review Organizations

Problem

There are substantial indications that a significant amount of health services paid for by Medicare and Medicaid are in excess of those which would be found to be medically necessary under appropriate professional standards. Furthermore, in some instances services provided are of unsatisfactory professional quality.

Finance Committee Amendment

The Committee provided for the establishment of Professional Standards Review Organizations sponsored by organizations representing substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and ongoing review of services covered under the Medicare and Medicaid programs. The purpose of the amendment would be to assure proper utilization of care and services provided in Medicare and Medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption in carrying out of the important review activities in the two highly expensive programs. The amendment provides discretion for recognition of and use by the PSRO of effective utilization review committees in hospitals and medical organizations.

Coverage of Drugs Under Medicare

Problem

The costs of outpatient prescription drugs represent a major item of medical expense for many older people, especially for those suffering from chronic and serious illness conditions. The costs of such drugs are not presently covered under the Medicare program.

Finance Committee Amendment

The Committee amended Part A of Medicare to cover the costs of certain specified drugs, purchased on an outpatient basis, which are necessary in the treatment of the most common, crippling or life-threatening chronic disease conditions of the aged. Beneficiaries would pay $1 toward the cost of each prescribed drug included in the reasonable cost range for the drug involved.

The amendment would cover specific drugs used in the treatment of the following conditions: arthritis, cancer, chronic cardiovascular

disease, chronic kidney disease, chronic respiratory disease, diabetes, gout, glaucoma, high blood pressure, rheumatism, thyroid disease and tuberculosis. The amendment would limit reimbursement to certain drug used in the treatment of these conditions. For example, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs which would be used by people without heart conditions.

Other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The major provisions of the amendment are:

Eligibility.—Medicare beneficiaries with one or more of the following conditions:

Diabetes.
High blood pressure.
Chronic cardiovascular disease.
Chronic respiratory disease.
Chronic kidney disease.
Arthritis, gout and rheumatism.
Tuberculosis.
Glaucoma.
Thyroid disease.
Cancer.

Benefits.—Would include those drugs:

Necessary over a prolonged period of time for treatment of the above conditions:

Generally subject to use only by those with the above conditions.

This recommendation would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used only for a short period of time, and drugs such as tranquilizers and sedatives which may be used by eligible beneficiaries but also by many other persons.

A list of the covered drug categories and illustrative drug entities follows:

THERAPEUTIC CATEGORY AND DRUG ENTITY

Adrenocorticoids (e.g., Cortisone, Dexamethasone, Hydrocortisone, Prednisone)
Anti-arrhythmics (e.g., Quinidine)
Anti-coagulants (e.g., Dicumarol)
Anti-hypertensives (e.g., Reserpine)
Anti-neoplastics (e.g., Cyclophosphamide, Flourouracil, Mercaptopurine, Methotrexate, Vincristine)
Anti-rheumatics (e.g., Phenylbutazone)
Bronchial dialators (e.g., Isoproterenol)
Cardiotonics (e.g., Digitoxin, Digoxin)

Coronary vasodilators (e.g., Nitroglycerin)
Diuretics (e.g., Hydrochlorothiazide)
Gout suppressants (e.g., Colchicine)
Hypoglycemics (e.g., Insulin)
Miotics (e.g., Philocarpine)
Thyroid hormones (e.g., Thyroid)
Tuberculostatics (e.g., Aminosalicylate, Isoniazid)

Reimbursement and Cost Controls.—The amendment would utilize a reasonable charge reimbursement method, and would incorporate a formulary approach. The formulary established could include only drug entities in categories specified above. Participating pharmacies would file either their usual and customary markups or professional fee schedules as of June 1, 1972, which would then be applied to the estimated acquisition cost of the drug product. The usual and customary charge, including mark-up or professional fee, for purposes of program payments and allowances, could not exceed the 75th percentile of charges by comparable vendors in an area for similar quantities of the dosage form of the drug. Outpatient drugs dispensed by a participating hospital or extended care facility would be reimbursed on the regular Part A Medicare costs basis. Increases in prevailing mark-ups or fees would be limited in a fashion essentially parallel to that applicable to physicians' fees.

Financing.—Part A Medicare payroll tax.

Cost.—$700 million with a $1 co-payment per prescription. There would be an offsetting reduction in Federal-State Medicaid costs of $100 million as a result of this Medicare drug coverage.

Inspector General for Medicare and Medicaid

Problem

There is, at present, no independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of Medicare and Medicaid in terms of the efficiency and effectiveness of program operations and compliance with Congressional intent. While HEW's Audit Agency and the General Accounting Office have done helpful work, there is a need for day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

Finance Committee Amendment

Under the amendment, an Office of Inspector General for Health Administration would be established within the Department of Health Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible for reviewing and auditing the Social Security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the Statute and Congressional intent.

The Inspector General would be authorized to issue an order of suspension of a formal regulation, practice, or procedure which he found inconsistent with the law or legislative intent. Generally speak-

ing, such suspension would become effective not less than 30 days after issuance unless specifically countermanded by the Secretary of HEW. Upon issuance of an order of suspension the Inspector General would be required to immediately advise the committees on Finance and Ways and Means as to the findings and basis for the order. If the Secretary countermands, he too would be required to immediately advise the legislative committees as to the reasons for his action. Thus, a serious issue involving a question concerning Congressional intent would be placed before the committees having jurisdiction in orderly and delineated fashion.

Medicaid Coverage of Mentally Ill Children

Problem

Present law limits reimbursement under Medicaid for care of the mentally ill to those otherwise eligible individuals who are 65 years of age or older.

Finance Committee Amendment

The Committee bill would authorize coverage of inpatient care in mental institutions for Medicaid eligibles under age 21, provided that the care consists of a program of active treatment, that it is provided in an accredited medical institution, and that the State maintains its own level of fiscal expenditures for care of the mentally ill under 21.

The amendment also provided for demonstration projects of the potential benefits of extending Medicaid mental hospital coverage to mentally ill persons between the ages of 21 and 65.

Public Disclosure of Information Regarding Deficiencies

Problem

Physicians and the public are currently unaware as to which hospitals, extended care facilities, skilled nursing home and intermediate care facilities have deficiencies and which facilities fully meet the statutory and regulatory requirements. This operates to discourage the direction of physician, patient, and public concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Finance Committee Amendment

The Committee added to the House bill a provision under which the Secretary of Health, Education and Welfare would be required to make reports of an institution's significant deficiencies or the absence thereof (such as deficiencies in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available at social security district offices. Following completion of a survey of a health care facility or organization, those portions of the survey relating to statutory requirements as well as those additional significant survey aspects required by regulation relating to the capacity of the facility to provide proper care in a safe setting would be matters of public record. In the case of Medicare, such information would be available for inspection within 90 days of completion of the survey upon request in Social Security District Offices, and, in the case of Medicaid, the information would be available in local Welfare offices.

Extended Care Facilities—Skilled Nursing Facilities

Problem

Serious problems have arisen with respect to the skilled nursing home benefit under medicaid and the extended-care benefit under medicare.

In the case of medicare, the definition of eligibility has been extremely difficult to apply objectively and, consequently, has led to great dissatisfaction on the part of patients, providers and practitioners, resulting in many facilities' refusal to participate in medicare and widespread retroactive denial of benefits.

Medicaid has its own set of problems with respect to skilled nursing home care. These include, according to the General Accounting Office and the HEW Audit Agency, widespread inappropriate placement of patients in skilled nursing homes who more properly belong in other institutional settings—such as intermediate care facilities—and widespread noncompliance with required standards. It appears difficult to insist that a skilled nursing facility meet all necessary standards without, at the same time, assuring that reimbursement is equitable for necessary care in the proper setting. In general, that is not the case today. The Comptroller General and others have reported on the often irrational payment mechanisms developed and utilized by many States in reimbursing for nursing home care. On an aggregate basis, it appears that nursing homes are not underpaid. However, because of the arbitrary payment structures in many States, in all probability, many facilities are being overpaid for the care they provide while others are being underpaid.

Finance Committee Amendments

a. *Conforming Standards for Extended Care and Skilled Nursing Home Facilities.*—The Committee bill would establish a single definition and set of standards for extended care facilities under Medicare and skilled nursing homes under Medicaid. The provision creates a single category of "skilled nursing facilities" which would be eligible to participate in both health care programs. A "skilled nursing facility" would be defined as an institution meeting the present definition of an extended care facility and which also satisfies certain other Medicaid requirements set forth in the Social Security Act. These changes are intended to reduce duplicative activity and red-tape.

b. *"Level of Care" Requirements for Extended Care.*—To make the Medicare extended-care benefit more equitable and suitable to the post-hospital needs of older citizens, as well as to avoid the problem of retroactive denials of coverage which have plagued Medicare patients and facilities, the Committee bill would change the level of care requirements with respect to entitlement for extended care benefits under Medicare. Present law would be amended to authorize skilled care benefits for individuals in need of "skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." Medicare coverage would also continue during short-term periods (e.g. a day or two) when no skilled services were actually provided but when discharge from a skilled facility for such brief period was neither desirable nor practical.

c. *14-Day Transfer Requirement for Extended Care Benefits.*—Under existing law, Medicare beneficiaries are entitled to extended care benefits only if they are transferred to an extended care facility within 14 days following discharge from a hospital. The Committee modified this with respect to certain patients. An interval of more than 14 days would be authorized for patients whose conditions did not permit immediate provision of skilled services within the 14-day limitation (e.g., patients with fractured hips whose fractures have not mended to the point where physical therapy and restorative nursing can be utilized). An extension not to exceed 2 weeks beyond the 14 days would also be authorized in those instances where an admission to an ECF is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area.

d. *Reimbursement Rates for Care in Skilled Nursing Facilities.*—The Committee added a provision amending Title 19 to require States, by July 1, 1974, to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary found to be acceptable for a State's Medicaid program would be adapted, with appropriate adjustments, for purposes of Medicare skilled nursing facility reimbursement in that State.

e. *Skilled Nursing Facility Certification Procedures.*—The Committee also added a provision under which the Secretary of HEW would decide whether a facility qualifies to participate as a "skilled nursing facility" in both the Medicare and Medicaid programs. The Secretary would make that determination, based principally upon the appropriate State health agency evaluation of the facilities. A State could, for good cause, decline to accept as a participant in the Medicaid program a facility certified by the Secretary but could not overrule the Secretary and receive Federal Medicaid matching funds for any institution not approved by the Secretary. The Committee also incorporated into the amendment proposals of the President regarding full Federal financing of skilled nursing facility and intermediate care facility survey and inspection costs attributable to the Medicare and Medicaid program and the training of additional Federal and State nursing facility inspection personnel.

Authority for Demonstration Projects Concerning the Most Suitable Types of Care for Beneficiaries Ready for Discharge From a Hospital or Skilled Facility

Problem

It is not unusual for a previously hospitalized medicare beneficiary to need services other than those covered under the program. A beneficiary who is discharged from a hospital may need further institutional care for a condition for which he was hospitalized, but the care required is not skilled care.

Finance Committee Amendment

The Committee authorized the Secretary of HEW to experiment with methods for determining suitable levels of care for Medicare patients who are ready for discharge from hospitals and skilled nursing facilities and no longer require skilled care, including some

terminally-ill patients but who are unable to maintain themselves at home without some sort of additional assistance. The experiments and demonstration projects could include (1) making Medicare payment for each day of care provided in an intermediate care facility, count as one covered day of skilled nursing facility care, if the care was for the condition for which the person was hospitalized, (2) covering the services of homemakers, where institutional services are not needed. Such experiments would be aimed at determining whether such coverage could effectively lower long-range costs by postponing or precluding the need for higher cost institutional care or by shortening the period of such care, and ascertaining what eligibility rules may be appropriate and the resultant costs of application of various eligibility requirements, if the project suggests that extension of such coverage generally, would be desirable.

Physicians' Assistants

Problem

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 100 experimental training programs for physician assistants and nurse practitioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while Medicare does not, in some instances, recognize all their services as reimbursable items.

Under present law, part B of Medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physician's office by para-medical personnel. For example, if a nurse administers an injection in the office, Medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, Medicare will not recognize a physician's charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home. Others argue that Medicare does reimburse physicians for services

provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They go on to argue that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for Medicare to take the lead in encouraging doctors—by generous reimbursement to use physicians' assistants to work independently or to expand their responsibilities.

Finance Committee Amendment

The committee authorized demonstration projects to determine the most appropriate and equitable methods of compensating for the services of physicians' assistants (including nurse practitioners). The objectives are development of non-inflationary and less-costly alternatives which do not impede the continuing efforts to expand the supply of qualified physicians' assistants.

The Role of the Joint Commission on the Accreditation of Hospitals in Medicare

Problem

Several problems have arisen with respect to the JCAH role in the Medicare certification process. Present law specifies that an institution may be deemed to meet the certification requirements of Medicare if it is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In addition, under the definition of a hospital, the section states that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. Another section of the law does allow an individual State to set higher standards.

The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to the Commission and the facility concerned. Consequently, the Federal agencies responsible to the Congress for the administration of Medicare, are not in a position to audit the validity of the overall JCAH survey process and are thus unable to determine the extent to which specific deficiencies may exist in the vast majority of participating hospitals, since JCAH survey reports are not available to the Social Security Administration. A further problem arises because, under present law, Medicare is barred from setting any standards which are higher than comparable JCAH requirements. This has been interpreted by Social Security to also bar establishment of any standards in an area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves as an almost total and blanket delegation of authority over hospital standards to a private agency. Thus, if the Joint Commission chooses to lower a standard, Medicare is obliged to also accept that reduced standard. Though the Federal Government is tied to JCAH standards, a State may promulgate higher standards for facilities within the State.

Finance Committee Amendment

The Committee approved a provision under which the State certification agencies, as directed by the Secretary, would survey on a random sample basis (or where substantial allegations of noncompliance have been made) hospitals accredited by the Joint Commission on Accreditation of Hospitals. This would serve as a mechanism to validate the JCAH survey process. If deficiencies from the JCAH standards were found to exist in an institution, the Medicare standards and compliance procedures would be applied in that facility. To implement this authority, JCAH hospitals would, as a condition of participating in Medicare, agree, if included in a survey, to furnish the State agency or the Secretary on request with copies of the JCAH survey report on a confidential basis. The Joint Commission on Accreditation of Hospitals has indicated that it would cooperate fully with such validation surveys and the Secretary would be expected to consult with and cooperate with JCAH in these activities.

Under the provision the Secretary would be authorized to promulgate standards as necessary for health and safety after consultation with JCAH and with adequate lead-time without being bound to JCAH standards.

Maternal and Child Health

Problem

The intent of the 1967 Amendments was to divide available funds between formula grants to the States, and special project grants for a few years, so that the Federal Government could fund innovative special project grants which the States might not be able to support out of their formula funds. The 1967 Amendments terminated special project grants as of fiscal year 1973 and converted all the project money to formula grants on the rationale that after a few years' time the States would recognize the value of and continue to support worthwhile project grants as part of an overall State program. Two problems have occurred in the interim. First the special project grant has been utilized primarily in urban ghetto areas, while the formula funds are weighted in favor of rural States. Therefore, a shift of funds from urban States with project grants to rural States without project grants would occur if the project grants were terminated. Additionally, many project grant directors feel that with the pressure on State finances, State health departments would be reluctant to use new formula funds to continue support for project grants however worthy they might be.

Finance Committee Amendment

The Committee added to H.R. 1 a provision which extends for two additional fiscal years (through June 30, 1974) the present special project grant authorization contained in Title V of the Social Security Act to support maternal and child health programs.

Coverage of Speech Pathologists and Clinical Psychologists Under Medicare

Problem

While speech pathology and clinical psychology services are at times useful to aged persons with certain disorders, such services are rela-

tively inaccessible to the aged due to the small percentage of speech pathologists who are employed by providers eligible to participate in the Medicare program. Part of the problem is the fact that the provider clinic or agency must be physician-directed.

Finance Committee Amendment

Coverage of the services of clinical psychologists and speech therapists on an outpatient basis is presently available under Medicare if the services of such personnel are rendered in a physician-directed clinic or outpatient department. The Committee included a provision removing the requirement that such care necessarily be rendered in a *physician-directed* clinic or outpatient department. However, the services would still have to be provided in an organized setting, and under a plan of care and treatment established by a physician who would retain overall responsibility for the patient's care. Additionally, with respect to psychological treatment, such costs would be included in and limited by the overall $250 annual limitation on reimbursement for outpatient treatment of mental illnesses.

Provide Secretary Greater Discretion in Selection of Intermediaries and Assignment of Providers to Them

Problem

A group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization (including the Federal Government) to act as the "fiscal intermediary" between the providers and the Government. (No such nomination is available with respect to carriers in part B of Medicare.)

The Secretary is authorized to enter into an agreement with an organization or agency only if he finds that to do so would be consistent with effective and efficient administration of the program. The Secretary may terminate an agreement with an intermediary if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

Problem

It would be helpful to strengthen administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers. The Secretary should have the primary authority to determine to which intermediary providers may be reassigned when they wish to change intermediaries or where continued availability of a particular intermediary in a given locale is inefficient, ineffective, or otherwise not in the best program interest. That is, the Secretary should consider the wish of the provider, but be able to take a different course of action in the interest of effective program operation.

Finance Committee Amendment

The Finance Committee amended section 1816 so as to authorize the Secretary to assign and reassign providers to available intermediaries. He would take into account any preferences expressed by the providers, but would not be bound by their choice. The primary consideration for his assignment action would be the effective and efficient administration of the Medicare program.

Disclosure of Information Concerning Medicare Agents and Providers

Problem

As part of its responsibility for administration of the Medicare program, the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers and intermediaries—and State agencies, which assist SSA in program administration. In addition, SSA also prepares program validation review reports, which are intended to be used as management devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own Medicare operations.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual contractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The Finance Committee recognized the dichotomy which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractor performance with the accompanying pressures for improvement in administration that only such awareness can bring. On the other hand, there is the need to avoid premature public disclosure of this type of information and to provide contractors with sufficient opportunity to respond to the information in the reports before their publication to avoid release of erroneous findings, without rebuttal, which may prove damaging to their reputations.

Finance Committee Amendment

To meet this problem, the Committee amendment provides that the SSA regularly make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals deleted.

The proposal would require public disclosure of future reports. Such reports would include only those which are official in nature and not include internal working documents such as informal memoranda, etc. Under the proposal, public disclosure of evaluations and reports would not be made until the contractor, State agency, or facility was given suitable opportunity for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment.

Disclosure of such evaluations and reports should not lessen the effort of SSA in its present information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting disclosure of information required under the Freedom of Information Act.

Access to Subcontractors' Records

Problem

It has come to the Committee's attention that subcontractors under the Medicare program apparently can create subsidiary and related organizations and thereby avoid requirements in Medicare contracts calling for production of pertinent financial books, documents, papers and records of the subcontractor involving transactions related to the subcontract. Although the Medicare statute does not require production by a subcontractor of his cost and other financial records, the Secretary generally has obtained access under the terms of his prime contracts.

Finance Committee Amendment

Under the Committee bill, a requirement would be included under titles XVIII and XIX providing that the Secretary must include in any prime contract a provision that prime contractors which in the future arrange for performance of part of their services by subcontractors, would make available to the government, on a consolidated basis, cost and financial data for subcontractors and organizations related to the subcontractor which perform any part of the services where the aggregate subcontract cost is $25,000 or more.

Similarly, it would be required that subcontracts specify that the subcontractor, and organizations related to the subcontractor, which perform any part of the subcontract would produce pertinent financial books, documents, papers and records upon request by the Secretary, the Comptroller General, the Inspector General, and, in the case, of the Medicaid program, appropriate State officials.

Failure to comply with these requirements would be grounds for terminating an intermediary's or carrier's (the prime contractor) participation in the Medicare program.

Duration of Subcontracts

Problem

Under present law, Medicare intermediaries and carriers (the prime contractors) are generally contracted for under terms which permit the Secretary to cancel the contract at the end of each year. If he fails to give the necessary notice of cancellation, the contract is automatically renewed for another year.

Instances have come to light where some of these prime contractors have entered into subcontracts which extend beyond the time at which the Secretary could terminate the prime contract. This seems inconsistent with the concept of the annual contract renewal procedure.

Proposal

To deal with this situation, the Committee bill would specify in the statute that future subcontracts may not be entered into for periods longer than the remaining term of a prime contract unless such subcontracts are subject to the same contract renewal limitations applicable to the prime contract.

Waiver of Beneficiary Liability in Certain Situations Where Medicare Claims Are Disallowed

Problem

Under present law, whenever a Medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary.

This is true even when the program has paid the claim and subsequently it is determined that the claim should be reopened and disallowed. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

Finance Committee Amendment

Under the Committee bill, a beneficiary could be "held harmless" in certain situations where claims were disallowed but the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether, for example, the provider utilized due care (i.e., acted reasonably) in applying Medicare policy in his dealings with the beneficiary and the Government. In the future, Professional Standards Review Organizations would be expected to give priority to determinations, either in advance or concurrent, designed to minimize the problem of retroactive denials.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the Medicare appeals process.

Where neither the beneficiary nor the provider knew that noncovered services were involved, the Government would assume liability for payment as though a covered service had been furnished. (This situation would arise in many cases disallowed because the services were not medically necessary or did not meet the level of care requirements.) However, when Medicare made such a payment, it would make certain that the provider is put on notice that the type of service rendered was not covered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case, he could not contend that he exercised due care. Thus, the Government's liability would be somewhat limited.

Where the provider did not exercise due care (that is, he knew or reasonably could be expected to know that such care was not covered), liability would shift to the provider, assuming that there was good faith on the beneficiary's part. The provider would be told that he could appeal the intermediary's decision, both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the Medicare program would indemnify the beneficiary (subject to deductibles and coinsurance) and would be required to seek to recover amounts so paid from the provider.

Family Planning

Problem

Though Federal law and policy permit and encourage States to extend services to low income families likely to become welfare recipients as well as families already on welfare, most States have not taken advantage of this opportunity.

The progress which has been made under the 1967 Amendments has not met the committee's expectations. The annual report by the Depart-

ment of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that *all* appropriate AFDC recipients be provided family planning services has not been fulfilled.

Finance Committee Amendment

The Committee amended the House bill to authorize 100 percent Federal funding for the costs of family planning services. The Committee amendment would also require States to make available on a voluntary and confidential basis such counseling, services, and supplies, directly and or on a contract basis with family planning organizations throughout the State, to present, former or likely recipients who are of child-bearing age desiring such services. The amendment would also reduce the Federal share of AFDC funds by 2 percent, beginning in fiscal year 1971, if a State in the prior year fails to inform the adults in AFDC families and on workfare of the availability of family planning services and or if the State fails to actually provide or arrange for such services for persons desiring to receive them.

Penalty for Failure To Provide Required Health Care Screening

Problem

Many States have failed to implement the statutory requirement—or have implemented it only partially—because of their contention that the screening of all children under age 21 is not possible given available financial and health care resources. Under HEW regulations States must now provide health care screening to children under age 6.

Finance Committee Amendment

Under the Committee amendment, States will be required to provide screening services to all eligible children between the ages of 7 and 21 by no later than July 1, 1973. The amendment also includes a provision that would reduce the Federal share of AFDC matching funds by 2 percent, beginning is fiscal year 1975, if a State (a) fails to inform the adults in AFDC families and on workfare of the availability of child health screening services; (b) fails to actually provide or arrange for such services; or (c) fails to arrange for or refer to appropriate corrective treatment children disclosed by such screening as suffering illness or impairment.

Outpatient Rehabilitation Coverage

Problem

Medicare presently provides a home health benefit under both Part A and Part B. Under Part A, a beneficiary may receive up to 100 home health visits in the year following discharge from a hospital or ECF. Part B covers up to 100 home health visits in a calendar year without a prior hospitalization requirement. To receive home health benefits under Part A or Part B, a patient must be homebound and require skilled nursing care on an intermittent basis or physical or speech therapy. Home health services must ordinarily be provided in the home; however, if use of equipment which cannot be taken to the home is involved, the services may be provided at an outpatient facility. Medicare also provides, under Part B, coverage of outpatient

hospital services, and of outpatient physical therapy services provided by certain organized rehabilitation agencies.

There is a relatively small but effective group of free-standing rehabilitation facilities which provide a range of rehabilitation services on an outpatient basis, including some services which would be covered under Medicare if they were provided by participating home health agencies or by hospital outpatient departments. Under present law, Medicare payment cannot be made when such services are provided by free-standing rehabilitation facilities.

Finance Committee Amendment

The amendment would consolidate the present Part B home health and outpatient physical therapy benefits. Coverage under the new benefit would be on two levels: homebound beneficiaries would be entitled to the full range of benefits, while beneficiaries who were not homebound would be entitled to rehabilitation benefits only. In order to qualify for rehabilitation services under the combined benefit, a beneficiary would have to have a need for physical or speech therapy. (That is, an individual who was not homebound could receive in the rehabilitation center covered clinical psychologists' services, medical social services or occupational therapy only if he also required physical or speech therapy.)

The new consolidated benefit would be subject to a coverage limit of 100 visits in a calendar year, as is the present Part B home health benefit. (There would be no change in the provisions of present law relating to Part A home health benefits or Part B outpatient hospital services.)

Home health agencies could provide the full range of benefits provided under the combined benefit. Qualified organizations (including providers of outpatient physical therapy services under present law and free-standing rehabilitation facilities) would be able to provide such rehabilitation services included in the combined benefit as the Secretary found they were qualified to provide. A rehabilitation center would not necessarily have to provide services to homebound patients in order to qualify.

Medicare Coverage for Spouses and Social Security Beneficiaries Under Age 65

Present Law

Under present law, persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs are entitled to hospital insurance (part A). Essentially all persons aged 65 and over are eligible to enroll for medical insurance (part B) without regard to insured status. The House bill includes a provision that would permit persons aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A, at a premium rate equal to the full cost of their hospital insurance protection ($31 a month through June 1973).

Problem

Many additional social security cash beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. This is particularly true if they are of an advanced age, say,

age 60-64. Frequently, these older beneficiaries—retired workers, widows, mothers, dependents, parents for example—have been dependent upon their own group coverage or that of a related worker who is now deceased for health insurance protection. It is a difficult task for such older persons to find comparable protection when they no longer are connected to the labor force.

Finance Committee Amendment

The provision makes Medicare protection available at cost to spouses aged 60-64 of Medicare beneficiaries and to other persons age 60-64 (such as a beneficiary who elects early retirement at age 62) entitled to benefits under the Social Security Act.

Alcoholism and Addiction

Problem

Under the House bill, alcoholics and addicts would be defined as disabled (applying the general social security definition of disability) for purposes of welfare eligibility. However, alcoholics and addicts would not receive cash assistance if treatment were available which they refused.

The Committee was concerned that this provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or only nominally involved—in treatment programs.

Finance Committee Amendment

The Committee approved an amendment establishing a program designed to encourage appropriate care and treatment of alcoholics and addicts. Below is a brief outline of the program:

Outline

Persons medically determined (as described below) to be alcoholics and addicts would not be eligible for welfare benefits under aid to the disabled.

Alcoholics and addicts who meet the income and resources test for welfare and who meet a definition of disability parallel to the social security definition—that is who are unable to engage in any substantial gainful activity by reason of a medically determinable addictive dependence on alcohol or drugs which has lasted or can be expected to last for a period of 12 months—would be eligible to receive help in an alcoholism or addiction treatment program which would be established under Title XV if the State wishes to institute such a program. Once enrolled in the treatment program, the alcoholic or addict would be referred to a local treatment organization or agency certified by the appropriate State agency designated under the Comprehensive Alcohol Abuse and Treatment Act of 1970 or the Drug Abuse and Treatment Act of 1972.

In a State which provides welfare payments under categories other than aid to the disabled to persons medically determined to be alcoholics or addicts (for example, an alcoholic mother or an addicted child on AFDC) the person must be referred for care and treatment to the appropriate agency as a condition of continued eligibility for Federal matching. Refusal of care and treatment by an

addict or alcoholic would result in termination of payments for that individual.

To assure maintenance of expenditure levels in the primary Federal programs directed toward treatment and rehabilitation of alcoholics and addicts and to avoid any shifting of the bulk of those expenditures to Title XV, the Committee required that:

(*a*) Title XV expenditures for care and treatment (including social services) not exceed amounts appropriated, allocated, and actually available in States for care and treatment of alcoholics and addicts.

(*b*) If a reduction in other Federal expenditures is made, either through reduction in appropriations or expenditure levels (including impounding of appropriated funds), then the Federal matching funds available under Title XV would be reduced proportionate to such decreases.

To be eligible for reimbursement under Title XV, the individual treatment program must be carried out under a professionally developed plan of rehabilitation designed to terminate dysfunctional dependency on alcohol or drugs and which must be renewed at three-month intervals. Additionally, the plan must include to the maximum extent feasible a program of work rehabilitation including participation in the new employment program established under the Committee bill.

If proper treatment or rehabilitation would be thwarted by the lack of maintenance funds for the enrolled alcoholic or addict, maintenance payments to the patient or protective payments could be made with Title XV funds. Maintenance payments may not exceed comparable welfare payments and the question of maintenance versus protective payments must be specifically reviewed at least every three months.

Matching under Title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at Medicaid rates and cash payments would be matched at the rates applicable to the category under which the person would otherwise be aided.

FINANCING SOCIAL SECURITY BENEFITS

In considering how to finance the Committee bill, the actuarial assumptions on which the cost estimates are based were reviewed.

Up to this time, the costs of the social security cash benefits programs have been based on the assumption that over the long-run neither benefit nor wage levels will change. While this has not been considered to be a forecast of what will happen, it has been considered a valid measure of the relative long-range costs of various changes in the program, and it has long been used to determine what levels of social security taxes are needed to pay for the program. Because the nature of the assumptions runs counter to the rising wage trends that have actually occurred, most reevaluations of the actuarial cost estimates have shown that the tax schedules in the law at the time of the reevaluation were higher than needed to pay for the benefits in the law.

In view of this, an Advisory Council on Social Security in April 1971 submitted a report which recommended a revision in the long-range actuarial assumptions that have been used in determining the cost of the social security program and which are, therefore, the basis for the schedule of tax rates that is in the law. In essence, the Council's recommendation is that the actuarial projections should properly assume an increase in both wages and prices in future years.

In the past decade, the balance in the social security trust funds has generally equalled one year's worth of benefits. The Advisory Council has suggested that the trust fund balance remain equal to one year's benefit payments, but the Council felt the balance could safely be 75 percent of one year's benefit payments. The Committee bill incorporates a tax schedule calculated to maintain a trust fund balance at least equal to three-quarters of one year's worth of benefits.

The tax schedule based on this assumption is compared with the schedule in present law and in the House-passed bill in the following table.

TABLE 2.—SOCIAL SECURITY TAXES UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL

	Maximum wages taxable	OASDI, percent	HI, percent	Total, percent
Employers and Employees				
Present law:				
1971	$7,800	4.6	0.6	5.2
1972	9,000	4.6	.6	5.2
1973-75	9,000	5.0	.65	5.65
1976-79	9,000	5.15	.7	5.85
1980-86	9,000	5.15	.8	5.95
1987 and after	9,000	5.15	.9	6.05

TABLE 2- SOCIAL SECURITY TAXES UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL—Continued

	Maximum wages taxable	OASDI, percent	HI, percent	Total, percent
House bill (excluding effect of the automatic adjustment provisions):				
1971	7,800	4.6	.6	5.2
1972-74	10,200	4.2	1.2	5.4
1975-76	10,200	5.0	1.2	6.12
1977 and after	10,200	6.1	1.3	7.4
Committee bill (excluding effect of the automatic adjustment provisions):				
1972	9,000	4.6	0.6	5.2
1973-77	10,200	4.55	1.15	5.7
1978-80	10,200	4.65	1.35	6.00
1981-84	10,200	4.65	1.5	6.15
1985-93	10,200	4.65	1.6	6.25
1994-2010	10,200	4.65	1.7	6.35
2011 and after	10,200	5.7	1.7	7.4
Self-employed persons				
Present law:				
1971	7,800	6.9	.6	7.5
1972	9,000	6.9	.6	7.5
1973-75	9,000	7.0	.65	7.65
1976-79	9,000	7.0	.7	7.7
1980-86	9,000	7.0	.8	7.8
1987 and after	9,000	7.0	.9	7.9
House bill (excluding effect of the automatic adjustment provisions):				
1971	7,800	6.9	.6	7.5
1972-74	10,200	6.3	1.2	7.5
1975-76	10,200	7.0	1.2	8.2
1977 and after	10,200	7.0	1.3	8.3
Committee bill (excluding effect of the automatic adjustment provisions):				
1972	9,000	6.9	0.6	7.5
1973-77	10,200	6.8	1.15	7.95
1978-80	10,200	7.0	1.4	8.4
1981-84	10,200	7.0	1.5	8.5
1985-93	10,200	7.0	1.6	8.6
1994 and after	10,200	7.0	1.7	8.7

It should be noted that the tax base and the tax rates shown in this schedule for years after 1974 do not reflect any wage base or tax rate increases, provided for in the Committee bill, which may be needed to finance the automatic cost-of-living benefit increases in the bill. Under these provisions, the cost of the increases will be met by increasing both the tax rates and the tax base as necessary each time there is a cost-of-living increase in benefits.

Social Security Cash Benefits

The income and outgo of the social security cash benefit trust funds are shown on the following table.

TABLE 3.—SOCIAL SECURITY CASH BENEFIT PROGRESS OF TRUST FUNDS UNDER PRESENT LAW AND UNDER THE SYSTEM AS MODIFIED BY THE COMMITTEE BILL, CALENDAR YEARS 1972–77 [1]

(Dollars in billions)

Calendar year	Income		Outgo		Net increase in funds		Assets, end of year	
	Present law	Finance Committee bill	Present law	Finance Committee bill	Present law	Finance Committee bill	Present law	Finance Committee bill
1972	$46.2	$46.2	$41.0	$43.1	$5.2	$3.1	$45.6	$43.5
1973	53.7	51.0	43.0	49.5	10.7	1.5	56.3	45.0
1974	57.9	55.0	44.9	52.3	13.0	2.6	69.3	47.7
1975	61.5	60.0	46.9	57.4	41.6	2.6	83.9	50.3
1976	66.5	63.5	49.8	60.3	17.6	3.2	101.5	53.4
1977	70.3	68.5	51.1	66.2	19.2	2.3	120.7	55.7

[1] These estimates assume that the following changes will become effective on Jan. 1, of:

Year	Benefit (percent) increase	Contribution and benefit base	Annual exempt amount under retirement test
1975	5.8	$11,400	$2,280
1977	5.5	12,600	2,520

Hospital Insurance

The schedule of taxes adopted for hospital insurance is designed to provide sufficient income to pay for the present program (including projected deficits under current financing) for the costs of the provisions added by the Committee, and to provide a reasonable reserve. The schedule adopted will cause the trust fund to increase from $6.1 billion at the end of 1973 to $14.8 billion at the end of 1977. The income, outgo, and year-end balance of the fund for the period 1973–1977 are shown in the following table.

TABLE 4.—PROGRESS OF HOSPITAL INSURANCE TRUST FUND, 1973-77 [1]

[Dollars in billions]

Calendar year	Income	Outgo	Fund at end of year
1973	$12.6	$8.8	$6.4
1974	14.1	11.3	9.2
1975	15.4	12. 9	11.7
1976	16.4	14.6	13.5
1977	17.7	16.4	14.8

[1] Assumes that the tax base will increase to $11,400 in 1975 and to $12,600 in 1977.

The Welfare Programs

The original Social Security Act of 1935 established our Federal-State grant programs which today provide assistance to the aged, blind, and disabled, and to needy families with children. Unlike the federally administered social security program, the welfare titles of the Social Security Act do not set benefit levels nor describe in detail methods of administering the welfare programs; States establish their own assistance programs within the broad guidelines of the Federal law.

Within the past 5 years, however, the Federal-State relationships have undergone substantial change. Three factors have played an important role in the changing relationships.

1. The tremendous growth in the Aid to Families with Dependent Children rolls has created both a fiscal and administrative burden which many States find difficulty coping with.

2. A number of court decisions have had far reaching impact on all aspects of the welfare programs under the Social Security Act, sometimes using the very broadness of the Federal statute (intended to allow States more latitude) against the States by saying that what the Congress did not expressly permit it must not have intended to permit. This position was explicitly stated by the Supreme Court in *Townsend* v. *Swank* (opinion dated December 20, 1971), where it was said that "at least in the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a State eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause."

3. The Department of Health, Education, and Welfare has issued a series of regulations beginning in January 1969, whose effect has been to make it easier to get on welfare and harder to get off welfare, regulations which many States have vigorously, but unsuccessfully, opposed.

Under present law each State plays the central role in determining the nature of its welfare program, within the broad outline of Federal law. The Committee bill largely reiterates this aspect.

AID TO THE AGED, BLIND, AND DISABLED

Present Law

Three categories of adults are eligible for Federally supported assistance: persons 65 and over, the blind (without regard to age), and permanently and totally disabled persons 18 years of age and older. Each State establishes a minimum standard of living (needs standard) upon which assistance payments are based; any aged, blind or disabled person whose income is below the State needs standard will

be eligible for some assistance, although the State need not pay the full difference between the individual's income and the needs standard.

Generally speaking, all income and resources of an aged, blind or disabled person must be considered in determining the amount of the assistance payment (though a portion of earnings may be disregarded as a work incentive). States also place limitations on the real and personal property an aged, blind or disabled individual may retain without being disqualified for assistance.

Monthly State payments to an aged, blind or disabled individual with no other income range between $70 and $250 and for an aged couple between $97 and $350.

Committee Amendments

The Committee bill would continue State administration of the programs of aid to the aged, blind, and disabled (in contrast to the federalized administration called for by the House bill) but would set a Federal guanteed minimum income level for aged, blind, and disabled individuals as discussed below.

National Minimum Welfare Standards and Disregard of Social Security or Other Income

Under the Committee's bill, State public assistance programs for needy individuals who are aged, blind, and disabled would have to assure those with no other income a monthly assistance payment of at least $130 for an individual or $195 for a couple. In addition the Committee bill would provide that the first $50 of social security or other income would not cause any reduction in these minimum assistance payments.

As a result, aged, blind, and disabled welfare recipients who also have monthly income from social security or other sources (which are not need-related) of at least $50 would, under the Committee bill, be assured total monthly income of at least $180 for an individual or $245 for a couple.

At present, only seven States have old age assistance programs which will guarantee a monthly income of at least $180 for an individual receiving social security benefits (Alaska, Idaho, Illinois, Massachusetts, Nebraska, South Dakota, and Washington). These States would, of course, be free to continue providing assistance at levels higher than the minimum standards required by the Committee action.

The cost to the States of providing additional assistance would be less under the Committee bill than under the House-passed version of H.R. 1; State savings are discussed under the heading "Fiscal Relief for States."

Earned Income Disregard

In addition to providing for a monthly disregard of $50 of social security or other income, the Committee approved an additional disregard for aged, blind or disabled recipients of $50 of earned income plus one-half of any earnings above $50. This will enable those recipients who are able to do some work to do so without suffering a totally offsetting reduction in their assistance grants.

Other Income Disregards

The Committee provided that in determining an individual's income for purposes of adult assistance, any rebate of State or local taxes (such as real property or food taxes) received by an aged, blind or disabled recipient would not be counted as income or assets.

This disregard would apply to the first $130 of income guaranteed an adult recipient (the Federal share); States would be free to determine how they wish to treat such tax rebates with respect to the State's share of welfare payments (if any) to such recipients.

Eligibility for Other Benefits

Adopting a provision of the House bill, the Committee bill requires applicants for and recipients of aid to the age, blind, and disabled, as a condition of welfare eligibility, to apply for any other benefits they are eligible for (such as social security, unemployment insurance, workmen's compensation, etc.).

Definitions of Blindness and Disability

Under present law each State is free to prescribe its own definition of blindness and disability for purposes of eligibility for aid to the blind and aid to the permanently and totally disabled.

The Committee approved amendments setting a Federal definition for blindness and disability.

The term "disability" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Under the disability insurance program, this definition is now found in section 223(d)(1) of the Social Security Act. The provisions of the disability insurance program further specify that this definition is met only if the disability is so severe that an individual "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." (Sec. 223(d)(2)(A)).

The term "blindness" would be defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. (Sec. 216(i)(1)(B).) Also included in this definition is the particular sight limitation which is referred to as "tunnel vision."

However, States will be permitted to continue assistance to disabled or blind individuals who were already on the rolls under the existing State definition, but who would not meet the Federal definition of blindness or disability.

Age Limit for Aid to the Disabled

Present law requires that an individual be 18 years or older in order to be eligible for aid to the disabled; the House bill would have deleted

this age requirement. The Committee bill retains the provision of existing law.

Medicaid Coverage

Under present law, the States are required to cover all cash assistance recipients under the Medicaid program. The Committee bill, like the House version, would exempt from this requirement newly eligible recipients who qualify because of the previously agreed provision of a $130 minimum benefit with a disregard of $50 of social security and other income.

Social Services

The Committee also approved an amendment, similar to a provision in the House bill, clarifying the types of social services for which Federal funding may be provided and setting a limitation on authorizations for appropriations for social services. This amendment is described in the section dealing with general welfare provisions, child welfare services, social services, and other provisions.

Prohibition of Liens in Aid to the Blind

The Committee bill prohibits the imposition of liens against the property of blind individuals as a condition of eligibility for aid to the blind.

Other Eligibility Requirements

The Committee decided that there would be no uniform Federal eligibility rules as in the House bill. The determination will be left to the States on such questions as assets, resources, relative responsibility and other eligibility factors except those specified above or in the section of this summary entitled "General Welfare Provisions, child welfare services, social services, and other provisions."

Administrative Costs

The Committee bill requiring minimum payment levels will make many individuals newly eligible for aid to the aged, blind, and disabled who are not now eligible, with a corresponding impact on State administrative costs. Under present law the Federal Government pays 50 percent of the cost of all administrative expenses.

The Committee decided that the Federal Government pay the States an amount equal to 100 percent of their calendar year 1972 administrative costs related to the aged, blind, and disabled, plus 50 percent of additional costs. The 1973 budget, relating to the period from July 1972 to June 1973, estimates an expenditure of $408 million for administration of aid to the aged, blind, and disabled; the State share of this amount is $204 million.

Statistical Material

TABLE 5.—RECIPIENTS OF AID TO THE AGED, BLIND, AND DISABLED, DECEMBER OF SELECTED YEARS

Year	Number of recipients	Percent increase since 1960
1940	2,143,000	
1945	2,128,000	
1950	2,952,000	
1955	2,883,000	
1960	2,781,000	
1961	2,721,000	−2
1962	2,710,000	−3
1963	2,713,000	−3
1964	2,725,000	−2
1965	2,729,000	−2
1966	2,745,000	−1
1967	2,802,000	+1
1968	2,810,000	+1
1969	2,959,000	+6
1970	3,098,000	+8
1971	3,172,000	+14
1972	3,341,000	+20
1973:		
Current law	3,500,000	+26
Committee bill	(not available)[1]	
1974:		
Current law	3,600,000	+29
Committee bill	(not available)[1]	

[1] The estimate of recipients of Aid to the Aged, Blind, and Disabled under the Committee bill will be included in the Committee report.

Source: Department of Health, Education, and Welfare.

Statistical Material

TABLE 6.—OLD-AGE ASSISTANCE: MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971

	Aged individual		Aged couple	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Alabama	$146	$103	$242	$206
Alaska	250	250	350	350
Arizona	118	118	164	164
Arkansas	149	105	249	210
California	178	178	320	320
Colorado	140	140	280	280
Connecticut	176	176	224	224
Delaware	140	140	197	197
District of Columbia	150	113	206	155
Florida	114	114	210	210
Georgia	100	91	165	165
Guam	140	140	201	201
Hawaii	132	132	205	205
Idaho	182	182	219	219
Illinois	183	183	224	224
Indiana	185	80	247	160
Iowa	122	117	186	178
Kansas	141	110	190	147
Kentucky	96	96	160	160
Louisiana	147	100	235	188
Maine	115	115	198	198
Maryland	130	96	187	131
Massachusetts	189	189	280	280
Michigan	165	165	218	218
Minnesota	158	158	210	210
Mississippi	150	75	218	150
Missouri	181	85	257	170
Montana	120	111	192	175
Nebraska	182	182	235	235
Nevada	169	169	271	271

TABLE 6.—OLD-AGE ASSISTANCE: MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971—Continued

	Aged individual		Aged couple	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
New Hampshire	$173	$173	$238	$238
New Jersey	162	162	222	222
New Mexico	116	116	155	155
New York	159	159	219	219
North Carolina	115	115	150	150
North Dakota	125	125	190	190
Ohio	126	126	208	208
Oklahoma	130	130	212	212
Oregon	141	113	200	160
Pennsylvania	138	138	208	208
Puerto Rico	54	22	88	34
Rhode Island	163	163	211	211
South Carolina	87	80	121	121
South Dakota	180	180	220	220
Tennessee	102	97	142	142
Texas	119	119	192	192
Utah	106	106	142	142
Vermont	177	177	233	233
Virgin Islands	52	52	103	103
Virginia	152	152	199	199
Washington	192	192	247	247
West Virginia	146	76	186	97
Wisconsin	108	108	164	164
Wyoming	139	108	195	186

TABLE 7.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971

	Blind individual		Disabled individual	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Alabama	$105	$75	$122	$71
Alaska	250	250	250	250
Arizona	118	118	118	118
Arkansas	149	105	149	105
California	192	192	172	172
Colorado	103	103	123	123
Connecticut	176	176	176	176
Delaware	189	150	117	117
District of Columbia	150	113	150	113
Florida	114	114	114	114
Georgia	100	91	100	91
Guam	140	140	140	140
Hawaii	132	132	132	132
Idaho	182	182	182	182
Illinois	183	183	183	183
Indiana	185	125	185	80
Iowa	161	156	122	117
Kansas	141	110	141	110
Kentucky	96	96	96	96
Louisiana	106	101	84	66
Maine	115	115	115	115
Maryland	130	96	130	96
Massachusetts	223	223	178	178
Michigan	165	165	165	165
Minnesota	158	158	158	158

TABLE 7.—AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED: MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971—Con.

	Blind individual		Disabled individual	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Mississippi	$150	$75	$150	$75
Missouri	255	100	170	80
Montana	132	123	120	111
Nebraska	182	182	182	182
Nevada	155	155	(1)	(1)
New Hampshire	173	173	173	173
New Jersey	162	162	162	162
New Mexico	116	116	116	116
New York	159	159	159	159
North Carolina	126	126	115	115
North Dakota	125	125	125	125
Ohio	126	126	126	116
Oklahoma	130	130	130	130
Oregon	151	151	141	113
Pennsylvania	150	150	138	138
Puerto Rico	54	22	54	22
Rhode Island	163	163	163	163
South Carolina	104	95	87	*80
South Dakota	180	180	180	180
Tennessee	102	97	102	97
Texas	116	110	116	105
Utah	116	116	106	106
Vermont	177	177	177	177
Virgin Islands	51	52	52	52
Virginia	153	153	152	152
Washington	192	192	190	190
West Virginia	146	76	146	76
Wisconsin	108	108	108	108
Wyoming	139	108	127	108

[1] No program.

GUARANTEED JOB OPPORTUNITY FOR FAMILIES

The whole Nation has become increasingly concerned at the rapid growth of the welfare rolls in recent years, and with good reason.

By far the major factor in this growth has been the increase in the number of persons receiving Aid to Families with Dependent Children. From 5.3 million recipients at the end of 1967, the number of AFDC recipients doubled during the next four years. The soaring costs of this program have forced States to shift funds into welfare that would otherwise go for education, health, housing and other pressing social needs. There is universal agreement that something must be done, but there remains much confusion about the nature of the problem that must be solved. The Committee feels that a more expensive and expansive welfare program is *not* the answer.

The soaring welfare rolls reflect three developments.

First, they show that there are a large number of children in this country who are needy and whose parents in most cases are not working.

Second, they show an alarming increase in dependency on the taxpayer. The proportion of children in this country who are receiving AFDC has climbed sharply, from three percent in the mid-fifties to nine percent today. This means that an increasing number of families are becoming dependent on welfare and staying dependent on welfare.

Third, the growth in the AFDC rolls reflects increasing family breakup and increasing failure to form families in the first place. Births out of wedlock, particularly to teenage mothers, have increased sharply in the past decade. Two striking statistics highlight the problem: the number of families headed by women increased by 15 percent between 1970 and 1971, while the number of families with both father and mother present declined in absolute numbers during the same one-year period. Today, almost 8 million women and children receive welfare because of the "absence of the father from the home"—principally due to family breakup or failure of the father to marry the mother of his child.

Many persons who strongly advocate increasing welfare benefits have simply glossed over the problems of family breakup and the increase of births out of wedlock. Even more importantly, they have avoided discussing the problem of increasing dependency.

In an article that appeared in the *New York Magazine* in November, 1971, Nathan Glazer raises the fundamental question of what increasing dependency on welfare has done for recipients in New York City:

> Has it reduced starvation and given them more food? Has it improved their housing? Has it improved their environment? Has it improved their clothing? Has it heightened their self-respect and sense of power? Has it better and more effectively incorpo-

rated them into the economic and political life of the city? . . . Blanche Bernstein, director of research at the New School's Center for New York City Affairs, has estimated that 50 percent of the increase in welfare recipients in New York City during the 1960's was due to desertion and 25 percent was due to illegitimate births. She reports that in 1961 there were 12,000 deserted families on welfare in New York City. By 1968 there were 80,000. What happened in New York City was not an explosion in welfare alone. The city witnessed an explosion in desertion and in illegitimacy. . . .

Welfare, along with those who pressed its expansion, deprived the poor of New York of what was for them—as for the poor who preceded them—the best and indeed only way to the improvement of their condition, the way that involved commitment to work and the strengthening of family ties. In place of this, the advocates of revolution through welfare explosion propagated a false and demeaning sense of the "rights" of the poor, one which had disastrous consequences . . .

Relief is necessary to the poor. In any civilized society it must be given generously, and if needed, extensively. But it should be the aim of every society to find and encourage other means to the maintenance of a decent standard of living than the distribution of charity. For whatever the position of modern advocates of welfare rights, welfare can never, if given regularly on an extensive scale, be other than alms, and whatever alms did for the souls of those who gave them, they could not be good for the souls of those who received them. Every society—capitalist, socialist, or "welfare state"—tries to find ways to replace money relief and to make it unnecessary. To advocate its expansion as a means of dealing with distress is one thing; to advocate its expansion as a means of breaking the commitment to work with its attendant effects on self-respect and on family life is irresponsible.

The fundamental problem is raised somewhat differently in an article entitled "Welfare: the Best of Intentions, the Worst of Results" that appeared in the August, 1971, issue of *Atlantic Magazine*. The author, Irving Kristol, begins by quoting from the 19th century social commentator Alexis de Tocqueville:

> There are two incentives to work: the need to live and the desire to improve the conditions of life. Experience has proven that the majority of men can be sufficiently motivated to work only by the first of these incentives. The second is only effective with a small minority. . . . A law which gives all the poor a right to public aid, whatever the origin of their poverty, weakens or destroys the first stimulant and leaves only the second intact.

At this point, we are bound to draw up short and take our leave of Tocqueville. Such gloomy conclusions, derived from a less than benign view of human nature, do not recommend themselves either to the twentieth-century political imagination or to the American political temperament. We do not like to think that our instincts of social compassion might have dismal consequences—not acci-

dentally but inexorably. We simply cannot believe that the universe is so constituted. We much prefer, if a choice has to be made, to have a good opinion of mankind and a poor opinion of our socio-economic system....

Somehow, the fact that more poor people are on welfare, receiving more generous payments, does not seem to have made this country a nicer place to live—not even for the poor on welfare, whose condition seems not noticeably better than when they were poor and off welfare. Something appears to have gone wrong: a liberal and compassionate social policy has bred all sorts of unanticipated and perverse consequences....

To raise such questions is to point to the fundamental problems of our welfare system, a vicious circle in which the best of intentions merge into the worse of results.

As Congress examines fundamental questions concerning the effect of dependency on welfare, it must also take note of developments in American society, such as the changing role of women in America and the increasing public demand for action to improve the quality of life in this country.

When the AFDC program was first established under the Social Security Act of 1935, American society generally viewed a mother's role as requiring her to stay at home to take care of her children; she would be considered derelict in her duties if she failed to do so. But values have changed, and today, one-third of all mothers with children under age six are members of the labor force, and *more than half* of the mothers with school-age children only are members of the labor force. Furthermore, in families where the father is not present, two-thirds of the mothers with children under age six are in the labor force. This number has been growing steadily in the past 20 years, and it may be expected to continue to grow.

At the same time, it is widely recognized today that many important tasks in our society remain undone, such as jobs necessary to improve our environment, improve the quality of life in our cities, improve the quality of education in our schools, improve the delivery of health services, and increase public safety in urban areas. The heads of welfare families are qualified to perform many of these tasks. Yet welfare pays persons not to work and penalizes them if they do work. Does it make sense to pay millions of persons not to work at a time when so many vital jobs go undone? Can this Nation continue to consider unemployable mothers of school-age children on welfare and pay them to remain unemployed when more than half of mothers with school-age children in the general population are already working?

It is the Committee's conclusion that paying an employable person a benefit based on need, the essence of the welfare approach, has not worked. It has not decreased dependency—it has increased it. It has not encouraged work—it has discouraged it. It has not added to the dignity in the lives of recipients, and it has aroused the indignation of the taxpayers who must pay for it.

As President Nixon has stated:

> In the final analysis, we cannot talk our way out of poverty; we cannot legislate our way out of poverty; but this Nation can work

its way out of poverty. What America needs now is not more welfare, but more "workfare". . . . This would be the effect of the transformation of welfare into "workfare," a new work-rewarding program.

The Committee agrees that the only way to meet the economic needs of poor persons while at the same time decreasing rather than increasing their dependency is to reward work directly by increasing its value. The Committee bill seeks to put the President's words into practice by:

(1) Guaranteeing employable family heads a job opportunity rather than a welfare income; and by

(2) Increasing the value of work by relating benefits directly to work effort.

In meeting these objectives the Committee bill will substantially increase Federal expenditures to low-income working persons, but the increased funds that go to them--about $2.1 billion--will be paid in the form of wages and wage supplements, not in the form of welfare, since the payments will be related to work effort rather than to need. Under the welfare system, an employed person who cuts his or her working hours in half receives a much higher welfare payment; under the Committee bill, a person reducing his or her work effort by half would find the Federal benefits also reduced by half.

Description of Program

Under the guaranteed employment program recommended in the Committee bill, persons considered employable would not be eligible to receive their basic income from Aid to Families with Dependent Children but would be eligible on a voluntary basis to participate in a wholly federally financed employment program. Thus, employable family heads would not be eligible for a guaranteed welfare income, but would be guaranteed an opportunity to work.

In the description of the guaranteed job program that follows, it is assumed that the Federal minimum wage will rise to at least $2.00 per hour.

The following table shows which families would continue to be eligible for welfare and those which would no longer be eligible to receive their basic income from welfare under the Committee bill:

Eligible for Welfare	*Not Eligible To Receive Basic Income from Welfare* [1]
1. Family headed by mother with child under age 6	1. Family headed by able-bodied father
2. Family headed by incapacitated father where mother is not in the home or is caring for father	2. Family headed by mother with no child under 6 (unless the mother is attending school full time)
3. Family headed by mother who is ill, incapacitated, or of advanced age	

Eligible for Welfare—Continued	*Not Eligible To Receive Basic Income from Welfare[1]—Continued*
4. Family headed by mother too remote from an employment program to be able to participate	
5. Family headed by mother attending school full time even if there is no child under 6	
6. Child living with neither parent, together with his caretaker relative(s) (though State may deny welfare if his mother is also receiving welfare)	

[1] These families would be eligible for State supplementation if the State payment level is over $2,400 a year for the family and if otherwise eligible under the State requirements

An estimated 10 percent or 1.2 million of the 3 million families currently receiving Aid to Families with Dependent Children would have to obtain their basic source of income from employment once the Committee bill becomes effective.

All heads of families, whether eligible for welfare or not, as well as heads of families no longer eligible for welfare, could volunteer to participate in the new employment program.

The Committee bill provides three basic types of benefit to heads of families:

1. A guaranteed job opportunity with a newly established Work Administration paying $1.50 per hour for 32 hours and with maximum weekly earnings of $48.

2. A wage supplement for persons employed at less than $2.00 per hour (but at least at $1.50 per hour) equal to three quarters of the difference between the actual wage paid and $2.00 per hour.

3. A work bonus equal to 10 percent of wages covered under social security up to a maximum bonus of $100 with reductions in the bonus as the husband's and wife's covered wages rise above $1,000.

Work Incentives Under the Program

The program would guarantee each family head an opportunity to earn $2,400 a year, the same amount as the basic guarantee under the House bill for a family of four. It also strengthens work incentives rather than undermine them, as shown in the table below.

In table 8, the three types of employment are compared under the guaranteed employment program.

The table also shows what happens to total family income under the proposal if the father works 40 hours a week (32 hours in the case of Government employment), 20 hours a week, or no hours a week.

The sources of income shown are: (a) wages paid by the employer, (b) wages paid by the Government, either as employer or in the form of a wage supplement to the employee (for those in jobs paying less

than $2.00 per hour), and (c) the work bonus equal to 10 percent of wages covered under social security.

The table shows these major points about the Committee plan:

(1) Since the participant is paid for working, his wages do not vary with family size. Thus a family with one child would have no economic incentive to have another child. This feature also preserves the principle of equal pay for equal work.

(2) As the employee's rate of pay increases, his total income increases.

(3) As the employee's income rises due to higher pay in a regular job, the cost to the Government decreases. $1.50-per-hour employment by the Government costs the taxpayer $48 for a 32-hour week; working 40 hours for a private employer at the same $1.50 hourly rate gives the employee a $33 boost in income while cutting the cost to the Government by $27. Moving to an unsubsidized job at $2.00 per hour increases the employee's income another $7 while saving the Government about $13 more.

(4) The less the employee works, the less he gets. No matter what the type of employment, the employee who works half-time gets half of what he would get if he works full time; he gets no Federal benefit if he fails to work at all.

(5) The value of working is increased rather than decreased. Working 32 hours for the Government is worth $1.50 per hour; when a private employer pays $1.50, the value of working to the employee is $2.02 per hour; and working at $2.00 per hour is worth $2.20 per hour to the employee. This will assure that any participant in private employment will receive more than $2.00 an hour. Under the House bill, by way of contrast, the value of working is decreased rather than increased, since the family would be eligible for welfare benefits if the family head does nothing.

Wage paid by employer	Actual value of 40 hours of employment under— House Bill (cents)	Committee bill
$1.50	73	$2.02
$2.00	[1] 90	2.20

[1] $1.23 for a family of 2; $1.04 for a family of 3.

(6) Earnings from other employment do not decrease the wages received for hours worked. Thus an individual able to work in private employment part of the time increases his income and saves the Government money. Virtually no policing mechanism is necessary to check up on his income from work.

TABLE 8.—WORK INCENTIVES UNDER THE COMMITTEE BILL

	Employed by—		
	Government at $1.50 per hour	Private employer at $1.50 per hour	Private employer at $2.00 per hour
40 hours worked (32 hours if Government employment):			
Wages paid by—			
Employer		$60.00	$80.00
Government	$48.00	15.00	.....
Special 10-percent payment		6.00	8.00
Total Government payment	48.00	21.00	8.00
Total income	48.00	81.00	88.00
20 hours worked: (16 hours if Government employment):			
Wages paid by—			
Employer		30.00	40.00
Government	24.00	7.50	.....
Special 10-percent payment		3.00	4.00
Total Government payment	24.00	10.50	4.00
Total income	24.00	40.50	44.00
No hours worked	0	0	0
Hourly value of working	**1.50**	**2.02**	**2.20**

Work Disincentives Under Present Law and Administration Proposal

By way of contrast, under present law a mother who is eligible for welfare is guaranteed a certain monthly income (at a level set by the State) if she has no other source of income; if she begins to work, her welfare payment is reduced. Specifically, in addition to an allowance for work expenses, her welfare payment is reduced $2 for each $3 earned in excess of $30 a month. Generally, then, for each dollar earned and reported to the welfare agency, the family's income is increased by 33 cents.

The House bill uses the same basic approach as present law but substitutes a flat $60 exemption plus one-third of additional earnings for the present $30 plus work expenses plus one-third of additional earnings. The disincentive effects of this are clearly illustrated in

the following examples of the effect of the House bill on the head of a family of 4 as shown in table 9:

(1) The less the individual works, the more the Government pays. For example, an individual working at $2.00 per hour for 20 hours receives $26.60 more in welfare than an individual working 40 hours a week at that wage; if he does not work at all, his government benefit goes up by $11.10.

(2) An individual cutting back on his work effort decreases his income by a relatively smaller amount, or, said another way, the value of work is substantially lower under the House bill than under the Committee bill. The total income of an individual working at $2.00 per hour for 20 hours under the House bill is only about $13 less than his total income if he works full time at that wage. An individual who works not at all receives only $36 less than the $82 received by an individual working 40 hours at $2.00 an hour.

(3) The value of working is decreased rather than increased. Since the family is eligible for $46.20 in welfare for doing nothing, the $29.20 in additional family income for 40 hours of work at $1.50 per hour amounts to a value of only 73¢ an hour for working. Working 40 hours a week at $2.00 per hour is worth only 90¢ per hour to the employee.

(4) Earnings from any employment (as well as child support payments), if reported, reduce the benefits received by the family.

TABLE 9.—WORK DISINCENTIVES UNDER THE HOUSE BILL: INCOME FOR FAMILY OF 4

	Employed by—	
	Private employer at $1.50 per hour	Private employer at $2.00 per hour
40 hours worked:		
Wages	$60.00	$80.00
Welfare	15.40	2.10
Total income	75.40	82.10
20 hours worked:		
Wages	30.00	40.00
Welfare	35.40	28.70
Total income	65.40	68.70
No hours worked:		
Wages	0	0
Welfare	46.20	46.20
Total income	46.20	46.20
Hourly value of working 40 hours	**.73**	**.90**

Eligibility to Participate

Except as noted below, eligibility to participate in the employment program would be open to all family heads who are U.S. citizens or aliens lawfully admitted for permanent residence with a child under age 18 (or under age 22 and attending school full time). Participation would be purely voluntary. Mothers with children under age 6 who were eligible for welfare would also be eligible to participate in the employment program if they so chose.

Participation in Work Program

Only one member of a family would be eligible to participate in the work program, the head of the household. This would be deemed to be the father unless he was dead, absent, or incapacitated, in which case it would be deemed to be the mother.

A head of a household would not be permitted to participate in the employment program as a $1.50-per-hour Government employee if he or she:

(1) is a substantially full time student;

(2) is a a striker, but this disqualification would *not* apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off work because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the government financing one side of a labor-management dispute.

(3) is receiving unemployment compensation;

(4) is a single person or is a member of a couple with no child under 18 (or under age 22 and attending school full time); or

(5) has left employment without good cause or been discharged for cause or malicious misconduct during the prior 60 days. The Work Administration would be authorized to extend the disqualification to as much as six months for individuals who are discharged because of malicious misconduct or for the commission of a crime against their employer.

In addition:

(6) a family would be ineligible if it has unearned income in excess of $300 monthly or if total family income exceeds $5,600 annually; and

(7) if an individual is able to find regular employment on a part-time basis, he or she will be assured an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours work per week. If an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, an individual working full time for the Government under the

employment program could work an additional 20 hours with no reduction in the number of hours of Government employment he or she is provided.

Kinds of Employment

Three kinds of employment are provided:

1. Regular employment in the private sector or in jobs in public or nonprofit private agencies, with no subsidy;
2. Partially subsidized private or public employment; and
3. Newly developed jobs, with the Federal Government bearing the full cost of the salary.

Placement in Regular Employment

Some participants with little or no preparation could be placed immediately in regular employment involving no Government subsidy. These jobs would all pay at least $2.00 per hour.

Subsidized Public or Private Employment

In this category would be jobs not covered by the Federal minimum wage law, in which the employer paid less than $2.00 per hour but at least $1.50 per hour. No supplement would be paid if the employer reduced pay for the job because of the supplement. Thus no jobs presently paying the minimum wage would be downgraded under the Committee bill, and the minimum wage itself would not be affected. Rather, the supplement relates solely to those jobs not covered today under the minimum wage law. Some of these include:

Small retail stores:
- Sales clerk
- Cashier
- Cleanup man

Small service establishments:
- Beautician assistant
- Waiter
- Waitress
- Busboy
- Cashier
- Cook
- Porter
- Chambermaid
- Counterman

Domestic service:
- Gardener
- Handyman
- Cook
- Household aide
- Child attendant
- Attendant for aged or disabled person

Outside salesmen in any industry.

Public sector:
- Recreation aide
- Swimming pool attendant
- Park service worker
- Environmental control aide
- Ecology aide
- Sanitation aide
- Library assistant
- Police aide
- Fire department assistant
- Social welfare service aide
- Family planning aide
- Child care assistant
- Consumer protection aide
- Caretaker
- Home for the aged employee

Agricultural labor:
- Jobs picking, grading, sorting, and grading crops; spraying, fertilizing, and other preparatory work; milking cows; caring for livestock

For these jobs, the Federal Government would make a payment to any employee who is the head of a household equal to three quarters of the difference between what the employer pays him and $2.00 per hour, for up to 40 hours a week. Thus if an employer paid $1.50 an hour the Federal subsidy would amount to 38 cents an hour (three-quarters of the 50-cent difference between $1.50 and $2.00). This wage supplement would be administered by the local office of the Work Administration.

Federally Funded Jobs

For persons who could not be placed in either regular or subsidized public or private employment, jobs would be created which would pay at the rate of $1.50 per hour. An individual could work up to 32 hours a week (an annual rate of about $2,400), and would be paid on the basis of hours worked just as in any other job. There would be no pay for hours not worked.

However, a woman with school-age children would not be required to be away from home during hours that the children are not in school (unless child care is provided), although she may be asked, in order to earn her wage, to provide after-school care to children other than her own during these hours.

If an individual is able to find regular employment on a part-time basis, he or she will be assured an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours work per week. If an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, an individual working full time for the Government under the employment program could work an additional 20 hours in private employment with no reduction in the number of hours of Government employment he or she is provided.

Participants would not be considered Federal employees, nor would they be covered by social security, unemployment compensation or workmen's compensation. The 10 percent special work-bonus would not apply to their salary.

For these individuals who cannot be placed immediately in regular employment at a rate of pay at least equal to the minimum wage, or in subsidized private employment, the major emphasis would be on having them perform useful work which can contribute to the betterment of the community. A large number of such activities are currently going undone because of the lack of individuals or funds to do them. With a large body of participants for whom useful work will have to be arranged, many of these community improvement activities could now be done. At the same time, safeguards are provided so that the program meets the goal of opening up new job opportunities and does not simply replace existing employees, whether in the public or private sector.

Any job in the regular economy paying $1.50 per hour or more, even a part-time job, would yield a greater income than $1.50 per-hour Government employment and it is anticipated that this will serve as an incentive for participants to seek regular employment. In addition,

the cost to the Government would be substantially less for an individual in regular employment.

Work Bonus for Low-Income Workers

Low-income workers in regular employment who head families would be eligible for a work bonus equal to 10 percent of their wages taxed under the social security (or railroad retirement) program, if the wage income of the husband and wife is $1,000 or less. For families where the husband's and wife's wage income exceeds $1,000, the work bonus would be equal to $100 minus one-quarter of the amount by which this income exceeds $1,000. Thus there would be no work bonus once income reached $5,600 ($5,600 exceeds $1,000 by $1,600; one quarter of $1,600 is $100, which subtracted from $100 equals zero).

The size of the work bonus is shown on the table below for selected examples:

Annual earnings of family taxed under social security	*Work bonus*
$2,000	$200
3,000	300
4,000	400
5,000	150
5,600	0

The plan incorporates the features of (1) not varying benefits by family size, but only by income, providing no economic incentive for having additional children; and (2) having a gradual phaseout of the amount of the payment as income rises above $1,000 so as not to create a work disincentive. The plan would cost an estimated $1.2 billion and would provide work bonus payments to 5½ million families.

There are certain types of work which are covered under social security but only when the amount of wages earned from a single employer exceeds $50 in a quarter. This limitation applies to the employment of domestics, yardmen and other similar non-business employees. Such employees, if they are the heads of a family, would get the work bonus with respect to all of their wages including those not covered by social security because of the $50 quarterly limitation. In order to qualify for the work bonus on these wages, however, the individual would have to arrange to perform the work as an employee of the Work Administration which would pay him the prevailing wage for the job and bill the private employer for the wages and other costs associated with making his services available. If the employment would ordinarily be covered by social security, then it will be covered under social security when arranged on this basis by the Work Administration. If the employment is not covered by social security, then the employer will not have to pay social security taxes. However, the Work Administration will have a record of all such wages which would have been subject to social security taxes but for the requirement that at least $50 be paid by a private employer during a quarter.

The 10 percent work bonus would be administered by the Internal Revenue Service.

Transportation Assistance

In recognition of the fact that a major reason for low-skilled jobs going unfilled in metropolitan areas is the difficulty an individual faces getting to the potential job, the Work Administration would be authorized to arrange for transportation assistance where this is necessary to place its employees in regular jobs. For example, the Work Administration might determine the upper limit of transportation time to get to a job—say, 15 minutes or one hour, depending on the average commuting time in the area. If the individual can get to the job within that amount of time through ordinary public transportation or other arrangements, then he would be expected to do so. If this could not be done, however, then the Work Administration would be authorized to provide transportation directly to employees who could be placed in regular jobs in order to cut the transportation time down to the standard. The Work Administration could only do this where it was necessary in order to increase employment opportunities. In any case, the cost would ordinarily not be borne by the Government—the employee would pay the Work Administration, and perhaps be reimbursed by the employer if this is customary in the area for the type of job involved. The Work Administration would have the flexibility to absorb some of the costs involved in unusual circumstances.

Training

Participants in the employment program would be eligible to volunteer for training to improve their skills under the training program administered by the Work Administration. The individual would be accepted for enrollment to the extent funds are available and only if they are satisfied that the individual is:

1. Capable of completing training; and
2. Able to become independent through employment at the end of the training and as a result of the training.

Employees under the employment program who wished to participate in training would be strongly motivated, for they would be paid only $1.30 rather than $1.50 for each hour of training. Following the successful completion of training (which could not exceed 1 year in duration), the trainee would receive a lump-sum bonus for having completed training.

Services

Since the purpose of the proposal is to improve the quality of life for children and their families, any member of a family whose head participates in the work program could be provided services to strengthen family life or reduce dependency, to the extent funds are available to pay for the services. Open-ended funding would be provided for family planning and child care services. The agency administering the employment program would refer family members to other agencies in arranging for the provision of social and other services which they do not provide directly. For example, a disabled family member might be referred to the vocational rehabilitation agency, or a 16-year-old out-of-school youth might be referred to an appropriate work or training program, even though the cost of the services themselves would not be borne by the employment program.

Former participants in the work program would have access to free family planning services and to child care on a wholly or partly subsidized basis, depending on family income. Other services needed to continue in employment, including minor medical needs, could be provided by the agency administering the program.

State Supplementation

In order to prevent the State welfare program from undermining the objectives of the Federal employment program the State would have to assume that individuals eligible for the State supplement who are also eligible to participate in the employment program are actually participating full time and thus receiving $200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Furthermore, the State would be required to disregard any earnings between $200 a month and $375 a month (the amount an employee would earn working 40 hours a week at $2.00 per hour) to ensure that the incentive system of the alternative plan is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of $200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at $1.50 per hour.

Food Stamps

Individuals participating in the employment program would not be eligible to participate in the food stamp program. However, States would be reimbursed the full cost of adjusting any supplementary benefits they might decide to give to participants so as to make up for the loss of food stamp eligibility. In order to avoid having States provide assistance to an entirely new category of recipient not now eligible for federally-shared Aid to Families with Dependent Children, the Committee provided that the Work Administration would pay families headed by an able-bodied father the amount equal to the value of food stamps (but only to the extent that the State provides cash instead of food stamps for families which are now in the Aid to Families with Dependent Children category).

Children of Mothers Refusing to Participate in the Employment Program

Under the employment program, mothers in families with no children under age six would generally be ineligible to receive their basic income from the Aid to Families with Dependent Children program. If it comes to the attention of a welfare agency, however, that children are suffering neglect because a mother who is ineligible for basic income under AFDC also refuses to participate in or is disqualified from the employment program, the Work Administration would be authorized to make payment to the family for up to one month if the mother is provided counseling and other services aimed at persuading

her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to vocational rehabilitation agency; or, if she is not found to be incapacitated, the State could arrange for protective payments to a third party to ensure that the needs of the children are provided for.

Administration of the Employment Program

The employment program would be administered by a newly created Work Administration headed by a 3-man board appointed by the President with the advice and consent of the Senate. The actual operations of the program would be carried out by local offices of the Work Administration.

The local office would hire individuals applying to participate, develop employability plans for participants, attempt to expand job opportunities in the community, arrange for supportive services needed for persons to participate (utilizing the Work Administration's Bureau of Child Care to arrange for child care services), and operate programs utilizing participants which are designed to improve the quality of life for the children of participants in the employment program.

Employment Program in Puerto Rico

Certain provisions relating to the employment program in Puerto Rico were made. These modifications are necessary because of the fact that Puerto Rico has a different minimum wage structure than the rest of the United States, has substantially lower per capita income, and has a high rate of unemployment. Under the Committee bill the wages paid to Government employees would be equal to three-quarters of the lowest minimum wage applicable to a significant percentage of the population. This would result in a lower wage for Government employees than in the rest of the United States, but it would be significantly higher than current welfare payments in Puerto Rico. The wage supplement program for persons in regular employment at less than the minimum wage would not be applicable to Puerto Rico, but the 10 percent work bonus for low-income earners in jobs covered by social security would apply.

Tax Credit to Develop Jobs in the Private Sector

The provision of the present tax law under which an employer hiring a participant in the Work Incentive Program is eligible for a tax credit equal to 20 percent of the employee's wages during the first 12 months of employment, with a recapture of the credit if the employer does not retain the employee for at least one additional year (unless the employee voluntarily leaves or is terminated for good cause), will be continued under the new guaranteed employment program.

Because the guaranteed job opportunity program, unlike the Work Incentive Program, would be open to the head of any family with children, the following limitations would be added to the provisions of the tax credit to ensure that the credit meets the primary aim of expanding employment opportunities for participants in the Committee's work program:

1. The credit would apply only with respect to individuals who have been participating in the guaranteed job program for at least one month;

2. The credit would not be applicable with respect to more than 15 percent of all employes of the employer in any one year (though the employer would always be permitted to take the credit for at least one employee);

3. The credit would not be available in cases where an employee is discharged and replaced by another employee who formerly worked for the Work Administration; and

4. The credit could not exceed $800 in the case of any one employee (20 percent of $4,000, approximately the amount of annual earnings at $2 an hour).

In order to create additional employment opportunities for participants in the guaranteed job program, the Committee bill would extend the credit to private employers hiring participants in addition to businesses. A private employer taking the credit would not be eligible at the same time for the income tax child care or household expense deduction.

Effective Dates

The effective date for the basic job opportunity program is January 1974. As of that date, families which include an employable adult (including a mother with no child under age 6) will no longer be eligible for welfare as their basic income. If unable to find a regular job, however, the family head will be assured of Government employment paying $1.50 an hour for 32 hours weekly, producing $2,400 of income annually, the same amount which would have been payable to a family of 4 under the House-passed family assistance plan.

The 10 percent work bonus and the wage supplement payment would become payable even before the full guaranteed employment program is operative. Specifically, the work bonus which will be paid quarterly to low-income workers will become effective starting in January 1973. The wage supplement for family heads in regular jobs not covered under the minimum wage law and paying less than $2.00 per hour will be effective July 1973, utilizing the services of the local employment service offices to make the payments until the Work Administration mechanism is functioning.

GENERAL WELFARE PROVISIONS, CHILD WELFARE SERVICES, SOCIAL SERVICES, AND OTHER PROVISIONS

1. GENERAL WELFARE PROVISIONS

The following amendments approved by the Committee apply to both the adult categories (Aged, Blind and Disabled) and to the Aid to Families with Dependent Children category. Other provisions for each category are specified in separate sections of this release relating to each program.

Welfare as a Statutory Right

A number of court cases in recent years have been based on the view that welfare is a property right rather than a gratuity provided for under a statute. The Committee agreed to make clear in the statute that welfare is a statutory right granted under law which can be extended, restricted, altered, amended or repealed by law. It is distinct from a property right or any right considered inviolate under the Constitution.

Declaration Method of Determining Eligibility

Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant's home and from other sources. For persons found eligible for assistance, redetermination of eligibility is required at least annually, and similar procedures are followed.

The Department of Health, Education, and Welfare has required States to use a simplified or "declaration method" for aid to aged, blind, and disabled, and has strongly urged that this method be used in the program of Aid to Families with Dependent Children. The simplified or "declaration method" provides for eligibility determinations to be based to the maximum extent possible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the caseworker. The Committee bill precludes the use of the declaration method by law. It also explicitly authorizes the States in the statute to examine the application or current circumstances and promptly make any verification from independent or collateral sources necessary to insure that eligibility exists. The Secretary could not, by regulation, limit the State's authority to verify income or other eligibility factors.

Denial of Welfare for Refusal to Allow Caseworker in Home

In 1969 a Federal District Court ruled on constitutional grounds that a State could not terminate welfare payments to a recipient who

refused to allow a caseworker in her home. In 1971, the Supreme Court reversed the lower court's decision. The Committee agreed to codify the Supreme Court's decision in the statute by amending the Act to permit a State to require as a condition of eligibility for welfare that a recipient allow a caseworker to visit the home at a reasonable time and with reasonable advance notice.

Furnishing Manuals and Other Policy Issuances

Regulations issued by the Department of Health, Education, and Welfare in October, 1970, require States to make available current copies of program manuals and other policy issuances without charge to public or university libraries, the local or district offices of the Bureau of Indian Affairs, and welfare or legal services offices or organizations. The material may also be made available, with or without charge, to other groups and to individuals. The Committee approved an amendment under which States would be permitted to be reimbursed for the cost (but no more than the cost) of making this information available.

Requirement of Statewideness for Social Services

The Social Security Act requires that social services (including child care and family planning services) under the welfare programs be in effect in all political subdivisions of a State in order for the State to obtain Federal matching funds. This requirement of statewideness has sometimes delayed the provision of these services. The Committee agreed to permit the Secretary to waive the requirement of statewideness for services.

Use of Social Security Numbers and Other Means of Identification

The Committee bill would require the use of social security numbers in the administration of assistance programs. States would use social security numbers for case file identification, for cross-checking purposes and as an aid in the compilation of statistical data with respect to the welfare programs. In addition, States would be authorized to use photographs and such other means of identification as they desire in administering the welfare programs, as well as setting penalties for misuse of these means of identification.

Duration of Residency

The Committee agreed to require States to establish a three-month duration of residence requirement in order to be eligible for welfare. If a welfare recipient in one State moves to another State, the State of origin would continue making the welfare payments for three months; however, no State would be required to make welfare payments more than 90 days after an individual has left the State.

The Committee also agreed with the provision in the House-passed version of H.R. 1 that would make an individual ineligible for welfare payments during any month in which the person is outside the United States the entire month; once an individual has been outside

the United States for at least 30 consecutive days, he must remain in the United States for 30 consecutive days before he may again become eligible for welfare.

In addition, to become eligible for welfare, an individual must be a resident of the United States and either a citizen or alien lawfully admitted for permanent residence or a person who is a resident under color of law.

Welfare Payments for Rent

Under existing law welfare payments are ordinarily made directly to the recipients. Some States have indicated that they could effect substantial administrative savings if they were permitted to make a single payment directly to public housing authorities of the rent portion of welfare payments for recipients in public housing. The Committee bill would permit States to do this. It would also permit State welfare agencies to make a vendor payment for rent directly to a landlord provided that (a) the welfare recipient has failed to make rent payments (whether or not to the same landlord) for two consecutive months, and (b) the landlord agrees to accept the amount actually allowed by the State to the recipient for shelter as total payment for the rent. The Committee also agreed to repeal a welfare amendment in Public Law 92-213 which would require welfare agencies in some circumstances to pay as a rental allowance more than the actual cost of rent.

Alcoholics and Addicts

The Committee was concerned over the fact that many thousands of recipients on welfare who have been determined to be alcoholics and addicts are not being provided necessary rehabilitative care and treatment. For explanation of committee amendments related to care and treatment of these persons, see the end of the section on Medicare and Medicaid provisions.

Sharing the Cost of Prosecuting Welfare Fraud

Under present law, the Federal Government pays 50 percent of the cost of administration of the welfare programs, as these costs are incurred by the State welfare agency. The Committee bill extends an amendment providing 50 percent Federal matching also for the cost of State and local prosecuting attorney efforts to prosecute welfare fraud.

Recent Disposal of Assets

Under present law, an individual with assets whose value exceeds the welfare eligibility level in the State, may dispose of those assets in order to qualify for assistance. For example, an elderly widow may give her assets to her children to qualify for assistance even though the children continue to make the assets available to her.

The Committee bill deals with this situation by providing that anyone who has voluntarily assigned or transfered property to a relative within one year prior to applying for public assistance and who has received less than fair market value for the property, will be ineligible for public assistance for one year period commencing with the date of transfer.

Recouping Overpayments

The Committee agreed to provide statutorily that overpayments constitute an obligation of an individual to be withheld from any future assistance payments or any amounts (other than Social Security death benefits) owed by the Federal Government to the individual: in addition, overpayments could be collected through ordinary collection procedures.

Ineligibility for Food Stamps

Under the Committee bill (as under the House version), individuals in the welfare programs will not be eligible for food stamps or surplus commodities. States would be assured that there would be no additional expenses to them if they adjust their welfare payment levels to take into account loss of entitlement for food stamps, so that recipients would suffer no loss of income as a result of losing entitlement to food stamps.

Appeals Process

Present law requires that a State plan must provide for granting an opportunity for a fair hearing before the State agency to any individual whose claims for aid is denied or not acted upon with reasonable promptness.

On March 23, 1970, the Supreme Court ruled in two cases (*Goldberg* v. *Kelly* (397 U.S. 254) and *Wheeler* v. *Montgomery* (397 U.S. 280)) that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The decision was made on the constitutional grounds that termination of payments before such a hearing would violate the due process clause. The Court argued that welfare payments are a matter of statutory entitlement for persons qualified to receive them, and that "it may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.' * * * The constitutional challenge cannot be answered by an argument that public assistance benefits are 'a "privilege" and not a "right."'"

The HEW regulations based on the court's decision (45 CFR 205.10) go much further than the court in spelling out the requirements for fair hearings. The tone and emphasis of the regulations is shown in these excerpts: "Agency emphasis must be on helping the claimant to submit and process his request, and in preparing his case, if needed. The welfare agency must not only notify the recipient of his right to appeal, it must also notify him that his assistance will be continued during the appeal period if he decides to appeal." The regulation continues: "prompt, definitive, and final administrative action will be taken within 60 days from the date of the request for a fair hearing, *except where the claimant requests a delay in the hearing*" (emphasis added).

The Committee bill deals with this situation by requiring State Welfare agencies to reach a final decision on the appeal of a welfare recipient within 30 days following the day the recipient was notified of the agency's intention to reduce or terminate assistance. The bill would also require the repayment to the agency of amounts which a recipient received during the period of the appeal if it was

determined that the recipient was not entitled to them. Any amounts not repaid would be considered an obligation of the recipient and would be recouped in the same manner as other overpayments. In addition, the Committee bill would stipulate that the recipient has a right to appeal at a higher administrative level but that payments need not be continued once an initial adverse determination has been made on the local level at a hearing at which evidence can be presented.

The Committee provision was designed to assure that the appeals procedures would be handled expeditiously by the State and also to assure that appeals would not be made frivolously.

Safeguarding Information

The statutes in all of the welfare programs under the Social Security Act provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of each welfare program. Regulations issued by the Department of Health, Education, and Welfare state that the same policies apply to requests for information from a governmental authority, the courts or law enforcement officials as from any other outside source.

The Committee bill re-enacts these statutory provisions but includes features making it clear that this requirement may not be used to prevent a court, prosecuting attorney, tax authority, law enforcement official, legislative body or other public official from obtaining information in connection with his official duties including the collection of support payments or prosecuting fraud or other criminal or civil violations.

Separation of Services and Eligibility Determination

A further example of legislation through regulation involves the separation of social services from the welfare payment process. On March 1, 1972, the Department of HEW issued a regulation requiring States to have completely separate administrative units handling the provision of social services and handling the determination of eligibility for welfare. The issuing of this regulation was justified on the grounds that the Family Assistance Plan in the House-passed bill would soon be enacted and it would require a separation of the State-administered services program from the Federal welfare payment programs. Under the Committee bill States would not be required to separate the provision of social services from the determination of eligibility for welfare.

Quality of Work Performed by Welfare Personnel

In an effort to try to upgrade the quality of work performed by welfare personnel, the Committee bill directs the Secretary of the Department of Health, Education, and Welfare to study and report to the Congress by January 1, 1974, on ways of enhancing the quality of welfare work, whether by fixing standards of performance or otherwise. In making this study, the Secretary could draw on the knowledge and expertise of persons talented in the field of welfare adminis-

tration, including those having direct contact with recipients. He should also benefit from suggestions made by recipients themselves as to how the level of performance in the administration of the welfare system might be improved, with a view toward ending the wide variations in employee conduct which characterize today's system, and moderating the extremes to which some social workers go in performing their duties.

Offenses by Welfare Employees

Under present Federal law there is no provision particularly directed to the question of employee conduct in the administration of the welfare program. On the other hand, the Internal Revenue Code (Sec. 7214) contains a list of offenses the commission of any of which, by a tax employee, would bring into effect discharge from employment and penalties of (a) fines not to exceed $10,000, or (b) imprisonment for not more than five years, or both. The provision in the Internal Revenue Code also authorizes a court to award out of any fines imposed an amount up to one-half of the fine to be paid to the informer whose information resulted in the detection of the criminal offense. This law has contributed to the high quality of performance of Internal Revenue employees and has been a factor in assuring relatively uniform standards of conduct.

Under the Committee bill similar rules would apply under the welfare laws that could relate to an upgrading of the quality of performance by welfare workers in general and serve as the basis for standards of conduct which hopefully might narrow the wide variations in employee conduct which exist today.

Specifically, under the Committee bill it would be a crime punishable by a fine of up to $10,000 or imprisonment of up to 5 years, or both, in the case of a welfare employee who is found guilty of:

(1) extortion or willful oppression under color of law; or

(2) knowingly allowing the disbursement of greater sums than are authorized by law, or receiving any fee, compensation, or reward, except as prescribed, for the performance of any duty; or

(3) failing to perform any of the duties of his office or employment with intent to defeat the application of any provision of the welfare statute; or

(4) conspiring or colluding with any other person to defraud the United States or any local, county or State government; or

(5) knowingly making opportunity for any person to defraud the United States; or

(6) doing or omitting to do any act with intent to enable any other person to defraud the United States or any local, county or State government; or

(7) making or signing any fraudulent entry in any book, or making or signing any application, form or statement, knowing it to be fraudulent; or

(8) having knowledge or information of the violation of any provision of the welfare statute which constitutes fraud against the welfare system, and failing to report such knowledge or information to the appropriate official; or

(9) demanding, or accepting, or attempting to collect, directly or indirectly as payment or gift, or otherwise, any sum of money or other thing of value for the compromise, adjustment, or settlement of any charge or complaint for any violation or alleged violation of law, except as expressly authorized by law.

In addition to these penalties the employee involved shall be dismissed from office or discharged from employment.

Limiting HEW Regulatory Authority in Welfare Programs

The Social Security Act permits the Secretary of Health, Education, and Welfare to "Make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions" with which he is charged under the Act. Similar authority is provided under each of the welfare programs. Particularly since January, 1969, regulations have been issued under this general authority with little basis in law and which sometimes have run directly counter to legislative history. Many States have attributed at least a part of the growth of the welfare caseload in recent years to these regulations of the Department of HEW.

A number of Committee decisions deal with problems raised by specific HEW regulations. In addition, the Committee agreed to modify the statutory language quoted above by limiting the Secretary's regulatory authority under the welfare programs so that he may issue regulations only, with respect to specific provisions of the Act and even in these cases the regulations may not be inconsistent with these provisions.

Demonstration Projects to Reduce Dependency on Welfare

The Social Security Act currently authorizes appropriations for research and demonstration projects in the area of public assistance and social services. The authority has been used to fund several guaranteed minimum income experiments and also a large number of projects related to providing social services to welfare recipients. The Committete agreed to place emphasis on those programs helping persons to become economically independent by requiring that one-half of the funds spent under these two sections be spent on projects relating to the prevention and reduction of dependency on welfare, rather than welfare expansion.

2. CHILD WELFARE SERVICES

Grants to States for Child Welfare Services (Including Foster Care and Adoptions)

The Committee adopted an amendment increasing the annual authorization for Federal grants to the States for child welfare services to $200 million in fiscal year 1973, rising to $270 million in 1977 and thereafter. For fiscal year 1973, this is $154 million more than the $46 million which has been appropriated every year since 1967. The Committee anticipates that a substantial part of any increased appropriation under this higher authorization will go towards meeting the costs

of providing foster care which now represents the largest single item of child welfare expenditure on the county level. The Committee, however, avoided earmarking amounts specifically for foster care so that wherever possible the State and counties could use the additional funds to expand preventive child welfare services with the aim of helping families stay together and thus avoiding the need for foster care. The additional funds can also be used for adoption services, including action to increase adoptions of hard-to-place children.

National Adoption Information Exchange System

The Committee bill would authorize $1 million for the first fiscal year and such sums as may be necessary for succeeding fiscal years for a Federal program to help find adoptive homes for hard-to-place children. The amendment would authorize the Secretary of Health, Education, and Welfare to "provide information, utilizing computers and modern data processing methods, through a national adoption information exchange system, to assist in the placement of children awaiting adoption and in the location of children for persons who wish to adopt children, including cooperative efforts with any similar programs operated by or within foreign countries, and such other related activities as would further or facilitate adoption."

3. SOCIAL SERVICES

Federal Matching for Social Services

The Committee also approved an amendment clarifying the types of social services for which Federal funding may be provided and bringing such funding within the limitations of the appropriations process. Under current law, each State determines what kinds and amounts of social services it will provide to welfare recipients (and other low-income persons who are classified as potential recipients). Whatever services the State provides are matched on a 75 percent Federal, 25 percent non-Federal basis.

Because this matching is completely open-ended and not subject to the ordinary limitations of the appropriation process, Federal costs for social services have soared in the past few years from $354 million in 1969 to $692 million in 1971, and to an estimated $1,363 million in 1972.

The Committee amendment would specifically list the services for which Federal matching may be provided. For families, the services would be:

(a) services to unmarried women who are pregnant or already have children, for the purpose of arranging for prenatal and postnatal care of the mother and child, developing appropriate living arrangements for the child, and assisting the mother to complete school through the secondary level or secure training so that she may become self-sufficient;

(b) protective services for children who are (or are in danger of being abused, neglected, or exploited;

(c) homemaker services when the usual homemaker becomes ill or incapacitated or is otherwise unable to care for the children

in the family, and services to educate appropriate family members about household and related financial management and matters pertaining to consumer protection:

(d) nutrition services:

(e) services to assist the needy families with children in dealing with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home management and maintenance;

(f) emergency services made available in connection with a crisis or urgent need of the family. Fires, floods, accidents, desertions and illnesses can all be disasters to people which may lead to institutionalization and dependency unless immediate response can be brought to bear on the problem:

(g) services to assist appropriate family members to engage in training or secure or retain employment; and

(h) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency, or private social agencies) and follow-up activities to assure that individuals referred to and eligible for available services from such other agencies received such services.

For the aged, blind, and disabled, the services would include:

(a) protective services for individuals who are (or are in danger of being abused, neglected, or exploited, such as institutional services for those aged or physically or mentally disabled who are unable to maintain their own place of residence:

(b) homemaker services, including education in household and related financial management and matters of consumer protection, and services to assist aged, blind, or disabled adults to remain in or return to their own homes or other residential situations and to avoid institutionalization or to assist in making appropriate living arrangements at the lowest cost in light of the care needed;

(c) nutrition services, including the provision, in appropriate case, of adequate meals, and education in matters of nutrition and the preparation of foods;

(d) services to assist individuals to deal with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home maintenance and management;

(e) emergency services made available in connection with a crisis or urgent need of an individual;

(f) services to assist individuals to engage in training or securing or retaining employment; and

(g) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency, or private social agencies) and follow-up activities to assure that individuals referred to and eligible for available services from such other agencies received such services.

Under the Committee amendment, Federal matching for social services beginning January 1973 would be the same as Federal matching for Medicaid (which ranges from 50 percent to 83 percent, depending on State per capita income), with two differences: (1) Federal matching would not exceed 75 percent, and (2) for the 12 months of

calendar year 1973, the Federal matching percent would not be below 65 percent even if the Medicaid matching rate is below 65 percent. Child care and family planning services would continue to be matched on an open-ended basis, and child welfare services would continue to be a separate Federal grant program; with these exceptions, Federal funds for all other social services in both the adult and AFDC categories (excluding child care, family planning, and child welfare services) would be limited to not more than $1 billion annually beginning in fiscal year 1973. The Federal funds appropriated for social services would be allocated among the States on the basis of the total State population. Any funds which are allotted but not used by one State may be reallotted among the other States.

Family Planning Services

The Committee approved payment by the Federal Government of 100 percent of the cost of Family Planning Services as compared with 75 percent under present law.

Eliminate Statutory Requirement of Individual Program of Services for Each Family

Present law requires States to develop an individual program of services for each family receiving AFDC. This has proven to be an unnecessary administrative burden. The Committee agreed to delete this statutory requirement.

Supportive Services for Participants in the WIN Program

Until the Government Employment Program begins on January 1, 1974, the Committee bill would continue 90 percent Federal matching for supportive services other than family planning services to enable AFDC recipients to participate in the Work Incentive Program.

4. OTHER PROVISIONS

Evaluation of Programs Under the Social Security Act

The Committee bill assigns to the General Accounting Office the basic role of evaluating programs under the Social Security Act. In addition, the amendment would not permit any Federal agency to enter into a contract to evaluate any program under the Social Security Act (if an expenditure of more than $25,000 is involved) unless the Comptroller General approves the study in advance. His approval would be conditioned on his determination that:

(a) The conduct of such study or evaluation of such program is justified;

(b) The department or agency cannot effectively conduct the study or evaluation through utilization of regular full-time employees; and

(c) The study or evaluation will not be duplicative of any study or evaluation which is being conducted, or will be conducted within the next twelve months, by the General Accounting Office.

Use of Federal Funds to Undermine Federal Programs

Another amendment approved by the Committee would prohibit the use of Federal funds to pay, directly or indirectly, the compensation or expenses of any individual who in any way participates in action relating to litigation which is designed to nullify Congressional statutes or policy under the Social Security Act. This prohibition may, however, be waived by the Attorney General 60 days after he has provided the Committee on Finance and the Committee on Ways and Means with notice of his intent to waive the prohibition. This will allow the Committees time to take legislative action if appropriate. This amendment is similar to one approved by the Committee in 1970 as part of the Social Security-Welfare bill of that year—a bill which was not finally enacted.

Appointment and Confirmation of Administrator of Social and Rehabilitation Services

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities at present are broad, encompassing the federally aided welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge; the bulk of the $14-billion 1972 budget for the agency is spent on the public assistance and medicaid programs. The Committee agreed to upgrade the stature of the Administrator of the Social and Rehabilitation Service by having the President select him and by having him confirmed by the Senate as his colleagues with equivalent positions in the Department (the Commissioner of Social Security, the Commissioner of Education, and the Surgeon General) now enjoy.

CHILD CARE

At the present time, the lack of availability of adequate child care today represents perhaps the greatest single obstacle in the efforts of poor families, especially those headed by a mother, to work their way out of poverty. It also represents a hindrance to those mothers in families above the poverty line who wish to seek employment for their own self-fulfillment or for the improvement of their family's economic status.

The Committee on Finance has long been involved in issues relating to child care. The committee has been dealing with child care as a segment of the child welfare program under the Social Security Act since the original enactment of the legislation in 1935. Over the years, authorizations for child welfare funds were increased in legislation acted on by the committee.

As part of its continuing concern for the welfare of families with children who are in need, and in order to provide for the expansion of child care required to enable the new employment program to meet its goal of making present AFDC recipients independent, the Committee is proposing a new approach to the problem of expanding the supply of child care services and improving the quality of these services. The Committee bill thus establishes within the new Work Administration a Bureau of Child Care with the eventual goal of making child care services available throughout the Nation to the extent they are needed, but are not supplied under other programs.

Bureau of Child Care

The Bureau of Child Care would have as its first priority making available child care services to participants in the employment program. Next in order of priority would be the provisions of child care to low-income working mothers and to other mothers desiring child care services.

Where child development services are available under any other legislation approved by the Congress, the Bureau would attempt to place children in those services.

To the maximum extent possible, the Bureau would attempt to utilize mothers participating in the employment program in providing child care services.

Initially, the Bureau would train persons to provide family day care and would contract with existing public, private non-profit, and proprietary facilities to serve as child care providers. To expand services, the Bureau would also give technical assistance and advice to organizations interested in establishing facilities under contract with the Bureau. In addition, the Bureau could provide child care services in its own facilities.

Federal child care standards are specified in the amendment to assure that adequate space, staff and health requirements are met. In

addition, facilities used by the Bureau will have to meet the Life Safety Code of the National Fire Protection Association. Any facility in which child care is provided by the Bureau, either directly or by contract, will have to meet the Federal standards, but will not be subject to any licensing or other requirements imposed by States or localities. This provision will make it possible for many groups and organizations to establish child care facilities under contract with the Bureau where they cannot now do so because of overly rigid State and local requirements.

Subsidization of child care for low-income working mothers will depend on the availability of appropriations. Mothers able to pay will be charged the full cost of services.

In addition to appropriations to subsidize child care costs for low-income working mothers, fees would be charged for services provided or arranged for by the Bureau. They would be set at a level which would cover the unsubsidized costs of arranging for child care. The fees would go into the revolving fund to provide capital for further expansion of services.

The child care amendment also includes provision to authorize the Bureau to issue bonds for construction if, after the first two years of operation, the Bureau feels that additional funds for capital construction of child care facilities are needed. Up to $50 million in bonds could be issued each year, with an overall limit of $250 million on bonds outstanding.

Authorization

The Committee agreed to authorize $800 million in fiscal year 1973 (and such sums as the Congress might appropriate thereafter) to arrange for and to pay for part or all of the cost of child care for the children of participants in the employment program and to other low income working mothers. (The House bill would provide $750 million for substantially the same purposes.)

Grants to States for Establishment of Model Day Care

The Committee expects that much of the child care offered by the Bureau of Child Care will be similar to that provided by mothers in their own home, since experience has shown that most working mothers prefer family day care because of its convenience and its informality. However, the Committee has also provided a 3-year program of grants to States to permit them to develop model child care. Appropriations would be authorized to permit each State in fiscal years 1973, 1974 and 1975 to receive a grant of up to $400,000 per year to pay all or part of the cost of model care, whether through the establishment of one child care center or a child care system. Special emphasis would be placed on utilizing the model child care for training persons in the field of child care.

AID TO FAMILIES WITH DEPENDENT CHILDREN

Persons Eligible for Aid to Families With Dependent Children

The Committee bill, when the Guaranteed Employment program goes into effect on January 1, 1974, will require that States:

1. Make eligible for AFDC only the following classes of families:
   a. Family headed by mother with child under age 6;
   b. Family headed by incapacitated father where mother is not in the home or is caring for father;
   c. Family headed by mother who is ill, incapacitated, or of advanced age;
   d. Families headed by mother too remote from an employment program to be able to participate;
   e. Family headed by mother attending school fulltime even if there is no child under 6; and
   f. Child living with neither parent, together with his caretaker relative(s), providing his mother is not also receiving welfare; and
2. Do not reduce payment levels to AFDC recipients below $1,600 for a two-member family, $2,000 for a three-member family and $2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

This requirement is not intended to act as a limitation on the right of a State to make other persons eligible at its own expense for benefits under its AFDC program. Indeed, in many States with benefit levels higher than those provided under the guaranteed employment program, AFDC-type families participating in the work program would receive supplemental payments under the State program sufficient to bring their incomes up to the payment standards generally applicable in the State. Specifically, the families not required to be covered by the State program (although it can be anticipated that many States will continue to supplement them) are families headed by an able-bodied male and families headed by an able-bodied female if all her children have reached age six.

Definition of "Incapacity" Under Aid to Families with Dependent Children

Under present law the Federal Government will match payments to families where the father is incapacitated. The definition of "incapacitated" is left up to the States. Under the Committee bill the term "incapacitated" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." This is the same definition as is used in determining disability under the social security disability insurance program, except that the definition suggested would also apply to

short term, temporary disability while social security benefits are available only to persons whose disability will last at least 12 months.

Ineligibility of Unborn Children

Regulations of the Department of Health, Education, and Welfare permit Aid to Families with Dependent Children payments for a child who has not yet been born. The Committee bill would make unborn children ineligible for AFDC.

Children Living in a Relative's Home

Under the present law an AFDC mother with more than one child can enable a relative to become eligible for welfare by lending the relative one of her children. The Committee bill would permit a State to deny welfare aid to the relative in such situation.

Cooperation of Mother in Identifying the Father and Seeking Support Payments

The Committee bill would require, as a condition of eligibility, that a mother cooperate in efforts to establish the paternity of a child born out of wedlock, cooperate in seeking support payments from the father, and assign the right to collect support payments on her behalf to the Government.

The provisions related to child support and establishing paternity are described in greater detail under the heading "Child Support."

Families Where There is a Continuing Parent-Child Relationship

The Committee has approved a provision which would clarify congressional intent with respect to the meaning of the term "parent" under the AFDC program. In most cases, AFDC families are eligible on the basis that the children in the family have been deprived of parental support by reason of the continued absence from the home of a parent. In 1968, the Supreme Court ruled that a State could not consider a child ineligible for AFDC when there is a substitute father with no legal obligation to support the child. This court decision was based on an interpretation that Congress did not intend that such a person would come within the meaning of the term "parent." The Committee bill would authorize States to determine whether a man is a "parent" on the basis of a total evaluation of his relationship with the child and not solely on the question of his obligation to support. The determination would have to consider the following indications of the existence of a parental relationship:

1. The individual and the child are frequently seen together in public;
2. The individual is the parent of a half-brother or half-sister of the child;
3. The individual exercises parental control over the child;
4. The individual makes substantial gifts to the child or to members of his family;
5. The individual claims the child as a dependent for income tax purposes;

6. The individual arranges for the care of the child when his mother is ill or absent from the home;

7. The individual assumes responsibility for the child when there occurs in the child's life a crisis such as illness or detention by public authorities;

8. The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;

9. The individual makes frequent visits to the place of residence of the child; and

10. The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

The relationship between an adult individual and a child would be determined to exist in any case only after an evaluation of the factors as well as any evidence which may refute any inference supported by evidence related to such factors. Under the Committee bill any natural parent or step-parent would meet these criteria.

Under the Committee bill, the use of this provision would be optional with the States. If a State affirmatively exercised its option, however, it would have to comply with this method in determining the child-father relationship.

Income Disregard

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first $30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full time at wages well above the poverty line.

Until the Committee's new employment program becomes effective in January, 1974, the earnings disregard formula would be modified by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). States would be required to disregard the first $60 earned monthly by an individual working full time ($30 for an individual working part time) plus one-third of the next $300 earned plus one-fifth of amounts earned above this. This differential between full time and part time employment is designed to encourage those who are able to move into full time jobs.

Once the employment program under the Committee bill becomes effective, however, these earned income exemptions under the residual welfare program would be replaced by a flat monthly exemption of $20, applicable to all kinds of income (with a separate $20 disregard

applicable to child support payments). It would be expected that mothers interested in working would receive their work incentives through participating in the employment program rather than by remaining on welfare.

In order to prevent the State welfare program from undermining the objectives of the Federal employment program, the States would have to assume for purposes of supplemental payments provided under AFDC or any welfare program that individuals, who are eligible to participate in the employment program (but no longer eligible to receive their basic income from AFDC), are actually participating full time in the employment program and thus receiving $200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Futhermore, the State would be required to disregard any earnings between $200 a month and $375 a month (the amount an employee would earn working 40 hours a week at $2.00 per hour) to ensure that the incentive system of the workfare program is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of $200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at $1.50 per hour.

The table below shows how wages under the employment program would be treated for State welfare purposes:

Hours worked per week	None	20	32	40
Hourly wage		$1.50	$1.50	$2.00
Approximate actual monthly income	0	$130	$200	$375
Income deemed available for State welfare purposes	$200	$200	$200	$200

Assistance Levels

Under existing law, each State decides the level of assistance it will provide for AFDC families. The Committee bill generally reaffirms the right of the State to make this determination. In moving to a block grant approach which involves substantial fiscal relief, however, the Committee feels it is appropriate to require that States could not reduce payments levels to AFDC recipients below $1,600 for a two-member family, $2,000 for a three-member family, and $2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

Right to Apply For Aid to Receive it With Reasonable Promptness

The present law requires 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.

The Committee bill would reiterate this provision, but would make clear the requirement that aid be furnished "with reasonable promptness" could not be so construed as to interfere with other requirements of the law such as seeking a mother's cooperation in establishing paternity and seeking support payments, or verifying information on income, resources and other eligibility factors.

Community Work and Training Programs

Prior to the enactment of the Work Incentive Program as part of the 1967 Social Security Amendments, the Federal statute permitted Federal matching of AFDC payments made to recipients participating in a community work training program. Since the enactment of the Work Incentive Program, however, the Department of Health, Education, and Welfare has taken the position that the Federal Government will not share in AFDC payments to recipients who are required by State law to participate in an employment program—unless the program is part of the Work Incentive Program. The Committee bill provides that during the period between enactment of the House bill and the effective date of the new Federal employment program, the community work training provisions in the law prior to the 1967 amendments would be applied so that States wishing to have such programs in the interim could do so.

Protective Payments for Children

The Committee bill requires States under the AFDC program to take certain actions to assure that welfare payments are being used in the best interests of children. Existing law provides that when the welfare agency has reason to believe that the AFDC payments are not used in the best interests of the child, it "may" provide counseling and guidance services so that the mother will use the payments in the best interests of the child. This failing, the agency "may" resort to protective payments to a third party who will use the funds for the best interest of the child. The Committee bill makes these procedures mandatory in such cases.

Emergency Assistance—Migrant Workers

Under existing law, emergency assistance may, at the option of the States, be provided to needy families in crisis situations, and it may be provided either statewide or in part of the State. Emergency assistance programs have been adopted in about half of the States, and they receive 50 percent Federal matching. Under the law, assistance may be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide living arrangements for the child. The Committee bill (1) requires that all States have a program of emergency assistance to migrant families with children; (2) requires that the program be statewide in application; and (3) provides 75 percent Federal matching for emergency assistance to migrant families.

Making Establishment of Advisory Committee Optional

Regulations issued by the Department of Health, Education, and Welfare in 1969 require States to establish a welfare advisory committee for AFDC and child welfare programs "at the State level and at local levels where the programs are locally administered," with the cost of the advisory committees and their staffs borne by the States (with Federal matching) as part of the cost of administering the welfare programs. The Committee bill makes the establishment of such committees optional with the States.

Administrative Costs

The Committee agreed that the Federal Government would continue to pay 50 percent of the cost of administration of the AFDC program including administrative costs related to the provision of Social Services.

Federal Financial Participation in Welfare Payments

The Committee bill would make a major change in the basic method of Federal funding for AFDC by providing a block Federal grant with substantially more Federal funds than are now provided under present law. This approach is described in detail under the heading "Fiscal Relief for States."

TABLE 10.—RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN, DECEMBER OF SELECTED YEARS

Year	Number of recipients	Percent increase since 1960
1940	1,222,000	
1945	943,000	
1950	2,233,000	
1955	2,192,000	
1960	3,073,000	
1961	3,566,000	+16
1962	3,789,000	+24
1963	3,990,000	+28
1964	4,219,000	+38
1965	4,396,000	+44
1966	4,666,000	+52
1967	5,309,000	+73
1968	6,086,000	+98
1969	7,313,000	+138
1970	9,659,000	+215
1971	10,651,000	+247
1972 [1]	12,573,000	+311
1973: [1]		
Current law	13,800,000	+349
Committee bill	[2] 13,800,000	+349
1974: [1]		
Current law	14,900,000	+385
Committee bill: persons eligible to receive basic income from AFDC	[3] 8,940,000	+191

[1] Estimated.

[2] Some reduction of caseload may be anticipated because of committee amendments related to eligibility rules and administration; the extent of the reduction will largely depend upon State action.

[3] Reflects estimate that about 40 percent of current caseload will no longer be eligible to get basic income from AFDC.

Source: Department of Health, Education, and Welfare.

Statistical Material

TABLE 11.—**AID TO FAMILIES WITH DEPENDENT CHILDREN:** INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID TO **FAMILY OF 4,** BY STATE, DECEMBER 1971

	Income eligibility level for payments	Largest amount paid for basic needs
Alabama	$81	$81
Alaska	400	300
Arizona	266	173
Arkansas	210	106
California	314	261
Colorado	235	235
Connecticut	335	335
Delaware	287	158
District of Columbia	245	245
Florida	223	134
Georgia	158	149
Hawaii	268	268
Idaho	241	241
Illinois	273	273
Indiana	355	175
Iowa	243	243
Kansas	290	226
Kentucky	193	193
Louisiana	104	104
Maine	349	168
Maryland	311	200
Massachusetts	283	283
Michigan	293	293
Minnesota	309	309
Mississippi	277	60
Missouri	338	130
Montana	225	206
Nebraska	275	226
Nevada	176	176
New Hampshire	314	314
New Jersey	324	324
New Mexico	203	179
New York	313	313
North Carolina	172	172
North Dakota	300	300

TABLE 11.—**AID TO FAMILIES WITH DEPENDENT CHILDREN:** INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID TO **FAMILY OF 4,** BY STATE, DECEMBER 1971—Continued

	Income eligibility level for payments	Largest amount paid for basic needs
Ohio	$258	$200
Oklahoma	189	189
Oregon	224	224
Pennsylvania	301	301
Rhode Island	255	255
South Carolina	198	103
South Dakota	270	270
Tennessee	217	129
Texas	148	148
Utah	224	224
Vermont	319	319
Virginia	261	261
Washington	282	270
West Virginia	138	138
Wisconsin	217	217
Wyoming	260	227

Source: Department of Health, Education, and Welfare.

CHILD SUPPORT

The Committee has long been aware of the impact of deserting fathers on the rapid and uncontrolled growth of families on AFDC. As early as 1950, the Congress provided for the prompt notice to law enforcement officials of the furnishing of AFDC with respect to a child that had been deserted or abandoned. In 1967, the Committee instituted what it believed would be an effective program of enforcement of child support and determination of paternity. Due to a total lack of leadership by the Department of HEW, most States have not implemented these provisions in a meaningful way. The Committee believes, therefore, that a new legislative thrust is required in this area which will create a mechanism to obtain compliance with the law. The major elements of this proposal have been adapted from those States who have been the most successful in establishing effective programs of child support and determination of paternity. Some of the modes of assistance which are created by the Committee plan will be available to deserted families generally, regardless of welfare status. It is hoped that making these provisions available to all deserted families will prevent further expansion of the welfare rolls.

Present law requires that the State welfare agency establish a separate, identified unit whose purpose is to undertake to determine the paternity of each child receiving welfare who was born out of wedlock, and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for him from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to both Social Security and (if there is a court order) to Internal Revenue Service records in locating deserting parents. The effectiveness of the provisions of present law have varied widely among the States.

Assignment of Right to Collection of Support Payments

In some instances, mothers may have personal reasons for fearing to cooperate in identifying and securing support payments from the father of the child. To protect the mother, and also to allow for a more systematic approach for the collection of support payments, the Committee approved an amendment requiring a mother, as a condition of eligibility for welfare, to assign her right to support payments to the Government and to require her cooperation in indentifying and locating the father and in obtaining any money or property due the family or Government. The assignment of family support rights would be to the Federal Government, and the Department of Justice would

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be authorized to delegate these rights to those States which have effective programs of determining paternity and obtaining child support. The Attorney General would also be authorized to delegate such collection rights to counties that have effective programs, but only if the State as a whole did not.

If the Attorney General found that a State did not have an effective program, the collection rights would remain with the Federal Government and would be enforced by Federal attorneys in either State or Federal Courts. OEO lawyers would be made available to assist Justice Department attorneys in carrying out their responsibility. In this situation the Federal Government would retain the full amount not payable to the family.

The House bill provided that the Federal share for State expenses for establishing paternity and securing support should be increased from 50 to 75 percent. The Committee adopted this provision, but with a proviso that there be no Federal participation in such State programs which do not meet the Attorney General's standards of effectiveness.

Locating a Deserting Parent; Access to Information

Under the Committee bill, the State or local Government would proceed to locate the absent parent, using any information available to it, such as the records of the Internal Revenue Service and the Social Security Administration. The Committee bill extends access to these Federal records to any parent seeking support from a deserting spouse regardless of whether the family was on welfare. Non-welfare families desiring to use this means of finding the absent parent would make the necessary application at local welfare offices. The Federal Government would have to be reimbursed for the cost of these services by the welfare agency or the individual if a welfare case was not involved.

As a further aid in location efforts, welfare information now withheld from public officials, under regulations concerning confidentiality, would be made available by the Committee bill; this information would also be available for other official purposes.

Incentives for States and Localities to Collect Support Payments

Under present law, when a State or locality collects support payments owed by a father, the Federal Government is reimbursed for its share of the cost of welfare payments to the family of the father; the Federal share currently ranges between 50 percent and 83 percent, depending on State per capita income. In a State with 50 percent Federal matching, for example, the Federal Government is reimbursed $50 for each $100 collected, while in a State with 75 percent Federal matching the Federal Government is reimbursed $75 for each $100 collected.

Consistent with the Committee's block-grant approach for AFDC, and as an incentive for the development of effective State and local programs, the Committee bill provides that the entire amount of welfare payments from support collections would remain with the State.

If, however, the actual collection and determination of paternity mechanism is carried out by local authority, the State would pay 25 percent of the governmental share of the support collections to such authority.

In the situation where the location of runaway parents and the enforcement of support orders is carried out by a State other than that in which the deserted family resides, the State or local authority which actually carries out the location and enforcement functions will be paid the 25 percent bonus.

The Committee bill provides, that the Federal Government would have to be reimbursed for any Federal costs incurred by the States and localities in their collection and determination of paternity efforts.

Voluntary Approach Stressed

Once located, the parent would be requested to enter voluntarily into an arrangement for making regular support payments. Primary reliance would be placed on such voluntary agreements as the most effective and efficient means of collecting support, avoiding the need for court action and formal collection procedures. The record of the State of Washington in collecting support payments voluntarily was highlighted in a recent study by the General Accounting Office as a key element in their highly successful support collection program; hopefully, the experience of Washington State can serve as a model for all States.

Civil Action To Obtain Support Payments—Residual Monetary Obligation

In the event that the voluntary approach is not successful, the Committee's bill provides for strong legal remedies. The States, as agents of the Federal Government, in enforcing the support rights assigned to them by welfare applicants would have available to them all the enforcement and collection mechanisms available to the Federal Government, including the use of the Internal Revenue Service to garnish the wages of the absent parent. As stated previously, if these mechanisms are utilized the Federal Government would have to be reimbursed on a cost basis. Support monies received would be distributed according to the formula described under "Incentives for States."

The welfare payment would serve as the basis of a continuing monetary obligation of the deserting parent to the United States. The obligation would be the lesser of the welfare assistance paid to the family, or 50 percent of the deserting spouse's income but not less than $50 a month.

A waiver of all or part of the Federal obligation might be allowed upon a showing of good cause.

Criminal Action

The Committee bill has provided for Federal criminal penalties for an absent parent who has not fulfilled his obligation to support his family and the family receives welfare payments in which the Federal

Government participates. His obligation to support would be determined by applying State civil and/or criminal law. The sanctions for failure to support could include a penalty of 50 percent of the amount owed or a fine of up to $1,000 or imprisonment for up to 1 year or a combination of these.

Determining Paternity

The Committee believes that an AFDC child has a right to have its paternity ascertained in a fair and efficient manner. Although this may in some cases conflict with the mother's short-term interests, the Committee feels that the child's right to support, inheritance, and his right to know who his father is deserves the higher social priority. In 1967, Congress enacted legislation requiring the States to establish programs to establish the paternity of AFDC children born out of wedlock so that support could be sought. The effectiveness of this provision was greatly curtailed both by the failure of the Department of Health, Education, and Welfare to exercise any leadership role and also by Court interpretations of Federal law in decisions which prevented State welfare agencies from requiring that a mother cooperate in identifying the father of a child born out of wedlock.

1. Cooperation of Mother

As noted earlier, the Committee has made cooperation in identifying the absent parent a condition for AFDC eligibility. As a further incentive for cooperation, the first $20 a month in support collections would be paid to the family and disregarded for purposes of determining the amounts of welfare payments to the family. Thus, the family would always be better off if support payments were made by the absent parent.

2. Blood Grouping Laboratories

The Committee has also taken additional steps to provide for a more effective system of determining paternity.

First, a father not married to the mother of his child would be required to sign an affidavit of paternity if he agreed to make support payments voluntarily in order to avoid court action. Most States do not permit initiation of paternity actions more than two or three years after the child's birth; the affidavit would serve as legal evidence of paternity in the event that court action for support should later become necessary.

Second, there is evidence that blood typing techniques have developed to such an extent that they may be used to establish evidence of paternity at a level of probability acceptable for legal determinations.

Moreover, if blood grouping is conducted expertly, the possibility of error can all but be eliminated. Therefore, the Committee adopted a provision to authorize and direct the Department of Health, Education, and Welfare to establish or arrange for regional laboratories that can do blood typing for purposes of establishing paternity, so that the State agencies and the courts would have this expert evidence available to them in paternity suits. No requirement would be

made in Federal law that blood tests be made mandatory. The services of the laboratories would be available with respect to any paternity proceeding, not just a proceeding brought by, or for, a welfare recipient.

Leadership Role of Justice Department

To coordinate and lead efforts to obtain child support payments, the Committee action would require each U.S. Attorney to designate an assistant who would be responsible for child support. This Assistant U.S. Attorney would assist and maintain liaison with the States in their support collection efforts and would undertake Federal action as necessary. The Attorney General would be required to submit a quarterly report to Congress concerning child support activities.

The Committee bill requires that records be maintained of the amounts of support collected and of the administrative expenditures incurred in the collection effort. Amounts collected but not otherwise distributed would be deposited in a separate account which would finance the expenses of the Federal collection efforts. An authorization for an appropriation would be included for the contingency of a deficit in this fund in order to reimburse the Departments of Justice and Treasury for their expenses in this area.

Attachment of Federal Wages

State officials have recommended that legislation be enacted permitting assignment and attachment of Federal wages and other obligations (such as income tax refunds) where a support order or judgment exists. At the present time, the pay of Federal employees, including military personnel is not subject to attachment for purposes of enforcing court orders, including orders for child support or alimony. The basis for this exemption is apparently a finding by the courts that the attachment procedure involves the immunity of the United States from suits to which it has not consented.

The Committee bill would specifically provide that the wages of Federal employees be subject to garnishment in support and alimony cases. This Committee amendment would be applicable whether or not the family bringing the garnishment proceeding is on the welfare rolls.

Child Support Under Workfare

A deserted parent participating in the workfare program could take advantage of the support collection and, where applicable, the paternity determination mechanism provided in the Committee bill. The cost of collection, however, would be deducted from the amounts recovered and the balance would be turned over to the deserted family.

Effective Dates

Unless otherwise indicated in the bill, new features added by the collection of support and determination of paternity provision would be effective January 1, 1973.

Statistical Material

TABLE 12.—AFDC FAMILIES BY PARENTAGE OF CHILDREN, 1971

Parentage	Number	Percent
Total	2,523,900	100.0
Same mother and same father	1,800,200	71.3
Same mother, but 2 or more different fathers	638,400	25.3
Same father, but 2 or more different mothers	5,200	.2
2 or more different mothers and 2 or more different fathers	53,400	2.1
Unknown	26,700	1.1

Source: Department of Health, Education, and Welfare.

TABLE 13.—AFDC FAMILIES WITH SPECIFIED NUMBER OF ILLEGITIMATE RECIPIENT CHILDREN, 1971

Number of children	Number	Percent
Total	2,523,900	100.0
None	1,426,000	56.5
1	559,600	22.2
2	262,400	10.4
3	129,600	5.1
4	71,700	2.8
5	37,300	1.5
6 or more	37,300	1.5

Source: Department of Health, Education, and Welfare.

TABLE 14.—AFDC FAMILIES BY STATUS OF FATHER, 1961, 1967, 1969, AND 1971

Status	Percent of families in—			
	1961	1967	1969	1971
Total	100.0	100.0	100.0	100.0
Dead	7.7	5.5	5.5	4.3
Incapacitated	18.1	12.0	11.5	9.8
Unemployed	5.2	5.1	4.8	6.1
Absent from the home:				
Divorced	13.7	12.6	13.7	14.2
Legally separated		2.7	2.8	2.9
Separated without court decree	8.2	9.7	10.9	12.9
Deserted	18.6	18.1	15.9	15.2
Not married to mother	21.3	26.8	27.9	27.7
In prison	4.2	3.0	2.6	2.1
Absent for another reason	.6	1.4	1.6	1.2
Subtotal	66.7	74.2	75.4	76.2
Other status:				
Stepfather case	2.2	1.9	1.9	2.6
Children not deprived of support or care of father, but of mother		1.3	.9	.9
Not reported			(1)	.1

[1] Less than 0.05.

Source: Department of Health, Education, and Welfare.

TABLE 15.—AFDC FAMILIES BY WHEREABOUTS OF FATHER, 1971

Whereabouts	Number	Percent
Total	2,523,900	100.0
In the home	472,900	18.7
In an institution:		
Mental institution	8,000	.3
Other medical institution	11,200	.4
Prison or reformatory	75,300	3.0
Not in the home or an institution; he is residing in:		
Same county	469,200	18.6
Different county; same State	156,300	6.2
Different State and in the United States	230,900	9.1
A foreign country	27,100	1.1
Whereabouts unknown	959,600	38.2
Inapplicable (father deceased)	113,400	4.3

Source: Department of Health, Education, and Welfare.

FISCAL RELIEF FOR STATES

The Committee is well aware that the growth of the welfare rolls since 1967 has been one of the significant factors in bringing about the fiscal crisis currently facing state and local governments. Much of this growth has been due to increased Federal intervention in the control of the welfare programs by the State. The Committee feels that having the Federal Government take over the control of the welfare program is not now a step that should be taken. It believes that the correct approach is in the opposite direction. Accordingly, the Committee carefully designed many parts of this bill so that the State's control of welfare programs would be strengthened rather than weakened. The Committee recognizes, however, that this represents a long-range solution and that many States feel an acute need for immediate relief from the pressures of swollen welfare budgets. Under the Committee bill therefore, the fiscal burden on the States will be substantially decreased through increases in the Federal funding of assistance payments as well as through indirect fiscal relief resulting from improvements which the Committee bill makes in the general structure of the welfare programs.

Over the next 2½ years, the bill provides $5 billion in fiscal relief to the States. Of this, $2.6 billion represents fiscal relief in 1974, the first year the new employment programs are fully effective. The table below shows the detail for each of the years 1972–74.

[Dollars in billions]

	1972	1973	1974	Tota
Aid to the aged, blind, and disabled	$0.2	$1.0	$1.2	$2.4
Aid to families with dependent children	.4	.8	1.4	2.6
Total	.6	1.8	2.6	5.0

The estimated fiscal relief provided for each State in calendar year 1974, with respect to cash public assistance payments is shown in the table below.

TABLE 16

STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974 [1]

[In millions of dollars]

State	Committee proposal			Estimated savings under H.R. 1
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	(4)
Total	1,230.4	1,378.9	2,609.3	1,859.2
Alabama	27.1	12.9	40.0	31.1
Alaska	2.6	2.9	5.5	3.5
Arizona	10.6	32.0	42.6	40.5
Arkansas	14.0	7.5	21.5	21.5
California	298.9	163.3	462.2	180.9
Colorado	15.9	15.3	31.2	16.5
Connecticut	10.4	11.5	21.9	16.7
Delaware	4.5	3.7	8.2	4.7
District of Columbia	10.4	45.4	55.8	50.8
Florida	32.6	90.3	122.9	135.3
Georgia	24.9	36.5	61.4	58.9
Hawaii	3.6	8.7	12.3	9.4
Idaho	1.7	1.8	3.5	2.0
Illinois	45.4	100.6	146.0	167.0
Indiana	9.2	29.2	38.4	28.2

Iowa	19.4	10.1	29.5	22.7
Kansas	7.0	13.2	20.2	12.1
Kentucky	15.4	10.8	26.2	15.3
Louisiana	32.8	39.5	72.3	68.8
Maine	4.4	3.2	7.6	2.5
Maryland	17.1	52.8	69.9	72.3
Massachusetts	51.5	39.9	91.4	64.8
Michigan	45.3	94.9	140.2	97.4
Minnesota	13.1	14.5	27.6	17.5
Mississippi	14.6	5.5	20.1	20.8
Missouri	34.3	15.0	49.3	10.8
Montana	1.8	1.7	3.5	1.7
Nebraska	2.4	4.4	6.8	7.1
Nevada	.8	1.9	2.7	1.7
New Hampshire	4.0	1.2	5.2	2.2
New Jersey	20.1	30.0	50.1	48.5
New Mexico	4.0	3.6	7.6	3.7
New York	168.5	135.8	304.3	168.3
North Carolina	19.9	16.7	36.6	31.2
North Dakota	2.1	2.2	4.3	1.2
Ohio	29.9	94.0	123.9	103.0
Oklahoma	33.5	14.1	47.6	39.0
Oregon	6.7	14.9	21.6	15.4
Pennsylvania	46.8	57.1	103.9	70.0
Rhode Island	4.4	9.4	13.8	7.1

See footnote at end of table.

STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974 [1]—Continued

[In millions of dollars]

State	Committee proposal			Estimated savings under H.R. 1
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	(4)
South Carolina	5.9	7.0	12.9	12.9
South Dakota	.7	1.4	2.1	1.4
Tennessee	13.2	16.3	29.5	26.8
Texas	42.4	32.5	74.9	44.8
Utah	2.5	5.6	8.1	5.2
Vermont	2.3	1.6	3.9	3.7
Virginia	9.5	12.1	21.6	20.8
Washington	15.4	14.6	30.0	12.0
West Virginia	8.5	7.0	15.5	14.4
Wisconsin	17.9	32.0	49.9	44.6
Wyoming	.5	.8	1.3	.5

[1] Based on fiscal year 1974 data.

Federal Funding of Aid to the Aged, Blind, and Disabled

The Committee bill establishes minimum Federal standards for assistance to the aged, blind, and disabled, but leaves to the States the administration of the program under State eligibility rules. To give the States both substantial fiscal relief and a fiscal stake in good administration, the cost of making assistance payments meeting the Federal payment level requirements would be borne entirely by the Federal Government up to a specified base amount under the following formula:

> Federal funding would be provided for the costs of assistance to the aged, blind, and disabled up to the standards required by the bill ($130 for an individual, $190 for a couple with a $50 disregard of all income and additional disregards of earned income). These costs would be fully Federal up to the higher of (1) the cost of meeting these standards for a State's existing caseload; or (2) the State's share of $5 billion distributed among the States in proportion to the number of aged individuals with income below $1,750 and aged couples with income below $2,200 in 1969. If State costs involved in meeting the Federally required payment levels exceeded the higher of these amounts, the Federal Government would also pay 90 percent of the excess. There would be no Federal funding with respect to assistance provided at levels above those required by the Committee decision.

Under this formula most States would be required to pay a relatively small proportion of the costs involved in the Committee decision. A number of States, however, would have no costs at all for 1974; but these States would be required to pay small amounts in future years when their caseload grows to the point that the fully Federal base amount is no longer sufficient to cover the payments required by the Federal standards. As a result, all States would be relieved of all but a very small amount of responsibility for the funding of aid to the aged, blind, and disabled and would enjoy the savings shown in column 1 of the preceding table. However, there would be an incentive for the States to exercise control over caseload growth since they would be required to pay a part of the costs related to all additional recipients once the Federal base amount is exceeded.

In 1974, it is estimated that this formula would result in Federal payments to the aged, blind, and disabled of $4.2 billion (compared with $2.0 billion under existing law). State costs under the bill would be $0.2 billion compared with $1.4 billion under existing law, yielding fiscal relief for the States of $1.2 billion. The same formulas would apply with respect to assistance for the aged, blind, and disabled in the remaining months of 1972 and in 1973. It is estimated that this will result in State savings of $0.2 billion this year and $1.0 billion in 1973.

Federal Funding of Aid to Families with Dependent Children

In the Aid to Families with Dependent Children program, the Committee bill changes the funding mechanism from the present formula matching to a block grant approach. This new method of providing Federal funds for AFDC results in substantial immediate fiscal relief and is also consistent with the Committee's desire to return to the States a greater measure of control over their welfare programs. For the last 6 months of calendar year 1972 and for 1973 the block grant would be based on the funding for calendar year 1972 under current law. Starting in 1974 the grant would be adjusted to take into account

the effects of the work program. The following formula would be used:

The grant for 1973 would equal the 1972 Federal share, plus an additional amount equal to one-half of the 1972 State share, or if less the amount needed in 1972 to bring family income up to $1,600, $2,000 or $2,400 for families with two, three, or four or more members, respectively. In no case, however, would the Federal block grant be less than 110 percent of the Federal share in 1972. For the last 6 months of calendar year 1972, the grant would be one-half of the 1973 grant.

After the employment program becomes effective in January 1974, the Federal grant for AFDC would be reduced somewhat in recognition of the fact that families with no children under age 6 would no longer be eligible for AFDC. This reduced grant would remain the same in future years, except that it would be increased or decreased to reflect changes in total State population.

For example, it is estimated that the Federal block grant for AFDC in California would be $689.4 million in 1973. After the employment program becomes effective, this would be reduced to $526.7 million. The $526.7 million would remain as the annual amount of the Federal grant to California for AFDC except that it would be adjusted each year to reflect any percentage increase or decrease in the State's population.

The table below shows the State savings under AFDC over the next 2½ years.

TABLE 17.—STATE SAVINGS IN AFDC COSTS UNDER COMMITTEE BILL

(In billions)

Year	Current law		Committee bill		
	Federal	Non-Federal	Federal	Non-Federal	Fiscal relief to States
1972 [1]	$2.2	$1.8	$2.6	$1.4	$0.4
1973	4.4	3.6	5.2	2.8	.8
1974 [2]	4.8	3.9	3.7	2.5	1.4

[1] Last 6 months only.
[2] Total AFDC costs are reduced under Committee bill because many current law recipients would no longer be eligible to receive their basic income from AFDC.

Federal Funding Costs of Public Assistance Administration

The Committee bill would retain the present financing arrangement with respect to the costs of administration of the AFDC program. Under this arrangement, such costs are shared on a 50 percent Federal—50 percent State basis.

In the programs of aid to the aged, blind, and disabled, the Committee bill would provide Federal funding equal to 100 percent of the administration costs in calendar year 1972 plus 50 percent of any costs above this base. The additional Federal funding would be needed because several States may have substantially greater administrative costs due to the new Federal assistance standards for the aged, blind, and disabled.

Internal Revenue Amendments

Retirement Income Credit

Under present law, a retirement income credit of up to $1,524 multiplied by 15 percent ($229) is allowed for single persons age 65 or over having "retirement income"—that is, income from pensions, dividends, interest, rents, and other passive income. The income eligible for this credit is reduced, however, by social security, railroad retirement, or other tax-exempt pension income. It is also reduced by 50 percent of earnings between $1,200 and $1,700 and on a dollar-for-dollar basis as income rises above $1,700. For most married couples, the limitation on the credit is $2,286, one and one-half times the amount allowed a single person, and the maximum benefit is $342.90.

In addition, under present law, the retirement income credit, determined substantially as indicated above, is available for retirement income received from governmental units where the individual is under age 65, except that if he is also under age 62, earnings in excess of $900 reduce the $1,524 limitation on a dollar-for-dollar basis.

The Committee bill includes, with minor modification, the liberalized and simplified retirement income credit contained in the House bill. As adopted by the Committee, the limitation would be raised to $2,500 for a single person and $3,750 for a couple. Thus, the maximum credit will be $375 for a single person and $562.50 for a couple. The Finance Committee did not include in its bill the feature of the House provision which would have extended the credit to persons who have not yet retired.

Social Security and Unemployment Tax of Affiliated Corporations

The Social Security tax is based on the wages paid an employee, with a limitation on the amount subject to tax. Under present law, the limitation is $9,000 ($10,200 under the Committee bill). In some instances, an employee on the payroll of one member of an affiliated group of corporations may perform services for other members of the group; in these cases, he may be treated as a separate employee of each member of the group for which he performs services and the remuneration he receives may be attributed to them. As a result, the $9,000 limitation on wages subject to social security is applied to the remuneration attributed to each company separately, rather than to the total remuneration received by such employee, and the FICA tax collected with respect to his employment may be based on compensation considerably in excess of the statutory limit. While the employee may obtain a refund of any excess social security tax paid, the related employers may not.

The Committee approved an amendment to eliminate duplication of FICA tax in the situation described. The amendment also applies to

eliminate the duplication of the Federal unemployment taxes which may occur under similar circumstances. Under the amendment, an individual who performs services for more than one member of an affiliated group of corporations would be treated as an employee only of the member or members of the group by which he is employed and from which he receives his compensation. Under the committee action the present practice of attributing payments of compensation to other members of an affiliated group would no longer prevail.

Analysis of Cost of Committee Bill

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Chart 1

Cost Increases in H.R. 1 and Committee Bill

The chart shows the net increase in cost over current law for calendar years 1973 and 1974 for H.R. 1 and the Committee bill. Details for each of the program categories are shown in the succeeding charts and text.

The estimated costs for H.R. 1 are those prepared by the Department of Health, Education, and Welfare. As discussed in the text accompanying chart 5, some of these costs are believed to be significantly understated.

The cost estimate for the tax credit provisions relates to the retirement income credit provision in the House bill plus the credit added by the Committee for employers hiring persons who have been in the Committee's employment program. This estimate was prepared by the staff of the Joint Committee on Internal Revenue Taxation.

In summary, the Committee bill would cost $5.7 billion more than the House bill in 1973 and $6.3 billion more in 1974. Of the 1974 increase, $3.9 billion represents increased social security benefits and $2.4 billion represents increased general fund costs (principally payments to low-income working persons).

The Committee bill would cost $17.6 billion more than existing law in 1974, as shown below:

[In billions of dollars]

	Present law	Committee bill	Increase
Social security cash benefits	$43.2	$50.6	+$7.4
Medicare Part A	8.3	10.7	+2.4
Medicare Part B	3.3	3.9	+.6
Medicaid	6.1	6.1	
Aid to the aged, blind, and disabled	2.7	4.9	+2.2
Programs for families	7.0	11.5	+4.5
Increase in tax credits			+.5
Total			+17.6

Chart 1

Cost Increases in H.R.1 and Committee Bill

(in billions)

	1973		1974	
	H.R.1	Committee bill	H.R.1	Committee bill
General Funds				
Medicare Part B	$0.4	$0.3	$0.4	$0.6
Medicaid	-0.5	---	-0.5	---
Aged, blind, disabled	1.1	2.0	2.6	2.2
Programs for families	1.3[1/]	2.7	2.5[1/]	4.5
Tax credit provisions	0.4	0.4	0.4	0.5
SUBTOTAL	2.7	5.4	5.4	7.8
Increase in Committee bill		(+2.7)		(+2.4)
Trust Funds				
Social security cash benefits	3.9	7.0	4.3	7.4
Medicare Part A	1.5	1.4	1.6	2.4
SUBTOTAL	5.4	8.4	5.9	9.8
Increase in Committee bill		(+3.0)		(+3.9)
TOTAL	8.1	13.8	11.3	17.6
Increase in Committee bill		(+5.7)		(+6.3)

1/ Based on HEW estimate; Committee estimate is $2.0 billion higher in 1974.

Chart 2

Social Security Cash Benefits

H.R. 1 as passed by the House of Representatives provided for a first year increase in the cost of social security cash benefits of $3.9 billion. A 5 percent general benefit increase accounted for $2.1 billion of this total. Under the Committee bill, there would be an additional increase in social security cash benefit costs of $3.1 billion for a total increase over existing law of $7.0 billion. The 10 percent general benefit increase in the Committee bill represents a cost of $2.2 billion over the 5 percent increase in the House bill.

Chart 2

Social Security Cash Benefits

(First full year costs, in billions)

Increases in House Bill

5 percent benefit increase	$2.1
Widow's benefits	0.9
Increase in earnings limit	0.6
Other changes	0.3
SUBTOTAL	3.9

Increases in Committee Bill

Benefit increase of 10% rather than 5%	2.2
Special minimum up to $200	0.3
Credit for delayed retirement	0.2
Other changes	0.4
SUBTOTAL	3.1
TOTAL INCREASE IN COMMITTEE BILL OVER PRESENT LAW	7.0

Chart 3

Medicare and Medicaid

Medicare Part B

The principal increased cost in the committee bill is attributable to covering the disabled under Medicare on a basis similar to that approved by the House.

The Committee also approved adding coverage of chiropractors under Medicare and limiting the percentage by which the Medicare Part B premium paid by older people could be raised from one year to the next.

In addition, other changes were approved that were designed to smooth Medicare operation.

Medicaid

The Committee bill would for the first time cover eligible mentally ill children under age 21 receiving treatment in an accredited medical institution.

The Committee also provided that workfare participants otherwise ineligible for Medicaid would have the opportunity to "buy in" by paying premiums, with Federal subsidy for any remaining costs of benefits.

The principal change resulting in a decrease in Medicaid costs was the Committee's repeal of Section 1902 (d) which presently prohibits States from moderating their programs.

Medicare Part A

Extension of hospital insurance for the disabled accounts for the major cost increase shown on the chart.

A new benefit was added by the Committee covering a limited number of drugs appropriate for use in treating the chronically ill.

The definition of eligibility for services in an extended care facility was liberalized in the committee bill so as to simplify administration and improve availability of benefits.

Chart 3

Medicare and Medicaid, 1974

	(dollars in billions)
GENERAL FUNDS	
Medicare Part B:	
Present law	$1.8
Extend coverage to disabled	0.4
Cover chiropractic, limit premium, other changes	0.2
Medicaid:	
Present law	5.3
Mentally ill children	0.1
Coverage of workfare participants	0.2
Other changes	-0.3
NET INCREASED GENERAL FUND COSTS	+0.6
TRUST FUNDS	
Medicare Part A:	
Present law	8.3
Extend coverage to disabled	1.5
Coverage of drugs	0.7
Extended care definition, other changes	0.2
NET INCREASED TRUST FUND COSTS	+2.4

Chart 4

Aid to the Aged, Blind, and Disabled

Under the Committee bill, the Federal share of aid to the aged, blind, and disabled for 1974 is estimated to be $4.9 billion, including $4.4 billion in assistance payments ($2.2 billion more than under current law) and $0.5 billion for administrative costs ($0.3 billion more than existing law). This $2.5 billion increase in Federal expenditures is offset by a reduction of $0.3 billion in food stamp costs for a net increased Federal cost of $2.2 billion. (Recipients would be ineligible for food stamps but would get offsetting increases in cash assistance.)

The increase in Federal costs results from the new Federal standards for assistance to the aged, blind, and disabled, and from the changed funding mechanism under which the Federal Government assumes most of the cost of assistance payments and an increased share of administrative costs.

Chart 4

Aid to the Aged, Blind and Disabled, 1974

	cost in billions
Present law:	
Welfare payments	$2.2
Administration	0.2
Food stamps	0.3
TOTAL	2.7
Committee increases:	
Welfare payments (including cashing out of food stamps)	+2.2
Administration	+0.3
Food stamps	-0.3
TOTAL INCREASE	+2.2

Chart 5

Cost of Programs for Families: H.R. 1 and the Committee Bill

The table shows the total cost of the program for families in H.R. 1 and the Committee bill for calendar year 1974 The comparable cost of present law is $7 billion. Two estimates are shown for each bill, one prepared by the Department of Health, Education and Welfare, and the other by Mr. Robert Myers, consultant to the Committee and former Chief Actuary of the Social Security Administration. The detailed bases of these estimates were submitted to the Committee.

Chart 5

Cost of H.R. 1 and Committee Bill, 1974: Programs for Families

(dollars in billions)	H.R. 1		Committee Bill	
	HEW estimate	Committee estimate	HEW estimate	Committee estimate
Government employment	---	---	$5.7	$2.6
Wage supplement	---	---	1.7	0.3
Children's allowance	---	---	0.5	---
10% work bonus	---	---	1.1	1.2
Welfare payments	$5.1	$7.1	3.2	3.7
Cost of cashing out food stamps	1.5	1.5	1.8	1.8
Child care: Additional	0.8	0.8	1.5	0.8
Included in Gov't employment	---	---	---	(0.4)
Public service jobs	0.8	0.8	---	---
Services, training	0.6	0.6	0.8	0.4
Administration: Additional	0.7	0.7	1.7	0.7
Included in Gov't employment	---	---	---	(0.4)
TOTAL	9.5	11.5	18.0	11.5
Present law	7.0	7.0	7.0	7.0
NET INCREASED COST	2.5	4.5	11.0	4.5