COMPARISON OF HEALTH PLANS FOR THE AGED PROPOSED IN HOUSE-PASSED SOCIAL SECURITY BILL H.R. 12580 AND OFFERED FOR SENATE CONSIDERATION AS AMENDMENTS TO OR SUBSTITUTES THEREFOR

COMMITTEE ON FINANCE
UNITED STATES SENATE
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AUGUST 8, 1960

Compiled and printed for the use of the Committee on Finance

UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1960

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	STATE-FEDERAL GRANTS-IN-AID APPROACH			SOCIAL SECURITY (OASI) APPROACH			
	House bill plan	Administration plan (S. 3784, introduced by Senator Saltonstall) proposed in committee by Secretary Flemming as an addition to the House plan	Javits amendment (6-27-60-H) cosponsored by the following Senators: Cooper, Scott, Fong, Aiken, Keating, and Prouty—In the nature of a substitute to the House plan	Morse amendment (6-27-60-F) (identical with Forand bill) and Humphrey amendment (6-28-60-G)—In the nature of a substitute to the House plan	Anderson amendment (6-30-60-B) cosponsored by Senators Humphrey and McCarthy—In addition to the House plan	McNamara amendment (6-24-60-C) cosponsored by the following Senators: Kennedy, Clark, Randolph, Symington, Humphrey, Williams of New Jersey, Magnuson, McGee, Young of Ohio, Douglas, Gruening, Long of Hawaii, Murray, Hart, Morse, Hennings, Jackson, Pastore, McCarthy, Bartlett, Engle, Green, and Mansfield—In the nature of a substitute to the House plan	Gore plan (S. 3763) cosponsored by Senator Yarborough—Intended to be offered as a substitute to the House plan
I. Basic approach	Provides for Federal program of grants-in-aid to States under which participating States would be reimbursed for a part of their expenditures in providing medical services for aged persons who are unable to meet the costs of their medical needs out of their own resources.	Provides for Federal program of grants-in-aid to States under which the States would be reimbursed for a part of their expenditures in assisting aged individuals with low incomes in meeting the cost of long-term or other expensive illnesses.	Provides Federal grants-in-aid to States which provide health insurance for aged persons and their spouses at a premium fixed according to the subscriber's income. Each State would have the option of providing such insurance through its own agency or through private insurers, both profit and nonprofit. If the latter method is chosen, the State would make payments to the insurers equal to any deficit arising from the income related premiums charged.	Would provide medical benefits for persons eligible to receive social security old-age or survivors benefits by adding a new category of benefits to title II of the Social Security Act.	Provides medical benefits for persons age 68 and over who are eligible to receive social security benefits by adding a new category of benefits to title II of the Social Security Act.	Provides medical benefits for aged persons who meet an earnings (retirement) test by adding a new category of benefits for social-security eligibles to title II; and similar benefits, under a new title XVI, for social-security ineligibles financed from general revenue but administered through the OASDI system.	Same as McNamara amendment.
II. Financing and costs (Cost estimates are made from materials supplied by the Department of Health, Education, and Welfare, unless otherwise indicated.)	Federal payments to States would be determined under an equalization formula based on the States' per capita income. Federal share would vary from 50 percent in the high income States to 65 percent in low income States. The Federal Government would pay half of the administrative expenses of all States. The Federal share would be financed from general revenue. Assuming all States participate, estimated costs for 1st year of full operation are as follows: *Millions* Federal .... $165.5 State .... 159.6 Total 325.1	Federal payments (out of general revenue) would be determined in much the same way as under the House bill, except that Federal share would run from 33⅓ percent in high income States to 66⅔ percent in low income States. Combined with House plan, estimated costs in the 1st year of full operation would be (assuming 80 percent of eligibles, 10 million persons, participate): *Million* Administration plan: Federal .... $602.5 State .... 627.2 Enrollment fees .... 181.7 House plan: Federal .... 122.9 State .... 116.8 Additional old-age assistance: Federal .... 74.3 State .... −19.3 Total Federal .... 799.7 Total State .... 724.7 Enrollment fees .... 181.7 Grand total .... 1,706.1 [As a substitute for House plan, estimated cost in the 1st year of full operation would be: *Million* Administration plan: Federal .... $602.5 State .... 627.2 Enrollment fees .... 181.7 Additional old-age assistance: Federal .... 65.5 State .... −10.5 Total Federal .... 668.0 Total State .... 616.7 Enrollment fees .... 181.7 Grand total .... 1,466.4]	From general revenues, using a Federal-State matching formula based on State per-capita income. The Federal share could run from 75 percent for lowest income States to 33⅓ percent for highest income States. Federal matching would be available on amounts expended by the States up to $13 per month per beneficiary, less any subscription charges. Assuming coverage is provided for 12 million persons, estimated costs for the 1st year of full operation are as follows: *Million* Minimum benefits: Federal .... $400 State .... 480 Subscriber premiums .... None Total .... 880 Maximum benefits: Federal .... 480 State .... 640 Subscriber premiums .... 400 Total .... 1,520 [NOTE.—Estimates taken from statement by Senator Javits. No estimates by Department of Health, Education, and Welfare available at present.]	Benefits would be paid out of a medical insurance trust fund derived from social security payroll taxes. Estimated costs are as follows: Morse amendment: Early year—0.53 percent of payroll, or $1,110 million. Level premium—0.79 percent of payroll, or $2,560 million per year. Humphrey amendment: Early year—0.44 percent of payroll, or $920 million. Level premium—0.67 percent of payroll, or $2,170 million per year. Tax increases are provided on both employers and employees of one-fourth of 1 percent and three-eighths of 1 percent on the self-employed beginning in 1961. These increases would derive funds equivalent to 0.50 percent of payroll on a level premium basis and, thus, the amendments are underfinanced.	Benefits would be paid out of a medical insurance account in the old-age and survivors insurance trust fund derived from the social security payroll tax. Estimated costs are as follows: Early year—0.30 percent of payroll, or $630 million. Level premium—0.48 percent of payroll, or $1,550 million per year. Tax increases are provided on both employers and employees of one-fourth of 1 percent and three-eighths of 1 percent on the self-employed beginning in 1961. These increases would derive funds equivalent to 0.50 percent of payroll and, thus, the amendment is fully financed. [The cost of the House plan (as combined with the Anderson plan) for the 1st year of full operation would be: *Million* Federal .... $137 State .... 131 Total .... 268]	Benefits for social security eligibles would be paid for out of a medical insurance trust fund derived in part from the social security payroll tax. The estimated costs of providing benefits for this group are as follows: Early year—0.50 percent of payroll, or $1,050 million. Level premium—0.89 percent of payroll, or $2,880 million per year. To finance the benefits for OASI eligibles, an increase in the tax on both employer and employees of ¼ of 1 percent beginning in 1961 is provided and an additional increase of ¼ of 1 percent in 1972. Similar increases in the self-employed tax of ⅜ and 3/16 of 1 percent are also provided. These increases derive 0.70 percent of payroll and, thus, the amendment is underfinanced. Benefits for those not eligible for social security benefits would also be paid out of the medical insurance trust fund, but the cost of such benefits would be financed out of general revenue rather than the social security payroll tax. The estimated cost for the 1st year of full operation of providing benefits for this group is $430 million a year, with an offset of about $100 million a year of savings in the old-age assistance and veterans programs.	Financing—same as the McNamara amendment. Estimated cost of providing benefits to social security eligibles: Early year—0.73 percent of payroll, or $1,540 million. Level premium—1.20 percent of payroll, or $3,890 million per year. To finance the benefits for OASI eligibles, an increase in the tax on both employer and employee of ¼ of 1 percent, beginning in 1961, is provided and an additional increase of ¼ of 1 percent in 1972. Similar increases in the self-employed tax of ⅜ and 3/16 of 1 percent are also provided. These increases derive 0.70 percent of payroll and, thus, the amendment is underfinanced. Estimated cost of providing benefits to persons ineligible for social security benefits would be $630 million for the 1st year of full operation. Offsetting this amount would be about $150 million of savings in the old-age assistance and veterans medical programs.
III. Coverage	Potential coverage—approximately 10 million. Actual coverage would depend upon the willingness of the States to undertake such programs and upon the eligibility standards formulated by each State.	Potential coverage—approximately 12.5 million. Actual coverage would depend upon the willingness of the States to undertake the programs and the willingness of individuals to participate. Cost estimates are based upon 10 million persons participating.	Potential coverage—approximately 16 million. Actual coverage would depend upon the willingness of States, insurance carriers, and individuals to participate. Cost estimates based on 12 million participants.	Approximately 15.6 million of which 13.2 million are aged eligibles for social security and 2.4 million are nonaged dependents and survivors.	Eight and one-half million persons would get benefits as social-security eligibles. In all, Anderson plan plus House plan would cover about 12 million.	Approximately 11.3 million eligible for social security benefits and approximately 3.5 million ineligible under social security. Total—approximately 14.8 million.	Same as McNamara amendment.

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IV. Eligibility for benefits	Each State could formulate its own eligibility standards within the State plan, except that benefits must be provided for residents of the State who— (1) have attained age 65; and (2) have income and resources considering their other living requirements as determined by the State, which are insufficient to meet the cost of their medical services. Persons under age 65 or persons receiving public assistance could not be made eligible under the State plan. The State plan may not require an enrollment fee as a condition of eligibility or impose a lien on the property of a beneficiary during his life or that of his surviving spouse.	The State plan must provide benefits for persons who— (1) have attained age 65; (2) did not pay income tax in the preceding year or whose adjusted gross income plus social security, railroad retirement, or veteran's pension did not exceed $2,500 in the preceding year ($3,800 for a married couple); and (3) have paid an enrollment fee to the State of $24 per year.	All persons 65 and over and their spouses would be eligible to purchase a policy either from the State agency or from a private insurer. The State would fix the income related premium, except that the State may not make the premium more than the "maximum premium cost" if that cost is less than $13 per month. "Income" is defined in the amendment to mean "adjusted gross income" plus social security benefits, railroad retirement benefits, and veterans' pensions. Benefits may be provided for public assistance recipients on a negotiated rate basis.	All persons eligible to receive (but not necessarily receiving) old-age or survivors benefits would be eligible for medical benefits.	All persons aged 68 or over who are eligible for (but not necessarily receiving) social security benefits would be eligible for medical benefits.	Benefits would be provided for all persons who— (1) have attained retirement age (65 for men, 62 for women); and (2) have "retired." An individual would be "retired" if— (i) he earned less than $2,000 in the calendar year he reached age 64 (61 for women) or in any year thereafter; or (ii) he had 3 months in each of which he earned $100 or less or did not engage in substantial self-employment in the calendar year he reached age 64 (61 for women) or in any year thereafter; or (iii) he had attained age 72. Retirees under Railroad and Civil Service (not eligible for Social Security) excluded but declares Congressional policy that similar benefits be provided for them as soon as possible.	Same as the McNamara amendment.
V. Scope of benefits	The State plan could include medical services of any scope, amount, and duration, provided that both institutional and noninstitutional services are included, and provided further, that the medical benefits are not greater in scope, amount, or duration than those available for old-age assistance recipients in the State. The Federal Government would share in the expense of providing the following kinds of medical services, without limit: (1) Skilled nursing home services; (2) Physicians' services; (3) Outpatient hospital services; (4) Private duty nursing services; (5) Organized home-care services; (6) Therapeutic services; and (7) Major dental care. The Federal Government would share in the expense of providing the following kinds of medical services, up to the limits stated: (1) Hospital services*—up to 120 days per year; (2) Laboratory and X-ray services—up to $200 per year; and (3) Prescribed drugs—up to $200 per year. The Federal Government would not share in the expense of providing any services not determined to be necessary by a physician, and would not share in the expense of providing any kind of medical services not listed above. The Secretary could not approve any plan which would result in a reduction of the public assistance programs.	State plans must provide the following benefits: (1) Hospital services*—180 days per year; (2) Nursing home care—365 days per year; (3) Organized home-care services—365 days per year; (4) Surgical procedures—no limit; (5) Dental services—no limit; (6) Laboratory and X-ray services—up to $200 per year; (7) Physicians' services—no limit; (8) Prescribed drugs—up to $350 per year; (9) Private duty nursing services—no limit; and (10) Physical restoration services—no limit. However, the above-listed benefits would be available only to the extent of 80 percent of the amount by which an individual's yearly medical expenses exceeded $250 ($400 for a married couple). These "deductible" and "coinsurance" provisions do not apply to public assistance recipients. An individual who elects not to participate in the program outlined above may instead purchase a major medical insurance policy from a private carrier. Half of his premium would be paid for by the program but such payments cannot exceed $60 per year for an individual.	The policies issued by the State agency or by insurers receiving payments from the State may provide either service or indemnity benefits, but must provide at least the following minimum benefits: (1) Hospital care—21 days per year (or equivalent nursing home care); (2) Physicians' services—12 home or office visits per year; (3) Diagnostic and laboratory services—up to $100 per year; and (4) Visiting nurse services—24 visits per year. The State plan may provide for additional benefits of any or all of the kinds listed above so long as one-third of the benefits are for ambulatory, out-patient services, or physicians' office calls.	The Morse amendment would provide the following benefits: (1) Hospital services*—60 days per year; (2) Nursing home services after transfer from hospital—120 days per year (less days of hospitalization); and (3) Nonelective surgery—no limit. The Humphrey amendment provides the same benefits except that surgery is excluded.	Benefits would include the following: (1) Hospital services*—365 days per year, with an initial deductible of $75, repeated after 24 days' continuous hospitalization; (2) Skilled nursing home recuperative care after transfer from hospital—180 days per year; and (3) Visiting nurse services—365 visits per year.	Benefits would include the following: (1) Hospital services*—90 days per year; (2) Nursing home care—180 days per year; (3) Home health services—240 days per year; (The first 3 kinds of benefits may be combined, but the maximum allowable amount is 90 units per year. 1 unit=1 hospital day 2 nursing home days 2⅔ home health days.) (4) Diagnostic outpatient services—to the extent prescribed by regulation; and (5) Very expensive drugs—to the extent prescribed by regulation.	Benefits would include the following: (1) Hospital services*—60 days per year; (2) Nursing home services—120 days per year; (3) Home health services—180 days per year; and (4) Physicians' services—25 visits per year; (The first 4 categories of benefits may be combined or substituted, but the maximum cannot exceed 60 units per year. 1 unit=1 hospital day 2 nursing home days 2 home physicians' visits 3 home health service days 4 office physicians' visits) (5) Diagnostic outpatient services—to the extent prescribed by regulation; (6) Surgical services—no limit; and (7) Specified drugs—to the extent prescribed by regulation, but not more than 30 days' treatment per year.
VI. Effective date of benefits	Payments to States commencing quarter beginning July 1, 1961.	Same as House bill.	Same as House bill.	First day of 12th calendar month after month of enactment.	July 1, 1961	Hospitalization and diagnostic outpatient services 7-1-61 or not later than 1-1-62; nursing home, 1-1-63 or not later than 7-1-63; home health services, 1-1-62 or not later than 7-1-62; very expensive drugs, 7-1-62 or not later than 1-1-63.	Hospital, physicians & surgical services, 7-1-61 or not later than 1-1-62; nursing home services, 1-1-63 or not later than 7-1-63; home health services, 1-1-62 or not later than 7-1-62; diagnostic outpatient services, 7-1-61 or not later than 1-1-62; specified drugs, 7-1-62 or not later than 1-1-63.

*The term "hospital services" is generally defined to include drugs, laboratory services, medical and nursing services, bed and board, etc., when furnished by a hospital to an inpatient, but does not include services in mental or tuberculosis hospitals.