The original documents are located in Box 17, folder "Health (11)" of the James M. Cannon Files at the Gerald R. Ford Presidential Library.

THE WHITE HOUSE

WASHINGTON

November 29, 1976

MEMORANDUM FOR: SPENCER JOHNSON

FROM: JIM CANNON

SUBJECT: Legislative Program for HEW

Please look this over and identify for me in a brief memo the key points of concern.

Attachments

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

NOV 22 1976

MEMORANDUM FOR THE HONORABLE DAN MCGURK

Subject: FY 78 Budget/Legislative Program Revisions

Attached are revisions in the FY 78 budget/legislative program we provided you on September 21, 1976.

Attachment A lists the number of the particular legislative proposal and the type of action taken, i.e., withdrawals, modifications, revisions, specifications, etc. Following this, at attachment B are copies of the revised proposals. As you will note, we have identified changes by underlining additions to the original proposal and by the marking lines in the margin beside the line and/or section where a deletion or other modification has been made.

Several legislative proposals originally submitted in September remain under consideration within the Department. We will inform you of the Department's position on these proposals as soon as decisions on them are made.

Signed

William A. Morrill
Assistant Secretary for
Planning and Evaluation

Attachments

11230?

ATTACHMENT A

Changes in A-19 Statements

95-1 Proposal has been revised and endorsed. (See attachment B.)

95-2 Proposal has been revised and endorsed. (See attachment B.)

95-3 Proposal has been revised and endorsed. (See attachment B.)

95-5 Proposal should be listed as under consideration, not as endorsed.

95-6 A typographical error in original submission indicated that it was Section 318 to be amended. This should have read Section 319. A corrected copy of proposal is included in attachment B.

95-9 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 562.

95-10 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 562.

95-11 Cost for FY 1979 has been revised. (See attachment B.)

95-12 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 484.

95-14 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 562.

95-16 The explanation of the purpose of and justification for the proposal has been revised. (See attachment B.)

95-23 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 484.

95-35 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 555.

95-43 The justification for the proposal has been revised. (See attachment B.)

95-46 Additional proposals which the Department previously proposed have been listed for submission to the 95th Congress. (See attachment B.)

95-47 Proposal has been revised and endorsed. (See attachment B.)

95-48 The justification for the proposal has been revised, and the proposal has been endorsed. (See attachment B.)

95-49 The explanation of the purpose of and justification for the proposal has been revised, and the proposal has been endorsed. (See attachment B.)

95-50 Proposal has been revised and endorsed. (See attachment B.)

95-51 Proposal has been endorsed.

95-52 Proposal has been withdrawn.

95-54 Proposal has been withdrawn.

95-55 Proposal has been endorsed.

95-56 The justification for the proposal has been revised and the proposal endorsed. (See attachment B).

95-57 The cost of the proposal has been revised and the proposal endorsed. (See attachment B.)

95-58 Proposal has been revised and endorsed. (See attachment B.)

95-59 The explanation of the purpose of and justification for the proposal has been revised, and the proposal has been endorsed. (See attachment B.)

95-60 Proposal has been withdrawn. Purpose accomplished by enactment of P.L. 484.

95-61 Proposal has been withdrawn.

95-62 Proposal has been withdrawn.

95-63 Proposal has been endorsed.

95-64 Proposal has been endorsed.

95-65 The explanation of the purpose of the proposal has been revised, and the proposal has been endorsed. (See attachment B.)

95-67 Proposal has been endorsed.

95-68 Proposal has been withdrawn. (See Proposal 95-47.)

95-69 Proposal has been withdrawn. (See Proposal 95-47.)

95-70 Proposal has been withdrawn.

95-71 Proposal has been withdrawn.

95-72 Proposal has been withdrawn.

95-73 Proposal has been withdrawn.

95-74 Proposal has been withdrawn.

95-75 Proposal has been endorsed.

95-76 The explanation of the purpose of the proposal has been revised and the proposal endorsed. (See attachment B).

95-77 The explanation of the purpose of and justification for the proposal has been modified, and the proposal has been endorsed. (See attachment B.)

95-78 Proposal has been endorsed.

95-79 Proposal has been endorsed.

95-80 The explanation of the purpose of the proposal has been revised and the proposal endorsed. (See attachment B).

95-81 Proposal has been withdrawn.

95-82 Proposal has been endorsed.

95-83 Proposal has been endorsed.

95-84 Proposal has been endorsed.

95-85 Proposal has been endorsed.

95-86 Proposal has been revised and endorsed. (See attachment B.)

95-87 Proposal has been withdrawn.

95-88 Proposal has been withdrawn. Proposed course of action to be followed instead is described in attachment B.

95-89 Proposal has been withdrawn.

95-90 Proposal has been endorsed.

95-91 Proposal has been endorsed.

95-92 The explanation of the purpose and the justification for the proposal has been modified, and the proposal has been endorsed. (See attachment B.)

95-92A A new endorsed proposal is included in attachment B.

95-92B A new endorsed proposal is included in attachment B.

95-92C A new endorsed proposal is included in attachment B.

95-92D A new endorsed proposal is included in attachment B.

INCOME SECURITY

95-94 Costs have been specified. (See attachment B.)

95-95 Costs have been specified. (See attachment B.)

95-99 Proposal has been withdrawn.

95-100 Costs have been revised to include man-years calculation. (See attachment B).

95-105 Proposal has been withdrawn.

95-108 Costs have been revised to include man-years calculation. (See attachment B.)

95-113 Costs have been revised for items #1, 2 and 4. Item #3, Authorization of Initial Payments to Presumptively Blind Individuals, has been withdrawn. (See attachment B.)

95-114 Statement of purpose of and justification for proposal has been revised. (See attachment B.)

95-117 Proposal has been withdrawn.

95-118 Proposal has been withdrawn.

95-119 Proposal has been endorsed.

95-120 Costs have been specified. (See attachment B.)

95-121 Proposal has been withdrawn.

95-121A A new endorsed proposal is included in attachment B.

95-123 Costs have been specified. (See attachment B.)

95-124 Proposal has been modified. The new proposal is now under consideration and is included in attachment B.

95-127 Proposal has been withdrawn.

95-127A A new proposal is under consideration. (See attachment B.)

95-128 Proposal has been endorsed.

95-130 Costs have been specified. (See attachment B.)

95-131 Proposal has been modified to include all Titles of the Social Security Act and endorsed. The new endorsed proposal will be submitted soon. At this time no significant changes in cost of the proposal is expected.

95-132 Several of the previously submitted proposals have been endorsed, and costs have been specified. (See attachment B.)

95-132A A new endorsed proposal is included in attachment B.

95-132B A new endorsed proposal is included in attachment B.

95-132C A new endorsed proposal is included in attachment B.

95-132D A new endorsed proposal is included in attachment B.

SOCIAL SERVICES/HUMAN DEVELOPMENT

95-136 Cost estimates have been revised. Increases represent an additional $.495 for projects for the Architectural and Transportation Barriers Compliance Board and $.2 for the Office of Handicapped Individuals projects. Also the specific amendments referred to in the original submission are included in attachment B.

95-137 Endorsed proposal has been revised to include authority for the Department to advance fund the State formula grant program as reflected in our budget submission. (See attachment B).

95-139 Out-year costs were not indicated in original submission. The cost for FY 79 through FY 82 continue at the $200 million level. A revised copy is part of attachment B.

EDUCATION

95-146 A typographical error in original submission cited Section 522(b). This should have read 552(b). A corrected copy of this proposal is included in the attachment B.

95-148 Proposal has been withdrawn.

95-149 Proposal has been withdrawn.

95-150 Proposal has been endorsed and revised. (See attachment B.)

95-151 Proposal has been endorsed. A typographical error in original submission indicated that it was Section 810(a)(2) that was being amended. This should have read Section 810(c)(2). A corrected copy of proposal is included in attachment B.

95-152 Proposal has been endorsed and a revised justification is shown in attachment B.

95-153 Proposal has been endorsed.

95-154 Proposal has been endorsed.

95-154A Modified and endorsed proposal is included in attachment B.

95-154B A new endorsed proposal is included in attachment B.

GENERAL

95-155 Proposal has been modified and draft specifications have been written. Copies of both are in attachment B.

ATTACHMENT B

95-1 Health Services Block Grant

The Department is proposing legislation to provide a health services block grant to the States, as described in the attached specifications. In addition, it is proposed that experimental authority be provided in several communities for a program to permit communities to utilize both the block grant funds and Medicaid funds flexibly to finance health services to low income families.

(Revised as of November 17, 1976)

95-1 Health Services Block Grant

I. Introduction

There is agreement on the desirability of proposing legislation to initiate a block grant to the States to aid in funding needed health services, targeted to primary health services for the poor and public health services needed by all. The block grant proposal submitted by the Administration last year was introduced in Congress by Administration request, but no hearings were held and no action taken. There was mixed reaction to the proposal as submitted. There was no support for the inclusion of Medicaid in the block grant. The proposal shifted Medicaid from an open-ended Federal match for State health care expenditures for the poor to a fixed Federal sum. This was interpreted as shifting the burden for control of rising health care costs to the States, or shifting to them the need to find the added funds. On the other hand, there were clear signs of support from the States for a block grant to replace the direct Federal funding of categorical service programs.

The proposal developed this year seeks to retain the desirable features and drop the undesirable. The specifications as proposed follow. Several aspects of timing and funding require comment.

(1) The transition period

The legislative proposal would consolidate 14 current categorical health programs into one block grant. Authority for several of these separate programs expires at the close of FY 1977. A question arises as to how to seek extension authority for FY 1978 as the proposed block grant is under consideration. Complicating this question is the desire to make programmatic changes in several of of these programs so long as they function as separate Federal programs (e.g., the termination of the required 90 per cent support for family planning).

There is the further important issue of allowing a reasonable period of time for Congressional and public consideration of the proposal. We believe it is unlikely that Congress would take conclusive action on the proposal in the first year of the 95th Congress. We therefore propose to seek an effective date for the new law on October 1, 1978 (FY 1979). Thus we would seek extension of expiring authorities through fiscal year 1978.

(2) Advance funding

Consistent with other Department proposals affecting block grants to the States, we would propose advance funding of the Health Services Block Grant. Thus the States could plan ahead for effective use of these funds and for their effective meshing with required State legislative actions on State funds and programs.

(3) The level of the grant

From the outset, it had been anticipated that in the first year of the block grant, States would receive more funds than the total of formula and project funds prior to the date of effectiveness of the block. This increase (referred to in discussions as a "sweetener") was important:

(a) In view of the high rate of inflation in health care costs.

(b) To support modest program growth to meet identified unmet needs.

(c) To make the block grant appealing to the States and project grantees.

However, as the FY 1978 budget evolved, the limitation on total funds for PHS and pressures of other needs led to fixing the level of the block grant at the anticipated Congressional action for FY 1977, thus eliminating the anticipated increase.

In view of the fact that the effective date is proposed as FY 1979, it is recommended that the grant level be about ten percent above the last year of categorical appropriations, i.e., $150 million higher than FY 1978.

II. Purpose

The primary purpose of this legislation is a consolidation and transfer of authority to the States for selected health programs now largely administered by the Federal government. These programs include personal health services for target populations and public health services for all. In addition, this legislation is intended to provide assistance to each State to: (1) develop and utilize preventive health services; (2) promote community health programs; (3) provide personal health services primarily to low income persons with significant financial barriers to access; and (4) improve the delivery of services by abolishing restrictive categorical requirements that have fragmented and impeded efficient delivery of health care. Under current legislation, the Federal government supports health programs through a variety of arrangements, including formula grants to States and project grants to organizations. The current system often requires the Federal government to determine need for a service in a specific geographic area, to select a qualified organization and to monitor the performance of the grantee. There is a principle that the closer the responsibility for decision making is to the people affected, the more responsive the program is likely to be. Under this principle, it is more appropriate for these programs to be the responsibility of the States than the Federal government. State level government can assess priorities of local needs and, as appropriate, pass funding through to local agencies. Indeed transfer of full responsibility for these health programs will enable States to consolidate them with the extensive programs supported by non-Federal funds.

A secondary effect of this proposal will be an increase in flexibility at the State and local levels and an increase in the capacity of non-Federal governmental agencies to administer health programs. Improved capacity is provided through technical assistance and financial support as well as consolidating and focusing authority for health programs. Another secondary effect of the legislation is to streamline the present health programs by reducing the administrative burden. The efficiency of the present health programs can be improved by removing duplicative and inconsistent requirements imposed by Federal funding. Federal financial assistance has been marked by a continued categorization of the aid extended, resulting in each program having its own authorization, appropriation, policy objectives, administrative guidelines, accounting rules, and reporting forms.

There exists a large need for a broad range of public health services and this need will continue regardless of any enactment of comprehensive or limited programs of national health insurance. While this proposal cannot fully satisfy this need, implementation of this proposal will make a contribution toward building the capacity of individual States and their political subdivisions to assume full responsibility for administering the broad range of public health services that will continue to be needed even after national health insurance is implemented.

III. Programs Included

It is proposed to consolidate 14 categorical Federal health service programs into a single health grant to States. The criteria for selection of programs to be included are: categorical and the general formula health grants to States and the categorical project grants that have evolved into grants that support community and personal health services. In general, programs that provide short term assistance for resources development are excluded from the consolidation.

The specific programs replaced by the consolidated grant are displayed in Table 1.

In contrast to the FY 1977 proposal, the health planning program is not included in the consolidated block grant because planning is an entirely different function than delivery of health services. In addition this planning program was enacted recently and is not yet fully implemented. It is expected that the health planning organizations will serve functions important to the Federal government. Under these circumstances, it is not in the best Federal interest to incorporate this program into a block grant; it should be implemented with direct Federal support and not be left to State discretion. Developmental Disabilities (DD) was excluded from this health services proposal because the DD program emphasizes many services that are not health services and the DD funds are utilized for demonstration and resources development projects rather than continuing support for health services. The most significant change is that Medicaid is excluded because

it is impractical to include Medicaid in a health services block at this time. Unlike the programs included in the proposal, Medicaid is basically an open-ended program. This feature makes Medicaid, in its present form, unsuitable for consolidated funding under a fixed budget. Including Medicaid will cause the proposal to be viewed as principally an attempt to transfer Federal obligation to the States and to contain Federal expenditures. Without Medicaid, the proposal will be judged on the merits of program consolidation. In addition, Medicaid is different from the other programs in the proposal because Medicaid reimburses existing providers while the other programs generally support health services in special settings that were established through Federal assistance. Finally, the programs in the health services block grant proposal focus on primary health care but less than 30% of Medicaid expenditures is spent on primary care. Most of Medicaid funds are used to reimburse hospital and nursing home services.

IV. Authorization

The proposal would be authorized for five years. The first year level would be determined as discussed above. Each year thereafter, the sum will be increased by $150 million.

V. Distribution of Funds

To avoid disruptions in health services delivery and to insure an orderly gradual transition of authority, States will be protected for five years from any budgetary reduction, and direct Federal grantees will be protected from large budgetary reductions during the first three years of the program. All new funds to the States will be distributed so as to increase the equity of Federal health funds among States according to unmet needs and available resources.

TABLE 1

Consolidated Health Block Grant

(Dollars in Millions)

	FY 1976		FY 1977
	Appropriation	Percent	Appropriation
Community Mental Health Project Grants (CMHIC)	$ 219	16%	232.8
Alcohol Abuse Project Grants and Formula Grants	124	9%	123.9*
Rat Control	13	1%	13.0
Venereal Disease	20	1%	18.0
Lead Based Paint	4	0.3%	8.5
Immunizations	5	0.4%	13.0
Community Health Centers	197	15%	215.1
Maternal and Child Health (Training, Crippled Children, Hemophilia, Sudden Infant Death Syndrome)	325	24%	350.7
Migrant Health Services	25	2%	30.0
Family Planning	101	8%	113.6
State Formula Grants (314(d))	90	7%	90.0
Emergency Medical Services	34	3%	33.6*
Drug Abuse Project Grants and Formula Grants	174	13%	200.0
Hypertension	4	0.3%	9.0
TOTAL	1,335	100%	1,451.2**

* EMS and Alcoholism figures are estimated.

** Removing roundoff errors the target base figure for the consolidated health block grant is $1,451,350,000.

A. Hold harmless provisions for States

The same level of funding as the last year of the separate programs will be assured as a minimum to each State in the first five years of the block grant. As in the past, it will be up to the State's discretion at what level to fund activities currently supported with formula funds.

B. Hold harmless provisions for direct Federal grantees

All grantees funded directly by the Federal government will no longer receive Federal grants when States assume responsibility for the block grant. Grantees formerly funded directly by the Federal government will retain the same basic missions but must meet the administrative requirements imposed by the States.

Each grantee formerly funded directly by the Federal government will be assured of funding in the first year at the same level as in the base year, except where declining Federal participation is already included in the regulations. In the second year, the level of assured support to each grantee will drop to 75% and in the third to 50%. In the second and third years, residual per grantee support will pass directly to States. After the third year, there is no hold harmless provision for direct Federal grantees.

C. Distribution of new funds

As noted, each State receives no less in each of the first five years than it received in the base year. The question then arises as to how to distribute the new funds provided in each of the first five years. The following principles are proposed:

1. The primary beneficiaries of most of the programs are low-income persons.

2. To the extent that current funding levels to the States do not correspond to the distribution of the low-income population of the country, the new money will seek to correct the imbalance.

3. The redistribution will also recognize prior State effort to meet health needs.

Therefore, the formula for distribution of new funds will take into account low-income population, prior efforts, and health needs. A State whose base amount in any year exceeds the amount it would receive under the formula will not receive any of the new funds and will not be cut back below its base amount during the first five years.

In applying their discretion in the use of new funds and of residual funds available to the States above the guaranteed level to each grantee, the States will be urged to take into account the needs of the low-income population, along with its consideration of other criteria such as special health needs, etc.

VI. Conditions and Requirements

A. Appeals

As funds are transferred to the State, it becomes the source of continuation support for individual projects formerly funded directly by DHEW (together with such other local, area, and private funds as the project can identify). The State, in distributing the block of funds, may believe that it has a valid basis on which a particular grantee should no longer be funded, or should receive fewer funds than the amount guaranteed under the hold harmless provision. These grantees must rely on the appeals provision of the State's administrative procedures and any other appeals provision (including legal recourses) available to all other projects supported by the State. Appeals to the Federal government by individual projects would not be provided. For a State to fund a former Federal grantee at less than the hold harmless provisions, the State shall be required to specify that it is making an exception and to demonstrate that it has (a) promulgated objective performance standards against which the project is clearly deficient; (b) offered technical assistance to improve project performance; (c) held a public hearing relative to terminating support for the project; (d) and developed a plan to ensure that the services offered by the project it proposes be terminated will be available to the project's clientele who require them.

B. State Plans

The process of developing a plan for the block grant shall be closely integrated with the requirements of the Health Planning and Resources Development Act of 1974, P.L. 93-641. That law establishes local and Statewide health planning organizations for "the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs..."

1. Development of Plan

a. The State agency that is designated by the Governor to receive the funds under the block grant will develop a plan for the use of those funds that will become a component of the State health plan developed by the State Health Planning and Development Agency (SHPDA)*

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* HSP, HSA, SHPDA, and SHCC are established by the Health Planning and Resources Development Act of 1974, P.L. 93-641.

In developing the plan for the use of the block grant funds, the designated State agency will confer with the SHPDA, will review the Health Systems Plans (HSP) of the Health Systems Agencies (HSA), and develop a preliminary plan for the block grant. The State Block Plan should delineate the priorities and programs to be developed to meet the community and public health needs of residents of the State and its communities. The plan should be limited to health services, relate offered services to the identified health needs, and give priority to low-income individuals. Locally elected officials must participate in the development of the plan. The State Health Planning and Development Agency (SHPDA)* will review and revise the State Block Plan and integrate it into the State health plan.

b. The Statewide Health Coordinating Council (SHCC)* approves or disapproves this State health plan, which includes the block grant component, as required under P.L. 93-641.

c. Under current provisions of the health planning act, HSAs have a review and approval role where the State makes a grant which includes funds provided under authority of the Public Health Service Act to a locality for public/community health services. The current health planning act provides for an appeal to the Secretary of HEW by an applicant or a grantee whose request is denied by the HSA. Under the law proposed here, no appeal to the Secretary is appropriate and shall not be provided. The applicant's right to appeal shall be in accordance with the provisions of the State's administrative procedures.

d. Under the current provisions of the health planning act, when a SHCC disapproves the State plan, the Secretary may not make Federal funds available under the State plan until he has made, upon request of the Governor of the State which submitted such plan, a review of the SHCC decision. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision. This provision shall apply to the health block grant funds, which are a part of the State health plan.

e. No provision of this proposal shall exempt health services from the appropriate State Certificate of Need laws including any requirements for approval from the HSA.

2. Goals and Contents of State Health Plan

The State's plan for use of the block grant funds shall set forth the specific goals at whose achievement the block grant is directed, a description of the health needs of the residents of the State, a description of the health resources available, a detailed description of the health services to be provided and a description of categories of eligibility. The plan for block grant funds should take into account

the Medicaid State Plan since both focus on low income populations. The State plan for use of block grant funds shall explicitly identify what health services will be provided in each of the following areas:

a. Prevention - including plans for venereal disease control, immunizations, control of lead-based paint poisoning and rodent control.

b. Maternal health, child health, and family planning.

c. Substance abuse - including plans for drug abuse and alcoholism services.

d. General mental health.

e. Comprehensive health services for target populations - including plans for comprehensive health centers and migrant health centers.

3. Publication of State Health Plans

Since the plan for block grant funds will be an integral component of the State health plan, the requirements for wide publication of State health plans and solicitation of public comments that are promulgated for the Health Planning Act will provide the essential opportunity for public input.

C. Maintenance of effort, matching, earmarks, and pass through to local governments

The purpose of this proposal is to consolidate and transfer authority for selected health programs from the Federal government to the States. Assistance is provided to the States which have the flexibility to provide services in the most effective and efficient manner possible including utilizing, as appropriate, local entities such as county health departments. Although there are no Federal requirements for matching, maintenance of effort, earmarks or pass through of funding, the aims of such provisions are achieved by several requirements in this proposed legislation. (1) The objective of adequate attention to the variety of health needs and priorities based on assessment of needs which earmarks are designed to achieve will be dealt with through the requirement for a plan (including public debate of the plan) and explicit comment in the plan on the major functional health areas such as preventive services, substance abuse, family planning, etc. (2) The objective of assuring that funds flow to the local level or to agencies operating at substate levels which pass-through provisions seek to achieve will be dealt with through the hold harmless requirement for former direct Federal grantees as well as through the plan requirement. (3) The objective of protecting against sweeping or politically motivated shifts in grantees or in the level to which funds are provided by the State which earmarks or pass-through provisions seek to achieve will be dealt with both through the hold harmless and the plan requirements.

D. Reporting, Certification, and Enforcement

1) Each State that receives funds under this proposal shall make such reports concerning its use of those funds as the Secretary may by regulation prescribe.

2) These reports shall describe, with respect to the provision of health services financed in whole or in part by State block grant funds - a) a definition of the services provided b) kind, amount, duration, and scope of services to each category of eligible recipients by geographic area c) number of individuals served and expenditures for each eligibility category d) expenditure for each of the types of services e) number of persons eligible for each eligibility category.

3) The Secretary shall periodically publish an assessment of the State block grant plans and the compliance of the States with the plans on the criteria of effectiveness and efficiency. This report shall include a description of the technical assistance furnished to the States and an evaluation of the technical assistance.

95-2 Hospital Cost Containment

There is an urgent need to set a course of actions designed to contain the continued rapid and disturbing rise in the cost of health care, particularly the cost of hospital care. These costs continue to increase much more rapidly than the overall cost of living, and abatement is not likely unless strong action is taken.

The Department therefore proposes this two-stage plan to contain the increase in hospital costs, with both phases based on a strong Presidential initiative.

(1) The President would call upon all third party payors who purchase hospital care to limit increases in their reimbursement rates per admission in FY 1978 to no more than 8 percent above the FY 1977 levels, plus those amounts necessary to cover the costs of new capital and services approved by planning agencies. In particular, he would ask Congress to legislate this change for Medicare and Medicaid and urge Blue Cross plans and commercial insurance carriers to modify their reimbursement agreements accordingly.

(2) The President would also announce that the limits on reimbursement increases would be a two-year emergency measure, and that he would convene a national level working conference to devise appropriate long term measures to contain rising health care costs. The conference would bring together health care providers, consumers, state government and industrial leaders who provide health services or who buy health insurance, organized labor which bargains for coverage, and all other interests. The President would also urge that similar working conferences be convened in the states. The broad outlines of the agendas for these state conferences would evolve from the national working conference. Hopefully, approaches and programs developed in individual states could then be fed back to the national level conferences for discussion and dissemination throughout the country.

I. Structural Characteristics of Hospital Reimbursement. Over 90 percent of all expenditures for hospital services are now paid for by some third party. More than 50 percent of hospital spending is reimbursed based on costs incurred by the hospital in providing services (cost-reimbursement), with another 40 percent paid by insurance companies based on the charges billed by the hospital. Medicare and Medicaid as well as most Blue Cross plans use the cost-reimbursement system. Cost-reimbursement was originally considered the best cost control device for public programs --hospitals would not lose money, nor would they make profits. However, it is now generally recognized that open-ended cost-reimbursement has not encouraged sufficient restraint in spending by health care providers. In effect, the higher the hospital's cost, the higher its reimbursement.

Since the introduction of Medicare and Medicaid, the average cost of a day in the hospital has tripled from $44 per day in 1965 to $137 per day in 1975 compared to only a 70 percent increase in the overall cost of living. During this past year alone, while the overall CPI rose 7 percent, the cost of a day in the hospital rose 16 percent, and the rate of increase is expected to be almost as high in the next few years. These cost-per-day increases alone have added about $2 billion to the budget of public financing programs in FY 1976 and are expected to add an additional $2.5 billion in FY 1977.

As part of its national health insurance proposal, the Administration has advocated, in the past, a cost containment system which included prospectively determined reimbursement limits for hospitals. As an interim measure, and as part of the FY 1977 budget, the Department recommended to OMB a 10 percent cap on permissible increases in per-day hospital reimbursement under Federal health financing programs, which, on the average, represent half of the total hospital revenues. Ultimately, the President recommended a 7 percent limit to Congress. The idea of limiting reimbursement has received considerable attention in the Congress, but the Administration's 1977 proposal had little chance of being adopted. The specific limit was considered unrealistically low, and the proposal, in general, was viewed as unnecessarily harsh because it focused only on inflation in Medicare costs rather than hospital costs in general. It is felt that such a system would place added pressure on Blue Cross and commercial insurance to subsidize costs that are not reimbursed by public programs. A final criticism of the proposal was that it was intended to limit increases in Medicare hospital reimbursement for only two years, with no clear statement of what program, if any, would follow to assure that there was no immediate return to prior inflationary patterns such as occurred following expiration of the Economic Stabilization Program in 1974.

II. Outlines of the Proposal

A. The Short-run "cap":

The President would recommend a target rate of increase in hospital costs in FY 1978, and all third-party payors would be strongly encouraged to participate in the effort. The Federal Government would take the lead, and ask Congress for authority to place "caps" on increases in Medicare and Medicaid hospital reimbursements per admission. Hospitals in states that have their own cost containment programs would be exempted from the Federal system and all their reimbursements would be subject to the provisions of the state system.

The short-term limits would apply only to inpatient costs, thereby adding an incentive for hospitals to use less expensive outpatient departments wherever possible. They would be applied on a per-admission basis, thereby adding an additional incentive for hospitals to reduce lengths of stay. Allowances would reflect both unavoidable increases in current operating costs and the need for some hospitals to add new services and facilities. The system would also be in effect for only two fiscal years to avoid the inflexibility that must inevitably result from a "cap" system on an industry. Finally, the state exemption would encourage states to continue investing in their own hospital cost containment systems.

B. Long-run Cost Containment System:

This system would be a series of state programs developed under Federal guidelines. There would be a residual Federal cost containment program for those states that were either unable or unwilling to develop their own systems. The system would be based on the principle of prospective budgeting for hospitals and would allow the states to include provisions they felt were necessary to assure equity of treatment for all hospitals--e.g., volume and patient mix indices, classification of providers, exceptions, etc. It would also include a great deal of flexibility in the methods to be allowed for budget development and review and the rate setting process itself. A key component in the development of this system would be consultation with interested groups and individuals on both the basic dimensions of the system and its technical details. Such discussions would be based on the need to follow up the short-term cost containment effort with a permanent program that can achieve long-run cost containment.

This two-stage approach to hospital cost containment has the following positive features:

1. It promises an immediate brake to the most recent inflationary cost spiral in hospitals, with savings to the Federal Government in FY 1978 of approximately $685 million under Medicare and $115 million under Medicaid (if implemented by April 1, 1977).

2. It approaches the entire problem directly, and places responsibility on the Federal Government to set an example for the private sector.

3. It encourages greater use of outpatient departments in hospitals, and shorter lengths of stay as well.

4. It allows for regularization of growth in hospital services while a permanent cost containment structure is being developed to take proper account of both the requirements of health care consumers and the long-run needs of the hospital industry.

5. It would be consistent with the goals of improving the fiscal integrity of public programs and of reducing the burden of Federal regulation wherever possible.

6. It is a necessary first-step to prepare for future implementation of national health insurance.

III. The Short-Run System

Basic Allowance: Except for isolated periods during the last two decades, about half of all increases in hospital per admission costs have resulted from increases in wages and prices, and about half have been due to the use of more and more expensive labor and non-labor inputs. During the past decade, too, wage increases for hospital workers have been about 2.7 percent greater than wage increases in the general economy. For most of this period

these extra increases have represented a "catch-up" in a traditionally low-wage industry. Further, each year hospitals have been increasing their labor inputs by about 3 percent per patient-day and non-labor inputs by about 10 percent. The short-run "cap" system will allow hospitals, on average, to increase their reimbursement to recover the following:

1. Increases in wages comparable to those expected by workers in the general economy, i.e., elimination of the ability of hospitals to include in the calculations wage increases for employees greater than the average wage increase for the general economy;

2. Increases in non-labor costs as measured by the expected increase in the consumer price index (all items); and

3. A small incremental fund allowed each hospital for increases in the use of inputs that do not result in increased volume of patients, e.g., more labor or non-labor input per admissions.

These reimbursement increases would be granted to each hospital in a lump sum, with complete flexibility retained by hospital management to determine how much of the increase actually was allocated for each input (labor, non-labor). Thus, while general wage increases would be used in the calculation of the overall limits, increased labor productivity in a hospital, for example, could be rewarded by greater wage increases.

Estimated FY 1978 Allowance - the basic "cap"

Expected increase in wages in the general economy		8.1%
Expected increases in price (total CPI)		5.5%
Weights: payroll	= 55%	
non-payroll	= 45%	

Calculation: 7.0% due to increases in wages and prices
(8.1% X .55 + 5.5% X .45 = 6.9%)

$\frac{1.0}{8.0}$ for added intensity per patient-day
total basic allowance for each hospital

Unit of Measure

Options: 1. Per day
2. Per admission

As under any system in which payments are based on some unit of volume, the incentive is to increase that unit in order to maximize reimbursement. Thus, it is desirable that any limits be placed on a per admission basis, since it is more difficult to arbitrarily or unnecessarily increase the number of new admissions than it is to increase the length of stay for patients already in a hospital. With a per-admission reimbursement limit there is also a strong incentive to reduce length of stay. Therefore, a per admission limit is proposed, with a strong emphasis on utilization review to reduce unnecessary admissions (Option 2).

Adjustments to the Basic Operating Allowance

Options: 1. Allow no adjustments to the basic allowance
2. Allow adjustments for changes in volume/patient mix/energy, etc.,

While in the long-run system it would be absolutely essential to provide for adjustments to the basic allowance, of the type listed above to they would add too much complexity to the short-run system to make it implementable in a short time with minimal additional Federal staff. Further, patient mix indices are still rather crude, and could not be calculated by a number of hospitals because of the primitive nature of their data systems. Thus, these adjustments were not included in the short-run system to allow further time for development (Option 1).

Treatment of Expansion in Capital and New Services

Options: 1. Allow no adjustment for capital expansion over $100,000 that requires an increase in reimbursement in excess of 8 percent per admission.
2. Allow adjustments only out of a fixed pool on a priority basis determined by HEW.
3. Allow adjustments in reimbursement to cover interest and depreciation for expansions approved by appropriate planning agencies.

Allowing no payment for capital expansion at all (Option 1), even for just two years, is unnecessarily harsh, and might result in sufficient opposition to defeat the entire proposal. On the other hand, allocation of a fixed fund for adjustment for new capital expenses (Option 2) would be extremely difficult to administer. Further, changes in hospital capital costs in 1978 will be affected by decisions made as much as 3 years ago. Similarly, decisions made by planning agencies in FY 1977 may not affect rates until 1980 or later. Thus, the only feasible solution is to rely on prioritization and decisions of existing planning agencies. However, past sanctions prohibiting Federal payments for interest and depreciation for non-approved services and facilities whould be strengthened to prohibit all payments by third-party payors for <u>any services</u> provided in facilities with unapproved services or capital.

Under Medicare, new debt service now amounts to approximately $100 million annually. Thus, the combined effect of this allowance for both Medicare and Medicaid might result, on average, in the equivalent of an additional 1 percent in reimbursement per admission. However, this added revenue would not be realized by all hospitals, but only by those with the greatest need for added reimbursement. We therefore recommend Option 3.

Federal-level Exceptions

Options:
1. Allow none
2. Allow exceptions only for negative cash flow and wage inequite problems
3. Allow additional exceptions for previously disapproved capital expansion and new services.

Given the tight basic limitation and absence of adjustments to the rates, it will be necessary to provide an exceptions mechanism for institutions that face severe financial problems. Exceptions should be considered for hospitals that are in imminent danger of closing, i.e., running negative cash flows, and for those hospitals that can demonstrate the need for higher wage increases due to inequities in wage levels of hospital workers compared to other workers in the community. However, it would not be desirable in the short-run for the Federal Government to run an exceptions process to relieve less severe financial pressures that would relieve hospitals of the need to find ways of containing cost increases (e.g. the desire to engage in a number of small service expansions that could not be cost-justified based on the services that they would generate). Nor should the Federal government run an additional exceptions process to second-guess the state and local capital approval process. We estimate the equivalent of 1 percent of reimbursements to be the upper limit of the cost of exceptions. We therefore recommend Option 2.

State Exemption

Options:
1. Allow state exemptions under HEW criteria.
2. Postpone exemptions until criteria for the long-run system are developed.

The long-run cost containment system would be based on the development of state cost containment efforts. Thus, it may not be desirable to encourage state cost containment efforts in the short-run if there is a possibility that the rules may change in two years. However, the time and effort necessary to develop state cost control mechanisms are sufficiently substantial that this concern is not very real. Most states that might be able to qualify for the exemption within the next few years, regardless of the specific criteria for approval, have already invested major resources, and have already submitted proposals for developmental or operational system contracts under the Social Security Act and Public Health Service Act provisions for demonstrations and experiments in prospective reimbursement and state rate regulation. These are just the types of systems that could be envisioned as being consistent with the goals of both the short-run and long-run cost containment programs. Therefore, any short-term criteria that might be established for approval of these programs should reinforce state efforts rather than hinder them. Thus, state exemptions should be included in the short-run "cap" system. We therefore recommend Option 1.

Future of Section 223 (P.L. 92-603)

Options: 1. Repeal Section 223.
2. Continue Section 223.
3. Expand Section 223 coverage to total costs.

Current Section 223 regulations limit Medicare reimbursement for routine inpatient hospital costs based on the costs in a group of comparable hospitals. They add an important component of cost control that would not be redundent under the short-run "cap" system which limits only the rate of increase in hospital costs, and does not affect the base level of costs. Therefore, they should not be ended. On the other hand, while expansion of the Section 223 limits to total costs could be considered as a reasonable component of the long-run system, existing methods of classifying providers at the national level are not yet sufficiently developed that they can be immediately applied without adding a significant administrative burden. Efforts in this area should continue, with expansion of Section 223 limits to total costs as soon as it is feasible. We therefore recommend Option 2.

IV. Considerations in the Long-Run Approach

It is clear to all who have proposed efforts to contain rising hospital costs that there are multiple forces at work, varied incentives, complex pressures, alternative value choices, and difficult economic and social decisions to be weighed. Thus, it must be recognized that solutions will inevitably be multiple, probably complex, and surely difficult to implement. Nevertheless, it is possible to outline an agenda for discussion of courses that hold promise of effective results.

A. Principles:

Two related principles are proposed to guide the choices that must be made.

1. Essentially Voluntary Action

Insofar as possible, the courses followed should avoid blanket and arbitrary regulatory control by governmental bodies. The professions, the industry and those involved in managing and financing health care delivery systems should be brought together for common voluntary action.

2. Authority to Execute Plans and Monitoring Programs

Relying entirely on voluntary action by each independent element of an interrelated health sector is bound to result in some inefficiency, and cannot by itself achieve the economies and increased efficiencies that we need. There needs to be some body or bodies, operating independent of the industry, with the ability to resolve differences, represent community needs and

interests, and ultimately make and enforce such decisions to limit or reallocate services or reimbursements as may be necessary to realize community needs.

B. Program Elements:

The following are suggested elements for a long-run program of cost containment. Many of these program elements are under development or are partially in place. They may require strengthening, more time to mature, monitoring or modification as experience reveals weaknesses, or replacement by other mechanisms if they fail.

1. Utilization practices: The PSRO Program and Benefit Provisions
   a. Appropriate professional and patient decisions on services
   b. Appropriate placement of patients
   c. Benefit provisions that encourage efficient and economical utilization, e.g., ambulatory care, preventive services
   d. Competition among providers (e.g., advertising)

2. Community Need: The Health Planning Process and Efficiency
   a. Supply and organization of community resources
   b. Organization of delivery of care - the HMO

3. Efficient Production of Services
   a. Development of lower cost technologies
   b. The care function (Use of paraprofessionals)
   c. Industrial engineering/efficiency/productivity

4. Impact of the Financing and Reimbursement Systems
   a. Prospective methods of inpatient reimbursement
   b. Approaches to reimbursement per episode
   c. Capitation systems
   d. Influence of cost-sharing
   e. State role in rate setting
   f. Considerations in national health insurance alternatives
   g. Classification of providers

5. Medical Practice Philosophy: The Health Manpower Program
   a. The approaches, principles and techniques conveyed by the medical education experience, e.g., greater stress on prevention, ambulatory care, etc.
   b. Continuing education

6. Quality: PSRO and Other Activities
   a. Improvement of medical practices
   b. Review of efficacy of treatment procedures
   c. Development of new (and lower cost) technologies
   d. Review of standards (e.g., life safety requirements)

7. Long-Run Influence on Practices of Consumers: The Health Education Program

   a. Appropriate decisions on use of health care personnel and facilities

   b. Understanding of cost effective insurance purchase and use

   c. Understanding of cost-sharing arrangements

   d. Understanding of personal practices for disease prevention and management

Cost: Savings in FY 1978 of approximately $685 million under Medicare and $115 million under Medicaid.

HEALTH ENDORSED-PROPOSAL

95-3 Medicare Catastrophic Coverage/Cost-Sharing

Proposal: Provide Medicare beneficiaries with protection against catastrophic illness costs and implement a more rational cost-sharing structure by:

Part A - Inpatient Care

Limiting annual beneficiary out-of-pocket costs for covered services to $500 in CY 78, increased annually in proportion to increases in health care costs.

Establishing ten percent coinsurance on all charges above the deductible.

Extending the benefit package to include unlimited hospital and skilled nursing facility (SNF) days.

Part B - Physicians Services

Limiting beneficiary out-of-pocket costs for covered services to $250 in CY 78, increased annually in proportion to increases in health care costs.

Increasing the deductible to $80 in CY 78 increased annually in proportion to increases in Social Security cash benefits (a dynamic deductible).

Imposing ten percent coinsurance on all hospital-based physician and home health service charges.

Purpose: To provide Medicare beneficiaries with protection against catastrophic illness costs by expanding the Part A benefit package to include unlimited hospital and SNF days and limiting annual Part A and Part B beneficiary out-of-pocket costs to $500 and $250, respectively. A more rational cost-sharing structure is also proposed which will pay for the catastrophic protection by providing incentives for more efficient utilization of health services.

(Revised as of November 17, 1976)

Justification: The present Medicare cost-sharing and benefit structures are inefficient because they encourage unnecessary institutionalization while at the same time not providing beneficiaries with protection against catastrophic illness costs. Currently, under Medicare Part A, once a beneficiary has paid a $104 hospital deductible ($124 in CY 77), he has no cost-sharing until the 61st day of hospitalization or the 21st day of SNF care. In addition, after a beneficiary has spent 90 days in a hospital or 100 days in an SNF during a benefit period and has used up his 60 lifetime hospital reserve days, his Medicare hospital and SNF benefits terminate. Thus, beneficiaries have few financial incentives to limit unnecessary hospitalization (or SNF care) during short stays and have the major part of their cost-sharing (which is potentially unlimited) fall at the end of a long hospital stay when they are least able to pay for it.

A related undesirable consequence of the current cost-sharing structure is that it encourages the use of expensive institutional services over less expensive ambulatory care. This occurs because hospital care is free until the 61st day (once the deductible is met), while Medicare Part B ambulatory care is subject to 20 percent coinsurance (once the annual $60 deductible is met).

This proposal is designed to remove these undesirable incentives by imposing a more rational cost-sharing structure and giving beneficiaries protection against catastrophic illness costs. In particular, the 10 percent coinsurance on all Part A (hospital, SNF, and home health) service charges above the deductible will discourage unnecessary utilization of institutional services by requiring beneficiaries with short hospital stays to pay a small share (10 percent) of the actual costs of the services received. On the other hand, all beneficiaries will receive catastrophic protection in the form of unlimited hospital and SNF days and a $500 limit on out-of-pocket expenses for covered services.

Similarly, beneficiaries will receive catastrophic protection against physician and other outpatient expenses by having their cost-sharing liability for covered Part B services limited to $250. A ten percent coinsurance will also be imposed on all Part B hospital-based physician and home health service charges to coincide with the ten percent Part A coinsurance in Part A home health and in the use of combined billing by hospitals and hospital-based physicians.

The Part B dynamic deductible maintains the integrity of the deductible as an initial cost to be borne by the beneficiary, deterring unnecessary utilization, and helps finance the catastrophic protection.

This proposal is identical to the Administration's catastrophic proposal introduced last year with two exceptions. First, the Part A and Part B catastrophic limits will increase annually in proportion to increases in health care costs, not Social Security cash benefits. Last year's proposal, by tying increases in the catastrophic limits to increases in cash benefits, would have resulted in major long-run financing problems for the Medicare Trust Funds. This would have occured because program outlays would be increasing in proportion to health care costs while the beneficiaries' out-of-pocket liability would be limited to increases in cash benefits. The overall result is that the Medicare program would pay for an increasing proportion of the health care costs of the elderly. Increasing the catastrophic limits in proportion to increases in health care costs alleviates this problem.

The second change in this proposal concerns the timing of the implementation. Last year's proposal would have been phased-in in such a way that a $300-$400 million program saving would have occurred in the first year. We propose a phase-in that results in no net first-year costs to the program or beneficiaries in the aggregate. There will, however, be some program costs in future years, since on an incurred basis (full year effects for all proposals), the catastrophic provisions cost more than the outlay reductions induced by the cost-sharing proposals. In the first full year, FY 79, program costs will increase by about $160 million.

Ironically, even though this proposal is somewhat less liberal than last year's (because the catastrophic limits will rise at a faster rate—health care cost versus Social Security cash benefits), it still is a significant expansion of Medicare benefits. Partially because of the first-year budget saving and the incidence of the costs and benefits (e.g., most beneficiaries would have to pay more while only a relatively small number would benefit from the catastrophic provisions), last year's proposal was soundly criticized. By being fiscally neutral in FY 78 and increasing benefits in future years, this proposal is an expansion of benefits and should be presented as such. The only legitimate rejoinder to the criticism that the proposal will help relatively few beneficiaries while leading to increased out-of-pocket costs for a large majority is that this is what the concept of insurance is all about.

Cost: None in 1978, $160 million in 1979.

95-6 Extend Migrant Health Program

Purpose and Justification: To amend Section 319, Subsection (h) of the PHS Act, Migrant Health, to continue providing health care to migrants for one year (prior to enactment of the block grant).

Cost:

Budget Authority
(In Millions)

FY				
1978	1979	1980	1981	1982
$44.0	--	--	--	--

HEALTH-ENDORSED PROPOSAL

95-11 Population Research

Purpose: To increase the FY 1977 authorization level to $60 million of Section 1004(b)(1) and extend the authorization for fiscal years 1978 thru 1980 at an authorization of $80 million.

Justification: The requested increase and extension of population research would maintain and continue the important advances that are being made in contraceptive development, contraceptive evaluation and behavioral sciences programs.

Cost:

Budget Authority
(In Millions)

FY				
1978	1979	1980	1981	1982
$ 60	$ 75	$ 80	$ 80	$ 80

(Revised as of November 12, 1976)

HEALTH-ENDORSED PROPOSAL

95-16 Protection of Confidentiality of Research Design and Protocols and Preliminary Scientific and Clinical Trial Data

Purpose: To provide statutory authority enabling the Secretary of HEW to close the Advisory Committee meetings held for reviewing biomedical and behaviorial research grant application and contract proposals, and to withhold preliminary scientific and clinical trail data. The recently enacted Government in the Sunshine Act (P.L. 94-409) deals with this subject, but we believe does not specifically provide the needed protection. Therefore, NIH recommends that we seek statutory authority to protect the contract and grant proposal review processes and the protocols, and preliminary scientific and clinical trial data.

Justification: The Department has been using the Freedom of Information Act exemptions 4, 5, and 6 to close research grant application and contract proposal meetings to the public; however, these exemptions have been challenged in courts and before Congress.

Cost: None.

(Revised as of November 12, 1976)

95-43 Hansen's Disease

Purpose: To provide for termination of "leprosy duty" pay differential for PHS employees whose assignments require intimate contact with persons afflicted with Hansen's disease, and to modernize the terminology referring to leprosy.

Justification: Modern medical science indicates minimal hazard is involved and thus incentive pay is an anachronism; it also provides more appropriate terminology regarding this disease. However, it is proposed that a grandfather clause be included to continue the pay differential to those employees receiving it at time of enactment of the proposal.

Cost: Savings negligible.

(Revised as of November 12, 1976)

95-46 Health Legislation Submitted or Proposed for Submission to the 94th Congress

1. Amend Social Security Act to improve State medical assistance utilization control programs.

2. Transfer of St. Elizabeth's Hospital to D. C.

3. Improving coordination between governing bodies for health planning and their public regional planning bodies or units of general local government.

4. Permitting each State's Governor to appoint the chairperson of the Statewide Health Coordinating Council.

5. The omnibus amendments to the Food, Drug and Cosmetic Act.

(Revised as of November 12, 1976)

95-47 Long-Term Care Demonstration

Purpose and Justification: This legislation would authorize a three-year demonstration program, in the form a block grant to selected States, to demonstrate alternative approaches for administering long-term care now provided under Medicaid.

There is reasons to believe the administrative reforms hold very useful potential for improving the Medicaid long-term care program. The identification or establishment of local community agencies with a function to rationalize the use of resources holds promise of achieving two desired goals: containment of costs, with appropriate placement of handicapped persons in their interest. The responsibility of the community referral and placement agency would be to utilize a fixed sum to arrange for the appropriate use of home health services, skilled nursing homes, intermediate care facilities and other resources. Thus, the program would consist of a block grant to the State for purchase of services, plus an additional sum to finance the community agency services.

Several States, representing up to 20 per cent of all Federal Medicaid long-term expenditures, would be selected for the demonstration of alternative administrative approaches. Federal financing would be pre-determined during a three-year demonstration period at levels based on FY 78 expenditures by participating States.

During the period of the demonstrations, authority would be granted for States to experiment with alternative institutional and home health accessing mechanisms under both Medicare and Medicaid. For example, the States would be authorized to waive the Medicare three-day prior hospitalization requirement for eligibility for Skilled Nursing Facility benefits, and to waive the homebound requirement for eligibility for Medicare home health services.

If successful, at the end of the three-year period, the long-term care component of Medicaid would separated from the remainder of Medicaid, and funded through a mandatory block grant to States at an annually fixed level.

Cost: It is assumed that the legislation would be effective in FY 1979. The cost of the Medicaid services in the demonstration

States would be estimated on the same basis as if the demonstration were not taking place. It is assumed that the demonstration would lead to containment of the increase in costs in future years, but not during the demonstration period.

The added cost for support of the demonstrations (principally for funding the community agency services) is estimated at $50 million per year (FY 1979, 1980, 1981), assuming coverage in States expending about 20 per cent of Federal Medicaid long-term care funds.

HEALTH-ENDORSED PROPOSAL

95-48 Extend Authorization for the Community Mental Health Centers Act

Purpose: To extend the authorization for the Community Mental Health Centers Act for one year (prior to enactment of the block grant).

Justification: The support authorized in the 1975 amendments does not allow a sufficient period of time to complete implementation of new services in catchment areas where there are no community mental health centers. This proposal will extend the authorizations for planning, initial operation, consultation and education services, financial distress and the conversion assistance authority for assistance one year.

Cost:

Budget Authority
(in millions)

	FY			
1978	1979	1980	1981	1982
$ 94	—	--	--	--

(Revised as of November 12, 1976)

HEALTH-ENDORSED PROPOSAL

94-49 Extend Hemophilia Program

Purpose: To extend the Hemophilia program authorized under P.L. 94-63 for one-year through FY 1978.

Justification: This extension is required to allow time to determine how the PHS obligations for treatment centers and blood separation centers authorized by P.L. 94-63 relate to, or are affected by, the new genetic disease authority in P.L. 94-278, authorizing testing, counseling, research, education, and training.

Cost:

Budget Authority
(In Millions)

FY	
1978	
$3.0	

(Revised as of November 12, 1976)

95-50 Expansion of Rate Review Programs

Purpose: To expand the rate review demonstration authority under P.L. 93-641 to allow up to 14 States willing to participate to receive grants, rather than just 6 States permitted under the existing statute.

Justification: Encourages more States to develop cost containing health rate regulation programs, and provides States with an incentive to participate in cost control programs.

Cost:

Budget Authority
(in Millions)

	FY			
1978	1979	1980	1981	1982
$ 2	$ 6	$ 10	$ 12	$ 12

(Revised as of November 17, 1976)

95-56 Home Health

Purpose: To extend the home health authorization of P.L. 94-63 for four years through 1980.

Justification: P.L. 94-63 authorized grants for the start-up and expansion of home health agencies and a training activity. The primary purpose of the legislation is to stimulate the growth and development of home health services and to determine their cost-effectiveness and efficiency through a special demonstration assistance program. This authority was for FY 1976 only, and $3 million was appropriated. The appropriation period was extended through the transition quarter and 56 home health developmental grants were made by the Bureau of Community Health Services. A one-year extension through FY 1977 was included in the HMO amendments (P.O. 94-460). Additional time is needed to carry out the program.

Cost:

Budget Authority
(in millions)

FY 1977	FY 1978	FY 1979	FY 1980
$ 3	$ 3	$ 5	$ 5

(Revised as of November 17, 1976)

95-57 Authorize Grants for Emergency Health Care Services During Natural Disaster and Similar Situations

Purpose: To authorize the Secretary to make grants to State and local agencies to help them provide emergency health care services necessitated by natural disasters and epidemic diseases to be used only in conjunction with the Disaster Relief Act of 1974.

Justification: Since the repeal of Section 314(e) of the Public Health Service Act, PHS has had no legislative authority to support these services.

Cost: No funds are being requested. However, if an emergency should arise, a request for reprogramming or a supplemental would be made to Congress.

(Revised as of November 17, 1976)

95-58 Coast Guard Medical Services

Purpose: To amend Section 326 of the Public Health Service Act to delete the obligation of the PHS to provide hospitalization and medical, surgical and dental treatment to Coast Guard personnel and to transfer the budget authority from DHEW to DOT budget.

Justification: In the past, PHS provided physicians to staff Coast Guard units and paid for contract medical services for Coast Guard out of funds in the PHS budget. The PHS and DOT have reached agreement to transfer budget authority from HEW to DOT for these functions.

The purpose of this proposal is to ensure that PHS does get reimbursed for this treatment.

Cost: Not yet determined.

(Revised as of November 17, 1976)

HEALTH-ENDORSED PROPOSAL

95-59 Migrant Health Jointly Funded Projects

Purpose: To amend Section 319 of the PHS Act to eliminate obstacles to joint funding of projects by modifying the provisions concerning the composition of the governing board of an entity which receives a grant for migrant health services but also provide services to non-migrants, and by eliminating restrictions on the distribution of migrant funds among the different types of migrant grantees.

Justification: PHS, particularly through its Rural Health Initiative, provides funds to agencies to serve both migrants and resident populations. Joint funding is impeded by restrictions in current law concerning the percentage of migrant funds that can be made available to different types of migrant grantees. Current law also is rigid on the composition of the governing board of a center receiving a migrant health grant, requiring that the board represent migrants. In order to permit a center to serve all groups, it will be necessary to amend the law to provide for a balance in representation on the board, including migrants and non-migrants.

Cost: None.

(Revised as of November 12, 1976)

HEALTH-ENDORSED PROPOSAL

95-65 Authority of Director of NIH to Reprogram Funds

Purpose: To include pertinent language in the appropriation act to authorize the Director of NIH, in conjunction with the proposed National Research Advisory Board, to reprogram up to 1% of research and development funds of any institute appropriation.

Justification: The reprogramming of funds will enable NIH to increase program flexibility.

Cost: None.

(Revised as of November 12, 1976)

95-76 Change in Limitation of Assistant Surgeon General Grade, and Above, Positions

Purpose: To amend Section 205 of the Public Health Service Act to change the statutory limitation on the number of Assistant Surgeon General positions to 60, rather than the present limitation of 3/4 of 1% of the active duty Corps. (Currently this would be 39 positions.)

Justification: Since the enactment of the statutory limitation in February 1948, there has been a tremendous expansion in health programs, functions and responsibilities; as a result, the number of Assistant Surgeon Generals is inadequate to meet the needs of the Public Health Service.

Cost: Negligible.

HEALTH-ENDORSED PROPOSAL

95-77 Make Medicaid and Medicare Fraud a Felony

Purpose: To increase the penalty for defrauding the Medicaid and Medicare programs from a misdemeanor to a felony. The penalty for a misdemeanor is not more than 1-year in prison or a fine of not more than $10,000 or both.

Justification: It is suggested that increasing the penatly for defrauding the Medicaid and Medicare programs to a felony will have two desirable effects. First, the increased penalty will discourage medical care providers from engaging in fraudulent practice. Second, it will increase the willingness of the Justice Department to prosecute Medicaid and Medicare fraud.

The Department has supported a felony penalty for fraud under the Medicare and Medicaid programs in its testimony on the original Medicare-Medicaid Anti-Fraud Amendments (H.R. 15536) and in its internal deliberations on Section 45 of the Talmadge Bill. This provision was deleted by Congress from the Inspector General bill at the close of the last session.

Cost: None.

(Revised as of November 12, 1976)

HEALTH-ENDORSED PROPOSAL

95-80 Revision to Narrow the Scope of the Term "Indirect Provider"

Purpose: To amend Section 1531(3) of the Public Health Service Act to redefine "indirect provider" to exclude: (a) members of the immediate family of a provider; (b) persons employed by, or having fiduciary interest, in a health care institution which does not have as its principal function the provision of health care or health manpower training; and (c) individuals who were appointed to serve as bona fide "consumer" members on the boards of health provider institutions or organizations.

Justification: The present statutory definition of an "indirect provider" is too broad, and results in classifying many non-providers as providers on the basis of any association, however peripheral or in whatever capacity, such individuals may serve.

Cost: None.

(Revised as of November 17, 1976)

95-86 Allow Physical Therapists and Speech Pathologists and Occupational Therapist to Develop Treatment Plans for the Delivery of Outpatient Speech Pathology and Physical Therapy Services Under Medicare

Purpose: Eliminate the requirement that a physician must detail the amount, scope, and duration of physical therapy, speech pathology and occupational therapy services to be provided in order for the care to be covered under the Medicare out-patient benefits. The requirements for physician referral for such treatment and general periodic review of the plan of treatment would be retained.

Justification: These are often in a better position to diagnose the needs of a patient than a physician. This proposal would remove the inconsistency between the statutory requirement, and actual practice by allowing the therapist or speech pathologist to prepare the treatment plan. The physician would still maintain general control over services provided through physician referral and periodic review.

Cost: None.

95-88 Repeal Benefits of Merchant Seamen at PHS Facilities

Efforts have been made over a number of years to terminate the anomalous system under which the Federal government, through PHS, continues to operate eight general hospitals whose primary patients are merchant seamen receiving free hospital and medical care.

Plans by the Administration to transfer these hospitals from federal to local control and use, or to close them, have been blocked by Congressional, special interest and local pressures and actions. Legislation currently in force (P.L. 93-155) prohibits the Department from taking any action to transfer or close the hospitals until Congress authorizes it, and requires any proposed action to be accompanied by unqualified approval by the State and area planning agencies. In fact, the Department is required by this statue to maintain services in the eight hospitals at the level and range of 1973 services.

During the recent discussion of this issue, it was suggested that the approach to be taken to resolve this issue be in the form of legislation to repeal the special benefit which merchant seamen have for free hospital and medical care. In examining this proposal, the following should be noted:

> The Nation is moving with increasing coverage for federal beneficiaries in the direction of universal comprehensive national health insurance, and this proposal should not be made except as a part of such legislation. The proposal is predicated on the assumption that the Merchant Marine is a typical privately employed group who should receive benefits through the private sector. In fact, the employment picture of the Merchant Marine is not clear. The percentage of seamen who are close to indigent is not known; unemployed merchant seamen are usually not eligible for Medicaid, for example, and, except for care in PHS facilities, would represent an underserved population. An inevitable increase in the federal subsidy to the Merchant Marine would be required because of the increased cost to provide private health insurance benefits for merchant seamen if their federal beneficiary status were removed. Furthermore, the federal medical benefits for merchant seamen continue to

provide a system for continuity of care which protects the public from the potential spread of infectious diseases; any system proposed to supplant it should meet those requirements.

The political objections to such proposals over the last 20 years have been formidable, not only from the regions in which PHS hospitals and clinics are located, but from the beneficiaries, their representatives, the health professional schools which have training affiliations with the PHS facilities, and from a broad spectrum of members of Congress. Further assessment of these substantive and political drawbacks should be undertaken before this legislative proposal is sent on to OMB.

One further observation merits consideration — that is, whether means can be found to overcome the "confrontation" obstacles in the path of a solution. Over a period of years, many of the former PHS hospitals have in fact been closed. This success was achieved in the absence of Administration directives to force the closing of all of the hospitals or some of the hospitals. It is conceivable that careful, sensitive and cooperative work in each community separately could produce successful results in at least several of the cities. This effort would need the leadership of Department staff committed to the objective. The Department has concluded that this is the course to follow.

95-92 Indian Health Service

The Department is proposing two changes regarding the Indian Health Service:

a) Open Indian Health Services in remote areas to non-Indians when space is available by making them community hospitals.

b) Provide rental guarantee for housing constructed for PHS personnel living on Indian reservations, and transferring to Indian tribes Indian Health Service housing now owned by the government, and renting the housing for PHS employees from the tribes.

Cost: Not yet determined.

(Revised as of November 12, 1976)

HEALTH-ENDORSED PROPOSAL

95-92A Redesignation of PSRO Beyond Initial Trial Period

Purpose: To amend Section 1154(b) of the Social Security Act to authorize the Secretary to redesignate PSROs on a conditional basis for two additional 24-month periods beyond their initial 24-month conditional period.

Justification: The Social Security Act requires that the Secretary initially designate an organization as a PSRO "on a conditional basis with a view of determining the capacity of such organization to perform the duties and functions (of a PSRO)." Section 1154(b) limits the conditional period to 24 months. Most PSROs have had significant problems in implementing review and many of these problems are related to external events beyond the control of the PSRO. If a PSRO cannot be redesignated on a conditional basis, it would have to be terminated and the Department would have to seek another organization with which it would enter into an agreement. For expeditious implementation of the PSRO program, there is a need for the authority to redesignate PSROs on a conditional basis.

Cost: None.

95-92B Repeal of Special Construction Authority of the National Center for Health Services Research

Purpose: To repeal Section 305(b)(3) of the PHS Act which gives the National Center for Health Services Research authority to support research and demonstration projects respecting "the design, construction, utilization, organization, and cost of facilities and equipment."

Justification: This section authorized the National Center for Health Services Research to support research and demonstration projects respecting "the design, construction, utilization, organization, and cost of facilities and equipment." In recent years, the Congress has Children's Hospital, Georgetown University Hospital and Rogers Memorial Hospital. It was never the legislative intent that this provision should be the basis for a general construction assistance program. Since we are proposing the medical facilities program to provide grant assistance in the modernization of facilities, we recommend that Section 305(b)(3) be repealed.

Such authority for research and demonstration as may be considered desirable should be included in the construction program, not in NCHSR.

Cost: None.

HEALTH-ENDORSED PROPOSAL

95-92C Technical Amendments Relating to the National Heart, Blood Vessel, Lung, and Blood Diseases Authority

1. Purpose: To amend Section 491A(a) to correct an erroneous reference to Advisory Council recommendations, i.e., to cite Section 418 instead of Section 414.

   Justification: This proposal is a technical correction of an erroneous reference added by P.L. 92-423. As paragraph 419A(a) presently reads, it refers to Section414 which used to describe Advisory Council functions (several years ago) but which in the present codification provides for prevention and control program authorizations. In order for the paragraph to be accurate, it should reference section 418, which currently describes Advisory Council functions.

2. Purpose: To amend Section 417(a)(1) to provide that the Director of the Office of Science and Technology Policy, rather than the Director of the National Science Foundation, serve on the National Heart, Lung, and Blood Advisory Council.

   Justification: The National Heart, Blood Vessel, Lung, and Blood Act of 1972 (P.L. 92-423) provided for the Director of the Office of Science and Technology to be an ex-officio member of NHLBI's Advisory Council. Because the White House Office of Science and Technology was abolished in 1973, P.L. 94-278 substituted the Director of the National Science Foundation, who also served as the President's Science Adviser. However, now that P.L. 94-282 has reestablished an Office of Science and Technology Policy, it is appropriate that the OSTP Director serve as the President's science policy representative.

   Cost: None.

HEALTH-ENDORSED PROPOSAL

95-92D Extend the Appropriation Authorization for Research Training

Purpose and Justification: To extend the appropriation authority through FY 1980 for the National Research Services Awards (NRSA) research training programs of NIH, ADAMHA and the Division of Nursing of HRA. The present authority expires at the end of FY 77.

Cost: The proposed authorization level under this authority for FY 78 is $128 million. The cost for the out-years has not yet been determined. (In addition, for FY 78, $20 million will be budgeted for phase-out of training commitments made under the previous authority in Section 301 of the PHS Act.) The policies which would be followed would provide for a reduction in the level of pre-doctoral training and for the same total number of awards for post-doctoral training.

95-94 Revision of Social Security Benefit Structure (Decoupling)

Purpose and Justification: The Administration's decoupling proposal, introduced in June 1976, is designed to correct the flaw in the social security system which, under current economic assumptions, overadjusts benefits for inflation. It is expected to produce replacement rates--benefits as a percent of preretirement earnings--that remain constant through time at approximately the levels that prevail when the new system becomes effective.

The Department is recommending that the Administration's decoupling proposal be resubmitted for consideration in 1977 without any major program changes. However, we recommend that the effective date of the proposal be advanced to January 1, 1979, to allow sufficient lead time for implementation. As a result, the proposal will not have any impact in FY 1978.

Cost:

Budget Authority
(in millions)

Program Costs
(effective date 1/1/78)

	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982
Costs	$ 70	$240	$220	$100	$ 60
Long-Range Savings	Approximately 3.95% of taxable payroll.				
Administrative Costs/ Man Years	$20.7 1300	$13.6 880	$13.6 880	$13.6 880	$13.6 880

(Revised as of October 19, 1976)

95-95 Eliminate the Monthly Retirement Test

Purpose: To eliminate the monthly retirement test so that social security benefits are paid only to individuals whose annual earnings fall below the annual exempt amount.

Justification: Under current law, the OASDI retirement test requires that an individual's annual earnings fall below an annual exempt amount before he becomes eligible for social security benefits. In addition, there is a monthly exception so that a beneficiary may qualify for benefits in any particular month in which his monthly earnings fall below a certain level.

This monthly exception creates several problems. It is confusing to the public. It results in some individuals with high annual earnings remaining eligible for benefits for particular months. Lastly, it is subject to manipulation in instances when individuals are able to lump their earnings into particular months in order to remain eligible for benefits in other months. This proposal will promote equity by insuring that individuals with annual earnings above the exempt amount do not qualify for benefits denied to other individuals who do not have uneven monthly income flows.

Cost:

Budget Authority
(in millions)

Effective Date
1/1/78

	FY 1978	1979	1980	1981	1982
Program Savings	$ 91	$278	$301	$324	$347
Long-Range	.01% of taxable payroll.				
Administrative Savings	$ 3	$3.2	$3.2	$3.2	$3.2

(Revised as of October 19, 1976)

95-100 Limitation of Variations in Federally Administered State Supplements (SSI Study Group Recommendation)

Purpose: Federally administered State supplemental benefits should be limited to one level of supplementation in a State, (except that no federally administered supplement would be paid to recipients living in Medicaid institutions). Administration of any additional supplementation based on living arrangements or special needs of recipients, should be returned to the States.

Justification: The Study Group believes that this proposal is in accordance with the intent of Congress that a federally administered State supplement should be a uniform amount, and that supplementation to meet exceptional needs of some individuals, such as the cost of non-medical insitutional care, should be administered by the States. The Study Group believes that the purpose of the federally administered program is to provide a basic uniform income, and that States should retain responsibility for any additional assistance needs that vary by individual circumstances.

Present federal regulations permit variations in State supplemental benefit levels by category (aged, blind or disabled), and by up to five living arrangements, and two or three geographic areas within a State. The administration of a number of variations requires that information be obtained in addition to that needed for administration of the basic federal program, and is subject to error because of unreported changes or inadequate information when recipients move.

SSA made a similar proposal in a September 1975 memorandum to the President, as a means of simplifying administration of the State supplement. The SSA proposal would (1) limit federal administration of a State's supplement to one amount for each category (aged, blind or disabled) for individuals, and one amount per category for eligible couples; (2) provide that federally administered supplementary payments would not be made to recipients, whose federal SSI benefits are determined subject to the $25-a-month benefit standard provision for individuals in Medicaid institutions; and (3) repeal the provision of law that allows a State with a federally administered supplement to elect additional income disregards, and stipulate that State payment amounts will be determined for purposes of making the federally administered payment under the income rules applicable to the SSI benefit.

(Revised as of October 19, 1976)

Cost: No change in program costs. Proposal would result in administrative savings of $6.5 million/385 man years and reduce the error rate by 0.5 percentage points.

95-108 Exclusion of Interest and Dividend Income

Purpose: Provide that interest and dividends derived from an individual's resources will be excluded from unearned income in determining an individual's SSI eligibility and benefit amount.

Justification: Under present law, interest and dividend income which are received frequently and regularly must be considered each time such payments are reported (or discovered). The frequency of these redeterminations complicates administration. Interest and dividend income are also a frequent source of overpayments which require additional time and processing to correct.

This proposal would significantly simplify program administration, and would reduce the error rate attributable to overpayments and payments to ineligibles by about .3 per cent. The amount of income excludable would be limited by the ceiling on countable resources ($1,500 for an individual and $2,250 for a couple) that can produce this income. About 25,000 SSI recipients have some income from interest and dividends.

Cost: Program costs: $3 million a year.

Administrative savings: $1.2 million a year/73 man years per year.

(Revised as of October 19, 1976)

The Department has previously endorsed a number of the SSI provisions contained in H.R. 8911. Although this bill passed the House, the Senate did not take action on these provisions during the last session of Congress. As such, the Department will submit these proposals for FY 1978:

95-113 SSI Proposals Which Were Contained in H.R. 8911

1. Change an Individual's Eligibility for SSI to a Monthly Basis from a Calendar Quarter

   Purpose and Justification: This proposal would change the period over which an individual's eligibility for SSI benefits is computed from a calendar quarter to a month, and will simplify administration. This proposal is also incorporated into proposal 95-102.

   Cost: Cost is now under review.

2. Eligibility of Individuals in Certain Medical Institutions

   Purpose and Justification: To amend the provision in Title XVI under which a recipient's monthly benefit is reduced to $25 during any entire month in which he or she is in a medical facility receiving Medicaid payments, such that the reduction would not occur until the fourth full month after entry into the medical facility. This proposed change will permit an individual receiving short-term medical care to maintain a household to which he can return at the conclusion of his institutional stay.

   Cost: Cost is now under review.

3. Terminate Deeming of Parents' Income and Resources to Child When Child Attains Age 18

   Purpose: To change treatment of children who are aged 18 to 20 and living with parents to same basis as other recipients in his age category.

   Justification: Title XVI currently requires the income and resources of parents to be deemed to child who is age 18

through 20 and attending school. No such provision covers non-students. This proposal would remove this disparity in treatment between students and non-students.

Cost: $1 million program costs.

4. Treatment of Gifts and Inheritances

Purpose: To prevent an SSI recipient from losing eligibility for, or receiving reduced benefits, due to a gift or inheritance which is not readily convertible to cash. Such gifts would not be regarded as income, but as resources.

Justification: It does not appear equitable to treat gifts and inheritances as income when they do not serve as income to the recipient. The proposal would simplify administration since it would not be necessary to evaluate gifts and inheritances of low value and change benefits accordingly.

Cost: Negligible.

95-114 AFDC Work Expense Disregard

Purpose: This proposal would repeal the present language in Title IV-A concerning the mandatory disregard of itemized work expenses in the determination of AFDC eligibility and computation of benefits. Instead, States will be required to select a fixed percentage of gross earnings in place of itemized work expenses (except child care expenses which will continue to be itemized). States may choose a standardized work expense disregard to be between 15 and 25 per cent of gross earnings. This percentage plus itemized child care expenses will be subtracted from gross earnings before the $30 plus one -third work incentive provision is applied.

Justification: The existing itemized work expense disregard is complex and costly to administer. In addition, it is a major source of case errors and can be subject to fraud and abuse. This proposal will simplify the grant determination process and reduce the opportunity for error and abuse. A standardized work expense disregard will also establish a more uniform upper limit on eligibility by reducing variations in the breakeven.

Cost: Savings: $50 million in FY 78.

INCOME SECURITY - PROPOSAL UNDER CONSIDERATION

95-120 Universal Coverage

Purpose: To make social security coverage mandatory for employees of Federal, State, and local governments and non-profit organizations.

Justification: The Department is currently studying the issues involved in a mandatory coverage proposal for these employees of governments and non-profit organizations. The adoption of such a proposal would eliminate the problem of windfall benefits to some workers and would assure a retirement system with complete portability.

Cost:

	Budget Authority		
	Effective Date 1/1/80		
	FY		
	1980	1981	1982
Program Costs	negligible	less than $50 million	$ .1 billion
Income			
a. Trust Fund Budget	$7.8 billion	$13.8 billion	$16.2 billion
* b. Unified Budget	5.3b	9.4b	10.4b
Administrative Costs	$ .6 million/85 man years		
Administrative Savings		$ .9m (no man years effect)	$ .9m

* Approximation only; would depend on ultimate revisions in the civil service retirement system.

(Revised as of October 19, 1976)

95-121A Proposals Related to Sex Discrimination in the OASDI Program

1. Purpose: Make divorced men eligible for benefits under the same circumstances as now apply to divorced women, subject to the conditions of the dependency test.

   Justification: Benefits are not provided for an aged divorced husband or an aged or disabled divorced widower based on his former wife's earnings; an aged divorced wife or aged disabled divorced widow can receive a benefit based on her former husband's earnings if the marriage lasted for twenty years or more.

   The provision of benefits to divorced women was begun in order to deal with some of the economic problems of women who spent substantial parts of their adult lives working within the home. It was not expected that all of these women would become eligible for benefits based on their own earnings records.

   Since it was assumed that most men worked in employment outside the home and earned social security protection based on their earnings, it did not seem necessary to make dependent and dependent survivor provision for divorced men.

2. Purpose: Provide fathers' benefits under the same conditions as mothers' benefits are now provided.

   Justification: A father who has in his care a child of his retired or disabled wife, or deceased wife or former wife, entitled to child's insurance benefits, cannot himself receive a benefit based on her earnings; a mother who has such a child in her care is entitled to a benefit for herself based on the earnings of her deceased, disabled or retired husband or former husband.

   Social Security benefits are payable to a retired or disabled worker's wife or a deceased worker's widow or divorced widow who has in her care a child of his entitled to Social Security child's insurance benefits if she does not have substantial earnings from work, as measured by the earnings test. Fathers in like circumstances do not receive OASDI benefits.

The provision of mothers' benefits was based on the belief that it was desirable, when a worker retired, became disabled or died, to pay benefits to a woman who had young children in her care and who did not have substantial earnings from work. It was considered unnecessary to extend the same treatment to men who had young children because few men worked primarily within the home.

This provision was overturned by the Supreme Court in March 1975. Statutory authority is now required to accommodate the Wiesenfeld decision.

3. Purpose: Provide the same benefits for husbands and widowers as are now available for wives and widows.

   Justification: Certain workers who attained age 72 before 1967 are eligible by the regular rules of eligibility. Benefits were also provided for certain wives and widows who attained age 72 before 1969 but no benefits were provided for husbands or widowers.

   The classification of transitionally insured status was included in the 1965 law to cover persons who had worked in covered employment but who had retired before they had become insured under the program. Under the transitional insured status provision, the minimum number of quarters required for insured status was lowered from 6 to 3. Wives and widows of eligible male workers received benefits under this provision but husbands and widowers of eligible female workers were not made eligible for benefits.

4. Purpose: Divide the payment for a couple equally between husband and wife.

   Justification: In a section which provides payments for certain uninsured individuals and couples at age 72, the couple is treated as though the husband were the retired worker and the wife a dependent even though each has to meet the same eligibility requirements he or she would have to have met if not married.

   In order for a couple to receive payments under this section, both the man and the woman would have to have attained the age 72 before 1972. The amount of the special payment for a couple - $96.60 - is not divided equally between the husband and the wife. The payment, which comes largely from general revenues, is $64.40 for the husband and $32.20 for the wife.

5. Purpose: Make the remarriage rule for widowers the same as it now is for widows. That is, widows and widowers would be eligible for benefits if they had remarried but were no longer married at age 60.

   Justification: Widows and widowers who remarry before age 60 are treated differently with respect to their entitlement to benefits based on their deceased spouses' earnings.

   Under current law, a widow cannot be married at the time she applies for a benefit based on the earnings record of a deceased. However, she does not lose eligibility if she remarries before age 60 but is no longer married at the time she applies for benefits. In the case of a widower, eligibility for benefits is lost if he ever remarries before age 60.

6. Purpose: Terminate payments to a beneficiary when his or her spouse is no longer eligible for benefits.

   Justification: If a male childhood disability beneficiary marries a woman receiving Social Security dependents' or dependent survivors' benefits, the continuation of her benefits is subject to his remaining entitled to benefits. On the other hand, if a female childhood disability beneficiary marries a man receiving Social Security dependents' or dependent survivors' benefits and her benefits are subsequently terminated, the husband's benefits continue.

   A childhood disability beneficiary is a person with a severe disability that began before age 22. The person is entitled to benefits as a son or daughter of an insured worker who is entitled to Social Security benefits or has died.

   In general, the Social Security law provides for termination of dependents' or dependent survivors' benefits upon marriage on the presumption that the dependency situation upon which the benefits are based no longer exists. An exception is made when one Social Security beneficiary marries another, since neither could be expected to support himself without the OASDI benefits. When a childhood disability beneficiary marries another Social Security beneficiary, neither's benefits are terminated by reason of the marriage. However, if the childhood disability beneficiary becomes ineligible for benefits, the subsequent treatment of the benefits

the spouse was receiving varies, depending on the sex of the childhood disability beneficiary. If the childhood disability beneficiary who is no longer eligible is male, then the benefits the wife was receiving are also terminated. If the childhood disability beneficiary who is no longer eligible is female, the benefits which her husband was receiving are not terminated.

There are two conditions under which childhood disability benefits can be terminated. If, in spite of some disability, a person is engaged in substantial gainful activity, benefits are terminated. If a person is judged medically to have recovered from a disability, benefits are terminated whether or not the person is engaging in substantial gainful activity.

7. Purpose: Terminate benefits of both husbands and wives when disabled worker spouses are no longer eligible for benefits.

   Justification: If a male disabled worker beneficiary marries a woman receiving dependents' or dependent survivors' benefits both individuals's benefits continue. If the husband is later no longer eligible for disability benefits, the female's benefits are terminated. If this situation is reversed, i.e., a female disability beneficiary marries a male receiving dependents' or dependent survivors' benefits, the male's benefits are not terminated if the female is no longer eligible for disability benefits.

   When a man overcomes a disability, either through medical recovery or through substantial gainful activity, it is presumed that he will support his wife. The same presumption is not made when a woman recovers. It should be emphasized that in order for a man or a woman to be entitled to disabled worker benefits, he or she had to have spent some amount of time in the work force.

8. Purpose: Apply the illegitimate benefit provisions to women as well as men.

   Justification: An illegitimate child can, under certain circumstances, receive benefits based on his father's earnings record. Such a child is not eligible to receive benefits based on his mother's earnings record.

An illegitimate child may receive benefits based on his father's earnins record, if among other things, (1) the father has been decreed by a court to be the father of the child, or (2) the father is shown by evidence satisfactory to the Secretary to be the father of the child. These provisions do not apply in the case of a mother.

9. Purpose: Apply the waiver of civil service survivors' annuity provision to widowers as well as widows.

Justification: A widow under certain circumstances may waive the right to a civil service survivors' annuity and receive credit for pre-1957 military service for purposes of determining eligibility for or the amount of social security survivors' benefits. This provision does not apply to widowers.

Generally, if a civil service annuity based in part on military service performed before 1957 is payable to an individual, such service may not be used in determining eligibility for or the amount of such individual's social security benefit. An exception applies to a widow (or child), but not a widower, entitled to a civil service survivors' annuity based in whole or in part on pre-1957 military service.

10. Purpose: Permit self-employment income of a married couple in a community property State to be credited for social security purposes to the spouse who exercises more management and control over the trade or business, effective with respect to taxable years beginning after the month of enactment.

Justification: In community property States all income from a business owned or operated by a married couple is deemed to be the husband's for social security purposes unless the wife exercises substantially all the management and control. In non-community property States, self-employment income of married couples is credited to the spouse who owns or is predominantly active in the business.

Under present law, wives in community property States may be treated less favorably than husbands with regard to social security coverage of their income from self-employment.

Cost (Of all ten items): Negligible.

95-123 Elimination of the Mandatory Supplement Requirement
(SSI Study Group Recommendation)

Purpose: Eliminate the requirement that States provide a supplement to maintain December 1973 payment levels for recipients converted from State rolls.

Justification: Present law provides that federal sharing in a State's Medicaid program may be withheld, if a State does not provide a supplement to former assistance recipients to maintain their December 1973 income levels.

The Study Group found that attempting to relate current payments to State standards in effect in 1973 is unduly cumbersome, and that the relationship of current circumstances to 1973 standards becomes increasingly tenuous as time goes on. The Study Group believes that this provision was a transitional device to protect former recipients from a loss of income, and that States should now be permitted to base the amount of supplementation on current need, rather than on standards used in programs that have been repealed. In the Study Group's view, the principle of supplementary assistance is sufficiently established, and the residents of a State should look to the State government for assistance needs not encompassed in the federal program, rather than depend on federal powers to enforce State actions.

H.R. 8911 includes a provision endorsed by the Administration which would terminate entitlement to a mandatory supplement in individual situations, such as when a recipient moves out of a State that is required to supplement, becomes ineligible for SSI because of resources or residence in a public institution, or the SSI benefit or optional State supplement exceeds the 1973 income level.

HEW concurs with the Study Group's recommendation, but recommends that it become effective no sooner than mid-1977. About 260,000 persons out of the 3 million converted in January 1974 are receiving a mandatory supplement. The effective date suggested will permit another SSI cost-of-living increase to take effect, which will further reduce the number of recipients receiving a mandatory supplement.

Cost: An administrative savings of $3.4 million/200 man years is expected for FY 78.

95-124 Elimination of Prohibition of SSI Payments to Residents of Public Institutions (SSI Study Group Recommendation)

Purpose: Statutory provisions prohibiting SSI payments to inmates of public institutions should be amended to apply only to those who are jailed or imprisoned.

Justification: Present law prohibits SSI payments to persons residing in a public institution, other than a public medical institution receiving Medicaid payments for the individual's care which has more than 16 beds.

The Study Group found that SSI payments are denied to many individuals residing in publicly operated or controlled homes for the aged, group homes for the mentally retarded, residential care facilities and other non-medical facilities providing personal or social services for persons unable to manage independently. The Study Group argues that individuals who are otherwise eligible for SSI should not lose entitlement to benefits because of their living arrangements, except for persons who are jailed or imprisoned. The Study Group's position is that it is not proper to live alone only because the facility providing the necessary care is under the control of a governmental unit.

Cost: It is estimated that from 230,000 to 280,000 persons in public institutions would be made eligible at a program cost of $310 million. There would be additional administrative costs in processing those new applications.

95-127A Elimination of the Consideration of In-kind Income and Reduction of Benefits When a Recipient Lives in Another Person's Household
(SSI Study Group Recommendation)

Purpose: The one-third reduction in the benefit level for persons living in the household of another should be eliminated; only cash, and not in-kind income should be counted.

Justification: Present law defines unearned income as including support and maintenance in-kind, which is used in determining both eligibility and the amount of the SSI payment. The law also provides that in the case of an individual or couple living in the household of another person, and receiving support and maintenance in-kind from that person, the applicable benefit standard shall be reduced by one-third, in lieu of counting the actual value of the support and maintenance as income. By regulation, the benefit level is not reduced if it is established that the recipient shares in household management, and pays a pro rate share of household expenses.

Present Policy also provides that the value of in-kind support and maintenance provided to persons not living in the household of another is presumed, subject to rebuttal, to be equivalent to one-third of the benefit level.

The Study Group believes that the one-third reduction in benefits when a recipient lives in another person's household creates inequities, and penalizes recipients who live with others to receive personal care, or who share expenses with others in order to economize. The Study Group believes that recipients should be free to choose living arrangements that promote efficient financial management without suffering a loss of income; and that considering in-kind support and maintenance as income is inconsistent with the purpose of SSI of assuring a uniform minimum level of cash income, which does not vary by differences in expenditures for maintenance needs.

The Administration opposed a provision in H.R. 8911 that would have changed the reduction to 20%, rather than one-third of the benefit level. The Committee on Ways and Means deleted this provision because it did not solve the problem, and entailed considerable cost.

P.L. 94-331, enacted June 30, 1976, waives the one-third reduction in benefits for up to six months, in respect to recipients who are forced to leave their own houses because of a major disaster, which occurs between June 1, 1976 and December 31, 1976.

SSA included the proposal in the September 1975 report to the President as a needed change for purposes of equity, administrative simplicity and reduction of errors. In-kind income is inherently difficult to evaluate and, because of the variety of living arrangements that exist, complex policies are needed for determining whether one is living in another person's household or sharing expenses in a way that does not require the one-third reduction. Experience has shown that determinations as to who heads a household in situations in which several members contribute to its maintenance, and as to the actual value of in-kind income in cases where the one-third presumption is contested, require detailed and time-consuming development and subjective judgments, and are a significant cause of payment errors.

The proposal could be criticized on the grounds that it would provide benefits to individuals who are in need because they are being supported by family or friends, but public understanding of the SSI program might be enhanced by the program simplification the proposal offers.

Cost: About 400,000 SSI recipients (8 to 10% of all recipients) are living in another person's household, and approximately 3% receive other in-kind support and maintenance. Program costs would increase by $360 million in FY 1978 and payment errors would decline by 3%.

Potential annual costs would be $390 million. Additional costs of $95 million in FY 1978 and $175 million in future years could be incurred, if persons currently eligible for, but not receiving benefits, are to apply because of the increased amount of benefits.

The Department will provide additional information on this proposal for discussion purposes.

95-130 To Revise the Treatment of Puerto Rico, Guam, and the Virgin Islands Under the Social Security Act

Purpose: To modify the Social Security Act to adjust the current federal fiscal treatment for cash assistance programs and Medicaid in Puerto Rico, Guam, and the Virgin Islands.

Justification: Puerto Rico and the Territories participate in the Social Security Act on the basis of special entitlement that limits through statutory ceilings, the amount of federal funding participation for income maintenance and Medicaid in these areas. In addition, federal funds available under the ceilings must be matched at a 50 per cent rate by these jurisdictions. States by contrast have no ceiling on federal funding participation for AFDC and Medicaid, and are subject to variable matching rates that range between 50 per cent in wealthier States to nearly 80 per cent in poorer ones.

The current ceilings for Puerto Rico and the Territories were established in 1967, and have not been revised since 1972. Inflation and mandated new service and management programs have driven up the cost of delivering assistance at the same time as rising unemployment has increased need. All three jurisdictions are currently spending substantial sums in excess of the ceilings for particular programs. No federal matching funds are available to offset these expenditures above the ceiling levels. Despite these additional expenditures, there is now some question as to whether Puerto Rico and the Territories are providing services and assistance to all eligible recipients. There is no evidence that Congress intended for the ceilings to remain unchanged after they were last adjusted in 1972.

Cost: The Department is now considering several alternative approaches to adjusting the funding treatment for cash assistance and Medicaid programs in these areas. The potential impact on the Department's budget will be not more than $45 million in FY 78.

(Revised as of October 19, 1976)

95-132 Previously Submitted Proposals

I. OASDI-Related Proposals

1. OASDI short-term financing (under consideration)

Cost: Not available.

2. Annual Reporting (endorsed): Two recommendations are being proposed as an alternative to resubmitting the previous proposal package. These are:

(a) delay implementation of parts of 94-202 until 1/1/1979

Cost: Long-range program savings of .01% of taxable payroll

(b) amend 94-202 according to Treasury-HEW recommendations

Cost:

	Program Costs (in millions) FY				
	1978	1979	1980	1981	1982
Outlays	negligible	$ 1	$ 3	$ 8	$ 15
Long-Range	.01% of taxable payroll.				
Administrative Savings	$2.4 million/200 man-years				

II. OASDI legislative proposals (endorsed by Department)

1. Coverage of Agricultural proposals

Cost: Negligible.

2. Limited Partnership Income

Cost: Negligible.

(Revised as of October 19, 1976)

3. Late State Deposits

Cost: Negligible.

4. Totalization Agreements (H.R. 14429)
(West Germany and Italy only)

Cost:

Effective Date: 10/1/77
(in millions)

	FY 1978	1979	1980	1981	1982
Short-Range Income	$ -4	$ -7	$ -8	$ -8	$ -9
Short-Range Program Costs	$ 3	$ 5	$ 4	$ 5	$ 6

Administrative Costs of $.6 million/32 man-years.

5. Mutual Assistance Arrangements with Foreign Counties

Cost: Negligible.

6. Reimbursement of Administrative costs of Pension Reform Act

Cost: Administrative savings of approximately $10 million annually, with aggregate savings on the order of $60 - $70 million over the seven year period expected to be required to enable pension funds to meet ERISH record-keeping requirements.

7. OASDI Simplification

Cost:

(in millions)

FY 1978	1979	1980	1981	1982
$ -145	$ -315	$ -535	$ -726	$ -893

A long-range savings of .23% of taxable payroll is expected.

INCOME SECURITY-ENDORSED PROPOSAL

95-132A Child Support

Purpose: Repeal Section 458 of the Social Security Act to eliminate the requirement for incentive payments to States and political subdivisions in interstate child support cases. Section 458 currently provides for an incentive reimbursement from the Federal government to the collecting State or locality of an amount equal to 25 per cent of the support obligations collected during the first 12 months and an amount equal to 10 per cent of the monies collected in subsequent months. This incentive applies to all collections made by one jurisdiction on behalf of another.

Justification: Repeal of Section 458 would eliminate a provision which has proven costly to the Federal government and complex to administer.

Cost: Savings: $8.7 million in FY 78.

132B Redefine Definitions of Income

Purpose: Redraft paragraphs 402(a)(7) and (8) of the Social Security Act to (1) define more precisely what is meant by the terms "earned" and "unearned" income and (2) standardize and simplify the language covering exclusions from income and to specify that the one-third marginal earned income disregard applies only to earned income that is reported in a timely manner.

Justification: Recent legislative, administrative and judicially induced changes in the definition and application of these terms have resulted in disparate treatment of similar kinds of income and have complicated understanding of AFDC financial eligibility criteria. This proposal will revise the current definitions of income to bring about greater clarity and consistency such that similar kinds of income receipts will be defined and treated in a like manner. This proposal will also clarify work incentives by specifying which receipts are to be treated as earned income and by specifying that the one-third marginal earned income disregard will be applied only to earned income that is reported in a timely manner. This latter feature will remove an inappropriate incentive to delay the reporting of earned income.

Cost: Savings: $29 million in FY 78.

132C Treatment of Applicant with Special Needs

Purpose: Provide that an applicant who is found to be eligible for an AFDC payment only because of a non-recurrent special need (i.e., an applicant who in the absence of the special need would be ineligible for AFDC) be treated as a new applicant for the purpose of determining eligibility in the subsequent month.

Justification: Under current law, a recipient who qualified because of a special need would be eligible for subsequent payments under the more lenient 30 and a third earned income disregard provision. This proposal will base eligibility for AFDC on a more accurate and appropriate current need basis by treating recipients as new applicants when their prior eligibility derived entirely from a non-recurrent special need.

Cost: Savings: $5 million in FY 78.

132D Mandatory Acceptance of Other Public Benefits

Purpose: To require AFDC applicants and recipients to apply for and accept other public benefits which are intended to meet basic needs and which would, if received, be an offset against AFDC payments.

Justification: This proposal would reduce AFDC costs by maximizing applicants' and recipients' use of alternative programs. This proposal would apply only to current need programs such as VA benefits, OASDI and U. It would not apply to Food Stamps which are designed to supplement AFDC. Nor would it apply where it would lead to a decrease in long-run income — as in the case of early retirement.

Cost: Data are not available on the number of AFDC cases which are also eligible for, but not receiving, other public benefits. To the extent that the "other benefits" are federally financed at rates higher than the federal share of AFDC, this proposal would have a net cost to the Federal government. In cases where the "other benefits" are State financed (e.g., SSI State Supplementation), there would be a net federal saving. In total, we believe that this proposal will have a negligible cost/saving.

95-136 Extend Vocational Rehabilitation Act

Purpose and Justification: Extend the Vocational Rehabilitation Act for three years. Various amendments to the Act are also being considered as specified in the following proposals a-k. State grant program will be advance funded. (This is already permitted under the statute.)

Cost:

Budget Authority
(in millions)

FY 1978	1979	1980	1981	1982
*$850.167	$870.167	$870.167	$870.167	$870.167

* All FY figures represent an additional $.495 for projects for the Architectural and Transportation Barriers Compliance Board and $.200 for the Office of Handicapped Individuals projects.

AMENDMENTS TO THE VOCATIONAL REHABILITATION ACT - UNDER CONSIDERATION

95-136a Through 95-136k

Proposal: Amend the statutory definition of "severe handicap" Section (7) (12) to substitute a definition of a "severely handicapped individual or an individual with severe handicaps" to provide that the term shall mean employable individuals with disability(ies) and functional limitations in vocational and major life activities, resulting from such conditions as those now specified in the Act, and any others as defined and specified by the Secretary in regulations he shall prescribe.

Justification: The current statutory definition does not lend itself readily to the realities of the State-Federal vocational rehabilitation system. We have now had several years of experience working with the statutory definition and given it intensive study. The Rehabilitation Services Administration statistics show that cases which require multiple services and those which remain in the caseload for an extended period of time are not uniquely the severely handicapped. The system judges severity in terms of functional limitations and difficulty in rehabilitation. The statutory term "multiple services over an extended period of time" has proved to be without utility.

Cost: None.

95-136b

Proposal: Amend Section 101(a)(2) of the Rehabilitation Act of 1973 to provide some flexibility in the single State organizational unit requirement.

Justification: This question arose in connection with the State plan submitted by Florida last year. The Administration provided draft legislation which was introduced by Senator Stafford, but no action was taken by the 94th Congress.

We are recommending that the semicolon at the end of subclause (B) be stricken, and in lieu thereof, the following be inserted: ":Provided That, in order to demonstrate and evaluate the effectiveness and efficiency of alternative organizational structures designed to improve the delivery of rehabilitative services within a State, the Secretary may waive any of the requirements of this clause in accordance with regulations designed (i) to limit the number of such demonstrations (ii) to insure opportunity for public comment on any such waiver, and (iii) to insure that any such waiver will not result in a reduction in the level of quality of program services;"."

Cost: None.

Proposal: Amend Section 101(d) to provide that, when a State is dissatisfied with a decision by the Commissioner, it may appeal — not to the Federal district court — but to the Federal court of appeals for the circuit in which the State is located, or that of the District of Columbia.

Justification: It has been noted that the Rehabilitation Act, for reasons undetermined, is not up-to-date on this point. The Developmental Disabilities Act, the Education for all Handicapped Children statute, among others, have provisions comparable to the one described above. It looks like a simple oversight.

Cost: This would save time and money for both parties should any such situation arise.

Proposal: Amend Section 202(a) (last sentence) to insert after "and related activities . . ." the following "including research utilization activities" 'which hold promise . . .'"

Justification: This change will reflect increased interest in development of ways to further the utilization of all research projects in the provision of services to disabled people, and the planning and evaluation of new and existing programs.

Cost: No additional costs anticipated.

Proposal: Amend Section 202(b)(2) from "Establishment and support of Rehabilitation Engineering Research Centers. . . ." to Establishment and support of Rehabilitation Engineering Research Program. . . ."

Justification: This will make possible more effective support for individual projects of a rehabilitation engineering research nature.

Cost: No additional costs anticipated.

Proposal: Amend Section 305 to delete references to the establishment of the National Center for Deaf-Blind Youth and Adults, and to extend the annual authorization for such funds as may be necessary for subsequent years.

Justification: Now that the Center has been established, the language should reflect its existence and provide only for the continuation of federal appropriations.

Cost: No additional costs anticipated.

95-136g

Purpose: Amend the reporting requirement in Section 404 by substituting "180" days for the "120" after the close of the fiscal year.

Justification: The tasks involved in gathering, editing, processing, tabulating and analyzing the massive amounts of reported data so that a "full and complete report" can result, showing the "maximum feasible detail" cannot be completed in the time presently authorized.

There is insufficient time to provide more than a surface analysis of these data. Data on client characteristics on one million client records are involved. Analyses based on that which can be tabulated would be uncertain and misleading. These client characteristics data have a due date six weeks after the fiscal year. Some agencies, especially those not having direct and immediate access to State computers, are unable to comply with this deadline.

Cost: No additional cost is involved; on the contrary, cost may decline if this amendment is adopted. This would come about because end of year data on client characteristics would need to be tabulated only once instead of twice as must now be the case (a "preliminary" tabulation for the Annual Report and a final report later).

Proposal: Amend Title IV to delete Section 406 and 407 providing authorizations for the Sheltered Workshop Study and the State Allocation Study.

Justification: The studies have been completed.

Cost: None.

Proposal: Amend Section 401 to eliminate duplication with reports required under Section 404 and provide that items eliminated be included in the annual reports.

Justification: This will reduce staff time expended in the preparation of reports, processing and disseminating them.

Cost: Will reduce costs.

Proposal: Amend Section 400(c) to authorize research contracts with profit making concerns.

Justification: This will make possible the development of contractual arrangements with a wide variety of profit making firms and organizations, as well as non-profit groups, which have demonstrated leadership in solving technical, engineering and other problems affecting the mobility and employment of disabled people.

Cost: None.

95-136k Amend the Rehabilitation Act to Change the Allotment Formula for Part B, Title I Funds

Purpose: Change the allotment formula by deleting Section 8 and amending Section 110(a) by deleting the existing language and substituting instead the Secretary's recommendation that the allotments of amounts authorized in Part B, Title I of the Act, as amended, be by a formula which is based solely upon an estimate of the relative fraction of the VR target population within each State. Further, the Secretary recommended that the existing formula be converted to the one recommended over a maximum period of five years.

Justification: The proposed formula was recommended as the most effective formula for assuring that the VR target population and identified special target groups are granted equal access to VR services, regardless of their States of residence. The five year phase-in was recommended to reduce the disruption in State program operations which might arise if an abrupt change in the method of computing State allotments is introduced.

Cost: None.

95-137 Amend and Extend Child Abuse Prevention and Treatment Act

The Department will resubmit this bill introduced during the 94th Congress, as well as proposing to advance (funded) State formula grants.

Cost

Budget Authority
(in millions)

FY 1978	FY 1979	FY 1980	FY 1981	FY 1982
$18.928	$18.928	$18.928	$18.928	$18.928

95-139 Increase Authorization for Title XX to $2.7 billion

Purpose and Justification: Extend the $2.7 billion ceiling on Title XX expenditures in FY 1978. The additional $200 million will be used to help States come into compliance with Federal staffing standards for child day care services serving children aged 6 weeks to 6 years. No changes in the day care provisions or matching requirements are being proposed at this time, but the Department is still in the process of considering what, if any, additional amendments to Title XX it should propose.

Cost:

Additional Budget Authority
(in millions)

FY				
1978	1979	1980	1981	1982
$200	$200	$200	$200	$200

(Revised as of October 19, 1976)

EDUCATION-ENDORSED PROPOSAL

95-146 Extend Follow Through Program

The Department proposes to extend the Follow Through program for three years, making the following changes in the law:

1. Section 551(a)(1) now reads:

"1. The Secretary is authorized to provide financial assistance in the form
2. of grants to local educational agencies, combinations of such agencies,
3. and, as provided in paragraph (2) of this subsection, any other public
4. or appropriate nonprofit private agencies, organizations and institutions
5. for the purpose of carrying out Follow Through programs focused primarily
6. on children from low-income families in kindergarten and primary grades,
7. including such children enrolled in private nonprofit elementary
8. schools, who were previously enrolled in Headstart or similar programs."

Lines 5 and 6 of section 551(a)(1) should be amended as follows:

"... focused primarily on children from low-income families in kindergarten and elementary grades...."

Rationale: Changing "primary" to "elementary" as in the original program authorization (EOA) would enable the extension of the Follow Through program into grades 4, 5, and 6. This would allow us to ascertain, among other things, the effects of longer term intervention.

2. Section 552(b) now reads:

"1. (b) Financial assistance extended under this part for a Follow Through
2. program shall not exceed 80 per centum of the approved costs of the

"3. assisted program or activities, except that the Secretary may approve
4. assistance in excess of such percentage if he determines, in accordance
5. with regulations establishing objective criteria, that such action is
6. required in furtherance of the purposes of this part. Non-Federal
7. contributions may be in cash or in kind, fairly evaluated, including
8. but not limited to plant, equipment, or services. The Secretary shall
9. not require non-Federal contributions in excess of 20 per centum of the
10. approved costs of programs or activities assisted under this part."

|| Lines 1 and 2 and lines 8, 9, and 10 of section 552(b) should be amended as follows:

"Financial assistance extended under this part for a Follow Through program shall not exceed 90 per centum of the approved costs.... The Secretary shall not require non-Federal contributions in excess of 10 percent of the approved costs of programs or activities assisted under this part."

Rationale: Follow Through is an experimental program. Experimental programs generally have no non-Federal share requirement. Because of new, internal, fiscal problems, several LEAs throughout the country are having understandable difficulty in meeting the current 20 percent non-Federal share requirement of Follow Through.

3. Section 553(a)(3) now reads:

"In conjunction with other activities authorized by this part, the Secretary may ....

(3) provide, directly or through grants or other appropriate arrangements

(A) technical assistance to Follow Through programs in developing, conducting,

"and administering programs under this part and (B) training for specialized or other personnel which is needed in connection with Follow Through programs."

Section 553(a)(3) should be amended to add the following clause:

"... and (C) for dissemination of approaches developed in Follow Through."

Rationale: Adding clause (C) would specifically allow OE to disseminate the materials and other features of models or site activities found to be successful.

Cost: $59 million FY 78-82

95-150 Amendment of P.L. 92-318, Title IV, Part A, Section 303 to Include Indian Tribes and Indian Organizations in Special Cases as Eligible Applicants

|| Purpose: Amend Section 303 of P.L. 92-318, Title IV, Part A, to include Indian tribes and organizations as eligible participants in those special cases where a Local Educational Agency decides not to apply for entitlement funds.

|| Justification: It is sometimes the case that Indian communities are unable to obtain Title IV, Part A funds because a Local Educational Agency chooses not to apply. In such an instance, Parent Committees have no recourse of action. Also, in such a case, eligible Indian children are denied Title IV, Part A services through no fault of their own. As a result, the services that these children need so badly are not made available to them. Therefore, to meet the special educational needs of these Indian students in cases wherein Local Educational Agencies choose not to apply, the entitlement for that school district may be applied for by an Indian tribe or an Indian organization.

|| Cost: None.

EDUCATION-ENDORSED PROPOSAL

95-151 Clarification of Intent Regarding Exemplary Projects in Part B of the Indian Education Act

Purpose and Justification: The inclusion of pilot and demonstration under one subsection and exemplary programs under another subsection is duplicative. For this reason, it is recommended that the section of 810(c)(2) be included in the Pilot and Demonstration program section as section 810(b)(4), and changing section 810(b)(4) to section 810(b)(5).

Cost: None.

(Revised as of October 19, 1976)

95-152 Merger of Authority of Section 422 of the Indian Education Act with Section 810(d) to Provide a Single Training Authority

Purpose and Justification: As written, Section 810(d) of Part B of the Indian Education Act did not come within the confines of the spirit of Indian self-determination as did the rest of Part B. Accordingly, the 1974 amendment, known as Section 422, was enacted by Congress with an authorization of $2,000,000 included in Section 422(c). This new section included and gives priority to Indian institutions and Indian organizations.

In order to provide a single training authority, the Office of Education is proposing a merger of Sections 810(d) and 422. This merger would drop as eligible applicants State and local education agencies in combination with institutions of higher education. Over the four years of funding Section 810(d) very few State and local education agencies have applied. Their needs could continue to be met by working through Indian institutions, Indian organizations, or institutions of higher education. Such an arrangement tends to increase the invovlement of the Indian community which is more in line with the spirit of Indian self-determination. The section resulting from the merger would continue to provide training for teachers, administrators, teacher aides, school social workers, and ancillary personnel at the undergraduate and graduate level and through in-service programs. It would also continue to provide traineeships and fellowships.

The Office of Education is also proposing the merger of the authorizations Sections 422(c) and 810(g), combining the $35,000,000 and $2,000,000 into a single authorization of $37,000,000.

Cost: None.

95-154A Extend Telecommunications Demonstration Authority

Purpose and Justification: The Department will submit a proposal to extend the telecommunications demonstration authority, which expires September 30, 1977, for four years. No amendments to the existing law are proposed at this time.

Cost:

Budget Authority
(In Millions)

FY			
1978	1979	1980	1981
$1.0	2	2.5	3

EDUCATION-ENDORSED PROPOSAL

95-154B Extend Library Services and Construction Act

Purpose and Justification: The Department proposes a one year extension of Title I (Library Services) and Title III (Interlibrary Cooperation) of the Library Services and Construction Act (LSCA) which expired in FY 1976 and is now operating based on a one-year extension under GEPA. Extension of Title II (Public Library Construction) is not being requested because the Administration has had a "no funding" policy since 1970 and the Congress has not appropriated funds since 1973.

During the 93rd and 94th Congresses the Administration recommended that LSCA be allowed to expire and that it be replaced by the Library Partnership Act (LPA). It did not prove possible to generate support in Congress for LPA, with its emphasis on demonstration and innovation. H.R. 11233, an extension of LSCA through FY 1981, passed the House of Representatives on February 17, 1976, but was not acted upon by the Senate. Given this posture by the Congress, the Department recommends a one year extension of LSCA, during which time a new and more acceptable Federal direction for aid to public libraries can be developed.

Cost:

Budget Authority
(In Millions)
FY

	1977 1/	1978 2/
Title I	$56.9	$45.237
Title III	3.337	15.0

1/ Appropriated in P.L. 94-439 (9/30/76)

2/ Authorization would be based on one-year extension under GEPA.

95-155 Partnership for Human Services Act (Revised Version of Allied Services Act)

Purpose and Justification: The Department will be resubmitting a revised and modified version of its Allied Services proposal. The new version contains significantly fewer procedural restrictions than the old bill, thus giving state and local governments greater flexibility as to how they implement their projects. Certain special authorities in the 1975 version of the bill are modified or eliminated. The bill will provide for demonstration and research grants for design, development and implementation of innovative approaches and techniques for improving human service policy and resources management of general purpose governments. The bill will also authorize the Secretary to engage in contracts or grants for technical assistance and for the purpose of establishing mechanisms for dissemination of information on ways of improving policy and resources management of general purpose governments.

Cost:

Budget Authority
(in millions)

FY				
1978	1979	1980	1981	1982
$20	$25	$30	$30	$30

We are developing further details which might provide for incorporation of portions of planning assistance funds now provided by other Departments including: DOL, HUD, Commerce, Justice, and CSA.

See attached draft specifications for the Partnership for Human Services Act.

SPECIFICATIONS: PARTNERSHIP FOR HUMAN SERVICES

Legislation to provide for improving the human service policy and resources management by State and local governments through grants, training, technical assistance, and the establishment of mechanisms for coordination among State and local governments in the management of human services, and for identification and dissemination of innovative and proven practices.

DEFINITIONS:

Policy Management: The identification of problems, analysis of alternative strategies, selection of programs, and allocation of resources on a jurisdiction-wide basis.

Resources Management: The establishment of basic administrative support systems such as budgeting, financial management, procurement and supply, and personnel administration.

Human Services: Any service or financial assistance provided to individuals or families to help them achieve or maintain personal independence and economic self-sufficiency, including health, education, income security, manpower, social, rehabilitation, aging, food and nutrition and housing services.

TITLE I: Research and Development Regarding Innovations in Human Services Policy and Resources Management.

Section 1: Provides project grants to States, to local governments and to associations of general purpose governments for purposes cited below.

Section 2: Provides project grants to universities, associations of general purpose government officials, and other private non-profit institutions for purpose of undertaking research designed to increase knowledge and understanding of approaches and techniques for improving policy and resources management of State and local general purpose governments.

Purpose: Provide funds to stimulate and support efforts to identify, develop and test innovative approaches and techniques for improved State and local governments' policy and resources management of human services and to develop improved approaches for State and local cooperation in human services policy and resources management.

TITLE II: Dissemination of Information Pertaining to Improving Policy and Resources Management of State and Local General Purpose Government.

Authorizes the Secretary, in cooperation with other Federal agencies, to engage in grants and contracts for the purpose of establishing mechanisms for the effective dissemination of information of means of improving human services policy and resources management of general purpose government.

TITLE III: Technical Assistance

Section 1: Authority to provide directly or through contract or grant technical assistance necessary to transfer existing systems, approaches and techniques for improving policy and resources management assistance to State and local general purpose government.

TITLE IV: Human Service Policy and Resources Management Assistance Grants

Section 1: Authority to provide management assistance grants to State or local governments for human service policy and resources management of human services.

Section 2: Authorizes providing a single grant comprised of all or any Federal human services planning assistance funds.

Section 3: Authorizes Federal human service agencies to waive any administrative requirement imposed by statute or regulation where the requirement impedes the logical coordination of State and local human services.

Section 4: Authorizes a Federal Agency to waive any technical grant or contract requirement in order to facilitate joint funding of human service programs or projects.

Purpose: Provide project grants to State and local governments for purposes of demonstrating and developing cross-program policy and resources management of human services and to encourage linkages in such management between States and localities, and/or within a group of local governments. Also to provide these governments with certain tools for diminishing the negative impact on policy and resources management caused by State and local government having to respond to requirements of multiple Federal agencies and programs.

Performance Requirements: (Not conditions for receipt of grant)

(a) Grantee must develop its own human services policy and management plan that would link the basic human services block grants--Title XX, CETA, Health and Education--with other human service activities of the grantee.
(b) Grantee plan must show how coordination will be effected with the human services management of the other general purpose governments operating in the geographic area that is the focus of the grantee's activities (e.g., city-county or state-local linkages).
(c) Grantees plan should provide for coordination of human service activities with physical and economic development activities of the applicant, although not mandatory.
(d) Local grantees must show in their plan how principal private sector providers will be involved in implementation.

Administration: A Partnership Policy Board--composed of representatives of Federal domestic agencies, the major public interest groups, chief elected officials of state and local government--will be charged with providing the Secretary with general policy guidance.

cc: Quern

THE WHITE HOUSE

WASHINGTON

1976 DEC 4 PM 1 33

December 3, 1976

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: JIM CANNON

FROM: JIM CONNOR JEC

SUBJECT: Congressman Al Cederburg

The following notation was directed to you in the President's outbox:

"Al Cederburg called me re this:

NIOSH project - Cincinnati - U. of M.
Study? How imminent decision?"

Please follow-up with appropriate action.

cc: Dick Cheney
Max Friedersdorf

cc: Johnson

NATIONAL COMMISSION FOR MANPOWER POLICY

DEC 15 1976

Honorable James M. Cannon
Assistant to the President
for Domestic Affairs
The White House
Washington, D.C. 20500

Dear Mr. Cannon:

Enclosed is the most recent Special Report of the Commission, Special Report No. 11, Employment Impacts of Health Policy Developments. The report reflects the continuing efforts of the Commission to solicit expert advice on employment and training matters from nongovernmental sectors on important national manpower issues.

The report, written by Professors Rashi Fein and Christine Bishop, presents an assessment of the interface between health manpower and general manpower problems and identifies fundamental issues and elements that the Commission should consider in developing policy guidance on national manpower issues. The Fein-Bishop report includes estimates of the prospective changes in the financing of the health care industry, and how these changes will impact on the future demand for health manpower. In addition, the authors examine the rapidly changing contours of the career opportunity structure for physicians that are underway as a consequence of the rapid increase in their numbers.

Additional copies of this report can be obtained from Ms. Margaret Corsey (202) 724-1557.

Sincerely,

Robert T. Hall.

ROBERT T. HALL
Director

Enclosure

THE WHITE HOUSE

WASHINGTON

INFORMATION

December 17, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: National Health Expenditures

On Wednesday, December 22, the Department of Health, Education, and Welfare will release the Fiscal Year 1976 national health expenditures.

The annual report indicates that health care spending in the United States reached $139.3 billion in FY 1976, an increase of $17 billion, or 14 percent, over the FY 1975 figure of $122.2 billion.

The HEW summaries and press release are attached at Tabs A and B.

THE WHITE HOUSE

WASHINGTON

INFORMATION

December 17, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Annual premium increases for voluntary Medicare physicians' and hospital services

Attached are two memoranda from HEW Secretary Mathews indicating his action on mandatory rate increases for the Medicare voluntary programs covering hospital insurance and physicians' services and outpatient hospital services.

The Secretary is required by statute to establish these monthly premium payment increases.

The monthly premium rate for the voluntary hospital insurance program will be increased from $45 to $54 as of July 1, 1977. (Secretary Mathews' memorandum at Tab A.)

The monthly premium rate for the Supplementary Medical Insurance program covering physicians' services and outpatient hospital services will be increased to $7.70 from $7.20 beginning July 1, 1977. (Secretary Mathews' memorandum at Tab B.)

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

DEC 13 1976

MEMORANDUM FOR THE PRESIDENT

The law requires that the Secretary of Health, Education, and Welfare promulgate each December the monthly premium rate to be paid by enrollees under the Supplementary Medical Insurance program during the next 12-month period beginning July 1 of the following year. This program is the voluntary part of Medicare, primarily covering physicians' services and outpatient hospital services.

At the same time, the Secretary must determine rates based on which general revenue payments will be made to supplement premium payments in order to pay the full incurred costs of the program. The law is specific in the manner in which the premium and matching rates are to be determined. There is very little discretion given to the Secretary in the determination.

The monthly premium rate paid by enrollees will be $7.70 starting next July. The percentage increase in the premium is based on the increase in benefits that old-age, survivors, and disability insurance beneficiaries received last July.

/s/ David Mathews

Secretary

PA6
health

THE WHITE HOUSE
WASHINGTON

INFORMATION

December 21, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Letter From Frank Gard Jameson

In response to your question "can we help," I have looked into this matter and the answer, in my opinion, is no.

I have discussed the background with Jack Marsh and he concurs.

cc: Quern

THE WHITE HOUSE

WASHINGTON

December 20, 1976

1976 DEC 20 PM 1 12

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: JIM CANNON

FROM: JIM CONNOR JEC

Subject: Letter from Frank Gard Jameson

The attached letters were returned in the President's outbox with the following notation:

"Can we help?"

Please follow up with appropriate action.

cc: Dick Cheney

122005

FRANK GARD JAMESON
1211 AIR WAY
GLENDALE, CALIFORNIA 91201

December 10, 1976

THE PRESIDENT HAS SEEN....

Miss Mildred Leonard
Personal Assistant to
the President
The White House
Washington, D. C.

Dear Mildred:

Mr. Jameson would be most appreciative if you would show the enclosed letter to the President as soon as he has a spare moment.

Sincerely,

Marilyn Suarez

(Mrs.) Marilyn Suarez
Executive Secretary

Enclosure

FRANK GARD JAMESON
1211 AIR WAY
GLENDALE, CALIFORNIA 91201

December 9, 1976

The Honorable Gerald Ford
President of the United States
The White House
Washington, D. C.

Dear Mr. President:

Mimi Harris, you may remember, was the lady who really helped the campaign in California working with Gene Klein as Co-Chairman of Democrats for Ford. The enclosed request that she has made is, in my opinion, not improper. Apparently the only problem is time, and this group which she is interested in will lose a great deal if they do not get the expected approval from HEW by the 15th of December so that they can then get their California approval.

In the event that Mr. Mathews in HEW feels that this request is controversial in any way except time, then I respectfully withdraw from the picture.

Most sincerely,

Frank Gard Jameson

FGJ/ms
Enclosure

December 8, 1976

Mr. Frank Gard Jameson
Glenair
1211 Air Way
Glendale, CA 91201

Dear Frank:

I am asking for your good auspices in helping to secure the completion of the HMO Certification by the Department of HEW. I am requesting notification of completion of this system to Omni Health Systems and the State of California Department of Health Care Services Pre-Paid Division by Wednesday, December 15, 1976 at 12:15 p.m. The certified package is presently under the name of Omni-X Health Systems at HEW.

Implicit herein is the urgent time factor since the entire company programming, employment contracts and other annual commitments depend upon Omni's obtaining this immediate certification.

Thank you for any help you may extend in this matter.

Sincerely,

Mimi Harris
President

MH:jak