Aid to Families with Dependent Children (AFDC) and Child Support Enforcement (CSE)

Agency: Department of Health and Human Services

Functional Code: 609

Budget Reform Criterion: 1

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority[1/]	7,727	5,731	8,043	8,314	8,621	8,907
Outlays	7,793	7,685	8,043	8,314	8,621	8,907
REESTIMATES & ADJUSTMENTS[2/]						
Budget Authority	−22	−147	−351	−474	−592	−732
Outlays	−24	−194	−351	−474	−592	−732
PROGRAM CHANGES:						
Budget Authority	− −	−651	−817	−899	−990	−1,018
Outlays	− −	−651	−817	−899	−990	−1,018
REAGAN BUDGET:						
Budget Authority	7,705	4,933	6,874	6,941	7,039	7,157
Outlays	7,817	6,840	6,874	6,941	7,039	7,157

1/ Includes proposed legislation items.

2/ The Carter budget already included savings for proposed legislation adopted in the Reagan revisions, as follows:

	1981	1982	1983	1984	1985	1986
Budget Authority	− −	−1,182	−1,360	−1,456	−1,563	−1,609
Outlays	− −	−1,182	−1,360	−1,456	−1,563	−1,609

Program Description

AFDC is often viewed as the primary Federal welfare program (although SSI spends as much for the poor). AFDC is administered by the States with Federal matching funds ranging from 50% to 83%. Within benefit standards established by each State, cash assistance is provided to low-income families based on household size and family income. Family eligibility and benefits depend greatly on what is counted as income.

CSE is designed to reduce AFDC costs by helping States locate absent parents who are liable for child support and enforce collection of such support (this program can also be used by non-AFDC families). The Federal government finances 75% of the State's administrative costs and shares in collections for AFDC cases in the same proportion as the AFDC matching rate for that State. Incentive payments (15% of the amount collected) to cooperating jurisdictions are paid out of the Federal share of collections. While the States reap large net savings from this program, the Federal government incurs substantial net costs.

Proposed Change

A legislative package is proposed with most of the savings accounted for by addressing the treatment of family income for AFDC purposes and greater sharing of CSE costs by non-Federal sources.

AFDC:

- *Retrospective accounting and monthly reporting* — States would be required to determine each month's AFDC benefits based on the family's income and circumstances in the previous month. This would replace the current prospective procedure of estimating future income and family circumstances to calculate benefits, which can result in overpayments and undetected ineligibility and may take several months to correct, if at all.
- *Stepparent income* — The income of stepparents and those assuming the role of stepparents would be counted in determining a child's eligibility and benefits for AFDC, in contrast to current Federal requirements which do not assume any financial responsibility on behalf of stepparents. This proposal would eliminate the anomalous situation of providing AFDC to a child who is an integral part of a household that is not eligible for AFDC, but should be expected to support her/him.

- *Earned Income Tax Credit (EITC)* — Advance payment of the EITC would be assumed and counted against a family's monthly AFDC payment (the EITC can now be taken either on an advance payment basis or as a lump sum payment with the family's income tax refund). This proposal would correct the present inequity by which those receiving EITC payments monthly get their AFDC payments reduced and those who receive their benefits in the form of a tax refund have that amount incorporated into their asset base, which only marginally affects AFDC payment levels. It would also take into effect more appropriately the income AFDC families are receiving, and thus better reflect the family's actual current need for public assistance.

- *Minimum AFDC payments* — AFDC payments below $10 per month would be prohibited. This simplifies administration for marginal cases, especially those that may fluctuate on and off the rolls, with little effect on AFDC family income, and would affect only higher income AFDC families.

- *State and local training costs* — The Federal matching rate would be reduced from the current 75% to 50%, the same as for other regular AFDC administrative costs. This change will encourage States to evaluate training needs on the same basis as other administrative priorities, rather than skew such judgments toward the richer Federal match.

- *Countable other income* — States would be permitted to offset a family's AFDC grant to the extent (or any fraction thereof) that (1) the family's food stamp bonus duplicates the State AFDC food need standard, and (2) the Federal rent subsidy (Section 8 or public housing) exceeds the State AFDC shelter need standard. This will allow States to take into account the other sources of support AFDC recipients have and would reduce the effect of pyramiding various public assistance benefits that result in high total income to welfare families. This will also enable States to target more funds on the truly needy by increasiong AFDC benefit levels as well. (Note—not all States have a shelter need standard and would be required to establish one.)

- *Limited eligibility to 150% of Needs Standard* — Families with gross income greater than 150% of the State needs standard would be ineligible for AFDC. Families with income over the 150% level can now be eligible for AFDC due to the disregard of earned income because of child care costs, work-related expenses, and other disregards. Families with such high incomes have resources on which to rely and should not draw on public assistance resources that should be reserved for these unable to support themselves.

- *Individuals over age 18* — Children over age 18 would be ineligible for AFDC unless they were in their senior year of high school. Current AFDC policy is a remnant of the time when the age of majority was 21. Individuals over 18 are legally adults and should be independent. AFDC should be reserved for children who are truly dependent.

- *Standard work-related expense disregard* — Work-related expenses and child care, which are at present unlimited disregards for earned income, would be capped at $75 and at $50/child, respectively. There would also be disregarded 1/3 of the earned income remaining after all other disregards has been subtracted form total earned income—at present, the "one-third" disregard applies before the work expense and child care disregards are substracted from earned income.

  These provisions will greatly simplify AFDC administration and address a major source of error and abuse. They will also provide a strong incentive for AFDC recipients to economize on their work and child expenses. Altering the order of application of the "one-third" disregard will ensure that one-third of work-related expenses are not accounted for twice.

- *"$30 and 1/3" four-month rule* — The "$30 and 1/3" disregards noted above would apply only to those AFDC recipients who obtain work when they are already on the rolls, and then only for a four-month period. This is a sufficient transition period and provides an incentive for AFDC recipients to join the labor force. It is not reasonable to continue to substantially increase welfare families' income indefinitely once they are capable of meeting their own needs through employment.

- *Resource limits* — A limit of $1,000 (equity value) would be placed on an AFDC family's allowable resources. As a result of a recent court decision, resources are valued based on fair market value less encumberances (equity value) rather than full market value, which was the measure used by many States to determine their resource limits prior to the court decision. Because of the change, the value of excluded resources will be considerably more than most States intended.

- *Community work experience* — Each State shall be required to establish and maintain a community work experience program approved by the Secretary of HHS for those individuals required to work (exceptions would be the disabled, persons under 18 or over 65, those working full-time, or mothers with very young children) as a condition of receiving AFDC. Community jobs would be provided if private sector jobs were unavailable. This mandatory requirement for AFDC recipients would encourage attachment to the labor force and self-support and would reduce the public assistance rolls so that more resources would be available for the truly needy.

- *Lien provision* — States would be permited to place a lien on an AFDC recipient's house for the value in excess of the average value of all houses in the State. The lien would be satisfied on transfer of ownership of the house, except that it would be deferred as long as a member of the household eligible for AFDC continues to reside in the house. Many recipients of AFDC own a valuable home that is not considered an asset for purposes of eligiblity. This proprosal would allow the AFDC recipient to retain his home, but upon the sale of the house the State would be able to recover some of the benefits paid during the period of need.

- *AFDC-U primary wage earner* — For two-parent AFDC families, the unemployed parent shall be defined as the primary wage earner. At present, the States operate under an "unemployed parent" concept. Under the unemployed parent concept, either parent can qualify as the unemployed parent, and even if the other parent were employed, the family could still be eligible for AFDC benefits under the current earning disregards. Adopting the primary wage earner concept will relate eligibility for AFDC more closely to a family's actual need for public assistance.

- *Non-recurring lump-sum payments* — Lump-sum payments would be considered available to meet ongoing needs in the AFDC programs, i.e., the lump-sum payment would be considered as income in the month received. If such a payment exceeded the standard of need, the household would be ineligible for aid. Any amount of the lump-sum payment that exceeded the monthly needs standard would be divided by the monthly needs standard, and the household would be ineligible for aid for the number of months resulting from that calculation.

  Under current law, all income available to recipients of AFDC is supposed to be taken into account in determining benefit amounts and continued eligiblity. However, the law is sufficiently vague that there is currently no way to ensure that one-time lump-sum payments are spent for any purpose related to the family's needs over a period of time.

  If a recipient receives an inheritance, lump-sum insurance, death or disability payment, income from the sale of property, or income tax refund, the money may be spent immediately on any item. If that occurs, the welfare grant is not reduced or eliminated in future months even though the lump-sum payments would have been sufficient to meet basic living requirements for several months if properly budgeted. This proposal would overcome this deficiency in current law by considering lump-sum payments as income in the month received. Individuals would be held responsible for prudent use of such income.

- *Vendor payments* — The provision limiting vendor payments to 20% of AFDC cases would be eliminated. Present law restricts the number of vendor payments (direct payments by the welfare agency for housing, utilities, etc.) to 20% of the AFDC caseload in a State. At present, welfare recipients could spend their AFDC benefit for other items, and the vendors can have great difficulty in collecting what is legitimately owed them. Removal of this arbitrary limitation will make vendors more willing to provide housing, utilities, etc., to welfare recipients, since they would be assured of receiving payment.

- *Recoupment of overpayments* — Any overpayment or underpayment of assistance would have to be corrected as a basic policy of efficient and equitable program administration. Recovery of any overpayment of assistance would be made from a recipient's current assistane payments, available income and resources, and/or legal process.

  There is no specific reference in current law to the adjustment of overpayments in the AFDC program. Federal regulations hold that overpayments cannot be adjusted unless the recipient willfully failed to report a significant change in circumstances or has some current resource, such as exempt earned income or money in the bank. This proposal would mandate recovery of overpayments from future grants or other income. In addition, retroactive corrective payments of underpayments would not be considered as income or as a resource in the month paid or the next months.

- *Deeming Provision* — This proposal would consider the income of the sponsor part of the income of the immigrant during the immigrant's first three years in the U.S. for purposes of determining eligibility for AFDC, Medicaid and Food Stamps. Exceptions would be permitted when sponsors are unable to take care of the immigrants because of unforeseen circumstances. Our immigration policy is to admit members of families and others based on the sponsor's demonstrated ability and willingness to provide support.

- *Offers of employment of college students* — AFDC parents who are attending college would be required to register for work and to meet all other work requirements under the AFDC program. Under current law, an individual may be exempt from the AFDC work requirement and can get a college education at the expense of the taxpayers without having to meet the scholarship and other requirements for education grant or loan programs. The AFDC program was designed to meet the basic living requirements of needy children and their families, not to enable individuals to attend college at taxpayers' expense. It is inequitable to allow able-bodied adults to avoid the work registration requirement because they are atending school, while the taxpayers who pay for their welfare assistance may be unable to afford to go to college themselves or to send their children to college.

- *Aid to strikers* — Participation in a strike because of a labor dispute (other than a lockout) shall not constitue good cause to leave, or to refuse to seek or accept, employment. Individuals unemployed by reason of going on strike would therefore be ineligible for AFDC benefits. Current Federal law does not expressly prohibit strikers from obtaining AFDC benefits. In States where strikers can qualify for AFDC, the first day of a strike produces an immediate surge in applications. AFDC caseloads continue to increase during the strike until most eligibles have found their way onto welfare. When the strike is ended, however, some remain on the rolls. Because of income disregards contained in the law, some persons may be able to remain on the welfare rolls indefinitely. This is inconsistent with the basic purpose of the AFDC program, and reduces the resources available for the truly needy.

- *National Recipient Information Systems* — A National Recipient Information System (NRIS) would be established to collect information from the States and, in turn, provide them with information on individuals receiving public assistance. Central collection of information on recipients of and applicants for public assistance and dissemination of the information to the States will simplify and standardize information collecting and reporting requirements placed on the States, make information available on a more accurate and timely basis, and improve the administration of the various assistance programs. The system should serve as a strong deterrent to fraud and abuse.

- *Access to information* — Information concerning applicants for, or recipients of, aid would be made accessible to any State or local agency for public assistance purposes. Access to information on such individuals is essential to fair and efficient administration of public assistance. The leading cause of error in the AFDC program, underreporting of income, could be reduced through access to more complete inormation.

State and local administrative savings from these AFDC provisions would be $105 million.

CSE:

- *Funds for non-AFDC cases* — An applicant fee of 10% of collections would be charged to defray at least part of the costs for non-AFDC cases. This proposal would alleviate the cost burdens on State and Federal governments for activities in which they have no direct interest, since no AFDC collections are involved. This proposal would also prevent relatively well-off non-AFDC families from using CES services for free. More resources would also be freed up to obtain increased AFDC collections.

- *Collection of alimony or Spousal support* — CSE activities would be expanded to cover collection and distribution of alimony for current AFDC cases in the same way as child support. Present law authorizes only the collection of child support. This proposal would resolve problems where existing support orders do not differentiate between alimony and child support, which makes it difficult for local CSE agencies to make and correctly distribute collections.

- *Financing of State and local incentive payments* — The incentive payment of jurisdictions that cooperate with other jurisdictions in collecting child support would be financed jointly by the State and Federal governments in the same proportion that they share in CSE collections. At present, the incentive payment (15% of collections) is financed entirely out of

the Federal share of CSE collections. This proposal would go far to redress the State–Federal imbalance in net return from the CSE program.

- *Federal income tax refunds* — The IRS would halt and collect from an absent parent's Federal income tax refund the amounts owed for child support arrearages identified by a State. Due process would protect the individual's rights. A number of States have used this procedure successfully and have found that many absent parents began making regular support payments when they learned of the existence of the procedure. Under current law, IRS already makes collections from income tax refunds for child support in those cases where a State has certified that it is unable to make the collection.
- *Child support obligations discharged in bankruptcy* — The Bankruptcy Act would be amended to prohibit the discharge in bankruptcy of child support obligations. Fulfillment of child support obligations is crucial to the benefit of inividual children and to overall social policy. Failure by an individual to meet the obligation results in a burden on the State and Federal governments, and may also mean less support for the child even if the child receives AFDC benefits. States indicate that they have had to pay large amounts for child support of bankruptcy individuals. Child support should be honored even by someone who is legally bankrupt.

Reduce Alcohol, Drug Abuse and Mental Health Research and Training

Agency: Department of Health and Human Services

Functional Code: 552,553

Budget Reform Criterion: 6

Funding

	($ in millions)					
	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	356	390	404	419	434	450
Outlays	324	341	353	366	379	392
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	24	--	--	--	--
PROGRAM CHANGES						
Budget Authority	-33	-46	-154	-169	-184	-200
Outlays	-9	-18	-107	-116	-129	-142
REAGAN BUDGET:						
Budget Authority	323	344	250	250	250	250
Outlays	315	347	246	250	250	250

Program Description

ADAMHA provides support through grants and contracts, as well as through direct Federal programs, for research and training activities in the areas of alcohol, drug abuse, and mental health. In total, the 1981 and 1982 Carter budget provided increases over the 1980 levels of $9 and $43 million in 1981 and 1982 budget authority, including about $77 and $100 million for new awards to conduct research in biomedical and behavioral sciences and to train researchers and health personnel in these areas.

Proposed Changes

The Reagan Budget proposes rescissions of $32 million in 1981 budget authority and reductions of $46 million in 1982 budget authority for these programs. Funding for new starts in biomedical research and research training would be $45 million in 1981 and $51 million in 1982 budget authority. Continuations would be funded, but no new awards would be supported in 1981 and 1982 for social sciences research and research training. No new awards would be made in 1981 and 1982 for funding clinical training and by the end of 1982 all clinical training programs would be phased out.

Rationale

Research. Reductions in 1981–1986 are proposed to slow the rate of growth of funding for ADAMHA biomedical research to a rate below projected inflation and to reduce the level of funding for social sciences research below current levels. Across the board reductions in Federal spending — including research — are necessary for economic recovery; social sciences research has been reduced substantially because this research has been less productive than biomedical research.

Research Training. The level of support for trainees in social science areas has been reduced. In addition, institutional overhead has been eliminated from the National Research Service Act research training awards because the Federal Government should not pay higher costs to support a research trainee than are normally charged for a nonfederally supported student at the same institution.

Clinical Training. The supply of mental health professionals is now generally adequate, mental health professionals generally have a good income potential, and thus Federal subsidies for such training are no longer necessary.

Key Facts About the Program

Since 1963, the supply of psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses has almost doubled:

- psychiatrists: from 16,000 to about 30,000;
- psychologists: from 20,000 to more than 40,000;

- employed registered nurses — of whom about 4% specialize in mental health — from one-half million to over a million;
- social workers in the National Association of Social Workers — of whom about 14% specialize in mental health — from 36,000 to 76,000.

Mental health professionals are employed not only in hospitals, clinics, and mental health facilities, but also in courts, correctional institutions and schools. Many other paraprofessionals are now also providing mental health services.

Ratio of ADAMHA service providers to general population:

- Psychiatrists 12.1 per 100,000 (1977)
- Psychologists 11.8 per 100,000 (1976)
- Nurses 18.1 per 100,000 (1972)
- Social Workers 34.9 per 100,000 (1978)
- Paraprofessionals 250 per 100,000 (estimate)

Salary level of ADAMHA service providers:

- Psychiatrists: Average 1978 income of $49,000.
- Psychologists: For psychologists with doctoral level training, median 1978 income of $35,000.
- Nurses: In 1978, for a beginning psychiatric nurse, $15,000; median $17,500.
- Social Workers: In 1978, for a beginning masters level social worker, $17,500; median $25,000.

Energy And Emergency Assistance Block Grant

Agency: Department of Health and Human Services

Functional Code: 609

Budget Reform Criterion: 7

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	--	1,893	1,910	1,911	1,911	1,914
Outlays	--	1,907	1,910	1,911	1,911	1,914
REESTIMATES & ADJUSTMENTS						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	--	-493	-509	-509	-509	511
Outlays	--	-507	-509	-509	-509	511
REAGAN BUDGET:						
Budget Authority	--	1,400	1,400	1,400	1,400	1,400
Outlays	--	1,400	1,400	1,400	1,400	1,400

Program Description

The Federal Government assists low-income households in meeting high energy costs and households in need of emergency financial aid or other crisis support through grant programs administered by the Department of Health and Human Services. Although these categorical programs share common goals, differing requirements for eligible services and recipients restrict State flexibility in meeting priority needs in the most cost-effective manner. For example, only energy costs are eligible services under one program but a broader definition of assistance is authorized under the smaller emergency assistance (Title IV-A) program. Grants under Title IV-A of the Social Security act may be used to provide emergency assistance only to needy families with children and not, for example, to an elderly person living alone, who may need emergency assistance as much or even more.

Proposed Change

As part of the effort to consolidate categorical programs into block grants to States, the Administration proposes to replace HHS low-income energy assistance and emergency assistance programs with a flexible block grant to States for energy and emergency assistance. State matching funds will not be required. Under this proposal, States would have complete flexibility in the delivery of fuel assistance and other emergency services to meet the needs of their citizens.

Rationale

Consolidation of energy and emergency assistance activities into a block grant to States will eliminate unnecessary restrictions on those programs and increase State flexibility in delivering this type of assistance. This increased flexibility is especially important for energy and crisis assistance, given the severe consequences of a State's inability to act swiftly to assist a poor family heat their home in an unusually severe winter or help a family in a fire, flood or other crisis situation. States are in a better position to determine the most appropriate distribution of these funds, since they are closer to the individuals and families needing assistance.

Under the Administration's proposal, States could adopt innovative aproaches to deliver more cost-effective energy and emergency assistance. For example, grants under the low-income energy assistance categorical program cannot be used for low cost conservation projects or minor home repairs which could lower fuel bills or avoid major breakdowns of heating equipment. Under the block grant proposal, States would be free to use these funds to reduce potentially higher future energy consumption and costs. States would also have greater flexibility in the delivery of services provided in the event of emergency situations. For example, temporary financial asistance, food, clothing, shelter, emergency medical care or social services could be given to assist a family in a emergency. In a crisis situation, State and local officials would not have to stop and ask themselves "Can I use these Federal funds to provide this particular service, good, money, etc. to this family?"

Key Facts About the Program

- Only 27 States participate at present in the emergency assistance program which has certain serious shortcomings, e.g., States cannot determine who can participate types of emergencies covered, and the duration and frequency of payments.

Health Block Grants

Agency: Department of Health and Human Services

Functional Code: 551

Budget Reform Criterion: 7

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	--	1,753	1,753	1,753	1,753	1,753
Outlays	--	621	1,581	1,770	1,753	1,753
REAESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	--	371	371	371	371	371
Outlays	--	121	581	570	371	371
REAGAN BUDGET:						
Budget Authority	--	1,382	1,382	1,382	1,382	1,382
Outlays	--	500	1,000	1,200	1,400	1,400

Program Description

Through the years, a complex, duplicative, and uncoordinated array of some 25 Federal health service programs has developed. These programs provide services based on varying criteria including age, income, health status, disease category, occupation, and residence. Most of the programs overlap and duplicate other programs in services provided and/or populations served. Some of these programs are formula grants to States for provision of services at the local level, usually by local governments or agencies. Others make project grants or provide in-kind services or federally paid workers to local public agencies, community-based organizations, and similar non-profit groups. Each program generally has its own separate planning process.

Proposed Change

As part of the effort to return decisionmaking authority, where appropriate, to States and localities, the Administration proposes to consolidate the present collection of 25 Federal categorical health service grants into two block grants to States: health services and preventive health services.

Rationale

Aside from the confusion caused by the total lack of coherence in the Federal delivery effort itself, day to day management has developed into a costly bureaucratic morass of planning, regulating, and reporting at the Federal, State, and local levels. The problems of categorical grant programs are not limited just to this waste and inefficiency or to management difficulties. Because of the fragmented nature of the current funding system, often persons in need of these services must go to several different and unrelated grantees for different services and must receive related health services from different providers. The current system's administrative requirements have resulted in nearly insurmountable barriers for States, local governments, communities, and even individual providers who wish to integrate funds from all grant programs into comprehensive assistance systems.

The Administration's block grant proposal will enable States to plan and coordinate their own service programs, establish their own priorities, and exercise effective program control over resources provided to localities and non-profit organizations. This approach will reduce the multiplicity of rules and regulations (and, hence, Federal direction) under which service agencies currently operate. States will thus have greater flexibility—as well as greater responsibility for results—in providing needed health services to their populations. Overlapping funding from different programs for the same services could be eliminated. States could select the service delivery agency best able to provide certain services that are now provided by direct Federal grantees. The overall result would strengthen State governments and provide publicly-financed services more effectively and at lower costs to those in need.

Appropriation action has been proposed to carry out the Administration's proposal, effective in October of this year, contingent upon enactment of authorizing legislation which will be submitted as soon as possible. The proposed funding level for 1982 is 75% of the 1981 current base or $1,382 million. Because the new block grant legislation would allow significant savings in program overhead and more efficient service delivery due to the elimination of overlapping service responsibilities, this funding change need not result in a reduction of services.

Key Facts About the Program

- Over 1,600 Federal employees manage these programs.
- There are over 12,000 grant sites.
- There are 218 pages of Federal law and 235 pages of Federal regulations for these programs.
- 365,000 manhours are required each year to complete Federal reports.
- The programs included in the health services block grant are:
  - — Primary Health Care Centers
  - — Primary Care Research and Demonstrations
  - — Black Lung Clinics
  - — Migrant Health
  - — Home Health Services
  - — Maternal and Child Health Services
  - — Maternal and Child Health/ Supplemental Security Income Disabled Children's Services
  - — Hemophilia
  - — Mental Health Services
  - — Drug Abuse Community Projects
  - — Drug Abuse Grants to States
  - — Alcoholism Community Projects
  - — Alcoholism Grants to States
  - — Emergency Medical Services
  - — Sudden Infant Death Syndrome
- The programs included in the preventive health services block grant are:
  - — High Blood Pressure Control
  - — Risk Reduction and Health Education
  - — Flouridation
  - — Lead-Based Paint Poisoning Prevention
  - — Family Planning Services
  - — Health Incentive Grants
  - — Venereal Diseases
  - — Rat Control
  - — Genetic Diseases
  - — Adolescent Health Services

Social Services Block Grant

Agency: Department of Health and Human Services | Functional Code: 506 | Budget Reform Criterion: 7

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	--	5,251	5,539	5,767	5,951	6,030
Outlays	--	5,281	5,547	5,751	5,936	6,015
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	—	—	— --
—	--					
PROGRAM CHANGES:						
Budget Authority	--	-1,451	-1,739	-1,967	-2,151	-2,230
Outlays	--	-1,208	-2,037	-2,251	-2,436	-2,515
REAGAN BUDGET:						
Budget Authority	--	3,800	3,800	3,800	3,800	3,800
Outlays	--	3,500	3,500	3,500	3,500	3,500

1/ Some activities were previously classified in function 609 (income security).

Program Description

The Federal Government funds numerous programs to help low-income individuals and others with special needs become self-sufficient, to prevent unnecessary institutionalization, and to protect children from abuse and neglect. While each program was established to meet laudable goals, in practice they often overlap and duplicate other services and target populations. For example, the Title XX, child welfare and child abuse programs all fund child welfare-related activities. Community action agencies in localities receive funding directly from the Federal Government for social services which are also funded through the States under Title XX. Differing Federal mandates and eligibility requirements make it difficult for States and local communities to tailor services to needy beneficiaries. More often than not, Federal requirements outweigh recipient needs in deciding who gets what type of service in which location.

Proposed Change

The Administration proposes to replace various Federal categorical social service programs with a flexible block grant to States. .States would be free to decide what mix of social services are provided, by whom, and under what eligibility conditions. Burdensome Federal regulations, reporting requirements, standards, etc., would be eliminated. States would thus have greater flexibility — and be accountable for results — in meeting the needs of low-income persons and those with special needs, including children at risk and the disabled. No matching or maintenance of effort requirements would be imposed on States.

Rationale

Consolidation of categorical grant programs into block grants is an important element in the Administration's effort to return major responsibility for the administration of various health, education, and social service activities to the States, while slowing the rate of growth of Federal spending.

In the area of social services, the Administration's proposal would significantly reduce State and grantee administrative costs associated with meeting Federal planning, auditing, and reporting requirements. States would be free to develop innovative delivery systems which emphasize continuity of care for individuals rather than fragmented systems which force clients to shop around among numerous local providers. States could devote more resources to high priority services. For example, one State may have a much higher foster care caseload than another State, requiring relatively more resources for child welfare service activities. Another State may need more money for homemaker services.

Greater State flexibility in delivering social services will also eliminate much of the present duplication of services which constitutes a drain on State resources. For example, instead of funding 5 different programs which provide similar information and referral services in a particular county and which are underutilized, the State could fund one such referral center and devote the dollars saved to expanding other types of services.

Key Facts About the Program

Examples of problems addressed by this block grant:

- Of 3 providers the General Accounting Office surveyed in Seattle, all received duplicative funds to provide the same information and referral services. In Los Angeles, 5 of 10 and in Cleveland, 4 of 7 providers received Federal funds to provide the same information and referral services. consolidation of information and referral services was recommended (HRD 77-134).
- In *Children Without Homes* (April 1977, Children's Defense Fund), proliferation of Federal funding sources, requirements, and regulations in the child welfare area was criticized. Administrative and programmatic consolidation was urged.
- A General Accounting Office study found $1 million of duplicative reimbursements for programs and services, involving only six Community Action Agencies.
- A General Accounting Office study (HRD 80-43) criticized the lack of coordination on a Federal level for hindering Developmental Disabilities State Planning Councils' attempts to use and coordinate activities for a variety of health, education, rehabilitation and other social service programs.
- The programs which are included in this block grant are:

  Title XX Social Services
  Title XX Day Care
  Title XX State and Local Training
  child Welfare Services
  Child Welfare Training
  Foster Care
  Adoption Assistance
  Child Abuse
  Runaway Youth
  Developmental Disabilities
  OHDS Salaries and Expenses
  Rehabilitation Services
  Community Services Adminsitraiton
  (except community economic development)

Cuban/Haitian Domestic Assistance

Agency: Department of Health and Human Services

Functional Code: 609

Budget Reform Criterion: 1

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	90	88	--	--	--	--
Outlays	153	83	15	--	--	--
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	--	-15	--	--	--	--
Outlays	--	--	-15	--	--	--
REAGAN BUDGET:						
Budget Authority	--	73	--	--	--	--
Outlays	--	83	--	--	--	--

Program Description

The HHS Cuban/Haitian Domestic Assistance program reimburses States for cash and medical assistance, social services and services for unaccompanied minors to Cuban/Haitian entrants who arrived in the U.S. since 1980. The program also may fund transitional education assistance (through the Department of Education) for school districts with large numbers of Cuban/Haitian entrant children.

Proposed Change

The proposed change would eliminate $15 million in special educational grants to local educational agencies which had been requested in the Carter budget.

Rationale

In March 1981, school districts received $7.7 million for Cuban/Haitian entrant children for the 1981–82 school year through the Department of Education. Florida received about $5.3 million of the 1981 funds. While current U.S. policy permits special educational assistance funding to school districts for an entrant child's initial year in the U.S., the $15 million previously requested for 1982 would actually provide a *second* year of special educational assistance funding for the 1982–83 school year.

Special educational assistance is best limited to the first year, when school districts are most heavily affected. Continuation of funding could lead to an entitlement expectation and prove difficult to terminate, as in the case of the 20 year 1962–78 arrival Cuban Program. In addition, special educational assistance funding in the form of general grants to school districts may not ensure that Federal funds are spent only on new services for entrant children.

More appropriate channels for possible educational assistance to Florida include:

- Secretary of Education discretionary funds which could be allocated for special uses such as English language instruction. This project approach would ensure that funds are targeted to services for entrant children.
- Education and social services block grant funds, from which heavily impacted areas of a State could receive added funds at the State's discretion.

Key Facts About the Program

- Five States have 93% of the new Cuban/Haitian entrant population with Florida alone having 75%.
- Florida is receiving $7 million for FY 81 for educational assistance to Cuban children through the old Cuban program.
- Florida also received $7.8 million for bilingual education (Title VII of Elementary and Secondary Education Act) during 1980.

Health Maintenance Organizations

Agency: Department of Health and Human Services | Functional Code: 551 | Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	56[1/]	48	48	48	48	48
Outlays	30	31	40	48	48	48
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-28	-40	-48	-48	-48	-48
Outlays	-10	-22	-32	-42	-48	-48
REAGAN BUDGET:						
Budget Authority	28	8	--	--	--	--
Outlays	20	9	8	6	--	--

[1/] Excludes $17 million supplemental request for the HMO loan and loan guarantee program which has been withdrawn.

Program Description

The HMO program provides grants and loans for the establishment or expansion of HMOs. Loans may also be awarded for construction of ambulatory care facilities.

Proposed Change

As part of the effort to eliminate unnecessary Federal subsidies, the Administration will propose to phase out the Federal grant and loan subsidy program to health maintenance organizations (HMOs) by the end of 1982.

Rationale

The Administration believes that after 8 years of Federal support the feasibility of HMO prepaid health care delivery has been adequately demonstrated, and that HMOs can be financially self-supporting institutions developed without continued Federal subsidies. There are now 235 HMOs with 9 million members located in every urban area with a population greater than 1 million, and affiliated with 15% of the Nation's physicians. In recent years, substantial amounts of private capital have been provided for HMO development.

A major impediment to further investment of private capital in HMO development is not a dearth of Federal support but, rather, the unnecessarily restrictive requirements for Federal qualification presently found in the Health Maintenance Organizations Act. In fact, artificially high minimum benefit requirements and organizational standards have been a leading source of defaults among small, federally supported HMOs that have found that the heavy Federal requirements priced their benefit packages out of the market.

Amendments will be proposed to the HMO Act, which expires at the end of the fiscal year, to remedy this problem. Once HMOs are no longer required to undertake uneconomic activities, private capital should be more available for HMO development, obviating the need for further subsidies.

This proposal will also halt Federal losses from further attempts to start HMOs that are not economically competitive. The current subsidy program focuses on entities that could not obtain private financing because of their high risk, and then imposes unusually extensive, costly benefit packages and other conditions that inhibit their competitiveness. As a result, defaults on unsecured loans for HMO operating deficits and required interest subsidy payments will exhaust the $35 million HMO loan revolving fund by the end of the year and will require substantial future spending even without awarding any new loans.

This proposal should have no significant effect on development of economically viable HMOs, which can be funded through private sources. Moreover, competitive HMOs will be more effectively encouraged through the health financing reform proposals that the Administration is developing for later submission than through grants and loan subsidies.

Key Facts About the Program

- Corporations supporting HMO development or enrollment include R. J. Reynolds, Deere and Co., General Motors, Chrysler, Ford, IBM, Xerox, Blue Cross/Blue Shield, INA, and Prudential.
- Only 2% of medicare and medicaid beneficiaries are enrolled in HMOs due to restrictive HMO legislation and regulations and medicare/medicaid reimbursement policies.
- More than half of HMO membership is in private HMOs which have not received Federal support.

Health Planning

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	146	147	147	145	145	145
Outlays	162	160	150	145	145	145
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-24	-89	-145	-145	-145	-145
Outlays	-9	-45	-107	-120	-145	-145
REAGAN BUDGET:						
Budget Authority	122	58	2	--	--	--
Outlays	153	115	43	25	--	--

Program Description

The health planning program provides support, primarily through formula grants, for 213 local health systems agencies (HSAs) and 57 State health planning and development agencies (SHPDAs). The program has a dual charge to assure equal access to quality medical care and to control costs. The Federal government now provides 90% of HSA funds and 75% of SHPDA funds.

Proposed Change

The Federal health planning program is proposed for phase-out over the 1981-1983 period, consistent with a 2-year Administration timetable to develop and carry out health financing reforms that encourage competition in the health sector. To begin the phase-out, a $24 million reduction in funding for local health planning is proposed for 1981.

Rationale

As part of the general effort to restrain health care costs by stimulating competition in the health care industry, the Administration proposes phasing out the Federal health planning program. This program represents an effort to impose a complex national health regulatory program on States and localities. Moreover, it has not proved effective in controlling costs on a national basis, and it inhibits market forces needed to strengthen competition and provide less costly services.

If competitive forces are to restrain costs, free entry into health care markets is essential. Otherwise, high-cost providers can monopolize health care markets. The certificate-of-need review process conducted under the health planning program is a system whereby hospitals and other institutional providers must receive a Government franchise before beginning operations. This system inhibits free market entry, often propping up high-cost institutions behind a Government-created entry barrier. Elimination of this franchising system is a necessary element in the Administration's efforts to promote the effective functioning of private market forces in the health care sector.

Key Facts About the Program

- Health planning advocates argue that the excess hospital bed supply has decreased, proving the national effectiveness of the planning program. In reality, 5 States alone accounted for over 75% of the decreases and the 2 States with the greatest decreases in excess bed supply—New York and Minnesota—owe their success largely to State rate setting commissions and strongly pro-competitive environments, not to entry regulation.
- GAO, in a March 1980 report entitled *Unreliability of the American Health Planning Association's Savings Estimate for the Health Planning Program*, disputes the AHPA's claim that $3.4 billion was saved due to health planning between 1976 and 1978.

Health Professions Education

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	231	170	170	170	170	170
Outlays	418	288	355	339	291	228
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-45	-44	-44	-44	-44	-44
Outlays	-8	-20	-50	-50	-50	-48
REAGAN BUDGET:						
Budget Authority	186	126	126	126	126	126
Outlays	410	268	305	289	241	180

Program Description

The Department of Health and Human Services supports 27 project and formula grant training programs for institutions and students aimed at increasing the supply of health professionals, primarily physicians, dentists, and nurses.

Proposed Change

As part of its plans for better targeting the allocation of Federal funds, the Administration proposes to end large general subsidies for the training of physicians and other health professionals. Such programs are no longer necessary in light of the growing projected supply of most health professionals. Instead, Federal programs will be targeted directly on training needs of national priority.

Rationale

During the 1960's and the 1970's the supply of health professionals increased dramatically, partly as a result of Federal subsidies of about $18 billion. During the 1970's, the annual number of graduates from medical schools doubled from 8,000 to nearly 16,000. Today, the Nation as a whole has reached or exceeded the estimated required level of health professionals for almost every major specialty. The number of active physicians alone is expected to reach nearly 600,000 by 1990, an increase of 58% between 1975 and 1990. Moreover, the ratio of physicians per 100,000 population is projected to rise from 173 per 100,000 to 239 per 100,000 in the same time period.

The Administration will propose legislation to refocus Federal aid on a limited number of national priority medical specialties, rather than providing large subsidies for all specialties. In addition, support for training in nonphysician specialities will be focused on occupations such as physicians assistants and nurse practitioners which help address the problem of maldistribution of health professionals.

By more directly targeting Federal health professions training subsidies on national priorities, program costs can be reduced. At the same time, higher-priority, more targeted programs will subsidize the education of health professionals in those fields where they are most needed.

The proposed change is not expected to affect the projected surpluses for the coming decade in nearly all health professions areas. Federal student assistance programs in the Department of Education will continue assisting students to finance their own education and the Department of Health and Human Services will fund a $120 million grant program for high priority health professions. Included in this program, the Administration will continue support at the 1981 appropriated level of $20 million for assistance programs to encourage minorities, who are now under-represented in health professions fields, to choose health careers.

Key Facts About the Program

- Federal capitation payments amount to only 3% of medical schools' annual revenues.
- Nurse training will continue to be supported through nursing special projects as opposed to general support since the total supply of nurses appears to be adequate but too many qualified nurses have chosen other professions or are being utilized in nonpatient care positions.
- Average medical school tuition in 1980 was about $3,000, and was only $1,600 for the two-thirds of students enrolled in public schools in their own states.
- There are three times as many qualified applicants as there are spaces available in health professions schools, indicating that, even with decreased Federal support, helath professions enrollment will likely remain at its high current level.

Indian Health Service

Agency: Department of Health and Human Services

Functional Code: 551

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	715	772	801	831	863	897
Outlays	688	740	766	786	817	850
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	−33	−137	−166	−196	−228	−262
Outlays	−3	−53	−68	−165	−196	−229
REAGAN BUDGET:						
Budget Authority	682	635	635	635	635	635
Outlays	686	687	688	621	621	621

Program Description

The Indian Health Service provides preventive, curative and environmental health services and facilities construction for approximately 795,000 American Indians and Alaska Natives living on or near reservations. The Carter budget provided 1982 construction funds for 3 clinics and 3 hospitals added by Congress to the 1981 appropriation and a $23 million 1981 supplemental request for sanitation facilities construction.

Proposed Change

Funds for facilities construction are reduced by $32 million in 1981 and $109 million in 1982 by eliminating additional requests for sanitation facilities construction and seeking rescission of funds for the new hospitals and clinics added by Congress. Funds requested for health services in 1982 are $20 million greater than 1981 but $28 million less than in the Carter budget. Urban health projects and Indian health manpower scholarships would be phased out.

Rationale

By slowing construction of health facilities, this proposal would impose needed fiscal restraint for this program. In recent years, facilities construction for Indians has proceeded at a high rate; since 1978, 9 other hospitals and 6 other clinics have been funded.

As part of the slowdown in construction, no additional funds are requested for HUD Indian housing construction.

Key Facts About the Program

- Funds not requested for new facilities were similarly opposed by the Carter Administration.
- Urban health projects largely provide referral, rather than medical, services; are not required by treaty obligation; and are over and above services available to the general population.
- Indian manpower projects would be eligible for funding on their merits from $120 million of 1982 funding provided for all health professions training programs.
- Despite these restraints, outlays from all Federal Indian programs will average more than $12,000 for each Indian family of 4 in 1982.

Increasing the Cost-Effectiveness of the Medicaid Program

Agency: Department of Health and Human Services | Functional Code: 551 | Budget Reform Criterion: 1

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	17,236	18,802	21,699	24,933	28,421	32,311
Outlays	16,452	18,120	21,027	24,178	27,565	31,346
REESTIMATES & ADJUSTMENTS:						
Budget Authority	−1	34	−416	−1,185	−2,350	−3,844
Outlays	−1	29	−245	−925	−2,007	−3,437
PROGRAM CHANGES:						
Budget Authority	−589	−1254	−2,567	−3,939	−5,144	−6,526
Outlays	−339	−944	−2,325	−3,652	−4,878	−6,196
REAGAN BUDGET:						
Budget Authority	16,646	17,582	18,716	19,809	20,927	21,941
Outlays	16,112	17,205	18,457	19,601	20,680	21,713

Program Description

Medicaid is a program of grants to States to assist them in providing medical insurance coverage to low income families and individuals. The Federal government provides States with open-ended matching payments for their expenditures, with the Federal match (based on State per capita income) ranging from 50% to 78%.

The Carter budget included a mix of minor savings proposals and benefit expansions, with a net impact of −$95 million from current services in 1982. By 1986, Carter budget legislative proposals would have added $1.1 billion to current services.

Proposed Change

Legislation will be requested to impose an interim limitation on currently open-ended Federal matching payments for Medicaid while fundamental program reforms are developed. Federal payments would be reduced $100 million below current projections in 1981, would be limited to a 5% increase in 1982, and would be limited to the percentage increase in the GNP deflator in subsequent years. During the interim period, States would be given additional flexibility to manage and structure the program. The limitation would be allocated so that States would retain their current relative share of total Federal Medicaid spending.

In addition, the new budget does not endorse benefit expansions included in the Carter budget and proposes immediate recovery of Federal matching payments to States for previously disallowed erroneous expenditures. The latter change is estimated in the Reagan budget to result in a one-time 1981 saving of $270 million. Currently, it takes up to eighteen months to recover such disallowances.

Rationale

As health care costs have risen dramatically over the last 15 years, the cost of maintaining health care entitlement benfits has escalated alarmingly. Costs under federally supported medical assistance programs for the needy have risen from $5.2 billion in 1970 to over $29 billion in this fiscal year. Combined Federal and State expenditures for Medicaid now exceed $1,300 for each eligible beneficiary.

Federal and State regulatory efforts to date have failed to stem the increase in costs because they fail to affect the underlying cost-increasing bias in the health care system that results from the insulation of all parties in medical care markets from the cost consequences of their decisions. The Administration will propose comprehensive legislation to remedy these market distortions.

As an interim measure prior to the adoption of these Administration initiatives, the Administration will propose legislation to establish a limit on the Medicaid program's unconstrained growth. As part of this proposal, Federal program requirements would be modified to allow States to amend their present programs to ensure that essential services are provided to needy persons in a timely and cost-effective manner.

The Medicaid program has been growing faster than 15% per year for the last 5 years. High Federal matching, excessive benefit provisions, and overly-generous eligibility have made the Medicaid program a very poorly managed social program that fails to provide cost-effective services to those most in need.

Because under the interim cap Federal expenditures would no longer be open-ended, States would have additional incentives to reduce fraud, waste, and abuse in this State-administered program. In addition, the new flexibility granted States would enable them to reorganize their programs to deliver care more effectively and at lower cost.

The Administration believes the degree of restraint provided by the interim limit can be achieved by States without reducing basic services for the most needy. In the 1983-1986 period, the Administration expects to institute comprehensive health financing and Medicaid reforms to reduce the rate of health cost inflation and to improve Medicaid.

Under the Administration proposal, States would not be forced to shoulder unreasonable additional burdens. Legislative changes would be sought to ensure that States have the flexibility to amend quickly the eligibility, benefits, and payment provisions of their State Medicaid plans so as to allow them to meet the essential health care needs of their needy citizens at a lower cost. Under current law, excessive Federal mandates are an obstacle to cost control. The Administration proposal would ensure that States had the authority to reorient their program quickly toward essential services to those most in need. No State, however, would be prevented from providing whatever additional services it deemed appropriate out of its own resources.

Key Facts About the Program

- Eligibility errors by the States are currently estimated to cost Federal and State governments approximately $1.2 billion annually.
- The previous Administration's HEW Inspector General's first annual report (1977) estimated $4.1-$4.6 billion worth of waste, fraud and abuse in the Medicaid program.
- The proposed 1982 reduction is only 3% of anticipated Federal-State program expenditures.
- States vary widely in their control over annual expenditure growth. In November, 1980, the five States with the slowest growing programs projected their expenditures would only increase 2.3% in 1981, while the top five States projected a 32.2% average growth.
- States vary widely in expenditures per beneficiary. In 1980, the five highest expense States averaged an estimated $1,877 per beneficiary, compared to $712 in Federal-State expenditures in the five lowest expense States.

National Center for Health Care Technology

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	4	6	6	6	6	6
Outlays	3	5	6	6	6	6
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	--	-6	-6	-6	-6	-6
Outlays	--	-5	-6	-6	-6	-6
REAGAN BUDGET:						
Budget Authority	4	--	--	--	--	--
Outlays	3	--	--	--	--	--

Program Description

The National Center for Health Care Technology (NCHCT) was created by statute in 1978. NCHCT has focused on assessments of new and emerging health care technologies and on making Medicare coverage recommendations to the Health Care Financing Administration (HCFA).

Proposed Change

The Administration proposes to eliminate NCHCT as a separate organization and to assign responsibility for its functions, where appropriate, to other HHS activities.

Rationale

As part of President Reagan's plans to manage Federal funds more efficiently, the elimination of a separate health care technology center is a good example of a way in which the Federal budget and the level of Federal employment can be responsibly reduced. Rather than continuing to support an ever expanding separate HHS technology center, this change eliminates an unnecessary Federal agency whose functions can be carried out by other activities. Appropriate Federal actions in this area, such as Medicare coverage issues or technology assessments, will be conducted by HCFA, the National Center for Health Services Research (NCHSR), and the National Institutes of Health (NIH).

Key Facts About the Program

- As administered by HHS, NCHCT grew from a funding level of $344 thousand in 1979 to $6.2 million and 50 staff proposed in the 1982 Carter budget.
- The work of NCHCT parallels closely similar functions carried out by HCFA, NCHSR, and NIH.

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National Health Service Corps (NHSC)

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	171	193	224	258	295	335
Outlays	147	187	206	231	264	300
REESTIMATES & ADUSTMENTS:						
Budget Authority						
Outlays						
PROGRAM CHANGES:						
Budget Authority	−23	−56	−87	−121	−158	−198
Outlays	−6	−38	−100	−110	−130	−150
REAGAN BUDGET:						
Budget Authority	148	137	137	137	137	137
Outlays	141	149	106	121	134	150

Program Description

The National Health Service Corps (NHSC) provides federally employed physicians and other health professionals to areas classified by the Department of Health and Human Services (HHS) as health manpower shortage areas. Most of the NHSC recipients receive full tuition and stipend support while in medical school for which they owe service on a year-for-year basis.

Proposed Change

As part of its efforts to reduce market distortions and Federal subsidies, the Administration proposes no new scholarships for the NHSC program. This action is intended to prevent unnecessary program growth and costs in the 1990's, when persons receiving new scholarships would complete their training and report for assignment as Federal employees. This proposal would maintain a constant, long term NHSC size of 2,500 assignees to be utilized only in the highest priority areas where physicians and other needed health professionals are not likely to locate voluntarily or where scholarship obligated health professionals could not choose the private practice option because the underserved area could not support a private practice. (The "private praction option" is available to assignees who wish to enter a private practice in shortage areas in return for forgiveness of scholarship obligation.)

Rationale

Serious remaining problems of access to adequate primary care will probably be virtually eliminated within the next few years due to growth in the Nation's supply of physicians and past NHSC scholarship commitments. At most, 6,000 health professionals—to serve approximately 12 million underserved people—are necessary to cover all health manpower shortage areas. However, the NHSC placement program alone, under Carter Administration placement policies, would have grown from 2,060 in 1980 to our 9,000 by 1990, even if new awards were frozen today. HHS, working with States, local communities, and potential assignees, will make maximum use of the private practice option and other non-Federal placement to assure that the maximum strength of the NHSC does not exceed 2,500 Federal employees. In addition, recent data indicate that physicians in general, and primary care physicians in particular, are voluntarily locating in smaller communities, and that specialists in rural areas spend 30% or more of their time on primary care. Finally, since the scholarship pipeline is so long, whatever short-term problems in primary care access remain would not be addressed by new awards.

In addition to the excess supply problem, total program costs for assignees obligated by scholarship are very high. Federal costs in 1980 averaged $100,000 per physician for each year of scholarship-obligated service. Alternative aid programs would be more cost effective. Consequently, the Administration proposes to eliminate all new NHSC scholarship awards in 1981 and 1982 but will allow students who currently have scholarships to complete their training.

Key Facts About the Program

- Physician supply expansion is so rapid—34% during the 1970s, and an estimate additional 38% during the 1980s—that a surplus of physicians is expected by 1990 for most medical specialties.
- Access to medical care has improved greatly since the early 1960's, so that even when data are corrected for disability, the poor now see physicians at least as often as the non-poor.

Moderate Growth for the National Institutes of Health

Agency: Department of Health and Human Services

Functional Code: 552,553

Budget Reform Criterion: 6

Funding

	($ in millions)					
	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	3,594	3,849	3,968	4,099	4,236	4,381
Outlays	3,410	3,655	3,750	3,875	3,999	4,130
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-81	-86	-91	-97	-102	-107
Outlays	-36	-73	-83	-92	-98	-103
REAGAN BUDGET:						
Budget Authority	3,512	3,762	3,877	4,002	4,135	4,274
Outlays	3,374	3,583	3,667	3,783	3,901	4,027

Program Description

Reflecting the Administration's commitment to Federal support of essential biomedical research activities, funding increases will be proposed for continued growth of the National Institutes of Health (NIH). NIH provides support for biomedical research, primarily through NIH's eleven Institutes. Research project grants, made mostly to individual researchers and research teams, account for approximately one-half of NIH's budget. Other NIH funds support a variety of research and training activities.

Proposed Change

Funding wil allow continuation of previous years' commitments and permit substantial numbers of new awards each year. As part of a general effort to achieve economies and reduce lower priority activities, however, the funding increases will not fully cover projected inflation.

Rationale

Despite these overall reductions, however, the Administration remains commited to NIH research project grants as a vehicle for stimulating scientific breakthroughs that return benefits to society far in excess of the Federal commitment of funds. One of the principal areas of reduction will be the institutional payments made for NIH (and other) research training under the National Research Service Awards (NRSA) program. This proposal would eliminate the current practice of paying more to an institution for a federally supported trainee than is charged in tuition and fees to nonfederally supported students at the same institution. All trainees would continue to receive awards for their tuition, fees, and living expenses.

Key Facts About the Program

- Increased funding from 1981 to 1982 will be provided for all Institutes.
- The numbers of new and competing research project grants in 1981 and 1982 will exceed the 1980 level.
- The number of training grants will also be at approximately the 1980 level.

Office on Smoking and Health

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	3	3	3	3	3	3
Outlays	2	3	3	3	3	3
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-1	-3	-3	-3	-3	-3
Outlays	-1	-3	-3	-3	-3	-3
REAGAN BUDGET:						
Budget Authority	2	--[1/]	--	--	--	--
Outlays	2	--	--	--	--	--

[1/] Funding will continue under a combined OASH health promotion and smoking and health activity, including $2.9 million and 25 positions in 1982. This represents a reduction of $3.9 million and 12 positions from the Carter budget. An additional $10 million for smoking and health demonstration grants has been folded into the proposed health block grants.

Program Description

The HHS Office on Smoking and Health (OSH) was established in 1979 by former HEW Secretary Califano as a separate office under the Office of the Assistant Secretary for Health (OASH). OSH coordinates HHS' national smoking and health program, including providing technical assistance and preparation of an annual report to Congress. Funding for this activity totalled $2.5 million in 1980 and $3 million in 1981. President Reagan has proposed a $1 million rescission in 1981 as part of plans to eliminate a separate OSH by 1982.

Proposed Change

This change provides for eliminating a separate OSH activity and combining it with the OASH health promotion activity. This combined activity will continue to assist Federal, State and local agencies and private organizations to develop programs in nutrition, exercise, smoking, and alcohol and drug abuse.

Rationale

Consistent with other Administration efforts to eliminate unnecessary and duplicative Federal activities, the elimination of a separate OSH terminates low priority activities that should more appropriately be carried out at the State and local levels. The President's proposed health block grants ensure that States will have the flexibility to fund smoking and health programs if they are considered a high priority. Maintenance of a separate Federal smoking and health office will no longer be necessary under these circumstances.

Key Facts About the Program

- Since OSH's establishment, one of its major functions has been to coordinate smoking and health activities carried out in several HHS activities, including NIH, CDC and ADAMHA.
- As noted above, implementation of the health block grant proposals coupled with other administrative improvements will enable the Administration to combine smoking and health coordination with the OASH health promotion program.

Professional Standards Review Organization (PSROs)

Agency: Department of Health and Human Services

Functional Code: 551

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Obligations	174	174	174	174	174	174
Outlays	171	171	171	171	171	171
REESTIMATES & ADJUSTMENTS:						
Obligations	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Obligations	-38	-104	-107	-174	-174	-174
Outlays	-38	-102	-106	-171	-171	-171
REAGAN BUDGET:						
Obligations	135	70	67	--	--	--
Outlays	133	68	65	--	--	--

Program Description

This program—administered through 185 Federally funded PSROs of widely differing effectiveness—is intended to assure the necessity and quality of medical care funded through Medicaid and Medicare. The Carter budget provided a new requirement that the PSRO program have as a national objective for 1982 a 2% reduction in Medicare and Medicaid days of hospital care.

Proposed Change

A competitive system of funding would be introduced by which only those PSROs judged most effective in reducing medical costs and improving quality of care would be refunded. No Federal objective setting would be required and the mandate for utilization review where PSROs are not active would be removed. After 1983, Federal support for PSROs would stop.

Rationale

The phase-out of the PSRO program would substantially reduce Federal regulation of health care services. By defunding the least effective PSROs, this proposal would also impose needed fiscal restraint. Recent studies on the effects of the PSRO program by the Congressional Budget Office provide evidence that the PSRO program *raises* national health care spending. According to these studies, the cost of the nationwide system of hospital utilization review organizations exceeds the resulting savings achieved by reductions in length of hospital stay and lower admission rates. Even this analysis fails to factor in the reality that, due to the way in which hospitals are presently reimbursed for services on a cost basis, cost "savings" achieved through lower medicare and medicaid utilization are simply passed on to hospital users who pay their own bills, or who are covered by private insurance. The phase-out of the PSRO program over the 1981–1983 period is consistent with a 2-year Administration timetable to develop health financing reforms that encourage competition in the health sector. The transitional funding for the most effective PSROs would be continued into 1983 to allow competing systems of care to contract for their services.

Key Facts About the Program

- The Congressional Budget Office estimates the PSRO program results in a net loss of $0.60 for every dollar spent.
- Some PSROs appear to be effective; 50 receive funding from industry or insurance carriers to cover non-Federal patients.
- The American Medical Association and American Hospital Association recently called for the abolition of the PSRO program.

Public Health Service Hospitals and Clinics

Agency: Department of Health and Human Services

Functional Code: 551

Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	168	172	160	170	170	170
Outlays	168	172	160	170	170	170
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	-39	-99	-150	-160	-160	-160
Outlays	-39	-99	-150	-160	-160	-160
REAGAN BUDGET:						
Budget Authority	129	73	10[1/]	10[1/]	10[1/]	10[1/]
Outlays	129	73	10[1/]	10[1/]	10[1/]	10[1/]

[1/] This level would continue to support the National Center for Hansen's Disease and the Tuskeegee syphilis study.

Program Description

The Public Health Service (PHS) has operated a wholly federally financed medical care system for merchant seamen since 1798. The original purpose of the entitlement was to protect the Nation from communicable diseases that could be brought into the country from foreign ports at a time when there were few medical facilities in American port cities. Today, those cities have sufficient medical facilities. Moreover, through the years, this entitlement has been expanded from merchant seamen to include tugboat operators, fishermen, offshore drilling crewmen, dredge industry employees, and others in addition to oceangoing seamen. Thus, a program that was originally designed to provide occasional onshore benefits for seamen who spent most of their days at sea has become, in effect, a free Government health delivery program for selected occupational classes.

Proposed Change

The Administration will seek repeal of this entitlement and closure of the remaining eight PHS hospitals and 27 clinics now providing free medical care. This change requires a 1981 rescission of $39 million and a 1982 reduction to the Carter budget of $99 million.

Rationale

The provision of free Government health care for merchant seamen is unnecessary and unwarranted. Moreover, the PHS hospital and clinic system is under-used and actually aggravates health care costs in the cities where the hospitals are located. Improved health and the growth of collectively bargained health care plans have led to low demands on the PHS hospital system. Occupancy rates of the hospitals have averaged about 65% since 1976, compared to national minimum standards of 80% occupancy. In addition, all of the hospitals are located in areas with adequate or excess supply of hospital beds, and all of the eight affected cities have at least one other Federal facility operating at less than 80% occupancy to care for nonmerchant seamen patients entitled to Federal care. Thus, this proposal will not affect appreciably merchant seamen's access to care.

Most of the hospitals and clinics have also been serving a small number of low-income people in their areas, largely on an outpatient basis, in order to fill unused cpacity. This proposal includes funds to allow the Department of Health and Human Services to pay for such services by contract in 1982 while seeking arrangements for indigent care with other under-utilized hospitals in affected areas.

Under this schedule, PHHS operational support of the hospitals and clinics would cease as of October 1 of this year. The entire system would either be closed or turned over to local communities that wish to maintain the facilities by the end of 1982.

Key Facts About the Program

- Seamen union members earn between $12,000 per year to $79,000 per year and have medical coverage through noncontributory employer financed health insurance plans.
- Over 70% of the PHS system employees are physicians, dentists, nurses, and skilled technicians who would not be expected to face great difficulty in obtaining other employment in the rapidly growing medical care industry.
- The Federal Government will provide $415 million in subsidies to the American shipping industry in the 1982 budget.

PHS Commissioned Corps Physician Bonuses

Agency: Department of Health and Human Services

Functional Code: 553

Budget Reform Criterion: 2

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	44	48	52	56	60	64
Outlays	44	48	52	56	60	64
REESTIMATES & ADJUSTMENTS:						
Budget Authority	--	--	--	--	--	--
Outlays	--	--	--	--	--	--
PROGRAM CHANGES:						
Budget Authority	--	-3	-3	-3	-3	-3
Outlays	--	-3	-3	-3	-3	-3
REAGAN BUDGET:						
Budget Authority	44	45	49	53	57	61
Outlays	44	45	49	53	57	61

Program Description

Under an amendment to the Mental Health Systems Act (MHSA) (P.L. 96-398), the 2,700 PHS Commissioned Corps physicians are authorized the same bonus levels as military physicians —a potential annual maximum of $29,500 above basic salary. The MHSA amendment changed a significant feature in the Uniformed Services Health Professionals Special Pay Act of 1980 (P.L. 96-284) that increased military physician bonuses but held the Commissioned Corps to its existing bonus levels—a potential annual maximum of $25,700 above basic salary. The MHSA amendment was enacted despite objections from the previous administration which had earlier vetoed such increases.

Proposed Change

This change would modify the MHSA amendment that tied the bonuses paid to Commissioned Corps physicians to the level paid to the military and allow PHS physician bonuses to be related to HHS needs.

Rationale

The argument that both the military and the Commissioned Corps should receive the same pay and benefits because both are "uniformed" services is not valid. While it has been a uniformed service, the Commissioned Corps has functioned very differently from the military health corps. Corps members receive the same benefits as the military—free retirement and medical care, commissary and PX privileges, etc., without comparable hardships and rotational assignments, and without being subject to the Uniformed Code of Military Justice. As part of President Reagan's plan to reduce middle and upper income benefits, the continuation of entitlement bonuses to Commissioned Corps physicians at the same level and on the same basis as the military is unwarranted.

Moreover, there is no difference in function between Corps and General Schedule (GS) health personnel to justify additional benefits. Corps members are paid substantially more for doing the same job than GS employees—$10,000-$15,000 more annually for senior Corps physicians. Many Commissioned Corps physicans do not practice medicine—rather, they function as researchers, administrators, or health planners.

With the proposals in President Reagan's 1982 Budget to eliminate inappropriate Federal activities, e.g., closing the PHS hospitals, an estimated 500 Commissioned Corps physicians can contractually be reassigned to meet any documented PHS physician shortages. Thus, as with proposed changes for VA physician bonuses, it is unnecessary to maintain artificially high bonus levels for Commissioned Corps physicians. Rather, bonus levels will be tailored to the needs of each physician personnel system.

Key Facts About the Program

- The Administration will develop further reforms of the Commissioned Corps system so that it better meets HHS, rather than DOD, recruitment/retention needs and is better integrated with the HHS GS physician payment system.

Refugee Assistance

Agency: Department of Health and Human Services | Functional Code: 609 | Budget Reform Criterion: 6

Funding

($ in millions)

	1981	1982	1983	1984	1985	1986
CARTER BUDGET:[1/]						
Budget Authority	690	652	600	494	335	304
Outlays	579	658	678	581	485	389
REESTIMATES & ADJUSTMENTS*						
Budget Authority	−50	−21	– –	– –	– –	– –
Outlays	—31	−13	−6	– –	– –	– –
PROGRAM CHANGES:						
Budget Authority	– –	48	−57	−24	−14	−14
Outlays	– –	−41	−47	−39	−22	−15
REAGAN BUDGET:						
Budget Authority	640	583	543	470	321	290
Outlays	548	604	625	542	463	374
[1/] The Carter budget already included savings for this proposal. Total savings expected are as follows:						
Budget Authority		124	112	73	56	48
Outlays		88	103	84	62	48

Program Description

The Refugee Assistance program reimburses States for cash, medical assistance, and social services to refugees for up to three years after their arrival in the U.S. Up to 50% of the 181,000 refugees arriving in the U.S. during fiscal year 1981 may require public assistance. The voluntary agency grant program provides a $1,000 matching per capita grant for Soviet Jewish refugee resettlement social services in the U.S. The Cuban program phasedown gradually decreases the reimbursement to States (60% in FY 81, 45% in FY 82 and 25% in FY 83) for costs in providing services and benefits to "old" Cubans who arrived in 1962–78.

Proposed Change

- Rescind $30.4 million in 1981 for cash and medical assistance, and for voluntary agency grant programs, due to a decrease in the number of refugees (mainly Soviet and Indochinese) arriving in the U.S. in the first quarter of FY 81.
- Rescind $15 million in 1981 for "old" Cuban program phasedown for cash and medical assistance, and for reimbursement to states for services to Asylum Applicants, due to lower State cost estimates than projected earlier.
- Rescind $4.5 million in the 1981 Refugee Assistance budget for non-essential non-State administered social service projects and Federal Administration.
- Reduce the level of refugee benefits starting in 1982 to a level comparable to those given to the general population.

Rationale

Because of lower refugee flows, as displayed below, $30.4 million less will be needed in the state administered cash and medical assistance programs, and in the voluntary agency grants for resettlement social services.

	1st Quarter Projected	1st Quarter Actual	Decrease in Flow	% Decrease
Soviet Jewish	6,000	2,198	-3,802	64%
Indochinese	42,000	32,777	-9,223	22%

Eliminating the 20 year Cuban program in 1982 makes our refugee policy more consistent with the Refugee Act of 1980, which allows only 3 years of special Federal reimbursment. The old Cuban program is no longer needed as the average annual income of the old Cuban refugee families equals

96% of the average annual U.S. family income. A different program provides services to Cubans and Haitians arriving after 1978.

The proposed cash assistance changes makes the refugee assistance program more comparable to the AFDC program, and general assistance programs. This will eliminate the higher than normal U.S. public assistance program benefits paid in the refugee program.

Key Facts

- For services and assistance costs to the 125,000 Cubans and Haitians who arrived in Florida during the summer of 1980, states and localities have been reimbursed with Federal funds authorized by the Refugee Educational Assistance Act of 1980 (P.L. 96–422). This Act (also known as Fascell–Stone) provides up to $100 million in reimbursements to States and localities for services to Cuban and Haitians entrants for FY 82..
- The Federal Government reimburses States at the rate of 100% for services and assistance to refugees for up to three years.
- Voluntary agencies receive a $350 per capita grant for initial reception and placement services in addition to the $1000 resettlement social services grant for each Soviet Jewish refugee resettled in the U.S. Soivet Jewish refugees are entitled to all refugee benefits under the Refugee Act of 1980.

Social Security Overview

Funding

	($ in millions)					
	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	132,672	152,318	168,554	185,052	210,803	233,916
Outlays	139,884	161,551	183,078	203,705	224,196	244,638
REESTIMATES & ADJUSTMENTS:[1/]						
Budget Authority	+1,379	+649	+1,765	+2,256	+2,130	+2,680
Outlays	-294	-2,024	-6,741	-11,882	-17,172	-22,897
PROGRAM CHANGES:						
Adult Student Payments:						
Outlays	-35	-1,030	-1,675	-2,075	-2,225	-2,350
(Student Assist. Offset)	(- -)	(+30)	(+50)	(+75)	(+100)	(+100)
Minimum Payment Amount:[2/]						
Outlays	-60	-1,300	-1,400	-1,500	-1,500	-1,500
Payments on a Worker's Death:						
Outlays	- -	-150	-175	-200	-200	-200
Disability Insurance:						
Improve Administration Outlays	-50	-200	-500	-700	-900	-1,100
Institute a Megacap Outlays	-5	-50	-75	-100	-125	-150
Tighten recency-of-work (6 out of 13 quarters)						
Outlays	-5	-120	-350	-630	-950	-1,220
REAGAN BUDGET:						
Budget Authority	134,051	152,967	170,319	187,308	212,933	236,596
Outlays	139,435	156,677	172,162	186,618	201,124	215,221

[1/] Includes effects of student assistance (Pell Grant) offset.

[2/] Offsetting increases in other Federal programs associated with this proposal are not included above.

Social Security: Adult Student Payments

Agency: Department of Health and Human Services

Functional Code: 601

Budget Reform Criterion: 1

Program Description

Full time adult students age 18–21 get social security payments as dependents of retired, disabled or deceased workers. Aproximately 800,000 adult students now receive these payments. The average adult student payment is $255 per month and ranges from a low of $20 to a high of $700.

Proposed Change

Adult student payments would be eliminated. No new adult students would receive payments and existing student payments would be reduced by 25 percent each year over the next three years. Social security revenues would be more fully dedicated to basic benefits.

Rationale

- The benefit is inappropriate — social security protects against loss in income from risks (old age, disability and death) which are beyond the worker's control. Continuing the adult student payment past age 18 because adult students choose to go to school should not be an insurable risk.
- The payment is poorly designed as educational assistance — The payment amount is unrelated to the student's educational costs, proficiency in school, or ability to meet educational expenses.
- Educational assistance is granted more equitably and efficiently under other Federal programs — Financial aid for adult students from Federally insured student loans, national defense student loans, and basic educational opportunity grants would be increased for those needing assistance to offset the elimination of social security payments.
- Social security can no longer afford this drain — The present financial condition of social security was not anticipated when the student payment was introduced in 1965. The adult student payment departs from the basic purpose of social security. They should be eliminated particularly when trust funds are not adequate to assure basic benefits.

- Program participation rates and costs have exploded since 1965 — In the past ten years, the cost to social security of adult student payments have more than quadrupled. During that time, the number of student recipients increased only one–third. This occurred during a massive build–up in direct Federal student assistance.

Key Facts About the Program

The Federal Government invests heavily in post–secondary students, in recognition of the vital importance of education. Excluding social security, Federal assistance to post–secondary students multiplied 25 times since 1965, growing from less than $.3 billion in 1965 to $7.5 billion in 1982.

At the same time, payments to adult students from the social security trust funds were also rapidly increasing, from $.2 billion in 1965 to $.5 billion in 1972 to $2.2 billion in 1982.

Unlike other Federal aid to students, adult student payments in social security are unrelated to educational cost, need, or family income. These payments have become a sizable drain on the social security trust funds, which can simply no longer afford the more than $2 billion annual cost for these low–priority payments. Other, better targeted, federal educational assistance programs provide for those students needing aid.

	($ in billions)		
	1965	1972	1982
OASDI Balances (end–of–year)	22.2	43.8	20.3
OASDI Outlays	17.5	40.2	157.7
OASDI Reserves (Balance/Outlays)	127%	109%	13%

Social Security: Disability Insurance

Agency: Department of Health and Human Services	Functional Code: 601	Budget Reform Criterion: 1

Program Description

Disability insurance (DI) benefits replace worker's earnings (due to their inability to work) for the worker and the family. Both GAO and Social Security Administration studies show that hundreds of thousands of current recipients are not currently disabled but still receive payments. Benefits larger than a disabled worker's prior earnings may induce some individuals to apply for or remain on the DI rolls even though they could work and support themselves. Disability benefits also go to people who, not having been in social security covered work in the past 5 years, lack a reasonable basis to claim social security disability insurance payments. DI caseloads have risen by 80% since 1970, and costs have climbed by 500%.

Proposed Change

The Social Security Administration will be intensively reviewing cases to insure that only the truly disabled receive disability benefits. To remove the work disincentive caused by excessive benefit levels, a "megacap" will be established to ensure that disability income from all public sources never exceeds the worker's prior after tax earnings, adjusted for inflation. Legislation will also more closely focus eligibility for DI on those individuals who have recently worked in social security covered jobs before becoming disabled.

Rationale

The purpose of DI is to provide for workers and their families when a worker can no longer work. Payments should not go to people who are not disabled.

- Intensified reviews of new applicants and current recipients will weed out the 500,000 people receiving payments whom GAO says are not disabled, saving the trust fund hundreds of millions of dollars in mispent payments.
- Other weaknesses in the administration of DI, documented by GAO over the past 4 years, will be corrected by HHS.

Originally, to be eligible for DI, applicants must have worked for at least 6 of the previous 13 calendar quarters. This would relate their loss of earning due to disability to recent social security covered employent. The test was subsequently liberalized, when DI costs were quite low, so that individuals who did not depend on social security covered jobs — perhaps had not even worked in the past 5 years — could qualify for payments.

- Reinstituting the "recency of work" test would more closely link benefits to the replacement of lost (covered) earnings, the original purpose of DI.
- Benefits would be better targeted on individuals whose livelihood came from social security covered employment, while screening out wasteful payments to those with little social security covered work.
- The Supplemental Security income program is the proper "safety net" for the truly needy disabled without recent work experience.

The "megacap" proposal would limit public disability benefits so that they do not exceed a worker's prior after-tax earned income about (80% of earnings), adjusted for inflation. This would avoid:

- Individuals receiving more while disabled than they were paid for working.
- Continuing overly-generous benefits from uncoordinated, multiple sources which offer a perverse incentive, inducing people not to work.

Key Facts About the Program

The costs of disability insurance have grown by leaps and bounds, as shown below:

	Number of Disabled Workers Receiving Benefits	Annual Benefits ($ millions)	Average Monthly Benefits
1965	988,074	1,159	98
1970	1,492,948	2,352	131
1975	2,488,774	6,747	226
1981	2,869,000	16,978	410
1985	2,991,000	24,000	655

- "As a result of SSA's [previous] ... poor management ... as many as 584,000 beneficiaries who do not currently meet SSA's eligibility criteria may be receiving disability benefits. These beneficiaries represent over $2 billion annually in Trust Fund costs. ... substantial savings could be achieved if SSA focused on this problem." (HRD 81-48, March 3, 1981)
- SSA "has no means of measuring program efficiency" and "does not know how often [disability was determined based on]...medical examinations which were too comprehensive or were inadequate." (HRD 79-119, October 9, 1979)
- "The disability claims process needs to be more effectively managed by the Social Security Administration. Weaknesses in the disability claims proccess cause lengthy delays ...and...overexpenditures". (HRD 78-40, February 16, 1978)

Social Security: Minimum Payment Amount

Agency: Department of Health and Human Services	Functional Code: 601	Budget Reform Criterion: 1

Program Description

A minimum initial payment of $122 per month is given to social security recipients who, under the normal benefit formula, earned a lesser amount. Once on the rolls, the $122 minimum payment amount is increased by the CPI.

Proposed Change

Pay social security recipients only their "earned" benefits, no longer giving an artificial minimum amount above their earned benefits.

Rationale

Both GAO and various Social Security Advisory Councils concluded that the minimum benefit has outlived its usefulness and generates undersirable windfalls to workers with substantial employment not covered by social security. First enacted in 1939 at a $10 per month level before social security expanded to cover more than 9 out of 10 workers, the original purpose was to raise retirement income for those with very low wage histories, as well as those who worked in jobs before social security extended to their work.

Suppplemental Security Income (SSI), with benefits about double the social security minimum, better fulfills the social objective underlying the minimum. SSI provides a safety net for those in need without diverting over $1 billion annually from basic social security. The social security trust funds can no longer afford these low-priority payments.

Key Facts About the Program

- Since 1974, SSI has given cash assistance to the needy aged, blind, and disabled. For these individuals, the minimum payment merely offsets, dollar for dollar, the amount of SSI assistance they would otherwise receive.
- Only 17% (500,000) of minimum payment recipients are truly needy (on SSI). They would not experience any reduction in Federal payments.
- GAO found that for 74% of minimum payment recipients, social security is not the primary income source, and that they receive unintended windfalls beyond their modest social security contributions.

Of the 3 million minimum payment recipients, 1.7 million would not have their income reduced by eliminating minimum payments.

- 1.2 million would have offsetting increases in their OASDI benefits (i.e., derivative benefits to spouses, survivors, etc.).
- 500,000 minimum recipients would have offsetting increases in their SSI benefits.

GAO data show that at least 800,000 minimum recipients do not depend primarily on their social security payments.

- 450,000 (or 15% of minimum recipients) receive Federal pensions averaging over $900 per month.
- 350,000 (or 12% of minimum recipients) have working spouses whose earnings average over $14,000 annually.

For the remaining 500,000 minimum recipients, GAO data suggest that a significant number would have public pensions from State or local governments or "other" income.

Social Security: Payments On A Worker's Death

Agency: Department of Health and Human Services	Functional Code: 601	**Budget Reform Criterion: 1**

Program Description

Lump sum death payments of $255 are made when an insured worker dies regardless of whether there are surviving family members. The payment is made regardless of income, need, or the size of an estate. Typically, payments go directly to funeral home operators.

Proposed Change

Continue the lump sum death payment only for deceased workers when a surviving spouse or minor children are receiving survivors benefits. Eliminate the burial payment where no survivors benefits are payable. This payment would not go to funeral homes, estates, grown surviving children, or non-aged spouses who are not eligible for survivors benefits (i.e. who have no minor children in their care).

Rationale

The original intent of the worker's death payment was not only to help meet expenses for the last illness and burial of a deceased worker, but also to insure that the "return" on social security to a worker (or his estate) exceeded his social security taxes.

- Except for early deaths of beneficiaries without survivors, in virtually all cases social security retirement benefit payments now exceed a worker's social security taxes.
- The lump sum death payment is a maximum of $255; it would not generally cover full burial costs.

The cost of administering these small payments is 5 times higher than handling basic social security benefits. This proposal would not affect widows and orphans who would receive survivors benefits.

Key Facts About the Program

Almost half of current payments go to estates with no surviving spouse or surviving minor children. The payment is unrelated to social insurance, prior social security contributions, or benefits.

- The payment has remained frozen since 1954 because of its marginal relation to basic social security.
- Eliminating these payments to estates would better protect orphans and widows because social security's solvency would be improved.

Supplemental Security Income

Agency: Department of Health and Human Services

Functional Code: 609

Budget Reform Criterion: 1

Funding

	($ in millions)					
	1981	1982	1983	1984	1985	1986
CARTER BUDGET:						
Budget Authority	7,278	7,938	9,443	8,704	10,194	10,926
Outlays	7,305	7,972	9,453	8,675	10,186	10,926
REESTIMATES & ADJUSTMENTS*						
Budget Authority	−35	153	29	518	−196	−433
Outlays	−35	140	28	141	−193	−432
PROGRAM CHANGES:						
Budget Authority	− −	−110	−110	−110	−110	−110
Outlays	− −	−110	−110	−110	−110	−110
REAGAN BUDGET:						
Budget Authority	7,243	7,981	9,362	9,112	9,888	10,383
Outlays	7,270	8,002	9,371	8,706	9,883	10,376

* Effect of outlay reestimates, revised economic assumptions, and offsetting increase associated with proposed OASDI reductions.

Program Description

Supplemental Security Income (SSI) pays the needy elderly, blind and disabled based on their income with a minimum indexed guarantee of $238 a month for an individual and $357 a month for a couple.

Proposed Change

- Initiate retrospective accounting rather than prospective quarterly budgeting. Thus, instead of projecting income of recipients forward for 90 days, the actual income received over the prior period would be used to determine the Federal benefit payment. (−$60 million annually).
- Verify interest and divided income through IRS records and tighten SSI regulations conerning the exclusion of irregular income. (−$50 million annually).

Rationale

GAO report HRD 81–37 has recommended that retrospective accounting be used. Such a procedure reduces errors by relying on actual rather than estimated data. It is used in income tested (AFDC and Medicaid) programs by 12 States and is a federally authorized option in the Food Stamp program. A similar change is being sought in AFDC and Food Stamps.

Verifying interest and dividend income was recommended by GAO Report HRD 81–4 (February 4, 1981). This could be done at little cost through computer tape matching.

Key Facts About the Program

- By cross–checking records with the Veterans Administration, the Railroad Retirement Board, and the Civil Service retirement benefits system, the Social Security Administration was able to save $61 million in SSI overpayments annually. Similar cross–checking is proposed for IRS.