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SOCIAL SECURITY

1680 —

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

FIRST SESSION

ON

H.R. 6675

AN ACT TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR THE AGED UNDER THE SOCIAL SECURITY ACT WITH A SUPPLEMENTARY HEALTH BENEFITS PROGRAM AND AN EXPANDED PROGRAM OF MEDICAL ASSISTANCE, TO INCREASE BENEFITS UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM, TO IMPROVE THE FEDERAL-STATE PUBLIC ASSISTANCE PROGRAMS, AND FOR OTHER PURPOSES

PART 1

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SOCIAL SECURITY

THURSDAY, APRIL 29, 1965

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

The committee met, pursuant to notice, at 10 a.m., in room 2221, New Senate Office Building, Senator Harry Flood Byrd (chairman) presiding.

Present: Senators Byrd, Long, Smathers, Anderson, Douglas, Gore, Talmadge, McCarthy, Hartke, Ribicoff, Williams, Carlson, and Curtis.

Also present: Elizabeth B. Springer, chief clerk.

Senator LONG. The chairman will be a few minutes late. He has asked that I chair the meeting temporarily until he arrives. The hearing today is on the Social Security Amendments of 1965 (H.R. 6675).

(A copy of the bill follows:)

[H.R. 6675, 89th Cong., 1st sess.]

AN ACT To provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance programs, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1965".

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TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

SHORT TITLE

Sec. 100. This title may be cited as the "Health Insurance for the Aged Act."

PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Sec. 101. Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

"Sec. 226. (a) Every individual who—

"(1) has attained the age of 65, and

"(2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

"(b) For purposes of subsection (a)—

"(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services (as such terms are defined in part C of title XVIII) furnished him in the United States during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or post-hospital home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later; and

"(2) an individual shall be deemed entitled to monthly insurance benefits under section 202, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

"(c) For purposes of this section, the term 'qualified railroad retirement beneficiary' means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 21 of the Railroad Retirement Act of 1937.

"(b) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965."

HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS

SEC. 102. (a) The Social Security Act is amended by adding after title XVII the following new title:

"TITLE XVIII—HEALTH INSURANCE FOR THE AGED

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

"SEC. 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

"FREE CHOICE BY PATIENT GUARANTEED

"SEC. 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

"OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

"SEC. 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

"PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

"DESCRIPTION OF PROGRAM

"SEC. 1811. The insurance program for which entitlement is established by section 226 provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system.

"SCOPE OF BENEFITS

"SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(1) inpatient hospital services for up to 60 days during any spell of illness;

"(2) post-hospital extended care services for up to 20 days (or up to 100 days in certain circumstances) during any spell of illness;

"(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and

"(4) outpatient hospital diagnostic services.

"(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsections (c) and (d)) be made for—

"(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 60 days during such spell; or

"(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 20 days during such spell.

"(c) The 20 days provided by subsection (b)(2) shall be increased (but by not more than 80 days) by twice the number by which the days for which the individual has already been furnished inpatient hospital services in the spell of illness are less than 60. The individual may terminate the application of this subsection with respect to any day (and the remaining days in the spell of illness) by an election made at such time and in such manner as may be prescribed by regulations. If the number of days of post-hospital extended care services in the spell of illness has been increased pursuant to this subsection, a corresponding reduction (on the basis of one day of inpatient hospital services for each two days of post-hospital extended care services in excess of 20 plus, where the number of such days of post-hospital extended care services is an odd number, one day of inpatient hospital services) shall be made in the number of days allowable under subsection (b)(1) for the same spell of illness.

"(d) If an individual is an inpatient of a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day shall be included in determining the 60-day limit under subsection (b)(1).

"(e) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.

"(f) For purposes of subsections (b), (c), (d), and (e), inpatient hospital services, post-hospital extended care services, and post-hospital home health services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

"(g) For definition of 'spell of illness', and for definitions of other terms used in this part, see section 1861.

"DEDUCTIBLES

"SEC. 1813. (a)(1) Payment for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible; except that such deductible shall itself be reduced by any deduction imposed under paragraph (2) with respect to a diagnostic study

by the same hospital which began before but did not end more than 20 days before the first day of such spell of illness or, if less, the charges imposed with respect to the individual for the outpatient hospital diagnostic services provided during such study.

"(2) Payment for outpatient hospital diagnostic services furnished an individual during a diagnostic study shall be reduced by a deduction equal to one-half of the inpatient hospital deductible which is applicable to spells of illness beginning in the same calendar year as such diagnostic study. For purposes of the preceding sentence and paragraph (1), a diagnostic study for any individual consists of the outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (not included in a previous diagnostic study) on which he is entitled to hospital insurance benefits under section 226 and on which outpatient hospital diagnostic services are furnished him.

"(3) Payment to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by an amount equal to the cost of the first three pints of whole blood furnished to him as part of such services during such spell of illness.

"(b)(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) shall be $40 in the case of any spell of illness or diagnostic study beginning before 1969.

"(2) The Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5 (or, if it is midway between two multiples of $5, to the next higher multiple of $5). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1866, to individuals who are entitled to hospital insurance benefits under section 226, plus the amount which would have been so paid but for subsection (a)(1) of this section.

"CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

"Requirement of Requests and Certifications

"SEC. 1814. (a) Except as provided in subsection (d), payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

"(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe;

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

"(A) in the case of inpatient hospital services (other than inpatient tuberculosis hospital services), such services are or were required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is or was medically required and such services are or were necessary for such purpose;

"(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition of which such treatment is or was necessary or (ii) render the condition noncommunicable;

"(C) in the case of post-hospital extended care services, such services are or were required to be given on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving impatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) prior to transfer to the extended care facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

"(D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

"(E) in the case of outpatient hospital diagnostic services, such services are or were required for diagnostic study;

"(3) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

"(4) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect at the time of admission of such individual to the hospital or extended care facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

"(5) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4)) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

"Reasonable Cost of Services

"(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall be the reasonable cost of such services, as determined under section 1861(v).

"No Payments to Federal Providers of Services

"(c) No payment may be made under this part (except under subsection (d)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of serv-

ices for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

"Payments for Emergency Hospital Services

"(d) Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

"Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

"(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

"PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1815. The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

"USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

"SEC. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hosptials, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such

audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

"(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless he finds (1) that to do so is consistent with the effective and efficient administration of this part, (2) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and (3) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part.

"(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of such of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement.

"(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

"(e) An agreement with the Secretary under this section may be terminated—

"(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

"(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

"(f) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(g) (1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"FEDERAL HOSPITAL INSURANCE TRUST FUND

"SEC. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

"(1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

"(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each year. It shall be the duty of the Board of Trustees to—

"(1) Hold the Trust Fund;

"(2) Report to the Congress not later than the first day of March of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

"(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which

are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

"(f)(1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary shall furnish the Managing Trustee such information as may be required by the Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

"(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

"(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

"(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

"PART B—SUPPLEMENTARY HEALTH INSURANCE BENEFITS FOR THE AGED

"ESTABLISHMENT OF SUPPLEMENTARY HEALTH INSURANCE PROGRAM FOR THE AGED

"SEC. 1831. There is hereby established a voluntary insurance program to provide health insurance benefits in accordance with the provisions of this part for individuals 65 years of age or over who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

"SCOPE OF BENEFITS

"SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

"(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for—

"(A) physicians services; and

"(B) medical and other health services, except those described in paragraph (2)(C); and

"(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

"(A) inpatient psychiatric hospital services for up to 60 days during a spell of illness;

"(B) home health services for up to 100 visits during a calendar year; and

"(C) medical and other health services furnished by a provider of services or by others under arrangements with them made by a provider of services.

"(b) For definitions of 'spell of illness', 'medical and other health services' and other terms used in this part, see section 1861.

"PAYMENT OF BENEFITS

"SEC. 1833. (a) Subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Health Insurance Benefits Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

"(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; and

"(2) in the case of services described in section 1832(a)(2)—80 percent of the reasonable cost of the services (as determined under section 1861(v)).

"(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $50; except that the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year.

"(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

"(1) $312.50, or

"(2) 62½ percent of such expenses.

"(d) Notwithstanding any other provision of this part, expenses for whole blood furnished to an individual in a hospital shall be considered incurred expenses for purposes of subsections (a) and (b) only if he has already been furnished in the same spell of illness 3 pints of whole blood for which (except for this subjection or section 1813(a)(3)) payment would be made under this title.

"(e) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

"(f) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

"DURATION OF SERVICES

"SEC. 1834. (a)(1) Payment under this part for inpatient psychiatric hospital services furnished an individual during a spell of illness may not be made after such services have been furnished to him for 60 days during such spell; and no payment under this part for inpatient psychiatric hospital services furnished an individual may be made after such services have been furnished to him for a total of 180 days during his lifetime.

"(2) If an individual is an inpatient in a psychiatric hospital on the first day on which he is entitled to benefits under this part, the days in the 60-day period immediately before such first day on which he was an inpatient in such a hospital

shall be included in determining the 60-day limit under paragraph (1) but not in determining the 180-day limit under such paragraph.

"(b) Payment under this part may not be made for home health services furnished an individual during any calendar year after such services have been furnished to him during such year for 100 visits. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

"(c) For purposes of subsections (a)(1) and (b), inpatient psychiatric hospital services and home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.

"PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

"SEC. 1835. (a) Payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

"(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulations prescribe;

"(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient psychiatric hospital services not later than the 20th day of such period) that—

"(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

"(B) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or because he needed physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the case of a physician; and

"(C) in the case of medical and other health services, such services are or were medically required;

"(3) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

"(4) with respect to inpatient psychiatric hospital services furnished to the individual after the 20th day of a continuous period of such services, there was not in effect, at the time of admission of such individual to the hospital, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital); and

"(5) with respect to inpatient psychiatric hospital services furnished to the individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4)) pursuant to the system of utilization review that further inpatient psychiatric hospital services are not medically necessary; except that, if such a finding has been made, payment may be made with respect to such services furnished before the 4th day after the day on which the hospital received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A), (B), or

(C) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

"(b) No payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

"(c) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient psychiatric hospital services furnished by any psychiatric hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1834 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

"ELIGIBLE INDIVIDUALS

"SEC. 1836. Every individual who—

"(1) has attained the age of 65, and

"(2) is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence,

is eligible to enroll in the insurance program established by this part.

"ENROLLMENT PERIODS

"SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

"(b)(1) No individual may enroll for the first time under this part more than 3 years after the close of the first enrollment period during which he could have enrolled under this part.

"(2) An individual whose enrollment under this part has terminated may not enroll for the second time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the effective date of such termination. No individual may enroll under this part more than twice.

"(c) In the case of individuals who first satisfy paragraphs (1) and (2) of section 1836 before January 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on March 31, 1966.

"(d) In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 on or after January 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later.

"(e) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on October 1 and ending on December 31 of each odd-numbered year beginning with 1967.

"COVERAGE PERIOD

"SEC. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his 'coverage period') shall begin on whichever of the following is the latest:

"(1) July 1, 1966; or

"(2) the first day of the third month following the month in which he

enrolls pursuant to subsection (d) of section 1837, or the July 1 following the month in which he enrolls pursuant to subsection (e) of section 1837.

"(b) An individual's coverage period shall continue until his enrollment has been terminated—

"(1) by the filing of notice, during a general enrollment period described in section 1837(e), that the individual no longer wishes to participate in the insurance program established by this part, or

"(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of December 31 of the year in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period (not in excess of 90 days) in which overdue premiums may be paid and coverage continued.

"(c) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

"AMOUNTS OF PREMIUMS

"SEC. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be $3.

"(b)(1) The monthly premium of each individual enrolled under this part for each month after 1967 shall be the amount determined under paragraph (2).

"(2) The Secretary shall, between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in either of the two succeeding calendar years. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such two succeeding calendar years will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Health Insurance Benefits Trust Fund for such two suceeding calendar years. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin.

"(c) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) shall be increased by 10 percent of the monthly premium so determined for each full 12 months in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time.

"(d) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

"PAYMENT OF PREMIUMS

"SEC. 1840. (a)(1) In the case of an individual who is entitled to monthly benefits under section 202, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Health Insurance Benefits Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"(b)(1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937, his monthly

premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Health Insurance Benefits Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"(c) In the case of an individual who is entitled both to month benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.

"(d) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

"(e) In the case of an individual who participates in the insurance program established by this part but with respect to whom neither subsection (a) nor subsection (b) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

"(f) Amounts paid to the Secretary under subsection (d) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Health Insurance Benefits Trust Fund.

"(g) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

"FEDERAL SUPPLEMENTARY HEALTH INSURANCE BENEFITS TRUST FUND

"SEC. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Supplementary Health Insurance Benefits Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

"(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the 'Managing Trustee'). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each year. It shall be the duty of the Board of Trustees to—

"(1) Hold the Trust Fund;

"(2) Report to the Congress not later than the first day of March of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

"(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

"(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from,

the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

"(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

"(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

"(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

"(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

"(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

"USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

"SEC. 1842. (a) In order to provide for the administration of the benefits under this part, the Secretary shall to the extent possible enter into contracts with carriers which will undertake to perform the following functions or, to the extent provided in such contracts, to secure such performance by other organizations:

"(1) (A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

"(B) receive, disburse, and account for funds in making such payments; and

"(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

"(2) (A) determine compliance with the requirements of section 1861(k) as to utilization review; and

"(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2) to make reviews of utilization;

"(3) serve as a channel of communication of information relating to the administration of this part; and

"(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

"(b) (1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

"(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial reponsibility, legal authority, and other matters as he finds pertinent.

"(3) Each such contract shall provide that the carrier—

"(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

"(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, (i) such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and (ii) such payment will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service;

"(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

"(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

"(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate.

"(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

"(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

"(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(e) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud

the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(f) For purposese of this part, the term 'carrier' means—

"(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance polices or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

"(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

"STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

"SEC. 1843. (a) The Secretary shall, at the request of a State made before July 1, 1967, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

"(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

"(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

"(2) individuals receiving money payments under all of the plans of such State approved under titles I, IV, X, XIV, and XVI;

except that there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

"(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date and before July 1, 1967; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter before July 1967.

(d) In the case of any individual enrolled pursuant to this section —

"(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (c) thereof);

"(2) his coverage period shall begin on whichever of the following is the latest:

"(A) July 1, 1966;

"(B) the first day of the third month following the month in which the State agreement is entered into;

"(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

"(D) such date (not later than July 1, 1967) as may be specified in the agreement; and

"(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

"(A) the month in which he is determined by the State agency to have become ineligible for money payments of a kind specified in the agreement, or

"(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

"(e) Any individual whose coverage period attributable to the State agree-

ment is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c).

"(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, IV, X, XIV, or XVI, if the agreement entered into under this section so provides, the term 'carrier' as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, IV, X, XIV, and XVI.

"APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

"SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Health Insurance Benefits Trust Fund, a Government contribution equal to the aggregate premiums payable under this part.

"(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated during the fiscal year ending June 30, 1966, out of any moneys in the Treasury not otherwise appropriated, to remain available through the next fiscal year for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

"PART C—MISCELLANEOUS PROVISIONS

"DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

"SEC. 1861. For purposes of this title—

"Spell of Illness

"(a) The term 'spell of illness' with respect to any individual means a period of consecutive days—

"(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A or part B, and

"(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility.

"Inpatient Hospital Services

"(b) The term 'inpatient hospital services' means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

"(1) bed and board;

"(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

"(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

"(4) medical or surgical services provided by a physician, resident, or intern; and

"(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in the hospital by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association (or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association).

"Inpatient Psychiatric Hospital Services

"(c) The term 'inpatient psychiatric hospital services' means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

"Inpatient Tuberculosis Hospital Services

"(d) The term 'inpatient tuberculosis hospital services' means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

"Hospital

"(e) The term 'hospital' (except for purposes of section 1814(d), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treament, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) maintains clinical records on all patients;

"(3) has by laws in effect with respect to its staff of physicians;

"(4) has a requirement that every patient must be under the care of a physician;

"(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

"(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

"(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

"(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) (including determination of whether an individual received inpatient hospital services for purposes of such section), and subsections (i) and (n) of this section, such term includes any institution which meets the requirements of paragraphs (1), (2), (3), (4), (5), and (7) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis; except that for purposes of part A (and so much of this part as relates to part A) such term shall include such an institution if it is a tuberculosis hospital (as defined in subsection (g)), and for purposes of part B (and so much of this part as relates to part (B) such term shall include such an institution if it is a psychiatric hospital (as defined in subsection (f)). The term 'hospital' also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to the extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

"Psychiatric Hospital

"(f) The term 'psychiatric hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals enrolled under the insurance program established by part B;

"(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on the Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a 'psychiatric hospital' if the institution is accredited by the Joint Commission on the Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Tuberculosis Hospital

"(g) The term 'tuberculosis hospital' means an institution which—

"(1) is primarily engaged in providing, by or under the supervision of physician, medical services for the diagnosis and treatment of tuberculosis;

"(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);

"(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

"(4) meets such staffing requirements as the Secretary finds necessary fo the institution to carry out an active program of treatment for individual who are furnished services in the institution; and

"(5) is accredited by the Joint Commission on the Accreditation o Hospitals.

In the case of institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraph (3) and (4) of such sentence, such distinct part shall be considered to be 'tuberculosis hospital' if the institution is accredited by the Joint Commission o the Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

"Extended Care Services

"(h) The term 'extended care services' means the following items and service furnished to an inpatient of an extended care facility and (except as provide in paragraphs (3) and (6)) by such extended care facility—

"(1) nursing care provided by or under the supervision of a registere professional nurse;

"(2) bed and board in connection with the furnishing of such nursin care;

"(3) physical, occupational, or speech therapy furnished by the extende care facility or by others under arrangements with them made by th facility;

"(4) medical social services;

"(5) such drugs, biologicals, supplies, appliances, and equipment, fur nished for use in the extended care facility, as are ordinarily furnished b such facility for the care and treatment of inpatients;

"(6) medical services provided by an intern or resident-in-training of hospital with which the facility has in effect a transfer agreement (meetin the requirements of subsection (l)), under a teaching program of suc hospital approved as provided in the last sentence of subsection (b), an other diagnostic or therapeutic services provided by a hospital with whic the facility has such an agreement in effect; and

"(7) such other services necessary to the health of the patients as are generally provided by extended care facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

"Post-Hospital Extended Care Services

"(i) The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the extended care facility within 14 days after discharge from such hospital, and such individual shall be deemed not to have been discharged from the extended care facility if readmitted thereto within 14 days after discharge therefrom.

"Extended Care Facility

"(j) The term 'extended care facility' means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

"(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

"(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

"(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

"(5) maintains clinical records on all patients;

"(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

"(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"(8) has in effect a utilization review plan which meets the requirements of subsection (k);

"(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

"(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

"Utilization Review

"(k) A utilization review plan of a hospital or extended care facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical

necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

"(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

"(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

"(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or extended care facility where, because of the small size of the institution, or (in the case of an extended care facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

"Agreements for Transfer Between Extended Care Facilities and Hospitals

"(l) A hospital and an extended care facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any extended care facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

"Home Health Services

"(m) The term 'home health services' means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

"(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

"(2) physical, occupational, or speech therapy;

"(3) medical social services under the direction of a physician;

"(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

"(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

"(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

"(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

"(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

"(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

"Post-Hospital Home Health Services

"(n) The term 'post-hospital home health services' means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from an extended care facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or extended care facility.

"Home Health Agency

"(o) The term 'home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which—

"(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

"(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

"(3) maintains clinical records on all patients;

"(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

"(5) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

"Outpatient Hospital Diagnostic Services

"(p) The term 'outpatient hospital diagnostic services' means diagnostic services—

"(1) which are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital; and

"(2) which are ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

excluding, however—

"(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

"(4) any services furnished under such arrangements unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

"Physicians' Services

"(q) The term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in the last sentence of subsection (b)).

"Physician

"(r) The term 'physician', when used in connection with the performance of any function or action, means an individual legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)).

"Medical and Other Health Services

"(s) The term 'medical and other health services' means any of the following items or services (unless they would otherwise constitute inpatient hospital services, extended care services, home health services, or physicians' services):

"(1) diagnostic, X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

"(2) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

"(3) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

"(4) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home);

"(5) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

"(6) prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices; and

"(7) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

"Drugs and Biologicals

"(t) The term 'drugs' and the term 'biologicals', except for purposes of subsection (m)(5) of this section, include only such drugs and biologicals, respectively, as are included in the United States Pharmacopoeia or the National Formulary, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals.

"Provider of Services

"(u) The term 'provider of services' means a hospital, extended care facility, or home health agency.

"Reasonable Cost

"(v)(1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of

services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retractive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

"(2) (A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

"(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

"(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A or part B, as the case may be, shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or extended care facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

"(4) For purposes of this subsection, the term 'semi-private accommodations' means two-bed, three-bed, or four-bed accommodations.

"Arrangements for Certain Services

"(w) The term 'arrangements' is limited to arrangements under which receipt of payment by the hospital, extended care facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

"State and United States

"(x) The terms 'State' and 'United States' have the meaning given to them by subsections (h) and (i), respectively, of section 210.

"EXCLUSIONS FROM COVERAGE

"SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

"(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

"(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

"(3) which are paid for directly or indirectly by a governmental entity (other than under this Act), except in such cases as the Secretary may specify;

"(4) which are not provided within the United States;

"(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

"(6) which constitute personal comfort items;

"(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or examinations therefor, or immunizations;

"(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

"(9) where such expenses are for custodial care;

"(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member; or

"(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household.

"(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

"CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

"SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(8), (f)(4), (g)(4), (j)(10), and (o)(5) of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide (subject, in the case of hospitals, to the limitation provided in section 1861(e)(8)) higher requirements for such State than for other States.

"USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

"SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or extended care facility, or whether an agency therein is a home health agency. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, extended care facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. The Secretary may also, pursuant to agreement utilize the services of State health agencies and other appropriate State agencies (and the appropriate local agencies) to do any one or more of the following: (1) to provide consultative services to institutions or agencies to assist them (A) to establish and maintain fiscal records necessary for purposes of this title, or otherwise to qualify as hospitals, extended care facilities, or home health agencies, or (B) to provide information which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof, and (2) to provide

consultative services to institutions, agencies, or organizations to assist in the establishment of utilization review procedures meeting the requirements of section 1861(k) and in evaluating their effectiveness.

"(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

"EFFECT OF ACCREDITATION

"SEC. 1865. An institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861(e)(6). In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

"AGREEMENTS WITH PROVIDERS OF SERVICES

"SEC. 1866. (a)(1) Any provider of services shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

"(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provided of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e) or section 1835(c)), and

"(B) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.

"(2) (A) A provider of services may charge such individual or other person (i) the amount of any deduction imposed pursuant to section 1813 (a)(1) or (a)(2) or section 1833(b) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provided), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B. In the case of items and services described in section 1833 (c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section.

"(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

"(C) A provider of services may also charge any such individual for any whole blood furnished him with respect to which a deductible is imposed under section 1813(a)(3) or 1833(d), except that (i) any excess of such charge over the cost to such provider for the blood shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood, and (iii) such charge may not be made to the extent

such blood has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

"(b) An agreement with the Secretary under this section may be terminated—

"(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

"(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

"(3) in the case of inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after the effective date of such termination,

"(4)(A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

"(5) with respect to any other items and services furnished on or after the effective date of such termination.

"(c) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

"(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or extended care facility, he may, in lieu of terminating his agreement with such hospital of facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services), or inpatient psychiatric hospital services, after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of an extended care facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

"HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

"SEC. 1867. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of 16 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated

by the Secretary at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 4 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

"NATIONAL MEDICAL REVIEW COMMITTEE

"SEC. 1868. (a) There is hereby created a National Medical Review Committee (hereinafter in this section referred to as the 'Committee') which shall consist of nine persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as chairman. The members shall be selected from among individuals who are representative of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; except that at least one member shall be representative of the general public, and at least a majority of the members shall be physicians. Each member shall hold office for a term of three years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, three at the end of the second year, and three at the end of the third year after the date of appointment. A member shall not be eligible to serve continuously for more than two terms.

"(b) Members of the Committee, while attending meetings or conferences thereof or otherwise serving on business of the Committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

"(c) It shall be the function of the Committee to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seen desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Committee shall make an annual report to the Secretary of the results of its study, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.

"(d) The Committee is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Committee such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Committee may require to carry out its functions.

"DETERMINATIONS; APPEALS

"SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

"(b) Any individual dissatisfied with any determination under subsection (a) as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $1,000 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"OVERPAYMENTS ON BEHALF OF INDIVIDUALS

"SEC. 1870. (a) Any payment under this title to any provider of services with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

"(b) Where—

"(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

"(2) Any payment has been made under section 1814(e) or 1835(c) to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

"(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, or

"(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1834(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made.

"(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under sections 1814(e) and 1835(c)) with respect to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

"(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

"REGULATIONS

"SEC. 1871. The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term 'regulations' means, unless the context otherwise requires, regulations prescribed by the Secretary.

"APPLICATION OF CERTAIN PROVISIONS OF TITLE II

"SEC. 1872. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

"DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

"SEC. 1873. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

"ADMINISTRATION

"SEC. 1874. (a) Except as otherwise provided in this title, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

"(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

"STUDIES AND RECOMMENDATIONS

"SEC. 1875. (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program; and (4) the desirability of broadening or otherwise modifying the provisions of this title which authorize payment for additional days of post-hospital extended care services in cases where the number of days of inpatient hospital services in a spell of illness for which payment is made is less than the maximum number of days for which such payment could be made.

"(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B, and shall transmit to the Congress annually a report concerning the operation of such programs."

(b) If—

(1) an individual was eligible to enroll under section 1837(c) of the Social Security Act before April 1, 1966, but failed to enroll before such date, and

(2) it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for such failure to enroll before April 1, 1966,

such individual may enroll pursuant to this subsection at any time before October 1, 1966. The determination of what constitutes good cause for purposes of the preceding sentence shall be made in accordance with regulations of the Secretary. In the case of any individual who enrolls pursuant to this subsection, the coverage period (within the meaning of section 1838 of the Social Security Act) shall begin on the first day of the 6th month after the month in which he so enrolls.

TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE BENEFITS

SEC. 103. (a) Anyone who—

(1) has attained the age of 65,

(2)(A) attained such age before 1968, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(l) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1965 and before the year in which he attained such age,

(3) is not, and upon filing application for monthly insurance benefits under section 202 of the Social Security Act would not be, entitled to hospital insurance benefits under section 226 of such Act, and is not certifiable as a qualified railroad retirement beneficiary under section 21 of the Railroad Retirement Act of 1937 (as added by section 105(a) of this Act).

(4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is a citizen of the United States or an individual

who has resided in the United States (as so defined) continuously during the 10 years immediately preceding the month in which he files application under this section, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such act would become) entitled to hospital insurance benefits under section 226 or becomes certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of such month shall be deemed to have met such requirements in such month if he files such application before the end of the twelfth month following such month. No application under this section which is filed by an individual before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) The provisions of subsection (a) shall not apply to any individual who—

(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 210(a)(17) of the Social Security Act,

(2) has, prior to the beginning of such first month, been convicted of any offense listed in section 202(u) of the Social Security Act, or

(3) at the beginning of such first month, is covered by an enrollment in a health benefits plan under the Federal Employees Health Benefits Act of 1959 or could have been so covered had he or some other individual availed himself of opportunities to enroll in a health benefits plan under such Act and (where the Federal employee has retired) to continue such enrollment after retirement.

(c) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) from time to time such sums as the Secretary deems necessary, on account of—

(1) payments made from such Trust Fund under part A of title XVIII of such Act with respect to individuals who are entitled to hospital insurance benefits under section 226 of such Act solely by reason of this section,

(2) the additional administrative expenses resulting therefrom, and

(3) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position in which it would have been if the preceding subsections of this section had not been enacted.

SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

SEC. 104. (a)(1) Section 202(t) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(9) No payments shall be made under part A of title XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against payment of benefits to him is applicable (or would be if he were entitled to any such benefits)."

(2) Section 202(u) of such Act is amended by striking out "and" before the phrase "in determining the amount of any such benefit payable to such individual for any such month," and inserting after such phrase "and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month,".

(b)(1) No payments shall be made under part B of title XVIII of the Social Security Act with respect to expenses incurred by an individual during any month for which such individual may not be paid monthly benefits under title II of such Act (or for which such monthly benefits would be suspended if he were otherwise entitled thereto) by reason of section 202(t) of such Act (relating to suspension of benefits of aliens who are outside the United States).

(2) An individual who has been convicted of any offense under (1) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (2) section 4, 112, or 113 of the Internal Security

Act of 1950, as amended, may not enroll under part B of title XVIII of the Social Security Act.

RAILROAD RETIREMENT AMENDMENTS

SEC. 105. (a) (1) The Railroad Retirement Act of 1937 is amended by adding after section 20 the following new section:

"HOSPITAL INSURANCE BENEFITS FOR THE AGED

"SEC. 21. For the purposes of part A of title XVIII of the Social Security Act, in order to provide hospital insurance benefits for annuitants, pensioners, and certain other aged individuals, the Board shall, upon request of the Secretary of Health, Education, and Welfare, certify to the Secretary the name of any individual who has attained age 65 and who (1) is entitled to an annuity or pension under this Act, (2) would be entitled to such an annuity had he (i) ceased compensated service and (in the case of a spouse) had such spouse's husband or wife ceased compensated service and (ii) applied for such annuity, or (3) bears a relationship to an employee which, by reason of section 3(e) of such Act, has been, or would be, taken into account in calculating the amount of an annuity of such employee or his survivors. Such a certification shall include such additional information as may be necessary to carry out the provisions of part A of title XVIII of the Social Security Act, and shall become effective on the date of certification or on such earlier date not more than one year prior to the date of certification as the Board states that such individual first met the requirements for certification. The Board shall notify the Secretary of the date on which such individual no longer meets the requirements of this section."

(2) For purposes of section 21 of the Railroad Retirement Act of 1937 (and sections 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 shall be deemed to include entitlement under the Railroad Retirement Act of 1935.

(b) (1) Section 3201 of the Internal Revenue Code of 1954 (relating to rate of tax on employees under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3101 at such time exceeds the rate provided by paragraph (2) of such section 3101 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3101(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3101 as amended by the Social Security Amendments of 1956)".

(2) Section 3211 of such Code (relating to the rate of tax on employee representatives under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3101 at such time exceeds the rate provided by paragraph (2) of such section 3101 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3101(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3101 as amended by the Social Security Amendments of 1956)".

(3) Section 3221(b) of such Code (relating to the rate of tax on employers under the Railroad Retirement Tax Act) is amended by striking out "the rate of the tax imposed with respect to wages by section 3111 at such time exceeds the rate provided by paragraph (2) of such section 3111 as amended by the Social Security Amendments of 1956" and inserting in lieu thereof "the rate of the tax imposed with respect to wages by section 3111(a) at such time exceeds 2¾ percent (the rate provided by paragraph (2) of section 3111 as amended by the Social Security Amendments of 1956)".

(4) The amendments made by this subsection shall be effective with respect to compensation paid for services rendered after December 31, 1965.

(c) For amendments preserving relationship between the railroad retirement and old-age, survivors, and disability insurance systems, see section 326 of this Act.

MEDICAL EXPENSE DEDUCTION

SEC. 106. (a) Subsection (a) of section 213 of the Internal Revenue Code of 1954 (relating to allowance of deduction) is amended to read as follows:

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the following amounts, not compensated for by insurance or otherwise—

"(1) the amount by which the amount of the expenses paid during the taxable year (reduced by any amount deductible under paragraph (2)) for

medical care of the taxpayer, his spouse, and dependents (as defined in section 152) exceeds 3 percent of the adjusted gross income, and

"(2) an amount (not in excess of $250) equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents."

(b) The second sentence of section 213(b) of such Code (relating to limitation with respect to medicine and drugs) is repealed.

(c) Section 213(e) of such Code (relating to definitions) is amended by renumbering paragraph (2) as paragraph (4), and by striking out paragraph (1) and inserting in lieu thereof the following:

"(1) The term 'medical care' means amounts paid—

"(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

"(B) for transportation primarily for and essential to medical care referred to in subparagraph (A), or

"(C) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary health insurance for the aged) covering medical care referred to in subparagraphs (A) and (B).

"(2) In the case of an insurance contract under which amounts are payable for other than medical care referred to in subparagraphs (A) and (B) of paragraph (1)—

"(A) no amount shall be treated as paid for insurance to which paragraph (1)(C) applies unless the charge for such insurance is separately stated in the contract,

"(B) the amount taken into account as the amount paid for such insurance shall not exceed such charge, and

"(C) no amount shall be treated as paid for such insurance if the amount specified in the contract as the charge for such insurance is unreasonably large in relation to the total charges under the contract.

"(3) Subject to the limitations of paragraph (2), premiums paid during the taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care (within the meaning of subparagraphs (A) and (B) of paragraph (1)) for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 shall be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years)."

(d) Section 213(g) of such Code (relating to maximum limitation if taxpayer or spouse has attained age 65 and is disabled) is amended—

(1) by striking out "Has Attained Age 65 and" in the heading;

(2) by striking out "has attained the age of 65 before the close of the taxable year and" each place it appears in the text; and

(3) by striking out "have attained the age of 65 before the close of the taxable year and" in paragraph (1)(B).

(e) The amendments made by this section shall apply to taxable years beginning after December 31, 1966.

RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

SEC. 107. Section 6051(c) of the Internal Revenue Code of 1954 (relating to additional requirements) is amended by adding at the end thereof the following new sentence: "The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act."

TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

SEC. 108. (a)(1) Section 201(a)(3) of the Social Security Act is amended by inserting "(other than sections 3101(b) and 3111(b))" after "chapter 21" each place it appears therein.

(2) Section 201(a)(4) of such Act is amended by inserting "(other than section 1401(b))" after "chapter 2" and after "such subchapter or chapter".

(3) Section 201(g)(1) of such Act is amended to read as follows:

"(1) (A) There are authorized to be made available for expenditure, out of any or all of the Trust Funds (which for purposes of this paragraph shall include also the Federal Hospital Insurance Trust Fund and the Federal Supplementary Health Insurance Benefits Trust Fund established by title XVIII), such amounts as the Congress may deem appropriate to pay the costs of the part of the administration of this title and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. During each fiscal year or after the close of such fiscal year (or at both times), the Secretary of Health, Education, and Welfare shall analyze the costs of administration of this title and title XVIII during the appropriate part or all of such fiscal year in order to determine the portion of such costs which should be borne by each of the Trust Funds and shall certify to the Managing Trustee the amount, if any, which should be transferred among such Trust Funds in order to assure that each of the Trust Funds bears its proper share of the costs incurred during such fiscal year for the part of the administration of this title and title XVIII for which the Secretary of Health, Education, and Welfare is responsible. The Managing Trustee is authorized and directed to transfer any such amount (determined under the preceding sentence) among such Trust Funds in accordance with any certification so made.

"(B) The Managing Trustee is directed to pay from the Trust Funds into the Treasury the amounts estimated by him which will be expended, out of moneys appropriated from the general funds in the Treasury, during each calendar quarter by the Treasury Department for the part of the administration of this title and title XVIII for which the Treasury Department is responsible and for the administration of chapters 2 and 21 of the Internal Revenue Code of 1954. Such payments shall be covered into the Treasury as repayment to the account for reimbursement of expenses incurred in connection with such administration of this title and title XVIII and chapters 2 and 21 of the Internal Revenue Code of 1954."

(4) Section 201(g)(2) of such Act is amended by inserting after "the amount estimated by him as taxes" the following: "imposed under section 3101(a)".

(5) Section 201(h) of such Act is amended by inserting "(other than section 226)" after "this title".

(b) Section 218(h)(1) of such Act is amended by striking out "Trust Funds in the ratio in which amounts are appropriated to such Funds pursuant to subsections (a)(3) and (b)(1) of section 201" and inserting in lieu thereof "Trust Funds and the Federal Hospital Insurance Trust Fund in the ratio in which amounts are appropriated to such Funds pursuant to subsection (a)(3) of section 201, subsection (b)(1) of such section, and subsection (a)(1) of section 1817, respectively".

(c) Section 1106(b) of such Act is amended by striking out "and the Federal Disability Insurance Trust Fund" and inserting in lieu thereof ", the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Health Insurance Benefits Trust Fund".

ADVISORY COUNCIL ON SOCIAL SECURITY

SEC. 109. (a) Title VII of the Social Security Act is amended by adding at the end thereof the following new section:

"ADVISORY COUNCIL ON SOCIAL SECURITY

"SEC. 706. (a) During 1968 and every fifth year thereafter, the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Health Insurance Benefits Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

"(b) Each such Council shall consist of the Commissioner of Social Security, as Chairman, and 12 other persons, appointed by the Secretary without regard to the civil service laws. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public.

"(c) (1) Any Council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

"(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government employed intermittently.

"(d) Each such Council shall submit reports of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

"(1) a separate report with respect to the old-age, survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954,

"(2) a separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

"(3) a separate report with respect to the supplementary health insurance benefits program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the Council shall cease to exist."

(b) Effective January 1, 1966, section 116(e) of the Social Security Amendments of 1956 is repealed.

MEANING OF TERM "SECRETARY"

SEC. 110. As used in this Act, and in the provisions of the Social Security Act amended by this Act, the term "Secretary", unless the context otherwise requires, means the Secretary of Health, Education, and Welfare.

PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

ESTABLISHMENT OF PROGRAMS

SEC. 121. (a) The Social Security Act is amended by adding at the end thereof (after the new title XVIII added by section 102) the following new title:

"TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

"APPROPRIATION

"SEC. 1901. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

"STATE PLANS FOR MEDICAL ASSISTANCE

"SEC. 1902. (a) A State plan for medical assistance must—

"(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

"(2) provide for financial participation by the State equal to not less than

40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1970, provide for financial participation by the State equal to all of such non-Federal share;

"(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

"(4) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(5) provide that the State agency administering or supervising the administration of the plan of such State approved under title I, or under title XVI (insofar as it relates to the aged), shall administer or supervise the administration of the plan for medical assistance; and that any local agency administering the plan of such State approved under title I, or under title XVI (insofar as it relates to the aged), in a political subdivision, shall administer the plan for medical assistance in such subdivision;

"(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

"(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

"(9) provide for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;

"(10) provide for making medical assistance available to all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI; and—

"(A) provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan—

"(i) shall not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such State plan, and

"(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not receiving aid or assistance under any such plan; and

"(B) if medical assistance is included for any group of individuals who are not receiving aid or assistance under any such State plan and who do not meet the income and resources requirements of the one of such State plans which is appropriate, as determined in accordance with standards prescribed by the Secretary, provide—

"(i) for making medical assistance available to all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical care and services, and

"(ii) that the medical assistance made available to all individuals not receiving aid or assistance under any such State plan shall be equal in amount, duration, and scope;

"(11) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan;

"(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

"(13) provide for inclusion of some institutional and some noninstitutional care and services, and, effective July 1, 1967, provide (A) for inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and (B) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

"(14) provide that (A) no deduction, cost sharing, or similar charge will be imposed under the plan on the individual with respect to inpatient hospital services furnished him under the plan, and (B) any deduction, cost sharing, or similar charge imposed under the plan with respect to any other medical assistance furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, shall be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or his income and resources;

"(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide—

"(A) for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such title; and

"(B) where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to any such individual under the insurance program established by part B of such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

"(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

"(17) include reasonable standards (which shall be comparable for all groups) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, if he met the requirements as to need, be eligible for aid or assistance in the form of money payments under a State plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and amount of such aid or assistance under such plan, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or is blind or permanently and totally disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care of for any other type of remedial care recognized under State law;

"(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or is blind or permanently and totally disabled) of any medical assistance correctly paid on behalf of such individual under the plan;

"(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care

and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

"(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases—

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases or tuberculosis (as the case may be), and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for developing of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

"(D) provide methods of determining the reasonable cost of institutional care for such patients; and

"(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and the State agency which administered or supervised the administration of such plan approved under title I (or title XVI, insofar as it relates to the aged) may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

"(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

"(1) an age requirement of more than 65 years; or

"(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under title IV; or

"(3) any residence requirement which excludes any individual who resides in the State; or

"(4) any citizenship requirement which excludes any citizen of the United States.

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this title), provided for eligible individuals under a plan of such State approved under title I, IV, X, XIV, or XVI.

"PAYMENT TO STATES

"SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section and section 1117) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

"(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are recipients of money payments under a State plan approved under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

"(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency (or of the local agency administering the State plan in the political subdivision); plus

"(3) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

"(b) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection.

"(c)(1) If the Secretary finds, on the basis of satisfactory information furnished by a State, that the Federal medical assistance percentage for such State applicable to any quarter in the period beginning January 1, 1966, and ending with the close of June 30, 1969, is less than 105 per centum of the Federal share of medical expenditures by the State during the fiscal year ending June 30, 1965 (as determined under paragraph (2)), then 105 per centum of such Federal share will be the Federal medical assistance percentage (instead of the percentage determined under section 1905(b)) for such State for such quarter and each quarter thereafter occurring in such period and prior to the first quarter with respect to which such a finding is not applicable.

"(2) For purposes of paragraph (1), the Federal share of medical expenditures by a State during the fiscal year ending June 30, 1965, means the percentage which the excess of—

"(A) the total of the amounts determined under sections 3, 403, 1003, 1403, and 1603 with respect to expenditures by such State during such year as aid or assistance under its State plans approved under titles I, IV, X, XIV, and XVI, over

"(B) the total of the amounts which would have been determined under such sections with respect to such expenditures during such year if expenditures as aid or assistance in the form of medical or any other type of remedial care had not been counted,

is of the total expenditures as aid or assistance in the form of medical or any other type of remedial care under such plans during such year.

"(d) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

"(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced, or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

"(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"(e) The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

"OPERATION OF STATE PLANS

"SEC. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

"(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

"(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payment will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall made no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"DEFINITIONS

"SEC. 1905. For purposes of this title—

"(a) The term 'medical assistance' means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals who, except for section 406(a)(2), are (or would, if needy, be) dependent children under title IV (and are under the age of 21) or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 18 years of age or older and permanently and totally disabled, but whose income and resources are insufficient to meet all of such cost—

"(1) inpatient hospital services;

"(2) outpatient hospital services;

"(3) other laboratory and X-ray services;

"(4) skilled nursing home services;

"(5) physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere;

"(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

"(7) home health care services;

"(8) private duty nursing services;

"(9) clinic services;

"(10) dental services;

"(11) physical therapy and related services;

"(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select:

"(13) other diagnostic, screening, preventive, and rehabilitative services; and

"(14) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except that such term does not include—

"(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

"(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

"(b) The term 'Federal medical assistance percentage' for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 55 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8); except that the Secretary shall promulgate such percentage as soon as possible after the enactment of this title, which promulgation shall be conclusive for each of the six quarters in the period beginning January 1, 1966, and ending with the close of June 30, 1967."

(b) No payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX of such Act, or for any period after June 30, 1967.

(c)(1) Effective January 1, 1966, section 1101(a)(1) of the Social Security Act is amended by striking out "and XVI" and inserting in lieu thereof "XVI, and XIX".

(2) Section 1109 of such Act is amended by adding at the end thereof the following new sentence: "Any amount which is disregarded (or set aside for future needs) in determining eligibility for and amount of the aid or assistance for any individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX shall not be taken into consideration in determining the eligibility for or amount of medical assistance for any other individual under a State plan approved under title XIX."

(3) Effective January 1, 1966, section 1115 of such Act is amended by striking out "or XVI", "or 1602", and "or 1603" and inserting in lieu thereof "XVI, or XIX", "1602, or 1902", and "1603, or 1903", respectively.

PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY HEALTH INSURANCE

SEC. 122. Sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act are each amended by inserting "premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other" after "expenditures for" in the parenthetical phrase appearing in so much of paragraph (1) thereof as precedes clause (A).

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

PART 1—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

SEC. 201. (a) The first sentence of section 501 of the Social Security Act is amended by striking out "$40,000,000" and all that follows and inserting in lieu thereof "$45,000,000 for the fiscal year ending June 30, 1966, $50,000,000 for the fiscal year ending June 30, 1967, $55,000,000 for the fiscal year ending June 30, 1968, $55,000,000 for the fiscal year ending June 30, 1939, and $60,000,000 for the fiscal year ending June 30, 1970, and succeeding fiscal year."

(b) Section 504 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder for any period after June 30, 1966, unless it makes a satisfactory showing that the State is extending the provision of maternal and child health services in the State with a view to making such services available by July 1, 1975, to children in all parts of the State."

INCREASE IN CRIPPLED CHILDREN'S SERVICES

SEC. 202. (a) The first sentence of section 511 of the Social Security Act is amended by striking out "$40,000,000" and all that follows and inserting in lieu thereof "$45,000,000 for the fiscal year ending June 30, 1966, $55,000,000 for the fiscal year ending June 30, 1967, $55,000,000 for the fiscal year ending June 30, 1968, $55,000,000 for the fiscal year ending June 30, 1969, and $60,000,000 for the fiscal year ending June 30, 1970, and succeeding fiscal years."

(b) Section 514 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this subsection, no payment shall be made to any State thereunder for any period after June 30, 1966, unless it makes a satisfactory showing that the State is extending the provision of crippled children's services in the State with a view to making such services available by July 1, 1975, to children in all parts of the State."

TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

SEC. 203. (a) Part 2 of title V of the Social Security Act is amended by adding at the end thereof the following new section.

"TRAINING OF PROFESSIONAL PERSONNEL

"SEC. 516. There are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1967, $10,000,000 for the fiscal year ending June 30, 1968, and $17,500,000 for each fiscal year thereafter, for grants by the Secretary to public or other nonprofit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps."

(b) The second sentence of section 514(c) of such Act is amended by striking out "section 512(b)" and inserting in lieu thereof "section 512(b) or 516".

PAYMENT FOR INPATIENT HOSPITAL SERVICES

SEC. 204. (a) Section 503(a) of the Social Security Act is amended by striking out "and" before clause (7) and by inserting before the period at the end thereof the following new clause: "; and (8) effective July 1, 1967, provide for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan".

(b) Section 513(a) of such Act is amended by striking out "and" before clause (6) and by inserting before the period at the end thereof the following new clause: "; and (7) effective July 1, 1967, provide for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan".

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

SEC. 205. Part 4 of title V of the Social Security Act is amended (1) by revising the heading thereof to read as follows: "PART 4—GRANTS FOR SPECIAL MATERNITY AND INFANT CARE PROJECTS, FOR PROJECTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN, AND FOR RESEARCH PROJECTS"; (2) by redesignating section 532 as section 533; and (3) by inserting after section 531 the following new section:

"SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

"SEC. 532. (a) In order to promote the health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, there are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1966, $35,000,000 for the fiscal year ending June 30, 1967, $40,000,000 for the fiscal year ending June 30, 1968, $45,000,000 for the fiscal year ending June 30, 1969, and $50,000,000 for the fiscal year ending June 30, 1970, for grants as provided in this section.

"(b) From the sums appropriated pursuant to subsection (a), the Secretary is authorized to make grants to the State health agency of any State and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency of the State administering or supervising the administration of the State plan approved under section 513, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 per centum of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). No project shall be eligible for a grant under this section unless it provides (1) for the coordination of health care and services provided under it with, and utilization (to the extent feasible) of, other State or local health, welfare, and education programs for such children, (2) for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) of inpatient hospital services provided under the project, and (3) that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and no such project for children and youth of school age shall be considered to be of a comprehensive nature for purposes of this section unless it includes (subject to the limitation in the preceding provisions of this sentence) at least such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary.

"(c) Payment of grants under this section may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary may determine."

EVALUATION AND REPORT

SEC. 206. The Secretary shall submit to the President for transmission to the Congress before July 1, 1969, a full report of the administration of the provisions of section 532 of the Social Security Act (as added by section 205 of this Act), together with an evaluation of the program established thereby and his recommendations as to continuation of and modifications in that program.

PART 2—IMPLEMENTATION OF MENTAL RETARDATION PLANNING

AUTHORIZATION OF APPROPRIATIONS

SEC. 211. (a) Section 1701 of the Social Security Act is amended by adding at the end thereof the following new sentence: "There are also authorized to be appropriated, for assisting such States in initiating the implementation and carrying out of planning and other steps to combat mental retardation, $2,750,000 for the fiscal year ending June 30, 1966, and $2,750,000 for the fiscal year ending June 30, 1967."

(b) The first sentence of section 1702 of such Act is amended by inserting "the first sentence of" before "section 1701" and by inserting the following before the period at the end thereof "; and the sums appropriated pursuant to the second

sentence of such section for the fiscal year ending June 30, 1966, shall be available for such grants during such year and the next two fiscal years, and sums appropriated pursuant thereto for the fiscal year ending June 30, 1967, shall be available for such grants during such year and the succeeding fiscal year".

PART 3—PUBLIC ASSISTANCE AMENDMENTS RELATING TO HEALTH CARE

REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DSEASE

SEC. 221. (a) (1) Section 6(a) of the Social Security Act is amended to read as follows:

"(a) For the purposes of this title, the term 'old-age assistance' means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution)."

(2) Section 6(b) of such Act is amended by striking out all that follows clause (12) and inserting in lieu thereof the following:

"except that such term does not include any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."

(3) Section 2(a) of such Act is amended (A) by striking out "and" at the end of paragraph (10); (B) by striking out the period at the end of paragraph (11) and inserting in lieu thereof a semicolon; and (C) by adding after paragraph (11) the following new paragraphs:

"(12) if the State plan includes assistance to or in behalf of individuals who are patients in institutions for tuberculosis or mental diseases—

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases or tuberculosis (as the case may be), and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution;

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions, including appropriate medical treatment and other assistance; for services referred to in section 3(a)(4)(A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

"(D) provide methods of determining the reasonable cost of institutional care for such patients; and

"(13) if the State plan includes assistance to or in behalf of patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases."

(4) Section 3 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to patients in institutions for tuberculosis

or mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures in the State from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection."

(b) Section 1006 of such Act is amended by striking out clauses (a) and (b) and inserting in lieu thereof the following: "who is a patient in an institution for tuberculosis or mental diseases".

(c) Section 1405 of such Act is amended by striking out clauses (a) and (b) and inserting in lieu thereof the following: "who is a patient in an institution for tuberculosis or mental diseases".

(d) (1) Section 1605(a) of such Act is amended to read as follows:

"(a) For purposes of this title, the term 'aid to the aged, blind, or disabled' means money payments to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, needy individuals who are 65 years of age or older, are blind, or are 18 years of age or over and permanently and totally disabled, but such term does not include—

"(1) any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution); or

"(2) any such payments to or care in behalf of any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases."

(2) Section 1605(b) of such Act is amended by striking out all that follows clause (12) and inserting in lieu thereof the following:

"except that such term does not include any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution)."

(3) Section 1602(a) of such Act is amended (A) by striking out "and" at the end of paragraph (14); (B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof a semicolon; and (C) by adding after paragraph (15) the following new paragraphs:

"(16) if the State plan includes aid or assistance to or in behalf of individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases—

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases or tuberculosis (as the case may be), and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution;

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, in-

cluding appropriate medical treatment and other aid or assistance; for services referred to in section 1603(a)(4)(A) (i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

"(D) provide methods of determining the reasonable cost of institutional care for such patients; and

"(17) if the State plan includes aid or assistance to or in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of comunity mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases."

(4) Section 1603 of such Act is amended by adding at the end thereof the following new subsection:

"(d) Notwithstanding the preceding provisions of this section, the amount determined under such provisions for any State for any quarter which is attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases shall be paid only to the extent that the State makes a showing satisfactory to the Secretary that total expenditures in the State from Federal, State, and local sources for mental health services (including payments to or in behalf of individuals with mental health problems) under State and local public health and public welfare programs for such quarter exceed the average of the total expenditures in the State from such sources for such services under such programs for each quarter of the fiscal year ending June 30, 1965. For purposes of this subsection, expenditures for such services for each quarter in the fiscal year ending June 30, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination by him under this subsection for such State; and expenditures for such services for any quarter beginning after December 31, 1965, in the case of any State shall be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination under this subsection for such State for such quarter; and determinations so made shall be conclusive for purposes of this subsection."

(e) The amendments made by this section shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

SEC. 222. (a) Section 6(b) of the Social Security Act is amended by striking out "who are not recipients of old-age assistance" and inserting in lieu thereof "who are not recipients of old-age assistance (except, for any month, for recipients of old-age assistance who are admitted to or discharged from a medical institution during such month)".

(b) Section 1605(b) of such Act is amended by striking out "who are not recipients of aid to the aged, blind, or disabled" and inserting in lieu thereof "who are not recipients of aid to the aged, blind, or disabled (except, for any month, for recipients of aid to the aged, blind, or disabled who are admitted to or discharged from a medical institution during such month)".

(c) The amendments made by this section shall apply in the case of expenditures under a State plan approved under title I or XVI of the Social Security Act with respect to care and services provided under such plan after June 1965.

TITLE III—SOCIAL SECURITY AMENDMENTS

SHORT TITLE

SEC. 300. This title may be cited as the "Old-Age, Survivors, and Disability Insurance Amendments of 1965".

INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

SEC. 301. (a) Section 215(a) of the Social Security Act is amended by striking out the table and inserting in lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1958 Act, as modified)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
.....	$13.48	$40	...	$67	$44.00	$66.00
$13.49	14.00	41	$68	69	45.00	67.50
14.01	14.48	42	70	70	46.00	69.00
14.49	15.00	43	71	72	47.00	70.50
15.01	15.60	44	73	74	48.00	72.00
15.61	16.20	45	75	76	49.00	73.50
16.21	16.84	46	77	78	50.00	75.00
16.85	17.60	47	79	80	51.00	76.50
17.61	18.40	48	81	81	52.00	78.00
18.41	19.24	49	82	83	53.00	79.50
19.25	20.00	50	84	85	54.00	81.00
20.01	20.64	51	86	87	55.00	82.50
20.65	21.28	52	88	89	56.00	84.00
21.29	21.88	53	90	90	57.00	85.50
21.89	22.28	54	91	92	58.00	87.00
22.29	22.68	55	93	94	59.00	88.50
22.69	23.08	56	95	96	60.00	90.00
23.09	23.44	57	97	97	61.00	91.50
23.45	23.76	58	98	99	62.10	93.20
23.77	24.20	59	100	101	63.20	94.80
24.21	24.60	60	102	102	64.20	96.30
24.61	25.00	61	103	104	65.30	98.00
25.01	25.48	62	105	106	66.40	99.60
25.49	25.92	63	107	107	67.50	101.30
25.93	26.40	64	108	109	68.50	102.80
26.41	26.94	65	110	113	69.60	104.40
26.95	27.46	66	114	118	70.70	106.10
27.47	28.00	67	119	122	71.70	107.60
28.01	28.68	68	123	127	72.80	109.20
28.69	29.25	69	128	132	73.90	110.90
29.26	29.68	70	133	136	74.90	112.40
29.69	30.36	71	137	141	76.00	114.00
30.37	30.92	72	142	146	77.10	116.80
30.93	31.36	73	147	150	78.20	120.00
31.37	32.00	74	151	155	79.20	124.00
32.01	32.60	75	156	160	80.30	128.00
32.61	33.20	76	161	164	81.40	131.20
33.21	33.88	77	165	169	82.40	135.20
33.89	34.50	78	170	174	83.50	139.20
34.51	35.00	79	175	178	84.60	142.40
35.01	35.80	80	179	183	85.60	146.40
35.81	36.40	81	184	188	86.70	150.40
36.41	37.08	82	189	193	87.80	154.40
37.09	37.60	83	194	197	88.90	157.60
37.61	38.20	84	198	202	89.90	161.60
38.21	39.12	85	203	207	91.00	165.60
39.13	39.68	86	208	211	92.10	168.80
39.69	40.33	87	212	216	93.10	172.80
40.34	41.12	88	217	221	94.20	176.80
41.13	41.76	89	222	225	95.30	180.00
41.77	42.44	90	226	230	96.20	184.00
42.45	43.20	91	231	235	97.40	188.00
43.21	43.76	92	236	239	98.50	191.20
43.77	44.44	93	240	244	99.60	195.20
44.45	44.88	94	245	249	100.60	199.20
44.89	45.60	95	250	253	101.70	202.40
		96	254	258	102.80	206.40
		97	259	263	103.80	210.40
		98	264	267	104.90	213.60
		99	268	272	106.00	217.60
		100	273	277	107.00	221.60
		101	278	281	108.10	224.80
		102	282	286	109.20	228.80
		103	287	291	110.30	232.80
		104	292	295	111.30	236.00

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

"I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount under 1958 Act, as modified)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		105	296	300	112.40	240.00
		106	301	305	113.50	244.00
		107	306	309	114.50	247.20
		108	310	314	115.60	251.20
		109	315	319	116.70	254.00
		110	320	323	117.70	254.80
		111	324	328	118.80	256.80
		112	329	333	119.90	258.80
		113	334	337	121.00	260.40
		114	338	342	122.00	262.40
		115	343	347	123.10	264.40
		116	348	351	124.20	266.00
		117	352	356	125.20	268.00
		118	357	361	126.30	270.00
		119	362	365	127.40	271.60
		120	366	370	128.40	273.60
		121	371	375	129.50	275.60
		122	376	379	130.60	277.20
		123	380	384	131.70	279.20
		124	385	389	132.70	281.20
		125	390	393	133.80	282.80
		126	394	398	134.90	284.80
		127	399	403	135.90	286.80
			404	407	136.90	288.40
			408	412	137.90	290.40
			413	417	138.90	292.40
			418	421	139.90	294.00
			422	426	140.90	296.00
			427	431	141.90	298.00
			432	436	142.90	300.00
			437	440	143.90	301.60
			441	445	144.90	303.60
			446	450	145.90	305.60
			451	454	146.90	307.20
			455	459	147.90	309.20
			460	464	148.90	311.20
			465	466	149.90	312.00"

(b) Section 215(c) of such Act is amended to read as follows:

"Primary Insurance Amount Under 1958 Act, as Modified

"(c)(1) For the purposes of column II of the table appearing in subsection (a) of this section, an individual's primary insurance amount shall be computed as provided in, and subject to the limitations specified in, (A) this section as in effect prior to the enactment of the Social Security Amendments of 1965, and (B) the applicable provisions of the Social Security Amendments of 1960.

"(2) The provisions of this subsection shall be applicable only in the case of an individual who became entitled to benefits under section 202(a) or section 223 before the date of enactment of the Social Security Amendments of 1965 or who died before such date."

(c) Section 203(a) of such Act is amended by striking out paragraphs (2) and (3) and inserting in lieu thereof the following:

"(2) when two or more persons were entitled (without the application of section 202(j)(1) and section 223(b)) to monthly benefits under section 202 or 223 for any month which begins after December 1964 and before the

enactment of the Social Security Amendments of 1965, on the basis of the wages and self-employment income of such insured individual, such total of benefits for any month occurring after December 1964 shall not be reduced to less than the larger of—

"(A) the amount determined under this subsection without regard to this paragraph, or

"(B)(i) with respect to the month in which such Amendments are enacted or any prior month, an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of such Amendments, for each such person, for such month, by 107 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10, and

"(ii) with respect to any month after the month in which such Amendments are enacted, an amount equal to the sum of the amounts derived by multiplying the benefit amount determined under this title (including this subsection, but without the application of section 222(b), section 202(q), and subsections (b), (c), and (d) of this section), as in effect prior to the enactment of such Amendments, for each such person for the month of enactment, by 107 percent and raising each such increased amount, if it is not a multiple of $0.10, to the next higher multiple of $0.10;

but in any such case (I) paragraph (1) of this subsection shall not be applied to such total of benefits after the application of subparagraph (B) of this paragraph, and (II) if section 202(k)(2)(A) was applicable in the case of any of such benefits for any such month beginning before the enactment of the Social Security Amendments of 1965, and ceases to apply after such month, the provisions of subparagraph (B) shall be applied, for and after the month in which such section 202(k)(2)(A) ceases to apply, as though paragraph (1) had not been applicable to such total of benefits for such month beginning prior to such enactment."

(d) The amendments made by subsections (a), (b), and (c) of this section shall apply with respect to monthly benefits under title II of the Social Security Act for months after December 1964 and with respect to lump-sum death payments under such title in the case of deaths occurring in or after the month in which this Act is enacted.

(e) If an individual is entitled to a disability insurance benefit under section 223 of the Social Security Act for December 1964 on the basis of an application filed after enactment of this Act and is entitled to old-age insurance benefits under section 202(a) of such Act for January 1965, then, for purposes of section 215(a)(4) of the Social Security Act (if applicable) the amount in column IV of the table appearing in such section 215(a) for such individual shall be the amount in such column on the line on which in column II appears his primary insurance amount (as determined under section 215(c) of such Act) instead of the amount in column IV equal to his disability insurance benefit.

(f) Effective with respect to monthly benefits under title II of the Social Security Act for months after 1970 and with respect to lump-sum death payments under such title in the case of deaths occurring after such year, the table in section 215(a) of such Act (as amended by subsection (a) of this section) is amended by striking out all figures in columns II, III, IV, and V beginning with the line which reads

	"109	315	319	116.70	254.00"

and down through the line which reads

		"465	466	149.90	312.00"

and inserting in lieu thereof the following:

	"109	315	319	116.70	255.20
	110	320	323	117.70	258.40
	111	324	328	118.80	262.40
	112	329	333	119.90	266.40
	113	334	337	121.00	269.60
	114	338	342	122.00	273.60
	115	343	347	123.10	277.60
	116	348	351	124.20	280.80
	117	352	356	125.20	284.80
	118	357	361	126.30	288.80
	119	362	365	127.40	292.00
	120	366	370	128.40	296.00
	121	371	375	129.60	298.00
	122	376	379	130.60	299.60
	123	380	384	131.70	301.60
	124	385	389	132.70	303.60
	125	390	393	133.80	305.20
	126	394	398	134.90	307.20
	127	399	403	135.90	309.20
		404	407	136.90	310.80
		408	412	137.90	312.80
		413	417	138.90	314.80
		418	421	139.90	316.40
		422	426	140.90	318.40
		427	431	141.90	320.40
		432	436	142.90	322.40
		437	440	143.90	324.00
		441	445	144.90	326.00
		446	450	145.90	328.00
		451	454	146.90	329.60
		455	459	147.90	331.60
		460	464	148.90	333.60
		465	468	149.90	335.20
		469	473	150.90	337.20
		474	478	151.90	339.20
		479	482	152.90	340.80
		483	487	153.90	342.80
		488	492	154.90	344.80
		493	496	155.90	346.40
		497	501	156.90	348.40
		502	506	157.90	350.40
		507	510	158.90	352.00
		511	515	159.90	354.00
		516	520	160.90	356.00
		521	524	161.90	357.60
		525	529	162.90	359.60
		530	534	163.90	361.60
		535	538	164.90	363.20
		539	543	165.90	365.20
		544	548	166.90	367.20
		549	550	167.90	368.00"

COMPUTATION AND RECOMPUTATION OF BENEFITS

SEC. 302. (a) (1) Subparagraph (C) of section 215(b) (2) of the Social Security Act is amended to read as follows:

"(C) For purposes of subparagraph (B), 'computation base years' include only calendar years in the period after 1950 and prior to the earlier of the following years—

"(i) the year in which occurred (whether by reason of section 202(j) (1) or otherwise) the first month for which the individual was entitled to old-age insurance benefits, or

"(ii) the year succeeding the year in which he died.

Any calendar year all of which is included in a period of disability shall not be included as a computation base year."

(2) Clauses (A), (B), and (C) of the first sentence of section 215(b) (3) of such Act are amended to read as follows:

"(A) in the case of a woman, the year in which she died or, if it occurred earlier but after 1960, the year in which she attained age 62,

"(B) in the case of a man who has died, the year in which he died or, if it occurred earlier but after 1960, the year in which he attained age 65, or

"(C) in the case of a man who has not died, the year occurring after 1960 in which he attained (or would attain) age 65."

(3) Paragraphs (4) and (5) of section 215(b) of such Act are amended to read as follows:

"(4) The provisions of this subsection shall be applicable only in the case of an individual—

"(A) who becomes entitled, after December 1965, to benefits under section 202(a) or section 223; or

"(B) who dies after December 1965 without being entitled to benefits under section 202(a) or section 223; or

"(C) whose primary insurance amount is required to be recomputed under subsection (f) (2), as amended by the Social Security Amendments of 1965;

except that it shall not apply to any such individual for purposes of monthly benefits for months before January 1966.

"(5) For the purposes of column III of the table appearing in subsection (a) of this section, the provisions of this subsection, as in effect prior to the enactment of the Social Security Amendments of 1965, shall apply—

"(A) in the case of an individual to whom the provisions of this subsection are not made applicable by paragraph (4), but who, on or after the date of the enactment of the Social Security Amendments of 1965 and prior to 1966, met the requirements of this paragraph or paragraph (4), as in effect prior to such enactment, and

"(B) with respect to monthly benefits for months before January 1966, in the case of an individual to whom the provisions of this subsection are made applicable by paragraph (4)."

(b) (1) Subparagraph (A) of section 215(d) (1) of such Act is amended by striking out "(2) (C) (i) and (3) (A) (i)" and inserting in lieu thereof "(2) (C) and (3)", by striking out "December 31, 1936," and inserting in lieu thereof "1936", and by striking out "December 31, 1950" and inserting in lieu thereof "1950".

(2) Section 215(d) (3) of such Act is amended by striking out "1960" and inserting in lieu thereof "1965" and by striking out "but without regard to whether such individual has six quarters of coverage after 1950".

(c) Section 215(e) of such Act is amended by inserting "and" after the semicolon at the end of paragraph (1), by striking out "; and" at the end of paragraph (2) and inserting in lieu thereof a period, and by striking out paragraph (3).

(d) (1) Paragraph (2) of section 215(f) of such Act is amende dto read as follows:

"(2) With respect to each year—

"(A) which begins after December 31, 1964, and

"(B) for any part of which an individual is entitled to old-age insurance benefits,

the Secretary shall, at such time or times and within such period as he may by regulations prescribe, recompute the primary insurance amount of such individual. Such recomputation shall be made—

"(C) as provided in subsection (a) (1) and (3) if such year is either the year in which he became entitled to such old-age insurance benefits or the year preceding such year, or

"(D) as provided in subsection (a) (1) in any other case;

and in all cases such recomputation shall be made as though the year with respect to which such recomputation is made is the last year of the period specified in paragraph (2) (C) of subsection (b). A recomputation under this paragraph with respect to any year shall be effective—

"(E) in the case of an individual who did not die in such year, for monthly benefits beginning with benefits for January of the following year; or

"(F) in the case of an individual who died in such year (including any individual whose increase in his primary insurance amount is attributable to compensation which, upon his death, is treated as remuneration for employment under section 205 (o)), for monthly benefits beginning with benefits for the month in which he died."

(2) Effective January 2, 1966, paragraphs (3), (4), and (7) of such section are repealed, and paragraphs (5) and (6) of such section are redesignated as paragraphs (3) and (4), respectively.

(e) (1) The first sentence of section 223(a) (2) of such Act is amended by inserting before the period at the end thereof "and was entitled to an old-age insurance benefit for each month for which (pursuant to subsection (b)) he was entitled to a disability insurance benefit".

(2) The last sentence of section 223(a) (2) of such Act is amended by striking out "first year" and inserting in lieu thereof "year"; and by striking out the phrase "both was fully insured and had" both times it appears in such sentence.

(f) (1) The amendments made by subsection (c) shall apply only to individuals who become entitled to old-age insurance benefits under section 202(a) of the Social Security Act after 1965.

(2) Any individual who would, upon filing an application prior to January 2, 1966, be entitled to a recomputation of his benefit amount for purposes of title II of the Social Security Act shall be deemed to have filed such application on the earliest date on which such application could have been filed, or on the day on which this Act is enacted, whichever is the later.

(3) In the case of an individual who died after 1960 and prior to 1966 and who was entitled to old-age insurance benefits under section 202(a) of the Social Security Act at the time of his death, the provisions of section 215(f) (3) (B) and 215(f) (4) of such Act as in effect before the enactment of this Act shall apply.

(4) In the case of a man who attains age 65 prior to 1966, or dies before such year, the provisions of section 215(f) (7) of the Social Security Act as in effect before the enactment of this Act shall apply.

(5) The amendments made by subsection (e) of this section shall apply in the case of individuals who become entitled to disability insurance benefits under section 223 of the Social Security Act after December 1965.

(6) Section 303(g) (1) of the Social Security Amendments of 1960 is amended—

(A) by striking out "notwithstanding the amendments made by the preceding subsections of this section," in the first sentence and inserting in lieu thereof "notwithstanding the amendments made by the preceding subsections of this section, or the amendments made by section 302 of the Social Security Amendments of 1965,"; and

(B) by striking out "Social Security Amendments of 1960," in the second sentence and inserting in lieu thereof "Social Security Amendments of 1960, or (if such individual becomes entitled to old-age insurance benefits after 1965, or dies after 1965 without becoming so entitled) as amended by the Social Security Amendments of 1965,".

DISABILITY INSURANCE BENEFITS

SEC. 303. (a) (1) Clause (A) of the first sentence of section 216 (i) (1) of the Social Security Act is amended by striking out "impairment which can be expected to result in death or to be of long-continued and indefinite duration," and inserting in lieu thereof "impairment,".

(2) Section 223(c) (2) of such Act is amended by striking out "which can be expected to result in death or to be of long-continued and indefinite duration".

(b) (1) Paragraph (2) of section 216(i) of such Act is amended to read as follows:

"(2)(A) The term 'period of disability' means a continuous period (beginning and ending as hereinafter provided in this subsection) during which an individual was under a disability (as defined in paragraph (1)), but only if such period is of not less than 6 full calendar months' duration or such individual was entitled to benefits under section 223 for one or more months in such period.

"(B) No period of disability shall begin as to any individual unless such individual files an application for a disability determination with respect to such period; and no such period shall begin as to any individual after such individual attains the age of 65.

"(C) A period of disability shall begin—

"(i) on the day the disability began, but only if the individual satisfies the requirements of paragraph (3) on such day; or

"(ii) if such individual does not satisfy the requirements of paragraph (3) on such day, then on the first day of the first quarter thereafter in which he satisfies such requirements.

"(D) A period of disability shall end with the close of the last day of the month preceding the month in which the individual attains age 65 or, if earlier, the close of the last day of—

"(i) the month following the month in which the disability ceases if he has been under a disability for a continuous period of less than 18 months, or

"(ii) the second month following the month in which his disability ceases if he has been under a disability for a continuous period of at least 18 months.

"(E) No application for a disability determination which is filed more than 3 months before the first day on which a period of disability can begin (as determined under this paragraph), or, in any case in which section 223(d)(2) applies, more than 6 months before the first month for which such applicant becomes entitled to benefits under section 223, shall be accepted as an application for purposes of this paragraph. Any application for a disability determination which is filed within such 3 months' period or 6 months' period shall be deemed to have been filed on such first day or in such first month, as the case may be.

"(F) No application for a disability determination which is filed more than 12 months after the month prescribed by subparagraph (D) as the month in which the period of disability ends (determined without regard to subparagraph (B) and this subparagraph) shall be accepted as an application for purposes of this paragraph."

(2) Section 216(i)(3) of such Act is amended by striking out "clauses (A) and (B) of paragraph (2)" and inserting in lieu thereof "clauses (i) and (ii) of paragraph (2)(C)".

(3) Paragraph (1) of section 223(a) of such Act is amended to read as follows:

"(1) Every individual who—

"(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

"(B) has not attained the age of 65, and

"(C) has filed application for disability insurance benefits.

shall be entitled to a disability insurance benefit for each month in his disability payment period (as defined in subsection (d))."

(4) Section 223(c)(3)(A) of such Act is amended by striking out "which continues until such application is filed".

(c) Section 223 of such Act is amended by adding at the end thereof the following new subsection:

"Disability Payment Period

"(d)(1) For purposes of this section, the term 'disability payment period' means, in the case of any application, the period beginning with the last month of the individual's waiting period and ending with the month preceding whichever of the following months is the earliest:

"(A) the month in which he dies,

"(B) the month in which he attains age 65, or

"(C) either (i) the second month following the month in which his disability ceases if he has been under a disability for a continuous period of less than 18 calendar months, or (ii) the third month following the month in which his disability ceases if he has been under a disability for a continuous period of at least 18 calendar months.

"(2) If—

"(A) an individual had a period of disability (as defined in section 216(i)) which lasted at least 18 calendar months and which ceased within the 60-month period preceding the first month of his waiting period, and

"(B) such individual applies for disability insurance benefits on the basis of a disability which at the time of application can be expected to last a continuous period of at least 12 months or to result in death,

then for purposes of this section, the term 'disability payment period' includes each month in the waiting period with respect to which such application was filed."

(d)(1) Section 222(c)(5) of such Act is amended by striking out "who becomes entitled to benefits under section 223 for any month as provided in clause (ii) of subsection (a)(1) of this section," and inserting in lieu thereof "to whom section 223(d)(2) is applicable,".

(2) Section 223(a)(2)(B) of such Act is amended by striking out "clause (ii) of paragraph (1) of this section" and inserting in lieu thereof "subsection (d)(2)".

(3)(A) Section 223(b) of such Act is amended—

(i) by striking out "clause (ii) of paragraph (1) of subsection (a)" and inserting in lieu thereof "subsection (d)(2)", and

(ii) by striking out the last sentence and inserting in lieu thereof the following: "An individual who would have been entitled to a disability insurance benefit for any month had be filed application therefor before the end of such month shall be entitled to such benefit for such month if he files such application before the end of the 12th month immediately succeeding such month."

(B) The second sentence of section 202(j)(1) of such Act is amended by inserting "under this title" after "Any benefit".

(e)(1) The amendments made by subsection (a), paragraphs (3) and (4) of subsection (b), and paragraph (3) of subsection (d), and the provisions of subparagraphs (B), (E), and (F) of section 216(i)(2) of the Social Security Act (as amended by subsection (b)(1) of this section), shall be effective with respect to applications for disability insurance benefits under section 223, and for disability determinations under section 216(i), of the Social Security Act filed—

(A) in or after the month in which this Act is enacted, or

(B) before the month in which this Act is enacted, if the applicant has not died before such month and if—

(i) notice of the final decision of the Secretary of Health, Education, and Welfare has not been given to the applicant before such month; or

(ii) the notice referred to in subparagraph (i) has been so given before such month but a civil action with respect to such final decision is commenced under section 205(g) of the Social Security Act (whether before, in, or after such month) and the decision in such civil action has not become final before such month;

except that no monthly insurance benefits under title II of the Social Security Act shall be payable or increased by reason of the amendments made by subsections (a) and (b) for months before the second month following the month in which this Act is enacted.

(2) Section 223(d)(1) of such Act (added by subsection (c) of this section) shall be applicable in the case of applications for disability insurance benefits filed by individuals the last month of whose waiting period (as defined in section 223(c)(3) of such Act) occurs after the month in which this Act is enacted; except that subparagraph (C) of such section shall be applicable to individuals entitled to disability insurance benefits whose disability (as defined in section 223(c) of the Social Security Act as amended by this Act) ceases in or after the second month following the month in which this Act is enacted.

(3) Section 223(d)(2) of such Act (added by subsection (c) of this section), and the amendments made by subsection (d), shall be applicable in the case of applications for disability insurance benefits under section 223, and for disability determinations under section 216(i), of the Social Security Act filed after the month in which this Act is enacted.

(4) Section 216(i)(2)(D) of such Act (as amended by subsection (b)(1) of this section) shall apply with respect to a disability (as defined in section 216(i) of such Act as amended by this Act) which ceases in or after the second month following the month in which this Act is enacted.

PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER ENTITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

SEC. 304. (a) Section 202(k) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(4) Any individual who, under this section and section 223, is entitled for any month to both an old-age insurance benefit and a disability insurance benefit under this title shall be entitled to only such disability insurance benefit for such month."

(b) The heading of section 202(q) of such Act is amended to read as follows: "Reduction of Old-Age, Disability, Wife's, Husband's, or Widow's Insurance Benefit Amounts"

(c) Section 202(q) of such Act is further amended by renumbering paragraphs (2), (3), (4), (5), (6), and (7) as paragraphs (3), (4), (5), (6), (7), and (8), respectively, by renumbering the cross references in such section accordingly, and by inserting after paragraph (1) the following new paragraph:

"(2) If an individual is entitled to a disability insurance benefit for a month after a month for which such individual was entitled to an old-age insurance benefit, such disability insurance benefit for each month shall be reduced by the amount such old-age insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained age 65 in the first month for which he most recently became entitled to a disability insurance benefit."

(d) Subparagraph (B) of paragraph (3) (as redesignated by subsection (c) of this section) of section 202(q) of such Act is amended by—

(1) striking out "benefit," the first time it appears and inserting in lieu thereof "benefit and is not entitled to a disability insurance benefit,";

(2) striking out in clause (i) thereof "(1)," and inserting in lieu thereof "(1) for such month,"; and

(3) striking out in clause (ii) thereof "(1)" and inserting in lieu thereof "(1) for such month".

(e) Subparagraph (C) of paragraph (3) (as redesignated by subsection (c) of this section) of section 202(q) of such Act is amended to read as follows:

"(C) For any month for which such individual is entitled to a disability insurance benefit, such individual's wife's, husband's, or widow's insurance benefit shall be reduced by the sum of—

"(i) the amount by which such disability insurance benefit is reduced under paragraph (2) for such month (if such paragraph applied to such benefit), and

"(ii) the amount by which such wife's, husband's, or widow's insurance benefit would be reduced under paragraph (1) for such month if it were equal to the excess of such wife's, husband's, or widow's insurance benefit (before reduction under this subsection) over such disability insurance benefit (before reduction under this subsection)."

(f) Paragraph (3) (as redesignated by subsection (c) of this section) of section 202(q) is further amended by adding after paragraph (E) (added by section 307(b)(4) of this Act) the following new paragraphs:

"(F) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs with or after the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit to which such individual was first entitled for a month before she attained retirement age, then such disability insurance benefit for each month shall be reduced by whichever of the following is larger:

"(i) the amount by which (but for this subparagraph) such disability insurance benefit would have been reduced under paragraph (2), or

"(ii) the amount equal to the sum of the amount by which such widow's insurance benefit was reduced for the monh in which such individual attained retirement age and the amount by which such disability insurance benefit would be reduced under paragraph (2) if it were equal to the excess of such disability insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection).

"(G) If the first month for which an individual is entitled to a disability insurance benefit (when such first month occurs before the month in which such individual attains the age of 62) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit, then such disability insurance benefit for each month shall be reduced by the

amount such widow's insurance benefit would be reduced under paragraphs (1) and (4) for such month had such individual attained age 62 in the first month for which he most recently became entitled to a disability insurance benefit."

(g) Paragraph (4) (as redesignated by subsection (c) of this section) of section 202(q) of such Act is amended by striking out in subparagraph (A) thereof "under" and inserting in lieu thereof: "under paragraph (1) or (3) of".

(h) Paragraph (7) (as redesignated by subsection (c) of this section and as amended by section 307(b)(7) of this Act) of section 202(q) of such Act is amended by adding after subparagraph (E) the following new subparagraph:

"(F) in the case of old-age insurance benefits, any month for which such individual was entitled to a disability insurance benefit."

(i) Paragraph (8) (as redesignated by subsection (c) of this section) of section 202(q) of such Act is amended by striking out "(1)" and inserting in lieu thereof "(1), (2),".

(j) Section 202(r)(2) of such Act is amended by inserting after "eligible" the following: "(but for section 202(k)(4))".

(k) So much of section 215(a)(4) of such Act as follows clause (B) is amended by striking out "such disability insurance benefit" and inserting in lieu thereof "the primary insurance amount upon which such disability insurance benefit is based".

(l) Section 216(i)(2) of such Act is amended by striking out "(subject to section 223(a)(3))".

(m) Section 223(a)(2) of such Act is amended by striking out the word "Such" and inserting in lieu thereof "Except as provided in section 202(q), such".

(n) Section 223(a)(3) of such Act is repealed.

(o) The amendments made by this section shall apply with respect to monthly insurance benefits under title II of the Social Security Act for and after the second month following the month in which this Act is enacted, but only on the basis of applications filed in or after the month in which this Act is enacted.

DISABILITY INSURANCE TRUST FUND

SEC. 305. (a) Section 201(b)(1) of the Social Security Act is amended by inserting "and before January 1, 1966," after "December 31, 1956,", and by inserting after "1954," the following: "and ¾ of 1 per centum of the wages (as so defined) paid after December 31, 1965, and so reported,".

(b) Section 201(b)(2) of such Act is amended by inserting after "December 31, 1956," the following: "and before January 1, 1966, and 9/16 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965,".

PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING SCHOOL

SEC. 306. (a) Section 202(d)(1)(B) of the Social Security Act is amended to read as follows:

"(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time student and had not attained the age of 22, or (ii) is under a disability (as defined in section 223(c)) which began before he attained the age of 18 and which has lasted or can be expected to last a continuous period of at least 6 calendar months or to result in death, and".

(b)(1) So much of the first sentence of section 202 (d)(1) of such Act as follows subparagraph (C) is amended to read as follows:

"shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding whichever of the following first occurs—

"(D) the month in which such child dies, marries, or is adopted (except for adoption by a stepparent, grandparent, aunt, or uncle subsequent to the death of such fully or currently insured individual),

"(E) in the case of a child who is not under a disability (as so defined) at the time he attains the age of 18 and who during no part of the month in which he attains such age is a full-time student, the month in which such child attains the age of 18,

"(F) in the case of a child who is a full-time student during the month in which he attains the age of 18, the first month (beginning after he attains such age) during no part of which he is a full-time student or the month in which attains the age of 22, whichever occurs earlier, but only if in the third month preceding such earlier month he was not under a disability (as so defined) which began before he attained the age of 18,

"(G) in the case of a child who first becomes entitled to benefits under this subsection for the month in which he attains the age of 18 or a subsequent month and who in the month for which he becomes so entitled is not under a disability (as so defined) which began before he attained the age of 18, the first month (after he becomes so entitled) during no part of which he is a full-time student or the month in which he attains the age of 22, whichever occurs earlier,

"(H) in the case of a child who after he attains the age of 18 ceases to be under a disability (as so defined) which began before he attained the age of 18, and who either—

"(i) attains the age of 22 before the close of the third month following the month in which he ceases to be under such disability, or

"(ii) was a full-time student during no part of the third month following the months in which he ceases to be under such disability if he has been under a disability for a continuous period of at least 18 months (or the second month following the month in which he ceases to be under such disability if he has been under a disability for a continuous period of less than 18 months),

the third month (or the second month) following the month in which he ceases to be under such disability, or

"(I) in the case of a child who after he attains the age of 18 ceases to be under a disability (as so defined) which began before he attained the age of 18, but who has not attained the age of 22 before the close of the third month following the month in which he ceases to be under such disability if he has been under a disability for a continuous period of at least 18 months (or before the close of the second month following the month in which he ceases to be under such disability if he has been under a disability for a continuous period of less than 18 months) and is a full-time student in such third month (or such second month), the earlier of (i) the first month (after such third month or such second month) during no part of which he is a full-time student, or (ii) the month in which he attains the age of 22."

(2) The second sentence of section 202(d)(1) of such Act is repealed.

(3) Section 202(d) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(7) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specifed in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he is a full-time student and has not attained the age of 22 if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs: The first month during no part of which he is a full-time student, the month in which he attains the age of 22, or the first month in which an event specified in paragraph (1)(D) occurs.

"(8) For the purposes of this subsection—

"(A) A full-time student' is an individual who is in full-time attendance as a student at an educational institution, as determined by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the institutions involved, except that no individual shall be considered a 'full-time student' if he is paid by his employer while attending an educational institution at the request, or pursuant to a requirement, of his employer.

"(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time student during any period of nonattendance at an educational institution at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an educational institution immediately following such

period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an educational institution immediately following such period.

"(C) An 'educational institution' is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a nonaccredited school or college or university whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited."

(c)(1) Section 202 of such Act is amended by inserting immediately after subsection (r) the following new subsection:

"Child Aged 18 or Over Attending School

"(s)(1) For the purposes of subsections (b)(1), (g)(1), (q)(5), and (q)(7) of this section and paragraphs (2), (3), and (4) of section 203(c), a child who is entitled to child's insurance benefits under subsectio n(d) for any month, and who has attained the age of 18 but is not in such month under a disability (as defined in section 223(c)) which began before he attained such age, shall be deemed not entitled to such benefits for such month, unless he was under such a disability in the third month before such month and had been under such disability for a continuous period of at least 18 months (or in the second month if he had been under such disability for a continuous period of less than 18 months).

"(2) Subsection (f)(4), and so much of subsections (b)(4), (d)(6), (e)(4), (g)(4), and (h)(4) of this section as precedes the semicolon, shall not apply in the case of any child unless such child, at the time of the marriage referred to therein, was under a disability (as defined in section 223(c)) which began before such child attained the age of 18 or had been under such a disability in the third month before the month in which such marriage occurred and had been under such disability for a continuous period of at least 18 months (or in the second month if he had been under such disability for a continuous period of less than 18 months).

"(3) Subsections (c)(2)(B) and (f)(2)(B) of this section, so much of subsections (b)(4), (d)(6), (e)(4), (g)(4), and (h)(4) of this section as follows the semicolon, the last sentence of subsection (c) of section 203, subsection (f)(1)(C) of section 203, and subsections (b)(3)(B), (c)(6)(B), (f)(3)(B), and (g)(6)(B) of section 216 shall not apply in the case of any child with respect to any month referred to therein unless in such month or the third month prior thereto such child was under a disability (as defined in section 223(c)) which began before such child attained the age of 18 and had been under such disability for a continuous period of at least 18 months (or in the second month if he had been under such disability for a continuous period of less than 18 months)."

(2) So much of subsection (c)(2) of such section 202 as precedes subparagraph (A) is amended by inserting "(subject to subsection (s))" after "shall".

(3) So much of subsection (d)(6) of such section 202 as follows subparagraph (B) is amended by inserting "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)".

(4) So much of subsection (e)(4) of such section 202 as follows subparagraph (B) is amended by inserting "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)".

(5) So much of subsection (f)(2) of such section 202 as precedes subparagraphs (A) is amended by inserting "(subject to subsection (s))" after "shall".

(6) So much of subsection (f)(4) of such section 202 as follows subparagraph (B) is amended by inserting "but subject to subsection(s)" after "notwithstanding the provisions of paragraph (1)".

(7) So much of the first sentence of subsection (g)(1) of such section 202 as follows subparagraph (F) is amended by inserting "(subject to subsection (s))" after "shall".

(8) So much of subsection (g)(4) of such section 202 as follows subparagraph (B) is amended by inserting "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)".

(9) So much of subsection (h)(4) of such section 202 as follows subparagraph (B) is amended by inserting "but subject to subsection (s)" after "notwithstanding the provisions of paragraph (1)".

(10) The next to last sentence of subsection (c) of section 203 of such Act is amended by striking out "for any month in which" and inserting in lieu thereof "for any month in which paragraph (1) of section 202(s) applies or".

(11) The last sentence of subsection (c) of such section 203 is amended by striking out "No" and inserting in lieu thereof "Subject to paragraph (3) of such section 202(s), no".

(12) The last sentence of subsection (f)(1) of such section 203 is amended by inserting "but subject to section 202(s)" after "Notwithstanding the preceding provisions of this paragraph".

(13) Subsections (b), (c), (f), and (g) of section 216 of such Act are each amended by inserting before the period at the end thereof "(subject, however, to section 202(s))".

(14) Section 222(b) of such Act is amended by adding at the end thereof the following new paragraph:

"(4) The provisions of paragraph (1) shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student (as defined and determined under section 202(d))."

(15) Section 225 of such Act is amended by adding at the end thereof the following new sentence: "The first sentence of this section shall not apply to any child entitled to benefits under section 202(d), if he has attained the age of 18 but has not attained the age of 22, for any month during which he is a full-time student as defined and determined under section 202(d))."

(d) The amendments made by this section shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act for months after December 1964; except that—

(1) in the case of an individual who was not entitled to a child's insurance benefit under subsection (d) of such section for the month in which this Act is enacted, such amendments shall apply only on the basis of an application filed in or after the month in which this Act is enacted.

(2) section 202(d)(1)(H)(ii) of such Act (as amended by this section) shall apply only for months after the month in which this Act is enacted, and

(3) no monthly insurance benefit shall be payable for any month before the second month following the month in which this Act is enacted by reason of section 202(d)(1)(B)(ii) of the Social Security Act as amended by this section.

REDUCED BENEFITS FOR WIDOWS AT AGE 60

SEC. 307. (a)(1) Paragraph (1)(B) of section 202(e) of the Social Security Act (as amended by section 308(b) of this Act) is amended by striking out "age 62" and inserting in lieu thereof "age 60".

(2) Paragraph (2) of such section (as so amended) is amended by striking out "Such" and inserting in lieu thereof "Except as provided in subsection (q), such".

(b)(1) Paragraph (1) of section 202(q) of such Act is amended to read as follows:

"(1) If the first month for which an individual is entitled to an old-age, wife's, husband's, or widow's insurance benefit is a month before the month in which such individual attains retirement age, the amount of such benefit for each month shall, subject to the succeeding paragraphs of this subsection, be reduced by—

"(A) 5/9 of 1 percent of such amount if such benefit is an old-age or widow's insurance benefit, or 25/36 of 1 percent of such amount if such benefit is a wife's or husband's insurance benefit, multiplied by

"(B)(i) the number of months in the reduction period for such benefit (determined under paragraph (6)), if such benefit is for a month before the month in which such individual attains retirement age, or

"(ii) the number of months in the adjusted reduction period for such benefit (determined under paragraph (7)), if such benefit is for the month in which such individual attains retirement age or for any month thereafter."

(2) Paragraph (3)(A) (as renumbered by section 304(c) of this Act) of such section is amended—

(A) by striking out "wife's or husband's insurance benefit" each place it appears and inserting in lieu thereof "wife's, husband's, or widow's insurance benefit"; and

(B) by striking out "age 62" and inserting in lieu thereof "age 62 (in the case of a wife's or husband's insurance benefit) or age 60 (in the case of a widow's insurance benefit)".

(3) Paragraph (3)(D) (as so renumbered) of such section is amended by striking out "wife's or husband's" and inserting in lieu thereof "wife's, husband's, or widow's."

(4) Paragraph (3) (as so renumbered) of such section is amended by adding at the end thereof the following new subparagraph:

"(E) If the first month for which an individual is entitled to an old-age insurance benefit (whether such first month occurs before, with, or after the month in which such individual attains the age of 65) is a month for which such individual is also (or would, but for subsection (e)(1), be) entitled to a widow's insurance benefit to which such individual was first entitled for a month before she attained retirement age, then such old-age insurance benefit shall be reduced by whichever of the following is the larger:

"(i) the amount by which (but for this subparagraph) such old-age insurance benefit would have been reduced under paragraph (1), or

"(ii) the amount equal to the sum of the amount by which such widow's insurance benefit was reduced for the month in which such individual attained retirement age and the amount by which such old-age insurance benefit would be reduced under paragraph (1) if it were equal to the excess of such old-age insurance benefit (before reduction under this subsection) over such widow's insurance benefit (before reduction under this subsection)."

(5) Paragraph (5) (as so renumbered) of such section is amended by adding at the end thereof the following new subparagraph:

"(D) No widow's insurance benefit for a month in which she has in her care a child of her deceased husband (or deceased former husband) entitled to child's insurance benefits shall be reduced under this subsection below the amount to which she would have been entitled had she been entitled for such month to mother's insurance benefits on the basis of her deceased husband's (or deceased former husband's) wages and self-employment income."

(6) Paragraph (6) (as so renumbered) of such section is amended—

(A) by striking out "wife's, or husband's" and inserting in lieu thereof "wife's, husband's, or widow's";

(B) by striking out "or husband's" in subparagraph (A)(i) and inserting in lieu thereof ", husband's, or widow's"; and

(C) by striking out "age 65" in subparagraph (B) and inserting in lieu thereof "retirement age".

(7) Paragraph (7) (as so renumbered) of such section is amended—

(A) by striking out "wife's, or husband's" and inserting in lieu thereof "wife's, husband's, or widow's"; and

(B) by striking out "and" at the end of subparagraph (B), by striking out the period at the end of subparagraph (C) and inserting in lieu thereof a comma, and by adding at the end thereof the following new subparagraphs:

"(D) in the case of widow's insurance benefits, any month in which the reduction in the amount of such benefit was determined under paragraph (5)(D),

"(E) in the case of widow's insurance benefits, any month before the month in which she attained retirement age for which she was not entitled to such benefit because of the occurrence of an event that terminated her entitlement to such benefits, and".

(8) Section 202(q) of such Act (as amended by section 304(c) of this Act) is further amended by adding at the end thereof the following new paragraph:

"(9) For purposes of this subsection, the term 'retirement age' means age 65 with respect to an old-age, wife's, or husband's insurance benefit and age 62 with respect to a widow's insurance benefit."

(c) The amendments made by this section shall apply with respect to monthly insurance benefits under section 202 of the Social Security Act for and after the second month following the month in which this Act is enacted, but only on the basis of applications filed in or after the month in which this Act is enacted.

WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

SEC. 308. (a) Section 202(b) of the Social Security Act is amended to read as follows:

"Wife's Insurance Benefits

"(b)(1) The wife (as defined in section 216(b)) and every divorced wife (as defined in section 216(d)) of an individual entitled to old-age or disability insurance benefits, if such wife or such divorced wife—

"(A) has filed application for wife's insurance benefits,

"(B) has attained age 62 or (in the case of a wife) has in her care (individually or jointly with such individual) at the time of filing such application a child entitled to a child's insurance benefit on the basis of the wages and self-employment income of such individual,

"(C) in the case of a divorced wife, has not remarried,

"(D) in the case of a divorced wife, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

"(i) if he had a period of disability which did not end before the month in which he became entitled to old-age or disability insurance benefits, at the beginning of such period or at the time he became entitled to such benefits, or

"(ii) if he did not have such a period of disability, at the time he became entitled to old-age insurance benefits, and

"(E) is not entitled to old-age or disability insurance benefits, or is entitled to old-age or disability insurance benefits based on a primary insurance amount which is less than one-half of the primary insurance amount of such individual,

shall (subject to subsection (s)) be entitled to a wife's insurance benefit for each month, beginning with the first month in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs—

"(F) she dies,

"(G) such individual dies,

"(H) in the case of a wife, they are divorced and either (i) she has not attained age 62, or (ii) she has attained age 62 but has not been married to such individual for a period of 20 years immediately before the date the divorce became effective,

"(I) in the case of a divorced wife, she marries a person other than such individual,

"(J) in the case of a wife who has not attained age 62, no child of such individual is entitled to a child's insurance benefit,

"(K) she becomes entitled to an old-age or disability insurance benefit based on a primary insurance amount which is equal to or exceeds one-half of the primary insurance amount of such individual, or

"(L) such individual is not entitled to disability insurance benefits and is not entitled to old-age insurance benefits.

"(2) Except as provided in subsection (q), such wife's insurance benefit for each month shall be equal to one-half of the primary insurance amount of her husband (or, in the case of a divorced wife, her former husband) for such month.

"(3) In the case of any divorced wife of an individual—

"(A) who marries another individual, and

"(B) whose marriage to the individual referred to in subparagraph (A) is terminated by divorce which occurs within 20 years after such marriage,

the marriage to the individual referred to in subparagraph (A) shall, for the purposes of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month before whichever of the following is the latest: (i) the month after the month in which the divorce referred to in subparagraph (B) of the preceding sentence occurs, (ii) the twelfth month before the month in which such divorced wife files application for purposes of this paragraph, or (iii) the second month after the month in which this paragraph is enacted.

"(4) In the case of any divorced wife who marries—

"(A) an individual entitled to benefits under subsection (f) or (h) of this section, or

"(B) an individual who has attained the age of 18 and is entitled to benefits under subsection (d),

such divorced wife's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) (but subject to subsection (s)), not be terminated by reason of such marriage; except that, in the case of such a marriage to an individual entitled to benefits under subsection (d), the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under subsection (d) unless he ceases to be so entitled by reason of his death."

(b)(1) Paragraphs (1) and (2) of section 202(e) of such Act are amended to read as follows:

"(1) The widow (as defined in section 216(c)) and every surviving divorced wife (as defined in section 216(d)) of an individual who died a fully insured individual, if such widow or such surviving divorced wife—

"(A) has not remarried,

"(B) has attained age 62,

"(C)(i) has filed application for widow's insurance benefits, or was entitled, after attainment of age 62, to wife's insurance benefits, on the basis of the wages and self-employment income of such individual, for the month preceding the month in which he died, or

"(ii) was entitled, on the basis of such wages and self-employment income, to mother's insurance benefits for the month preceding the month in which she attained age 62,

"(D) in the case of a surviving divorced wife, was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or was receiving substantial contributions from such individual (pursuant to a written agreement) or there was in effect a court order for substantial contributions to her support from such individual—

"(i) at the time of his death (or, if such individual had a period of disability which did not end prior to the month in which he died, at the time such period began or at the time of his death), or

"(ii) at the time he became entitled to old-age insurance benefits or disability insurance benefits (or, if such individual had a period of disability which did not end before the month in which he became entitled to such benefits, at the time such period began or at the time he became entitled to such benefits), and

"(E) is not entitled to old-age insurance benefits or is entitled to old-age insurance benefits each of which is less than 82½ percent of the primary insurance amount of such deceased individual,

shall be entitled to a widow's insurance benefit for each month, beginning with the first month in which she becomes so entitled to such insurance benefits and ending with the month preceding the first month in which any of the following occurs: she remarries, dies, or becomes entitled to an old-age insurance benefit equal to or exceeding 82½ percent of the primary insurance amount of such deceased individual.

"(2) Such widow's insurance benefit for each month shall be equal to 82½ percent of the primary insurance amount of such deceased individual."

(2) Paragraphs (3) and (4) of section 202(e) of such Act are amended by striking out "widow" each place it appears and inserting in lieu thereof "widow or surviving divorced wife".

(3) Paragraph (4) of section 202(e) of such Act is amended by striking out "widow's" and inserting in lieu thereof "widow's or surviving divorced wife's".

(4) Section 202(e) of such Act is further amended by adding at the end thereof the following new paragraph:

"(5) In the case of any widow or surviving divorced wife of an individual—

"(A) who marries another individual, and

"(B) whose marriage to the individual referred to in subparagraph (A) is terminated by divorce which occurs within 20 years after such marriage,

the marriage to the individual referred to in subparagraph (A) shall, for the purposes of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month before whichever of the following is the latest: (i) the month after the month in which the divorce referred to in subparagraph (B) of the preceding

sentence occurs, (ii) the twelfth month before the month in which such widow or surviving divorced wife files application for purposes of this paragraph, or (iii) the second month after the month in which this paragraph is enacted."

(c) Section 216(d) of such Act is amended to read as follows:

"Divorced Wives; Divorce

"(d)(1) The term 'divorced wife' means a woman divorced from an individual, but only if she had been married to such individual for a period of 20 years immediately before the date the divorce became effective.

"(2) The term 'surviving divorced wife' means a woman divorced from an individual who has died, but only if she had been married to the individual for a period of 20 years immediately before the date the divorce became effective.

"(3) The term 'surviving divorced mother' means a woman divorced from an individual who has died, but only if (A) she is the mother of his son or daughter, (B) she legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18, (C) he legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18, or (D) she was married to him at the time both of them legally adopted a child under the age of 18.

"(4) The terms 'divorce' and 'divorced' refer to a divorce a vinculo matrimonii."

(d)(1) Section 202(c)(1) of such Act is amended by striking out "divorced a vinculo matrimonii," and inserting in lieu thereof "divorced,".

(2)(A) Subsections (d)(6)(A), (f)(4)(A), and (h)(4)(A) of section 202 of such Act are each amended by inserting "(b)," before "(e),".

(B) Subsections (b) and (c) of section 216 of such Act are each amended by striking out "(e) or" and inserting in lieu thereof "(b), (e), or".

(3) Subparagraph (F) of section 202(g)(1) of such Act is amended to read as follows:

"(F) in the case of a surviving divorced mother—

"(i) at the time of such individual's death (or, if such individual had a period of disability which did not end before the month in which he died, at the time such period began or at the time of such death)—

"(I) she was receiving at least one-half of her support, as determined in accordance with regulations prescribed by the Secretary, from such individual, or

"(II) she was receiving substantial contributions from such individual (pursuant to a written agreement), or

"(III) there was a court order for substantial contributions to her support from such individual,

"(ii) the child referred to in subparagraph (E) is her son, daughter, or legally adopted child, and

"(iii) the benefits referred to in such subparagraph are payable on the basis of such individual's wages and self-employment income,".

(4) Section 202(g) of such Act is amended by adding the following new paragraph:

"(5) In the case of any widow or surviving divorced mother—

"(A) who marries another individual, and

"(B) whose marriage to the individual referred to in subparagraph (A) is terminated by divorce which occurs within 20 years after such marriage,

the marriage to the individual referred to in subparagraph (A) shall, for the purposes of paragraph (1), be deemed not to have occurred. No benefits shall be payable under this subsection by reason of the preceding sentence for any month prior to whichever of the following is the latest: (i) the month after the month in which the divorce referred to in subparagraph (B) of the preceding sentence occurs, (ii) the twelfth month before the month in which such widow or surviving divorced mother files application for purposes of this paragraph, or (iii) the second month after the month in which this paragraph is enacted."

(5) Section 202(g) of such Act is further amended by striking out "former wife divorced" each place it appears and inserting in lieu thereof "surviving divorced mother".

(6) Section 203(a) of such Act (as amended by section 301(c) of this Act) is amended by striking out the period at the end of the first sentence and inserting in lieu thereof ", or" and by adding the following new paragraph:

"(3) when any of such individuals is entitled to monthly benefits as a divorced wife under section 202(b) or as a surviving divorced wife under

section 202(e) for any month, the benefit to which she is entitled on the basis of the wages and self-employment income of such insured individual for such month shall be determined without regard to this subsection, and the benefits of all other individuals who are entitled for such month to monthly benefits under section 202 on the wages and self-employment income of such insured individual shall be determined as if no such divorced wife or surviving divorced wife were entitled to benefits for such month."

(7) Section 203(c)(4) of such Act is amended by striking out "former wife divorced" and inserting in lieu thereof "surviving divorced mother".

(8) Section 203(d)(1) of such Act is amended by striking out "wife," and inserting in lieu thereof "wife, divorced wife,".

(9) The second sentence of section 205(b) of such Act is amended by striking out "wife, widow, former wife divorced," and inserting in lieu thereof "wife, divorced wife, widow, surviving divorced wife, surviving divorced mother,".

(10) Section 205(c)(1)(C) of such Act is amended by striking out "former wife divorced," and inserting in lieu thereof "surviving divorced wife, surviving divorced mother,".

(11) Section 222(b)(3) of such Act is amended by inserting "divorced wife," after "wife,".

(e) The amendments made by this section shall be applicable with respect to monthly insurance benefits under title II of the Social Security Act beginning with the second month following the month in which this Act is enacted; but, in the case of an individual who was not entitled to a monthly insurance benefit under section 202 of such Act for the first month following the month in which this Act is enacted, only on the basis of an application filed in or after the month in which this Act is enacted.

TRANSITIONAL INSURED STATUS

SEC. 309. (a) Title II of the Social Security Act is further amended by adding at the end thereof (after the new section 226 added by section 101 of this Act) the following new section:

"TRANSITIONAL INSURED STATUS

"SEC. 227. (a) In the case of any individual who attains the age of 72 before 1969 but who does not meet the requirements of section 214(a), the 6 quarters of coverage referred to in so much of pargaraph (1) of section 214(a) as follows clause (C) shall, instead, be 3 quarters of coverage for purposes of determining entitlement of such individual to benefits under section 202(a), and of his wife to benefits under section 202(b), but, in the case of such wife, only if she attains the age of 72 before 1969 and only with respect to wife's insurance benefits under section 202(b) for and after the month in which she attains such age. For each month before the month in which any such individual meets the requirements of section 214(a), the amount of his old-age insurance benefit shall, notwithstanding the provisions of section 202(a), be $35 and the amount of the wife's insurance benefit of his wife shall, notwithstanding the provisions of section 202(b), be $17.50.

"(b) In the case of any individual who has died, who does not meet the requirements of section 214(a), and whose widow attains age 72 before 1969, the 6 quarters of coverage referred to in pargaraph (3) of section 214(a) and in so much of paragraph (1) thereof as follows clause (C) shall, for purposes of determining her entitlement to widow's insurance benefits under section 202(e), instead be—

"(1) 3 quarters of coverage if such widow attains the age of 72 in or before 1966,

"(2) 4 quarters of coverage if such widow attains the age of 72 in 1967, or

"(3) 5 quarters of coverage if such widow attains the age of 72 in 1968.

The amount of her widow's insurance benefit for each month shall, notwithstanding the provisions of section 202(e) (and section 202(m)), be $35.

"(c) In the case of any individual who becomes, or upon filing application therefor would become, entitled to benefits under section 202(a) by reason of the application of subsection (a) of this section, who dies, and whose widow attains the age of 72 before 1969, such deceased individual shall be deemed to meet the requirements of subsection (b) of this section for purposes of determining entitlement of such widow to widow's insurance benefits under section 202(e)."

(b) The amendment made by subsection (a) shall apply in the case of monthly benefits under title II of the Social Security Act for and after the second month following the month in which this Act is enacted on the basis of applications filed in or after the month in which this Act is enacted.

INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM BENEFITS

SEC. 310. (a) Paragraph (3) of section 203(f) of the Social Security Act is amended by striking out "$500" wherever it appears therein and inserting in lieu thereof "$1,200".

(b) The amendments made by subsection (a) shall apply with respect to taxable years ending after December 31, 1965.

COVERAGE FOR DOCTORS OF MEDICINE

SEC. 311. (a)(1) Section 211(c)(5) of the Social Security Act is amended to read as follows:

"(5) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner."

(2) Section 211(c) of such Act is further amended by striking out the last two sentences and inserting in lieu thereof the following: "The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under section 1402(e) of the Internal Revenue Code of 1954 is in effect."

(3) Section 210(a)(6)(C)(iv) of such Act is amended by inserting before the semicolon at the end thereof the following: ", other than as a medical or dental intern or a medical or dental resident in training".

(4) Section 210(a)(13) of such Act is amended by striking out all that follows the first semicolon.

(b)(1) Section 1402(c)(5) of the Internal Revenue Code of 1954 (relating to definition of trade or business) is amended to read as follows:

"(5) the performance of service by an individual in the exercise of his profession as a Christian Science practitioner."

(2) Section 1402(c) of such Code is further amended by striking out the last two sentences and inserting in lieu thereof the following: "The provisions of paragraph (4) or (5) shall not apply to service (other than service performed by a member of a religious order who has taken a vow of poverty as a member of such order) performed by an individual during the period for which a certificate filed by him under subsection (e) is in effect."

(3)(A) Section 1402(e)(1) of such Code (relating to filing of waiver certificate by ministers, members of religious orders, and Christian Science practitioners) is amended by striking out "extended to service" and all that follows and inserting in lieu thereof "extended to service described in subsection (c)(4) or (c)(5) performed by him."

(B) Clause (A) of section 1402(e)(2) of such Code (relating to time for filing waiver certificate) is amended to read as follows: "(A) the due date of the return (including any extension thereof) for his second taxable year ending after 1954 for which he has net earnings from self-employment (computed without regard to subsections (c)(4) and (c)(5)) of $400 or more, any part of which was derived from the performance of service described in subsection (c)(4) or (c)(5); or".

(4) Section 3121(b)(6)(C)(iv) of such Code (relating to definition of employment) is amended by inserting before the semicolon at the end thereof the following: ", other than as a medical or dental intern or a medical or dental resident in training".

(5) Section 3121(b)(13) of such Code is amended by striking out all that follows the first semicolon.

(c) The amendments made by paragraphs (1) and (2) of subsection (a), and by paragraphs (1), (2), and (3) of subsection (b), shall apply only with respect to taxable years ending after December 31, 1965. The amendments made by paragraphs (3) and (4) of subsection (a), and by paragraphs (4) and (5) of subsection (b), shall apply only with respect to services performed after 1965.

GROSS INCOME OF FARMERS

SEC. 312. (a) The second sentence following paragraph (8) in section 211(a) of the Social Security Act is amended by striking out "$1,800" each place it appears and inserting in lieu thereof "$2,400", and by striking out "$1,200" each place it appears and inserting in lieu thereof "$1,600".

(b) The second sentence following paragraph (9) in section 1402(a) of the Internal Revenue Code of 1954 (relating to net earnings from self-employment) is amended by striking out "$1,800" each place it appears and inserting in lieu thereof "$2,400", and by striking out "$1,200" each place it appears and inserting in lieu thereof "$1,600".

(c) The amendments made by this section shall apply only with respect to taxable years beginning after December 31, 1965.

COVERAGE OF TIPS

SEC. 313. (a)(1) Section 209 of the Social Security Act is amended by striking out "or" at the end of subsection (j), by striking out the period at the end of subsection (k) and inserting in lieu thereof "; or", and by adding immediately after subsection (k) the following new subsection:

"(l) (1) Tips paid in any medium other than cash;

"(2) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more."

(2) Section 209 of such Act is further amended by adding at the end thereof the following new paragraph:

"For purposes of this title, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such tips shall be deemed to be paid to the employee by the employer and shall be deemed to be so paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954 or (if no statement including such tips is so furnished) at the time received."

(b) Section 451 of the Internal Revenue Code of 1954 (relating to general rule for taxable year of inclusion) is amended by adding at the end thereof the following new subsection:

"(c) SPECIAL RULE FOR EMPLOYEE TIPS.—For purposes of subsection (a), tips included in a written statement furnished an employer by an employee pursuant to section 6053(a) shall be deemed to be received at the time the written statement including such tips is furnished to the employer."

(c) (1) Section 3102 of such Code (relating to deduction of tax from wages) is amended by adding at the end thereof the following new subsection:

"(c) SPECIAL RULE FOR TIPS.—

"(1) In the case of tips which constitute wages, subsection (a) shall be applicable only to such tips as are included in a written statement furnished to the employer pursuant to section 6053(a), and only to the extent that collection can be made by the employer, at or after the time such statement is so furnished and before the close of the 10th day following the calendar month in which the tips were received, by deducting the amount of the tax from such wages of the employee (excluding tips, but including funds turned over by the employee to the employer pursuant to paragraph (2)) as are under control of the employer.

"(2) If the tax imposed by section 3101, with respect to tips received by an employee during a calendar month which are included in written statements furnished to the employer pursuant to section 6053(a), exceeds the wages of the employee (excluding tips) from which the employer is required to collect the tax under paragraph (1), the employee shall furnish to the employer on or before the 10th day of the following month an amount of money equal to the amount of the excess.

"(3) The Secretary or his delegate may, under regulations prescribed by him, authorize employers—

"(A) to estimate the amount of tips that will be reported by the employee pursuant to section 6053 in any quarter of the calendar year,

"(B) to determine the amount to be deducted upon each payment of wages (exclusive of tips) during such quarter as if the tips so estimated constituted the actual tips so reported, and

"(C) to deduct upon any payment of wages (other than tips) to such employee during such quarter such amount as may be necessary to adjust the amount actually deducted upon such wages of the employee during the quarter to the amount required to be deducted during the quarter without regard to this paragraph."

(2) The second sentence of section 3102(a) of such Code is amended by inserting before the period at the end thereof the following: "; and an employer who is furnished by an employee a written statement of tips (received in a calendar month) pursuant to section 6053(a) to which paragraph (12)(B) of section 3121(a) is applicable may deduct an amount equivalent to such tax with respect to such tips from any wages of the employee (exclusive of tips) under his control, even though at the time such statement is furnished the total amount of the tips included in statements furnished to the employer as having been received by the employe in such calendar month in the course of his employment by such is less than $20".

(3) Section 3121(a) of such Code (relating to definition of wages under the Federal Insurance Contributions Act) is amended by striking out "or" at the end of paragraph (10), by striking out the period at the end of paragraph (11) and inserting in lieu thereof "; or", and by adding after paragraph (11) the following new paragraph:

"(12)(A) tips paid in any medium other than cash;

"(B) cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more."

(4) Section 3121 of such Code is further amended by adding at the end thereof the following new subsection:

"(q) Tips.—For purposes of this chapter, tips received by an employee in the course of his employment shall be considered remuneration for employment. Such tips shall be deemed to be paid to the employee by the employer, and shall be deemed to be so paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if no statement including such tips is so furnished) at the time received."

(d)(1) Section 3401 of such Code (relating to definitions for purposes of collecting income tax at source on wages) is amended by adding at the end thereof the following new subsection:

"(f) Tips.—For purposes of subsection (a), the term 'wages' includes tips received by an employee in the course of his employment. Such tips shall be deemed to be paid to the employee by the employer, and shall be deemed to be so paid at the time a written statement including such tips is furnished to the employer pursuant to section 6053(a) or (if not statement including such tips is so furnished) at the time received."

(2) Section 3401(a) of such Code (relating to definition of wages for purposes of collecting income tax at source) is amended by striking out ", or" at the end of paragraph (6) and inserting in lieu thereof "; or", by striking out the period at the end of paragraph (12) and inserting in lieu thereof "; or", by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; or", and by adding after paragraph (15) the following new paragraph:

"(16) (A) as tips in any medium other than cash;

"(B) as cash tips to an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more."

(3) Subsection (a) of section 3402 of such Code (relating to income tax collected at source) is amended by striking out "subsection (j)" and inserting in lieu thereof "subsections (j) and (k)".

(4) Section 3402 of such Code is further amended by adding at the end thereof the following new subsection:

"(k) Tips.—In the case of tips which constitute wages, subsection (a) shall be applicable only to such tips as are included in a written statement furnished to the employer pursuant to section 6053(a), and only to the extent that the tax can be deducted and withheld by the employer, at or after the time such statement is so furnished and before the close of the calendar year in which the employee receives the tips which are included in such statement, from such wages of the employee (excluding tips, but including funds turned over by the employee to the employer for the purpose of such deduction and withholding) as are under the control of the employer; and an employer who is furnished by an employee a written statement of tips (received in a calendar month) pursuant to

section 6053(a) to which paragraph (16)(B) of section 3401(a) is applicable may deduct and withhold the tax with respect to such tips from any wages of the employee (excluding tips) under his control, even though at the time such statement is furnished the total amount of the tips included in statements furnished to the employer as having been received by the employee in such calendar month in the course of his employment by such employer is less than $20. Such tax shall not at any time be deducted and withheld in an amount which exceeds the aggregate of such wages and funds minus any tax required by section 3102(a) to be collected from such wages."

(e)(1) Section 6051(a) of such Code (relating to receipts for employees) is amended by adding at the end thereof the following new sentence: "In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraph (3) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a); and the amounts required to be shown by paragraph (5) shall include only such tips as are reported by the employee to the employer pursuant to section 6053(b)."

(2)(A) Subpart C of part III of subchapter A of chapter 61 of such Code (relating to information regarding wages paid employees) is amended by adding at the end thereof the following new section:

"SEC. 6053. REPORTING OF TIPS.

"(a) Every employee who, in the course of his employment by an employer receives in any calendar month tips which are wages (as defined in section 3121 (a) or section 3401(a)) shall report all such tips in one or more written statements furnished to his employer on or before the 10th day following such month. Such statements shall be furnished by the employee under such regulations, at such other times before such 10th day, and in such form and manner, as may be prescribed by the Secretary or his delegate.

"(b) For purposes of sections 3102(c), 3111, 6051(a), and 6652(c), tips received in any calendar month shall be considered reported pursuant to this section only if they are included in such a statement furnished to the employer on or before the 10th day following such month and only to the extent that the tax imposed with respect to such tips by section 3101 can be collected by the employer under section 3102."

(B) The table of sections for such subpart C is amended by adding at the end thereof the following:

"Sec. 6053. Reporting of tips."

(3) Section 6652 of such Code (relating to failure to file certain information returns) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) FAILURE TO REPORT TIPS.—In the case of tips to which section 6053(a) applies, if the employee fails to report any of such tips to the employer pursuant to section 6053(b), unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be paid by the employee, in addition to the tax imposed by section 3101 with respect to the amount of the tips which he so failed to report, an amount equal to such tax."

(f) Section 3111 of such Code (relating to rate of tax on employers under the Federal Insurance Contributions Act), as amended by section 321 of this Act, is amended by adding at the end thereof the following new subsection:

"(c) TIPS.—In the case of tips which constitutes wages, the tax imposed by this section shall be applicable only to such tips as are reported by the employee to the taxpayer pursuant to section 6053(b)."

(g) The amendments made by this section shall apply only with respect to tips received by employees after 1965.

INCLUSION OF ALASKA AND KENTUCKY AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

SEC. 314. The first sentence of section 218(d)(6)(C) of the Social Security Act is amended—

(1) by inserting "Alaska," before "California"; and

(2) by inserting "Kentucky," before "Massachusetts".

ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

SEC. 315. The first sentence of section 218(d)(6)(F) of the Social Security Act is amended by striking out "1963" and inserting in lieu thereof "1967".

EMPLOYEES OF NONPROFIT ORGANIZATIONS

SEC. 316. (a)(1) Section 3121(k)(1)(B)(iii) of the Internal Revenue Code of 1954 (relating to effective date of exemption of religious, charitable, and certain other organizations) is amended to read as follows:

"(iii) the first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is filed."

(2) The amendment made by paragraph (1) shall apply in the case of any certificate filed under section 3121 (k)(1)(A) of such Code after the date of the enactment of this Act.

(b) Section 3121(k)(1) of such Code (relating to waiver of exemption by religious, charitable, and certain other organizations) is further amended by adding at the end thereof the following new subparagraph:

"(H) An organization which files a certificate under subparagraph (A) before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the first day of the twentieth calendar quarter preceding the quarter in which such certificate is so amended."

(c)(1) Section 105(b) of the Social Security Amendments of 1960 is amended to read as follows:

"(b)(1) If—

"(A) an individual performed service in the employ of an organization with respect to which remuneration was paid before the first day of the calendar quarter in which the organization filed a waiver certificate pursuant to section 3121(k)(1) of the Internal Revenue Code of 1954, and such service is excepted from employment under section 210(a)(8)(B) of the Social Security Act,

"(B) such service would have constituted employment as defined in section 210 of such Act if the requirements of section 3121(k)(1) of such Code were satisfied,

"(C) such organization paid, on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization filed a certificate pursuant to section 3121(k)(1) of such Code, any amount, as taxes imposed by sections 3101 and 3111 of such Code, with respect to such remuneration paid by the organization to the individual for such service,

"(D) such individual, or a fiduciary acting for such individual or his estate, or his survivor (within the meaning of section 205(c)(1)(C) of such Act), requests that such remuneration be deemed to constitute remuneration for employment for purposes of title II of such Act, and

"(E) the request is made in such form and manner, and with such official, as may be prescribed by regulations made by the Secretary of Health, Education, and Welfare,

then, subject to the conditions stated in paragraphs (2), (3), (4), and (5), the remuneration with respect to which the amount has been paid as taxes shall be deemed to constitute remuneration for employment for purposes of title II of such Act.

"(2) Paragraph (1) shall not apply with respect to an individual unless the organization referred to in paragraph (1)(A), on or before the date on which the request described in paragraph (1) is made, has filed a certificate pursuant to section 3121(k)(1) of such Code.

"(3) Paragraph (1) shall not apply with respect to an individual who is employed by the organization referred to in paragraph (2) on the date the certificate is filed.

"(4) If credit or refund of any portion of the amount referred to in paragraph (1)(C) (other than a credit or refund which would be allowed if the service constituted employment for purposes of chapter 21 of such Code) has been obtained, paragraph (1) shall not apply with respect to the individual unless the amount credited or refunded (including any interest under section 6611 of such Code) is repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization filed a certificate pursuant to section 3121(k)(1) of such Code.

"(5) Paragraph (1) shall not apply to any service performed for the organization in a period for which a certificate filed pursuant to section 3121(k)(1) of such Code is not in effect."

(2) The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The provisions of section 105(b) of the Social Security Amendments of 1960 which were ineffect before the date of the enactment of this Act shall be applicable with respect to any request filed under section 105(b)(1) of such Amendments before such date. Nothing in the preceding sentence shall prevent the filing of a request under section 105(b)(1) of such Amendments as amended by this Act.

COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT OF COLUMBIA

SEC. 317. (a) Section 210(a)(7) of the Social Security Act is amended—

(1) by striking out "or" at the end of subparagraph (B),

(2) by striking out the semicolon at the end of subparagraph (C)(ii) and inserting in lieu thereof ", or", and

(3) by adding after subparagraph (C) the following new subparagraph:

"(D) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

"(i) in a hospital or penal institution by a patient or inmate thereof;

"(ii) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government; 5 U.S.C. 1052), other than as a medical or dental intern or as a medical or dental resident in training;

"(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

"(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem, meeting, or other fee basis;".

(b) Section 3121(b)(7) of the Internal Revenue Code of 1954 (relating to certain services not included in definition of employment) is amended—

(1) by striking out "or" at the end of subparagraph (A),

(2) by striking out the semicolon at the end of subparagraph (B) and inserting in lieu thereof ", or", and

(3) by adding after subparagraph (B) the following new subparagraph:

"(C) service performed in the employ of the District of Columbia or any instrumentality which is wholly owned thereby, if such service is not covered by a retirement system established by a law of the United States; except that the provisions of this subparagraph shall not be applicable to service performed—

"(i) in a hospital or penal institution by a patient or inmate thereof;

"(ii) by any individual as an employee included under section 2 of the Act of August 4, 1947 (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government; 5 U.S.C. 1052), other than as a medical or dental intern or as a medical or dental resident in training;

"(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency; or

"(iv) by a member of a board, committee, or council of the District of Columbia, paid on a per diem meeting, or other fee basis;".

(c)(1) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam and American Samoa) is amended by adding at the end thereof the following new subsection:

"(c) DISTRICT OF COLUMBIA.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be made by the Commissioners of the District of Columbia or by such agents as they may designate. The person making such return may, for convenience of administration, effective with respect to remuneration paid before 1971, make payments of the tax imposed by section 3111 with

respect to such service without regard to the $5,600 limitation in section 3121(a)(1) and, effective with respect to remuneration paid after 1970, without regard to the $6,600 limitation in such section 3121(a)(1)."

(2) The heading of such section 3125 is amended by striking out "AND AMERICAN SAMOA" and inserting in lieu thereof ", AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA".

(3) The table of sections for subchapter C of chapter 21 of such Code (relating to general provisions for Federal Insurance Contributions Act) is amended by striking out

"Sec. 3125. Returns in the case of governmental employees in Guam and American Samoa."

and inserting in lieu thereof

"Sec. 3125. Returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia."

(d) Section 6205(a) of such Code (relating to adjustment of tax) is amended by adding at the end thereof the following new paragraph:

"(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125 shall be deemed a separate employer."

(e) Section 6413(a) of such Code (relating to adjustment of certain employment taxes) is amended by adding at the end thereof the following paragraph:

"(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125 shall be deemed a separate employer."

(f)(1) Section 6413(c)(2) of such Code (relating to applicability of special refunds to certain employment taxes) is amended by adding at the end thereof the following new subparagraph:

(F) GOVERNMENTAL EMPLOYEES IN THE DISTRICT OF COLUMBIA.—In the case of remuneration received from the District of Columbia or any instrumentality wholly owned thereby, during any calendar year, the Commissioners of the District of Columbia and each agent designated by them who makes a return pursuant to section 3125(c) shall, for purposes of this subsection, be deemed a separate employer."

(2) The heading of such section 6413(c)(2) is amended by striking out "AND AMERICAN SAMOA" and inserting in lieu thereof ", AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA".

(g) The amendments made by this section shall apply with respect to service performed after the calendar quarter in which this section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and part A of title XVIII) of the Social Security Act extended to the officers and employees coming under the provisions of such amendments.

COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

SEC. 318. Section 102(k) of the Social Security Amendments of 1960 is amended by inserting "(1)" immediately after "(k)", and by adding at the end thereof the following new paragraph:

"(2) Such agreement, as modified pursuant to paragraph (1), may at the option of such State be further modified, at any time prior to the seventh month after the month in which this paragraph is enacted, so as to apply to services performed by any hospital affected by such earlier modification by any individual who after December 31, 1959, is or was employed by such State (or any political subdivision thereof) in any position described in paragraph (1). Such modification shall be effective with respect to (A) all services performed by such individual in any such position on or after January 1, 1962, and (B) all such services, performed before such date, with respect to which amounts equivalent to the sum of the taxes which would have been imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954 if such services had constituted employment for purposes of chapter 21 of such Code at the time they were performed have, prior to the date of the enactment of this paragraph, been paid."

TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO INSURANCE

SEC. 319. (a) Subsection (c) of section 1402 of the Internal Revenue Code of 1954 is amended by striking out "or" at the end of paragraph (4), by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and by adding after paragraph (5) the following new paragraph:

"(6) the performance of service by an individual during the period for which an exemption under subsection (h) is effective with respect to him."

(b) Subsection (c) of section 211 of the Social Security Act is amended by striking out "or" at the end of paragraph (4), by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and by adding after paragraph (5) the following new paragraph:

"(6) The performance of service by an individual during the period for which an exemption under section 1402(h) of the Internal Revenue Code of 1954 is effective with respect to him."

(c) Section 1402 of the Internal Revenue Code of 1954 is further amended by adding at the end thereof the following new subsection:

"(h) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

"(1) EXEMPTION.—Any individual may file an application (in such form and manner, and with such official, as may be prescribed by regulations under this chapter) for an exemption from the tax imposed by this chapter if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act). Such exemption may be granted only if the application contains or is accompanied by—

"(A) such evidence of such individual's membership in, and adherence to the tenets or teachings of, the sect or division thereof as the Secretary or his delegate may require for purposes of determining such individual's compliance with the preceding sentence, and

"(B) his waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person,

and only if the Secretary of Health, Education, and Welfare finds that—

"(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

"(C) such sect or division thereof has the established tenets or teachings referred to in the preceding sentence,

"(D) it is the practice, and has been for a period of time which he deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which in his judgment is reasonable in view of their general level of living, and

"(E) such sect or division thereof has been in existence at all times since December 31, 1950.

An exemption may not be granted to any individual if any benefit or other payment referred to in subparagraph (B) became payable (or, but for section 203 or 222(b) of the Social Security Act, would have become payable) at or before the time of the filing of such waiver.

"(2) TIME FOR FILING APPLICATION.—For purposes of this subsection, an application must be filed—

"(A) In the case of an individual who has self-employment income (determined without regard to this subsection and subsection (c)(6)) for any taxable year ending before December 31, 1965, on or before April 15, 1966, and

"(B) In any other case, on or before the time prescribed for filing the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, for which he has self-employment income (as so determined),

"(3) PERIOD FOR WHICH EXEMPTION EFFECTIVE.—An exemption granted to any individual pursuant to this subsection shall apply with respect to all taxable years beginning after December 31, 1950, except that such exemption shall not apply for any taxable year—

"(A) beginning (i) before the taxable year in which such individual first met the requirements of the first sentence of parargaph (1), or (ii) before the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member met the requirements of subparagraphs (C) and (D), or

"(B) ending (i) after the time such individual ceases to meet the requirements of the first sentence of paragraph (1), or (ii) after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof which he is a member ceases to meet the requirements of subparagraph (C) or (D).

"(4) APPLICATION BY FIDUCIARIES OR SURVIVORS.—In any case where an individual who has self-employment income dies before the expiration of the time prescribed by paragraph (2) for filing an application for exemption pursuant to this subsection, such an application may be filed with respect to such individual within such time by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of section 205(c) (1)(C) of the Social Security Act)."

(d) Section 202 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"Waiver of Benefits

"(v) Notwithstanding any other provisions of this title, in the case of any individual who files a waiver pursuant to section 1402(h) of the Internal Revenue Code of 1954 and is granted a tax exemption thereunder, no benefits or other payments shall be payable under this title to him, no payments shall be made on his behalf under part A of title XVIII, and no benefits or other payments under this title shall be payable on the basis of his wages and self-employment income to any other person, after the filing of such waiver; except that, if thereafter such individual's tax exemption under such section 1402(h) ceases to be effective, such waiver shall cease to be applicable in the case of benefits and other payments under this title and part A of title XVIII to the extent based on his self-employment income for and after the first taxable year for which such tax exemption ceases to be effective and on his wages for and after the calendar year (if any) which begins in or with the beginning of such taxable year."

(e) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1950. For such purpose, chapter 2 of the Internal Revenue Code of 1954 shall be treated as applying to all taxable years beginning after such date.

(f) If refund or credit of any overpayment resulting from the enactment of this section is prevented on the date of the enactment of this Act or at any time on or before April 15, 1966, by the operation of any law or rule of law, refund or credit of such overpayment may, nevertheless, be made or allowed if claim therefor is filed on or before April 15, 1966. No interest shall be allowed or paid on any overpayment resulting from the enactment of this section.

INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

SEC. 320. (a)(1)(A) Section 209(a)(3) of the Social Security Act is amended by inserting "and prior to 1966" after "1958".

(B) Section 209(a) of such Act is further amended by adding at the end thereof the following new paragraphs:

"(4) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $5,600 with respect to employment has been paid to an individual during any calendar year after 1965 and prior to 1971, is paid to such individual during such calendar year;

"(5) That part of remuneration which, after remuneration (other than remuneration referred to in the succeeding subsections of this section) equal to $6,600 with respect to employment has been paid to an individual during any calendar year after 1970, is paid to such individual during such calendar year;".

(2)(A) Section 211(b)(1)(C) of such Act is amended by inserting "and prior to 1966" after "1958", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 211(b)(1) of such Act is further amended by adding at the end thereof the following new subparagraphs:

"(D) For any taxable year ending after 1965 and prior to 1971, (i) $5,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(E) For any taxable year ending after 1970, (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(3)(A) Section 213(a)(2)(ii) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1966, or $5,600 in the case of a calendar year after 1965 and before 1971, or $6,600 in the case of a calendar year after 1970".

(B) Section 213(a)(2)(iii) of such Act is amended by striking out "after 1958" and inserting in lieu thereof "after 1958 and before 1966, or $5,600 in the case of a taxable year ending after 1965 and before 1971, or $6,600 in the case of a taxable year ending after 1970".

(4) Section 215(e)(1) of such Act is amended by striking out "and the excess over $4,800 in the case of any calendar year after 1958" and inserting in lieu thereof "the excess over $4,800 in the case of any calendar year after 1958 and before 1966, the excess over $5,600 in the case of any calendar year after 1965 and before 1971, and the excess over $6,600 in the case of any calendar year after 1970".

(b)(1)(A) Section 1402(b)(1)(C) of the Internal Revenue Code of 1954 (relating to definition of self-employment income) is amended by inserting "and before 1966" after "1958", and by striking out "; or" and inserting in lieu thereof "; and".

(B) Section 1402(b)(1) of such Code is further amended by adding at the end thereof the following new subparagraphs:

"(D) for any taxable year ending after 1965 and before 1971, (i) $5,600, minus (ii) the amount of the wages paid to such individual during the taxable year; and

"(E) for any taxable year ending after 1970, (i) $6,600, minus (ii) the amount of the wages paid to such individual during the taxable year; or".

(2)(A) Section 3121(a)(1) of such Code (relating to definition of wages) is amended by striking out "$4,800" each place it appears and inserting in lieu thereof "$5,600".

(B) Effective with respect to remuneration paid after 1970, section 3121(a)(1) of such Code as amended by subparagraph (A) of this paragraph is amended by striking out "$5,600" each place it appears and inserting in lieu thereof "$6,600".

(3)(A) The second sentence of section 3122 of such Code (relating to Federal service) is amended by striking out "$4,800" and inserting in lieu thereof "$5,600".

(B) Effective with respect to remuneration paid after 1970, such second sentence as amended by subparagraph (A) of this paragraph is amended by striking out "$5,600" and inserting in lieu thereof "$6,600".

(4)(A) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam and American Samoa) is amended by striking out "$4,800" where it appears in subsections (a) and (b) and inserting in lieu thereof "$5,600".

(B) Effective with respect to remuneration paid after 1970, section 3125 of such Code as amended by subparagraph (A) of this paragraph is amended by striking out "$5,600" where it appears in subsections (a) and (b) and inserting in lieu thereof "$6,600".

(5) Section 6413(c)(1) of such Code (relating to special refunds of employment taxes) is amended—

(A) by inserting "and prior to the calendar year 1966" after "the calendar year 1958";

(B) by inserting after "exceed $4,800," the following: "or (C) during nay calendar year after the calendar year 1965 and prior to the calendar year 1971, the wages received by him during such year exceed $5,600, or (D) during any calendar year after the calendar year 1970, the wages received by him during such year exceed $6,600".

(C) by inserting before the period at the end thereof the following: "and before 1966, or which exceeds the tax with respect to the first $5,600 of such wages received in such calendar year after 1965 and before 1971,

or which exceeds the tax with respect to the first $6,600 of such wages received in such calendar year after 1970".

(6) Section 6413(c)(2)(A) of such Code (relating to refunds of employment taxes in the case of Federal employees) is amended by striking out "or $4,800 for any calendar year after 1958" and inserting in lieu thereof "$4,800 for the calendar year 1959, 1960, 1961, 1962, 1963, 1964, or 1965, or $5,600 for the calendar year 1966, 1967, 1968, 1969, or 1970, or $6,600 for any calendar year after 1970".

(c) The amendments made by subsection (a)(1) and (a)(3)(A), and the amendments made by subsection (b) (except paragraph (1) thereof), shall apply only with respect to remuneration paid after December 1965. The amendments made by subsections (a)(2), (a)(3)(B), and (b)(1) shall apply only with respect to taxable years ending after 1965. The amendment made by subsection (a)(4) shall apply only with respect to calendar years after 1965.

CHANGES IN TAX SCHEDULES

SEC. 321. (a) Section 1401 of the Internal Revenue Code of 1954 (relating to rate of tax under the Self-Employment Contributions Act) is amended to read as follows:

"SEC. 1401. RATE OF TAX.

"(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"(1) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1969, the tax shall be equal to 6.0 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1968, and before January 1, 1973, the tax shall be equal to 6.6 percent of the amount of the self-employment income for such taxable year; and

"(3) in the case of any taxable year beginning after December 31, 1972, the tax shall be equal to 7.0 percent of the amount of the self-employment income for such taxable year.

"(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax as follows:

"(1) in the case of any taxable year beginning after December 31, 1965, and before January 1, 1967, the tax shall be equal to 0.35 percent of the amount of the self-employment income for such taxable year;

"(2) in the case of any taxable year beginning after December 31, 1966, and before January 1, 1973, the tax shall be equal to 0.50 percent of the amount of the self-employment income for such taxable year;

"(3) in the case of any taxable year beginning after December 31, 1972, and before January 1, 1976, the tax shall be equal to 0.55 percent of the amount of the self-employment income for such taxable year;

"(4) in the case of any taxable year beginning after December 31, 1975, and before January 1, 1980, the tax shall be equal to 0.60 percent of the amount of the self-employment income for such taxable year;

"(5) in the case of any taxable year beginning after December 31, 1979, and before January 1, 1987, the tax shall be equal to 0.70 percent of the amount of the self-employment income for such taxable year; and

"(6) in the case of any taxable year beginning after December 31, 1986, the tax shall be equal to 0.80 percent of the amount of the self-employment income for such taxable year.

For purposes of the tax imposed by this subsection, the exclusion of employee representatives by section 1402(c)(3) shall not apply."

(b) Section 3101 of the Internal Revenue Code of 1954 (relating to rate of tax on employees under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3101. RATE OF TAX.

"(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages received during the calendar years 1966, 1967, and 1968, the rate shall be 4.0 percent;

"(2) with respect to wages received during the calendar years 1969, 1970, 1971, and 1972, the rate shall be 4.4 percent; and

"(3) with respect to wages received after December 31, 1972, the rate shall be 4.8 percent.

"(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to the following percentages of the wages (as defined in section 3121(a)) received by him with respect to employment (as defined in section 3121(b), but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees)—

"(1) with respect to wages received during the calendar year 1966, the rate shall be 0.35 percent;

"(2) with respect to wages received during the calendar years 1967, 1968, 1969, 1970, 1971, and 1972, the rate shall be 0.50 percent;

"(3) with respect to wages received during the calendar years 1973, 1974, and 1975, the rate shall be 0.55 percent;

"(4) with respect to wages received during the calendar years 1976, 1977, 1978, and 1979, the rate shall be 0.60 percent;

"(5) with respect to wages received during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 0.70 percent; and

"(6) with respect to wages received after December 31, 1986, the rate shall be 0.80 percent."

(c) Section 3111 of the Internal Revenue Code of 1954 (relating to rate of tax on employers under the Federal Insurance Contributions Act) is amended to read as follows:

"SEC. 3111. RATE OF TAX.

"(a) OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b))—

"(1) with respect to wages paid during the calendar years 1966, 1967, and 1968, the rate shall be 4.0 percent;

"(2) with respect to wages paid during the calendar years 1969, 1970, 1971, and 1972, the rate shall be 4.4 percent; and

"(3) with respect to wages paid after December 31, 1972, the rate shall be 4.8 percent.

"(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to the following percentages of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b), but without regard to the provisions of paragraph (9) thereof insofar as it relates to employees)—

"(1) with respect to wages paid during the calendar year 1966, the rate shall be 0.35 percent;

"(2) with respect to wages paid during the calendar years 1967, 1968, 1969, 1970, 1971, and 1972, the rate shall be 0.50 percent;

"(3) with respect to wages paid during the calendar years 1973, 1974, and 1975, the rate shall be 0.55 percent;

"(4) with respect to wages paid during the calendar years 1976, 1977, 1978, and 1979, the rate shall be 0.60 percent;

"(5) with respect to wages paid during the calendar years 1980, 1981, 1982, 1983, 1984, 1985, and 1986, the rate shall be 0.70 percent;

"(6) with respect to wages paid after December 31, 1986, the rate shall be 0.80 percent."

(d) The amendments made by subsection (a) shall apply only with respect to taxable years beginning after December 31, 1965. The amendments made by subsections (b) and (c) shall apply only with respect to remuneration paid after December 31, 1965.

REIMBURSEMENT OF TRUST FUNDS FOR THE COST OF NONCONTRIBUTORY MILITARY SERVICE CREDITS

SEC. 322. Section 217(g) of the Social Security Act is amended to read as follows:

"(g)(1) In September 1965, and in every fifth September thereafter up to and including September 2010, the Secretary shall determine the amount which, if paid in equal installments at the beginning of each fiscal year in the period beginning—

"(A) with July 1, 1965, in the case of the first such determination, and

"(B) with the July 1 following the determination in the case of all other such determinations,

and ending with the close of June 30, 2015, would accumulate, with interest compounded annually, to an amount equal to the amount needed to place each of the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position at the close of June 30, 2015, as he estimates they would otherwise be in at the close of that date if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted. The rate of interest to be used in determining such amount shall be the rate determined under section 201(d) for public-debt obligations which were or could have been issued for purchase by the Trust Funds in the June preceding the September in which such determination is made.

"(2) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund—

"(A) for the fiscal year ending June 30, 1966, an amount equal to the amount determined under paragraph (1) in September 1965, and

"(B) for each fiscal year in the period beginning with July 1, 1966, and ending with the close of June 30, 2015, an amount equal to the annual installment for such fiscal year under the most recent determination under paragraph (1) which precedes such fiscal year.

"(3) For the fiscal year ending June 30, 2016, there is authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund such sums as the Secretary determines would place the Trust Funds and the Federal Hospital Insurance Trust Fund in the same position in which they would have been at the close of June 30, 2015, if section 210 of this Act as in effect prior to the Social Security Act Amendments of 1950, and this section, had not been enacted.

"(4) There are authorized to be appropriated to the Trust Funds and the Federal Hospital Insurance Trust Fund annually, as benefits under this title and part A of title XVIII are paid after June 30, 2015, such sums as the Secretary determines to be necessary to meet the additional costs, resulting from subsections (a), (b), and (e), of such benefits (including lump-sum death payments)."

ADOPTION OF CHILD BY RETIRED WORKER

SEC. 323. (a) Section 202(d) of the Social Security Act is amended—

(1) by striking out the last sentence in paragraph (1), and

(2) by adding at the end thereof (after the new paragraphs added by section 306 of this Act) the following new paragraphs:

"(9) In the case of—

"(A) an individual entitled to disability insurance benefits, or

"(B) an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits,

clauses (i) and (iii) of paragraph (1)(C) shall not apply to a child of such individual unless such child—

"(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

"(D) was legally adopted by such individual before the end of the 24-month period beginning with the month after the month in which such individual most recently became entitled to disability insurance benefits, but only if—

"(i) proceedings for such adoption of the child had been instituted by such individual in or before the month in which began the period of disability of such individual which still exists at the time of such adoption, or

"(ii) such adopted child was living with such individual in such month.

"(10) In the case of an individual entitled to old-age insurance benefits but not an individual included under paragraph (9)), clauses (i), and (iii) of paragraph (1)(C) shall not apply to a child of such individual unless such child—

"(A) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

"(B) was legally adopted by such individual before the end of the 24-month period beginning with the month after the month in which such individual became entitled to old-age insurance benefits, but only if—

"(i) such child had been receiving at least one-half of his support from such individual for the year before such individual filed his application for old-age insurance benefits or, if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, for the year before such period of disability began, and

"(ii) either proceedings for such adoption of the child had been instituted by such individual in or before the month in which the individual filed his application for old-age insurance benefits or such adopted child was living with such individual in such month."

(b) The amendments made by subsection (a) of this section shall be applicable to persons who file applications, or on whose behalf applications are filed, for benefits under section 202(d) of the Social Security Act on or after the date this section is enacted. The time limit provided by section 202(d)(10)(B) of such Act as amended by this section for legally adopting a child shall not apply in the case of any child who is adopted before the end of the 12-month period following the month in which this section is enacted.

EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

SEC. 324. (a) Section 202(p) of the Social Security Act is amended to read as follows:

"Extension of Period for Filing Proof of Support and Applications for Lump-Sum Death Payment

"(p) In any case in which there is a failure—

"(1) to file proof of support under subparagraph (C) of subsection (c)(1), clause (i) or (ii) of subparagraph (D) of subsection (f)(1), or subparagraph (B) of subsection (h)(1), or under clause (B) of subsection (f)(1) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subparagraph or clause, or

"(2) to file, in the case of a death after 1946, application for a lump-sum death payment under subsection (i), or under subsection (g) of this section as in effect prior to the Social Security Act Amendments of 1950, within the period prescribed by such subsection, any such proof or application, as the case may be, which is filed after the expiration of such period shall be deemed to have been filed within such period if it is shown to the satisfaction of the Secretary that there was good cause for failure to file such proof or application within such period. The determination of what constitutes good cause for purposes of this subsection shall be made in accordance with regulations of the Secretary."

(b) The amendments made by this section shall be effective with respect to (1) applications for lump-sum death payments filed in or after the month in which this Act is enacted, and (2) monthly benefits based on applications filed in or after such month.

TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT TEST PURPOSES

SEC. 325. (a)(1) Subparagraph (B) of section 203(f)(5) of the Social Security Act is amended to read as follows:

"(B) For purposes of this section—

"(i) an individual's net earnings from self-employment for any taxable year shall be determined as provided in section 211, except that paragraphs (1), (4), and (5) of section 211(c) shall not apply and the gross income shall be computed by excluding the amounts provided by subparagraph (D), and

"(ii) an individual's net loss from self-employment for any taxable year is the excess of the deductions (plus his distributive share of loss described in section 702(a)(9) of the Internal Revenue Code of 1954) taken into account under clause (i) over the gross income (plus his distributive share of income so described) taken into account under clause (i)."

(2) Such section 203(f)(5) is further amended by adding at the end thereof the following new subparagraph:

"(D) In the case of an individual—

"(i) who has attained the age of 65 on or before the last day of the taxable year, and

"(ii) who shows to the satisfaction of the Secretary that he is receiving royalties attributable to a copyright or patent obtained before the taxable year in which he attained the age of 65 and that the property to which the copyright or patent relates was created by his own personal efforts,

there shall be excluded from gross income any such royalties."

(b) The amendments made by subsection (a) shall apply with respect to the computation of net earnings from self-employment and the net loss from self-employment for taxable years beginning after 1964.

AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEMS

SEC. 326. (a) Section 1(q) of the Railroad Retirement Act of 1937 is amended by striking out "1961" and inserting in lieu thereof "1965".

(b) Section 5(l)(9) of such Act is amended by striking out "after 1958 is less than $4,800" and inserting in lieu thereof the following: "after 1958 and before 1966 is less than $4,800, or for any calendar year after 1965 and before 1971 is less than $5,600, or for any calendar year after 1970 is less than $6,600"; and by striking out "and $4,800 for years after 1958", and inserting in lieu thereof the following: "$4,800 for years after 1958 and before 1966, $5,600 for years after 1965 and before 1971, and $6,600 for years after 1970".

TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS

SEC. 327. Section 201(c) of the Social Security Act is amended by striking out "six months" in the fourth sentence and inserting in lieu thereof "calendar year".

TITLE IV—PUBLIC ASSISTANCE AMENDMENTS

INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

SEC. 401. (a) Section 3(a)(1) of the Social Security Act is amended (1) by striking out, in so much thereof as precedes clause (A), "during such quarter" and inserting in lieu thereof "during each month of such quarter"; (2) by striking out, in clause (A), "29/35", "any month", and "35" and inserting in lieu thereof "31/37", "such month", and "37", respectively; and (3) by striking out clauses (B) and (C) and inserting in lieu thereof the following:

"(B) the larger of the following:

"(i)(I) the Federal percentage (as defined in section 1101(a)(8) of of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess

with respect to such months as exceeds the product of $38 multiplied by the total number of recipients of old-age assistance for such month, plus (II) 15 per centum of the total expended during such month as old-age assistance under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such month as exceeds the product of $15 multiplied by the total number of recipients of old-age assistance for such month, or

"(ii)(I) the Federal medical percentage (as defined in section 6(c) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditures with respect to such month as exceeds (a) the product of $52 multiplied by the total number of such recipients of old-age assistance for such month, or (b) if smaller, the total expended as old-age assistance in the form of medical or any other type of remedial care with respect to such month plus the product of $37 multiplied by such total number of such recipients, plus (II) the Federal percentage of the amount by which the total expended during such month as old-age assistance under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B)(ii), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of such recipients of old-age assistance for such month;".

(b) Section 1603(a)(1) of such Act is amended (1) by striking out, in so much thereof as precedes clause (A), "during such quarter" and inserting in lieu thereof "during each month of such quarter"; (2) by striking out, in clause (A), "29/35", "any month", and "$35" and inserting in lieu thereof "31/37", "such month", and "$37", respectively; and (3) by striking out clauses (B) and (C) and inserting in lieu thereof the following:

"(B) the larger of the following:

"(i)(I) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the amount which may be counted under clause (A), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month, plus (II) 15 per centum of the total expended during such month as aid to the aged, blind, or disabled under the State plan in the form of medical or any other type of remedial care, not counting so much of such expenditure with respect to such month as exceeds the product of $15 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month, or

(ii) (I) the Federal medical percentage (as defined in section 6(c)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditures with respect to such month as exceeds (a) the product of $52 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month, or (b) if smaller, the total expended as aid to the aged, blind, or disabled in the form of medical or any other type of remedial care with respect to such month plus the product of $37 multiplied by such total number of such recipients, plus (II) the Federal percentage of the amount by which the total expended during such month as aid to the aged, blind, or disabled under the State plan exceeds the amount which may be counted under clause (A) and the preceding provisions of this clause (B)(ii), not counting so much of such excess with respect to such month as exceeds the product of $38 multiplied by the total number of such recipients of aid to the aged, blind, or disabled for such month;".

(c) Section 403(a)(1) of such Act is amended (1) by striking out "fourteen-seventeenths" and "$17" in clause (A) and inserting in lieu thereof "five-sixths" and "$18", respectively; and (2) by striking out "$30" in clause (B) and inserting in lieu thereof "$32".

(d) Section 1003(a)(1) of such Act is amended (1) by striking out, in clause (A), "29/35" and "$35" and inserting in lieu thereof "31/37" and "$37", respectively; and (2) by striking out, in clause (B), "$70" and inserting in lieu thereof "$75".

(e) Section 1403(a)(1) of such Act is amended (1) by striking out, in clause (A), "29/35" and "$35" and inserting in lieu thereof "31/37" and "$37", respectively; and (2) by striking out, in clause (B), "$70" and inserting in lieu thereof "$75".

(f) The amendments made by this section shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the Social Security Act.

PROTECTIVE PAYMENTS

SEC. 402. (a) Section 6(a) of the Social Security Act (as amended by section 221 of this Act) is amended by adding at the end thereof the following new sentence: "Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 2 includes provision for—

"(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

"(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of old-age assistance to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

"(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

"(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

"(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made."

(b) Section 1605(a) of such Act (as amended by section 221 of this Act) is amended by adding at the end thereof (after and below paragraph (2)) the following new sentence:

"Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1602 includes provision for—

"(A) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such aid through payments described in this sentence;

"(B) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the aged, blind, or disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

"(C) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

"(D) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not

and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

"(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made."

(c) The amendments made by this section shall apply in the case of expenditures made after December 31, 1965, under a State plan approved under title I or XVI of the Social Security Act.

DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER ASSISTANCE PROGRAMS FOR THE AGED

SEC. 403. (a) Effective January 1, 1966, section 2(a)(10)(A) of the Social Security Act is amended by striking out "; except that, in making such determination, of the first $50 per month of earned income the State agency may disregard, after December 31, 1962, not more than the first $10 thereof plus one-half of the remainder" and inserting in lieu thereof the following: "; except that, in making such determination, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder".

(b) Effective January 1, 1966, section 1602(a)(14) of such Act is amended by striking out "of the first $50 per month of earned income the State agency may, after December 31, 1962, disregard not more than the first $10 thereof plus one-half of the remainder" and inserting in lieu thereof the following: "of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder".

ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC ASSISTANCE DETERMINATIONS

SEC. 404. (a) Title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

"SEC. 1116. (a)(1) Whenever a State plan is submitted to the Secretary by a State for approval under title I, IV, X, XIV, XVI, or XIX, he shall, not later than 90 days after the date the plan is submitted to him, make a determination as to whether it conforms to the requirements for approval under such title. The 90-day period provided herein may be extended by written agreement of the Secretary and the affected State.

"(2) Any State dissatisfied with a determination of the Secretary under paragraph (1) with respect to any plan may, within 60 days after it has been notified of such determination, file a petition with the Secretary for reconsideration of the issue of whether such plan conforms to the requirements for approval under such title. Upon receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

"(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 1004, 1404, 1604, or 1904 may, within 60 days after notice of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

"(4) The findings of fact by the Secretary, unless substantially contrary to the weight of the evidence, shall be conclusive; but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall certify to the court the transcript and record of the

further proceedings. Such new or modified findings of fact shall likewise be conclusive unless substantially contrary to the weight of the evidence.

"(5) The court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

"(b) For the purposes of subsection (a), any amendment of a State plan approved under title I, IV, X, XIV, XVI, or XIX may, at the option of the State, be treated as the submission of a new State plan.

"(c) Action pursuant to an initial determination of the Secretary described in subsection (a) or (b) shall not be stayed pending reconsideration, but in the event that the Secretary subsequently determines that his initial determination was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied.

"(d) Whenever the Secretary determines than any item or class of items on account of which Federal financial participation is claimed under title I, IV, X, XIV, XVI, or XIX shall be disallowed for such participation, the State shall be entitled to and upon request shall receive a reconsideration of the disallowance."

(b) The amendment made by subsection (a) shall apply only with respect to determinations made after December 31, 1965.

MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

SEC. 405. Title XI of the Social Security Act is amended by adding at the end thereof (after the new section 1116 added by section 404 of this Act) the following new section:

"MAINTENANCE OF STATE EFFORT

"SEC. 1117. (a) The total of the amounts determined under sections 3, 403, 1003, 1403, 1603, and 1903 for any State for any quarter beginning after December 31, 1965, and ending before July 1, 1969, shall be reduced to the extent that—

"(1) the excess of (A) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, 1603, and 1903 for such quarter over (B) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, and 1603 for the same quarter of the fiscal year ending June 30, 1965, is greater than

"(2) the excess of (A) the total of the expenditures for such quarter (for which the determination is being made) under the plans of the State approved under titles I, IV, X, XIV, XVI, and XIX over (B) the total of the expenditures under the State plans of the State approved under titles I, IV, X, XIV, and XVI for the same quarter of the fiscal year ending June 30, 1965;

except that, at the option of the State, any of the following may be substituted (with respect to the quarters of any fiscal year) for the amount determined as provided in paragraph (1) (B)—

"(3) the total of the amounts determined for the State under sections 3, 403, 1003, 1403, and 1603 for the same quarter in the fiscal year ending June 30, 1964; or

"(4) the average of the totals determined for the State under sections 3, 403, 1003, 1403, and 1603 for each quarter in the fiscal year ending June 30, 1964, or June 30, 1965.

If the substitution of the total referred to in paragraph (3) is chosen by the State, there shall be substituted for the amount determined under clause (B) of paragraph (2) the total of the expenditures under the plans of the State approved under the titles I, IV, X, XIV, and XVI for the quarter referred to in such paragraph (3). If the substitution of the average for either of the years referred to in paragraph (4) is chosen by the State, there shall be substituted for the amount determined under clause (B) of paragraph (2) the average of the total expenditures under the plans of the State approved under titles I, IV, X, XIV, and XVI for each quarter in the same fiscal year.

"(b) For purposes of this section, expenditures under the plans of any State approved under titles I, IV, X, XIV, XVI, and XIX and the reduction determined with respect thereto under this section, shall be determined on the basis of data furnished by the State in the quarterly reports submitted by the State to the Secretary pursuant to and in accordance with the requirements of the Secretary under title I, IV, X, XIV, XVI, or XIX; and determinations so made shall be conclusive for purposes of this section.

"(c) If a reduction is required under the preceding provisions of this section in the total of the amounts determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 for any quarter, the Secretary shall determine which of such amounts shall be reduced and the extent thereof in such manner as in his judgment will best carry out the purpose of maintaining State effort under the Federal-State public assistance programs of the State, and with the total of such reductions to be equal to the reduction required under subsections (a) and (b) of this section."

DISREGARDING OASDI BENEFIT INCREASE, AND CHILD'S INSURANCE BENEFIT PAYMENTS BEYOND AGE 18, TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

SEC. 406. Notwithstanding the provisions of sections 2(a)(10), 402(a)(7), 1002(a)(8), 1402(a)(8), and 1602(a)(14) of the Social Security Act, a State may disregard, in determining need for aid or assistance under a State plan approved under title I, IV, X, XIV, or XVI of such Act, any amount paid to any individual under title II of such Act, for months prior to the month in which payment of such amount is received, to the extent that such payment is attributable—

(1) to the increase in monthly insurance benefits under the old-age, survivors, and disability insurance system resulting from the enactment of section 301 of this Act, or

(2) to the payment of child's insurance benefits under such system after attainment of age 18, in the case of individuals attending school, resulting from the enactment of section 306 of this Act.

EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

SEC. 407. Notwithstanding the provisions of section 701 of the Economic Opportunity Act of 1964, no funds to which a State is otherwise entitled under title I, IV, X, XIV, XVI, or XIX of the Social Security Act for any period before the first month beginning after the adjournment of a State's first regular legislative session which adjourns after August 20, 1964 (the date of enactment of the Economic Opportunity Act of 1964), shall be withheld by reason of any action taken pursuant to a State statute which prevents such State from complying with the requirements of subsection (a) of such section 701.

TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

SEC. 408. (a) Except as provided in subsection (i)(2), the amendments made by this section shall become effective July 1, 1967.

(b)(1) The heading of title I of the Social Security Act is amended by striking out "AND MEDICAL ASSISTANCE FOR THE AGED".

(2) The first sentence of section 1 of such Act is amended to read as follows: "For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to aged needy individuals, and (b) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help such individuals to attain or retain capability for self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

(3) The second sentence of section 1 of such Act is amended by striking out ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged".

(4) The heading of section 2 of such Act is amended by striking out "AND MEDICAL".

(5) So much of section 2(a) of such Act as precedes paragraph (1) is amended by striking out ", or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged".

(6) Section 2(a)(9) of such Act is amended by striking out "assistance for or on behalf of" and inserting in lieu thereof "assistance to".

(7) Section 2(a) of such Act is further amended by striking out paragraphs (10) and (11) and inserting in lieu thereof the following:

"(10) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming such

assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, of the first $80 per month of earned income the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;

"(11) include reasonable standards, consistent with the objectives of this title, for determining eligibility for and the extent of assistance under the plan;

"(12) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of assistance under the plan to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;".

(8) Section 2(a) of such Act is further amended by redesignating paragraphs (12) and (13) as paragraphs (13) and (14), respectively; and—

(A) the paragraph so redesignated as paragraph (13) is amended—

(i) by striking out "or in behalf of" in the matter preceding clause (A), and

(ii) by striking out "section 3(a)(4)(A)(i) and (ii)" in clause (C) and inserting in lieu thereof "section 3(a)(3)(A)(i) and (ii)"; and

(B) the paragraph so redesignated as paragraph (14) is amended by striking out "or in behalf of".

(9) Section 2(b)(2) of such Act is amended by striking out "(A) in the case of applicants for old-age assistance", and by striking out ", and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State".

(10) Section 2(c) of such Act is repealed.

(11) So much of section 3(a)(1) of such Act as precedes clause (A) is amended by striking out "during each month of such quarter" and inserting in lieu thereof "during such quarter", and by striking out "(including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

(12) Section 3(a)(1)(A) of such Act is amended by striking out "such month" where it first appears and inserting in lieu thereof "any month", and by striking out "(which total number" and all that follows and inserting in lieu thereof "; plus".

(13) Section 3(a)(1)(B) of such Act is amended to read as follows:

"(B) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of $75 multiplied by the total number of such recipients of old-age assistance for such month;".

(14) Section 3(a)(2) of such Act is amended to read as follows:

"(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as old-age assistance under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of old-age assistance for such month;".

(15) Section 3(a)(3) of such Act is repealed.

(16) Section 3(a)(4) of such Act is redesignated as section 3(a)(3).

(17) Section 3(a)(5) of such Act is redesignated as section 3(a)(4), and as so redesignated is amended by striking out "paragraph (4)" and inserting in lieu thereof "paragraph (3)".

(18) Section 3(c) of such Act is amended by striking out "paragraph (4)" each place it appears and inserting in lieu thereof "paragraph (3)", and by striking out "paragraph (5)" and inserting in lieu thereof "paragraph (4)".

(19) The heading of section 6 of such Act is amended by striking out "Definitions" and inserting in lieu thereof "Definition".

(20) The first sentence of section 6(a) of such Act (as amended by this Act) is amended—

(A) by striking out "(a)",

(B) by striking out ", or (if provided in or after the third month before the month in which the recipient makes application for assistance) medical care in behalf of or any type of remedial care recognized under State law in behalf of,", and

(C) by striking out "or care in behalf of".

(21) Sections 6(b) and 6(c) of such Act are repealed.

(c)(1) So much of section 403(a)(1) of such Act as precedes clause (A) is amended by striking out "(including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

(2) Section 403(a)(1)(A) of such Act is amended by striking out clauses (i), (ii), and (iii) and inserting in lieu thereof the following: "(i) the number of individuals with respect to whom such aid is paid for such month plus (ii) the number of other individuals with respect to whom payments described in section 406(b)(2) are made in such month and included as expenditures for purposes of this paragraph or paragraph (2))".

(3) Section 403(a)(2) of such Act is amended by striking out "(including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof)".

(4) So much of section 406(b) of such Act as precedes "to meet the needs of the relative" where it first appears is amended to read as follows:

"(b) The term 'aid to families with dependent children' means money payments with respect to a dependent child or dependent children, and includes (1) money payments".

(5) Section 409(a) of such Act is amended by striking out "(other than for medical or any other type of remedial care)".

(d)(1) So much of section 1003(a)(1) as precedes clause (A) is amended by striking out "(including expenditures for premiums, under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

(2) Section 1003(a)(1)(A) of such Act is amended by striking out "(which total number" and all that follows and inserting in lieu thereof "; plus".

(3) Section 1003(a)(2) of such Act is amended by striking out "(including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof)".

(4) Section 1006 of such Act is amended—

(A) by striking out ", or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of,", and

(B) by striking out "or care in behalf of".

(e)(1) So much of section 1403(a)(1) of such Act as precedes clause (A) is amended by striking out "(including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

(2) Section 1403(a)(1)(A) of such Act is amended by striking out "(which total number" and all that follows and inserting in lieu thereof "; plus".

(3) Section 1403(a)(2) of such Act is amended by striking out "(including expenditures for insurance premiums for medical or any other type of remedial care or the cost thereof)".

(4) Section 1405 of such Act is amended—

(A) by striking out ", or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of, or any type of remedial care recognized under State law in behalf of,", and

(B) by striking out "or care in behalf of".

(f)(1) The heading for title XVI of such Act is amended by striking out ", OR FOR SUCH AID AND MEDICAL ASSISTANCE FOR THE AGED".

(2) The first sentence of section 1601 of such Act is amended to read as follows: "For the purpose (a) of enabling each State, as far as practicable under the conditions in such State, to furnish financial assistance to needy individuals who are 65 years of age or over, are blind, or are 18 years of age or over and permanently and totally disabled, and (b) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help such individuals to attain or retain capability for self-support of self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title."

(3) The second sentence of section 1601 of such Act is amended by striking out ", or for aid to the aged, blind, or disabled and medical assistance for the aged".

(4) The heading for section 1602 of such Act is amended by striking out ", OR FOR SUCH AID AND MEDICAL ASSISTANCE FOR THE AGED".

(5) So much of section 1602(a) of such Act as precedes paragraph (1) is amended by striking out ", or for aid to the aged, blind, or disabled and medical assistance for the aged,".

(6) Section 1602(a) of such Act is further amended by striking out "or assistance" wherever it appears in paragraphs (4), (8), (10), (11), and (13).

(7) Section 1602(a)(9) of such Act is amended by striking out "aid or assistance to or on behalf of" and inserting in lieu thereof "aid to".

(8) Section 1602(a) of such Act is further amended by striking out paragraph (15), and by redesignating paragraphs (16) and (17) as paragraphs (15) and (16), respectively; and—

(A) the paragraph so redesignated as paragraph (15) is amended—

(i) by striking out "or in behalf of" in the matter preceding clause (A), and

(ii) by striking out "section 1603(a)(4)(A)(i) and (ii)" in clause (C) and inserting in lieu thereof "section 1603(a)(3)(A)(i) and (ii)"; and

(B) the paragraph so redesignated as paragraph (16) is amended by striking out "or in behalf of".

(9) The last sentence of section 1602(a) of such Act is amended by striking out "or for aid to the aged, blind, or disabled and medical assistance for the aged)".

(10) Section 1602(b) of such Act is amended—

(A) by striking out "or assistance",

(B) by striking out "(A) in the case of applicants for aid to the aged, blind, or disabled", and

(C) by striking out ", and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State".

(11) The last sentence of section 1602(b) of such Act is amended by striking out "(or for aid to the aged, blind, or disabled and medical assistance for the aged)" wherever it appears.

(12) Section 1602(c) of such Act is repealed.

(13) So much of section 1603(a)(1) as precedes clause (A) is amended by striking out "during each month of such quarter" and inserting in lieu thereof "during such quarter", and by striking out "(including expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other insurance premiums for medical or any other type of remedial care or the cost thereof)".

(14) Section 1603(a)(1)(A) of such Act is amended by striking out "such month" where it first appears and inserting in lieu thereof "any month", and by striking out "(which total number" and all that follows and inserting in lieu thereof "; plus".

(15) Section 1603(a)(1)(B) of such Act is amended to read as follows:

"(B) the Federal percentage (as defined in section 1101(a)(8)) of the amount by which such expenditures exceed the maximum which may be counted under clause (A), not counting so much of any expenditure with respect to any month as exceeds the product of $75 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month;".

(16) Section 1603(a)(2) of such Act is amended to read as follows:

"(2) in the case of Puerto Rico, the Virgin Islands, and Guam, an amount equal to one-half of the total of the sums expended during such quarter as aid to the aged, blind, or disabled under the State plan, not counting so much of any expenditure with respect to any month as exceeds $37.50 multiplied by the total number of recipients of aid to the aged, blind, or disabled for such month;".

(17) Section 1603(a)(3) of such Act is repealed.

(18) Section 1603(a)(4) of such Act is redesignated as section 1603(a)(3), and as so redesignated is amended by striking out "or assistance" wherever it appears.

(19) Section 1603(a)(5) of such Act is redesignated as section 1603(a)(4), and as so redesignated is amended by striking out "paragraph (4)" and inserting in lieu thereof "paragraph (3)".

(20) Section 1603(b)(3) of such Act is amended by striking out "or assistance" wherever it appears.

(21) Section 1603(c) of such Act is amended by striking out "paragraph (4)" wherever it appears and inserting in lieu thereof "paragraph (3)", and by striking out "paragraph (5)" and inserting in lieu thereof "paragraph (4)".

(22) The first sentence of section 1605(a) of such Act (as amended by this Act) is amended—

(A) by striking out "(a)",

(B) by striking out ", or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of,", and

(C) by striking out "or care in behalf of" each place it appears.

(23) Section 1605(b) of such Act is repealed.

(g)(1) Section 1902(a)(20)(C) of such Act is amended by striking out "section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii)" and inserting in lieu thereof "section 3(a)(3)(A)(i) and (ii) or section 1603(a)(3)(A)(i) and (ii)".

(2) Section 1903(a)(3)(A)(i) of such Act is amended by striking out "section 3(a)(4)" and inserting in lieu thereof "section 3(a)(3)".

(h) Section 618 of the Revenue Act of 1951 is amended by striking out "(other than section 3(a)(3) thereof)" and "(other than section 1603(a)(3) thereof)".

(i)(1) Section 1108 of such Act is amended—

(A) by striking out "(other than section 3(a)(3) thereof)" and "(other than section 1603(a)(3) thereof)";

(B) by striking out "$9,800,000, of which $625,000 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)" and inserting in lieu thereof "$9,800,000";

(C) by striking out "$330,000, of which $18,750 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)" and inserting in lieu thereof "$330,000"; and

(D) by striking out "$450,000, of which $25,000 may be used only for payments certified with respect to section 3(a)(2)(B) or 1603(a)(2)(B)" and inserting in lieu thereof "$450,000".

(2) The amendments made by paragraphs (1)(B), (1)(C), and (1)(D) shall be effective in the case of Puerto Rico, the Virgin Islands, or Guam with respect to fiscal years beginning on or after the date on which its plan under title XIX of the Social Security Act is approved, or beginning on or after July 1, 1967, whichever is earlier.

(j) Section 1109 of such Act is amended by striking out "2(a)(10)(A)" and inserting in lieu thereof "2(a)(10)".

(k)(1) Section 1112 of such Act is amended by striking out "for the aged".

(2) The heading of section 1112 of such Act is amended by striking out "FOR THE AGED".

(l) Section 1115 of such Act is amended by striking out "or XVI", "or 1602", and "or 1603" and inserting in lieu thereof "XVI, or XIX", "1602, or 1902", and "1603, or 1903", respectively.

Passed the House of Representatives April 8, 1965.

Attest:

RALPH R. ROBERTS, *Clerk.*

Senator LONG. We are pleased to have with us for the opening day hearing as our first witness the distinguished Secretary of Health, Education, and Welfare, Mr. Anthony J. Celebrezze, testifying on H.R. 6675.

Mr. Celebrezze, will you proceed however you would like to. If you want to you can summarize your statement, otherwise you can simply present the whole statement and we will go from there.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY FOR LEGISLATION; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; ROBERT J. MYERS, CHIEF ACTUARY, DIVISION OF THE ACTUARY; AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE DIVISION, WELFARE ADMINISTRATION

Secretary CELEBREZZE. Mr. Chairman and distinguished members of the committee, I have with me Wilbur J. Cohen, the Assistant Secretary in charge of Legislation to my left, Robert Ball, Commissioner of Social Security to my right, immediate right, Robert J. Myers, Chief Actuary of the Social Security Administration, and Mr. Charles Hawkins of the Welfare Administration in charge of the Kerr-Mills program to my far left.

Mr. Chairman and members of the committee, I welcome this opportunity to discuss H.R. 6675, the Social Security Amendments of 1965, as passed by the House of Representatives, and to urge the enactment of the many significant improvements that this bill would make in the Social Security Act.

The major purposes of H.R. 6675 are to provide protection for the Nation's workers and their families against the high cost of health care in old age, to increase cash benefits under social security and make other substantial improvements in the old-age, survivors, and disability insurance program, to provide for more adequate medical and monetary assistance for the needy, and to improve the health care of handicapped children.

No other social security amendments have approached the scope of these proposed amendments. For older people, for widows and orphans, and for the disabled and their families, the payment of benefits where none are now available would turn despair into hope. Every community in cur Nation would share in the good that the bill would do.

This proposed legislation will lift from the shoulders of our senior citizens a heavy burden of fear—fear that their lifetime savings will be wiped out by the heavy costs of major illness or that they will have to turn to welfare or private charity or sons and daughters for help in meeting these costs. It is my view that this bill, if enacted, will make the most important contribution to security in old age since the social security program was enacted 30 years ago.

It is one of the unfortunate facts of life that in old age, when people are living on substantially reduced incomes, health costs are much higher than in younger years. And since, as a general rule, old people have relatively little in the way of resources that can be readily converted into cash and little or no possibility of gaining new income or assets, many find that their high health costs are too much for them. The years of security and independence that they had hoped for and planned for are spent in a losing battle against dependency.

Despite commendable efforts by the private insurance industry, the voluntary health insurance effort has not proved adaptable to the almost universal need of the aged for adequate health insurance; few of the aged can afford to pay the premiums which older people must

be charged for broad health insurance protection. Nor does the solution to the problem lie in public assistance.

Though necessary and desirable, public assistance is not acceptable as the first line of defense against insecurity, whether that insecurity is caused by high health costs or other factors. Unlike social insurance, the public assistance program—even though strengthened and improved as proposed in H.R. 6675—cannot prevent dependency; it can only provide for relief after the dependency has occurred. A key to the solution of the problem lies in the approach taken by our well-established contributory social security program.

I would like to emphasize, though, that the health benefit provisions in the bill are built around the idea of using the several resources that can contribute the most, each in its own way, to fortifying ourselves against the insecurity that stems from illness in old age.

A system financed by earmarked employee, employer, and self-employed contributions would serve as the foundation. It would assure that practically everybody has basic hospital insurance in old age. Only such a system can provide this assurance. Under this method, people can contribute during their productive years toward the hospital insurance that they will need in later years when their incomes will generally be reduced. After they retire, they need make no further contributions.

The bill would also make provision for those relatively few people who are already in advanced years and not eligible for social security benefits. These people would be afforded the same hospital insurance protection, but it would be paid for out of general revenues.

The proposed hospital insurance protection would serve as a base on which the aged could build supplementary health insurance in much the same way as social security cash benefits now serve as a base on which the individual is encouraged to build additional retirement income through private pension plans, individual savings, private insurance, and other programs, both public and private.

As a matter of fact, I might say that since the enactment of the social security legislation in 1935, private pension arrangements have increased to such an extent that social security now works in partnership with some 34,000 private pension and profit-sharing plans in industry.

A supplementary health insurance program for the aged is one of the important features of H.R. 6675. After a deductible of $50 per year this program would cover 80 percent of the cost of physicians' services and certain other health and medical services that are not covered under the hospital insurance program. The supplementary protection would be provided through a plan of voluntary insurance that would be open to all older people who choose to enroll and pay the required premiums. It would be financed, in equal shares, by the older persons who elect to participate and by their Government through general revenues. And it would be administered through private carriers, thus bringing into play their experience in the medical insurance field.

Such a supplementary plan would meet an important need. It would also meet a major objection raised against past health insurance proposals in that it would assure that protection against the costs of physicians' services as well as protection against the cost of hospital and

related care would be available to virtually all older Americans.

While the proposed programs of basic and supplementary protection would, in combination, provide relatively complete coverage, there still would be ample opportunity for continuing growth of the private effort in the health insurance field since the 90 percent of the population who are under 65 would not be affected by the proposed programs.

The third resource that the bill would bring into play in solving the problems caused by high health costs in old age is public assistance. The bill would make a number of improvements in the assistance provisions which, together with the two health insurance plans, would enable the medical assistance program to be more effective in the role most appropriate for it—that is, it would enable the medical assistance effort to be focused more successfully on the relatively small number of the aged whose nursing home needs or other circumstances are such that they will be unable to meet their health costs through a combination of social and private insurance and individual savings.

Mr. Chairman, I would like next to outline the major features of the two health insurance plans.

BASIC HEALTH INSURANCE PLAN

The basic plan—which follows the social security approach—is, with certain exceptions, essentially the same as the hospital insurance program passed last year by the Senate.

Beginning in July 1966, hospital insurance protection would be provided as a part of the social security system but with separate contributions and a separate trust fund. It would apply to all people who are aged 65 and over and entitled to monthly benefits under the social security program or the railroad retirement program.

As I indicated earlier, the same protection would also be provided for practically all people who are now nearing or past age 65 and who are not eligible under one of these programs, but the cost would be borne by the Federal Government out of general revenues.

The basic plan would cover up to 60 days of hospital care less a deductible amount that would be $40 at the beginning of the program; up to 100 days of posthospital care in a qualified skilled-nursing home or other extended-care facility; up to 100 home health-care visits to a homebound patient following discharge from a hospital or extended-care facility; and hospital outpatient diagnostic services subject to a deductible amount equal to one-half the deductible for inpatient hospital benefits, or $20 at the beginning of the program.

The provision of these four types of benefits would enable the aged beneficiary to have the kinds of services and levels of care most appropriate to his needs. The benefits other than those for inpatient hospital care are essentially less expensive alternatives to inpatient hospital care and are included for this reason.

By providing insurance protection against these various other health costs, the bill would promote the most efficient and economical use of existing health-care facilities and reinforce the efforts of the health professions to reserve hospital beds for acute illnesses requiring the intensive treatment that can be provided only in a hospital.

The coverage of services in an extended-care facility would pay for the cost of followup convalescent and rehabilitation services which are often required after hospitalization. The extended-care provision, however, would not permit payment for services of a purely custodial nature.

(At this point, Senator Byrd (chairman) is presiding.)

Secretary CELEBREZZE (continuing). The provision in the bill passed by the Senate last year which required the extended-care facility—the skilled-nursing home—to be affiliated with a hospital in order to participate in the program has been removed. In its place is a provision under which the extended-care facility would be required to have an arrangement with a participating hospital for the timely transfer of patients and an interchange of medical information between the two institutions.

The transfer agreement would help assure that the proper level of care is provided as the patient's condition and health needs change but, at the same time, would be much easier to meet than the prior affiliation requirement.

Under the provisions for basic insurance against the cost of care in hospitals and extended-care facilities, the payment would be made on the basis of the reasonable cost of the covered services furnished. The reimbursement of hospitals by third parties on a reasonable cost basis has been the subject of extended and painstaking consideration for more than a decade, and principles governing such reimbursement have been developed which have been widely used and which have met with a large measure of acceptance.

The bill contemplates that full advantage would be taken of the experience of private agencies and that payment to hospitals will be fair to the institutions, to the contributors to the hospital insurance trust fund, and to the hospitals' other patients.

The hospital insurance program would be fully financed through contributions of employees, employers, and the self-employed plus the general revenue contributions for aged persons not insured under social security or railroad retirement. These contributions would be similar to the present social security contributions. However, they would be levied under a separate provision of the Internal Revenue Code.

Also, while the present social security contribution rate applicable to the self-employed is higher than that for the employee or the employer, the hospital insurance contribution rate would be the same for the self-employed as for the employee and employer. The proceeds of this new earmarked contribution would be deposited in a newly established hospital insurance trust fund.

The financing of the basic plan is based on very conservative cost estimates. The cost estimates used by the House committee assume, for example, that earnings will continue to rise over the 25-year period as they have in the past but that the annual limitation on taxable earnings will not be increased beyond the $6,600 level provided for in the bill for 1971 and thereafter. Thus, even if the contribution base should not be adjusted after 1971, the hospital insurance provisions would be amply financed.

If the contribution base in increased after 1971, the rates in the contribution schedule could be revised downward. In fact, keeping all other assumptions the same, if the contribution base is kept up

to date with the general earnings level, the hospital insurance contribution rate for employees, employers, and the self-employed could be held at 0.55 percent of taxable payroll instead of being scheduled to rise, as in the bill, to 0.80 percent by 1987.

H.R. 6675 adds to the provisions of S. 1 the payment for the cost of services in qualified tuberculosis hospitals and in Christian Science sanatoria. Another significant change from S. 1 adopted in H.R. 6675—and one with which, as I will explain shortly, I cannot concur—is the transfer of the coverage of services of certain medical specialists from the hospital insurance plan to the supplementary plan.

SUPPLEMENTARY HEALTH INSURANCE PLAN

The supplementary health insurance plan embodied in H.R. 6675 would be one providing voluntary medical insurance that would be administered through private carriers and would be available to virtually all older people who wish to enroll and pay the required premiums.

The major emphasis of the supplementary plan is on protection against the cost of physicians' services both in and outside the hospital. In addition payment would be made toward the costs of inpatient care in psychiatric hospitals, of home health visits in addition to those covered under the basic plan, of radiation and other medical therapy, of diagnostic tests, of ambulance services, and of other specified health care items and services.

Beginning July 1966 the beneficiary would pay the first $50 of expenses he incurs each calendar year for services of the type covered under the plan and 20 percent of the balance; the supplementary plan would pay the remaining 80 percent.

The vast majority of aged people would pay their contributions toward the program by having $3 per month, beginning July 1966, deducted from their social security and railroad retirement benefits. This premium rate would be in effect until 1968; thereafter, the rate would be subject to biennial adjustment, based on experience.

The minimum increase that the bill would make in cash social security benefits—$4 for a retired person aged 65 or over and $6 for a couple aged 65 or over—would fully cover the monthly premiums that an aged person would pay for the supplementary plan. These payments would be matched by equal payments from Federal general revenues.

A part of these general revenue expenditures would be recouped by modifying the income tax provisions that apply to medical expenses of the aged. Under the bill, aged people could deduct only medical expenses in excess of 3 percent of income and drug expenses in excess of 1 percent of income for income tax purposes. Of course, only aged persons whose incomes are high enough so that they must pay income taxes would pay additional taxes under this provision of the bill.

Aged recipients of cash public assistance payments who are not entitled to social security benefits could be enrolled in the supplementary plan by the public assistance agency. The State would pay contributions on behalf of the recipients out of its State-Federal assistance funds, and these payments would be matched by Federal contributions, as in the case of other enrollees.

Various protections against adverse selection are included in the enrollment provisions of this program. For example, provision is made for a waiting period before a newly enrolled person could become eligible for payments so that it would not be possible for him to delay enrollment until expensive health services were required.

We anticipate that a very high percentage of the aged would enroll because of the general revenue subsidy of 50 percent makes participation in the program very advantageous.

We anticipate that between 80 to 90 percent of the aged of 65 and over will enroll under this voluntary plan.

Now, as under the basic plan, payments for covered services provided by hospitals, extended care facilities, and home health agencies would be based on reasonable costs and would be made to the provider of services. In the case of all other covered services—physicians' services, for example—benefits would be based on reasonable charges and would be paid to the beneficiary or, alternatively, under certain circumstances, could be assigned to the physician or other person or organization which furnished the covered services.

In deciding whether a charge for a covered item is reasonable, the carriers responsible for administration of the payment provisions of the supplementary plan would consider the customary charges of the physician and the prevailing charges in the community for the services furnished. The carriers would make payment on the basis of charges which are no higher than the charges used for reimbursement on behalf of their own policyholders.

If the benefits are assigned to the physician or organization that rendered the services, the reasonable charge for the services rendered would have to be accepted by the physician or organization as payment in full for those services; in other cases, reimbursement would be made on the basis of receipted bills.

ADMINISTRATION OF THE TWO HEALTH INSURANCE PLANS

Overall responsibility for administration of the basic and supplementary plans would rest with the Secretary of Health, Education, and Welfare. The bill provides for the establishment of two advisory groups made up of experts from outside the Government: one to advise the Secretary on general policy matters in the administration of the heatlh insurance programs and the other to study and report on utilization of hospital and of other medical care and services.

The Secretary would also be required to consult with appropriate State agencies, national and State associations of provider of services, and recognized national accrediting bodies.

State governments license health facilities, and State public health authorities generally inspect these facilities to determine whether they are conforming with the requirements of the State licensing law. The proposal would put this experience to use by giving State agencies important duties in assisting the Federal Government in determining which providers of health services meet the appropriate definitions and also by furnishing consultation to hospitals and other facilities that wish to participate in the program.

Private organizations would also play an important role in the administration of both the basic and supplementary plans. Under the

basic plan, groups of hospitals, or associations of hospitals on behalf of their members, could nominate an organization to act as a fiscal intermediary between providers and the Federal Government.

Similarly, other providers of services, such as extended-care facilities, could have fiscal intermediaries. This arrangement would permit the same organizations that now reimburse hospitals and other providers of health services to perform a similar function under the hospital insurance program.

As I indicated earlier, the services covered under the supplementary plan are primarily those provided by physicians. The bill requires the Secretary of Health, Education, and Welfare to the extent possible to contract with health insurance carriers for the performance of functions related to such coverage—for example, determining the amounts to be paid for physicians' services and making the payments.

The Secretary would enter into such a contract with a carrier only if he finds that the carrier can carry out the required functions efficiently. The Secretary would contract with a sufficient number of carriers, selected on a regional or other geographical basis, to permit a comparative analysis of their performance.

ANCILLARY HOSPITAL SERVICES

Mr. Chairman, it would be a mistake, in my opinion, to exclude from coverage under the basic hospital insurance plan, as H.R. 6675 does, the services furnished hospital patients under arrangements with the hospital, by medical specialists in the fields of radiology, anesthesiology, pathology, and physicial medicine. These services should be covered under the basic hospital insurance plan subject to the conditions set forth in the Senate-passed bill of last year and in the bill introduced in this Congress by the distinguished senior Senator from New Mexico.

Our primary concern is that medical services furnished to hospital patients in these fields be covered under this bill in a way that is in accord with the practices that hospitals and the health professions have developed over the years.

Thus, we believe that the services in question should be covered as part of the hospital benefit if the specialist-hospital arrangement calls for the bill to be paid through the hospital.

Conversely, we believe that, where the arrangements are that the specialist is not paid by or through the hospital, reimbursement for the specialist's services should be made under the supplementary plan.

The specialists in these fields work in hospitals under various kinds of arrangements. Some work as hospital employees and are paid a salary, while others receive agreed upon percentages of the hospital's receipts for the services they furnish. Some of these specialists bill their patients directly.

The approach we suggest would follow whatever practices now exist or whatever practices may be arranged in the future in this field. On the other hand, the provisions in H.R. 6675 which exclude the hospital-related services of these specialists from coverage under the basic hospital insurance provisions would require substantial changes in the way these services are now paid for.

The billing for the nonphysician components of the affected hospital department would have to be entirely separate from the billing for the physician services in the Department. There are very few hospitals in the country that operate today on such a basis in the fields of pathology and radiology. Nor is there a health insurance plan, so far as we are aware, which requires the separation of the services of these specialists from the services provided by the hospital generally irrespective of the arrangements agreed upon by the hospital and the specialists.

We urge, therefore, Mr. Chairman, that the bill be modified to restore the provisions for covering these services made in last year's Senate bill and Senator Anderson's bill of this year. We will also have some clarifying and technical changes in the bill we would like to bring to the committee's attention at a later point.

CHANGES IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

In addition to the very important insurance proposals for protecting older people against high health costs, many other important changes in the social security program are included in the bill. These changes would modernize and improve the program of cash benefits under social security to take account of changes in economic and other conditions that have taken place over the last several years and to fill gaps in the protection of the program.

The bill provides a 7-percent across-the-board increase in benefits, with a minimum increase of $4 guaranteed for retired workers aged 65 and over and for disabled workers. The last general benefit increase was enacted in 1958 and the 7-percent increase takes into account the increases in prices since that time.

Monthly benefits for workers now on the rolls who retired at or after age 65 would range from $44 per month at the minimum to $135.90 at the maximum, as compared to $40 to $127 per month under present law. The initial increase in the contribution and benefit base provided by the bill—the increase to $5,600 a year—would make possible a maximum benefit of $149.90 per month for those who continue to work and pay on the higher amount.

Under the second-step increase in the contribution and benefit base thta the bill would make—the increase to $6,600 a year—a maximum benefit of $167.90 per month would be possible after the new earnings base has been in effect for some time.

The bill uses the same method for computing maximum family benefits that was used in last year's bill. Specifically, the bill provides a different family maximum amount at every average monthly earnings bracket in the benefit table.

The maximum, for families now on the rolls, is raised from $254 per month to $286.80 per month. In the future, the maximum family benefit payable per month would be $312 under the $5,600 contribution and benefit base and $368 per month under the $6,600 contribution and benefit base.

The 7-percent benefit increase would be retroactive to January 1965. As this committee stated last August in its report on H.R. 11865, a general increase in social security benefits was needed at that time. H.R. 11865, as passed by both Houses last year, provided for increased

social security benefits that would have been effective at about the beginning of 1965 if the bill had been enacted. Paying the increased benefits retroactively to January, then, would put beneficiaries in the same position they would have been in if H.R. 11865 had been enacted.

With passage of the bill, some 20 million people will be immediately eligible for increased benefits under this provision. An estimated $1.2 billion in additional cash benefits would be paid in 1965, and $1.4 billion in 1966, as a result of the benefit increase.

The proposed increase in the contribution and benefit base to $5,600 is scheduled for 1966, and the increase to $6,600 is scheduled for 1971. This increase in the base is very much needed. It has not been increased since 1958, and periodic adjustment of the base as earnings rise is of fundamental importance not only to the preservation of the wage-related character of social security benefits but also to the maintenance of a broad financial base for the program.

Another important change that H.R. 6675 would make in social security cash benefits is provision for the payment of child's insurance benefits to children between the ages of 18 and 22 who are attending school. Last year both the House and Senate passed a similar provision.

The provision for children reflects the fact that we can no longer assume that a child has finished his education and is ready for self-support when he was attained age 18. Like the provision for the general increase in benefits, it would be retroactive, with the first benefits payable for January 1965. About 295,000 children would be eligible for benefits for a typical school month in 1965; in 1966 about $195 million in benefits would be paid.

The disability insurance protection provided under social security would also be improved. The bill would remove the requirement that to be eligible for benefits a worker's disability must be expected to result in death or to be of long-continued and indefinite duration.

The effect of this change would be to make disability benefits available to insured workers without requiring that it be found that they cannot be expected to recover in the foreseeable future. This provision is along the lines of most private long-term disability insurance provisions.

Another change in the disability insurance provisions would enable the disabled worker, and those who are dependent on him, to become eligible for benefits after 6 months rather than after 7 months as is provided in present law. It is estimated that about 155,000 people—disabled workers and their dependents—would become immediately eligible for benefits, with $105 million in benefits payable in 1966 because of the changes.

The bill also provides for covering employees' tips that are $20 or more in a month as wages under social security. This provision is the same as the one that was in the bill considered by your committee last year, except that it includes provisions for income tax withholding on tips.

Failure to credit tips toward benefits constitutes one of the few remaining significant gaps in social security coverage. Tip income is estimated to represent, on the average, more than one-third of the work income of regularly tipped employees; in many cases, of course, tips represent a much larger part, or even all, of the employee's income.

The amount of tips received by employees who regularly receive tips is estimated at more than $1 billion a year. Coverage of tips would provide better protection under the social security program for more than a million employees and their dependents.

A waiter, for example, who receives $35 a week in wages and $55 a week in tips—a not unusual situation—would, under present law, receive a monthly retirement benefit, beginning at age 65, of $74. If his tips were covered, his benefit amount would be $125 per month.

The responsibility is put on the employee to report his tips to his employer. If he fails to do so within 10 days after the close of the month in which the tips are paid, the employer is relieved of all liability. The employee is then responsible for paying the employer's contribution as well as his own.

Tips would be covered also for income tax withholding purposes, so that tipped employees would pay their income taxes on tips on a pay-as-you-go basis. Under present law, employees who receive tips pay the income tax due on their tips on an estimate quarterly basis or in a lump sum at the end of the taxable year in which the tips were received.

The provision for income tax withholding on tips would make it more convenient and easier for them to pay their income taxes and, of course, would improve the collection of income taxes.

Another important provision of the bill would extend coverage to the self-employment earnings of physicians. Self-employed doctors of medicine—the only group of significant size whose self-employment income is excluded from coverage under social security—would be covered under the program on the same basis as other professional self-employed groups.

In addition, the bill increases the proportion of gross income which may be reported by low-income farmers in place of net income and also makes it possible for the Amish to elect not to be covered by the program. Certain other minor changes in the present coverage provisions are included.

The bill also provides benefits for certain aged people who have had some social security coverage but not enough to qualify for benefits under present law, and for certain aged divorced women who were married for many years prior to being divorced. In addition, benefits are provided for widows at age 60, payable in reduced amounts so as not to increase the cost of the program.

The bill also liberalizes the retirement provision in present law under which there is a $1 reduction in benefits for each $2 of earnings above $1,200 and up to $1,700 to provide for a $1-for-$2 reduction for earnings between $1,200 and $2,400. Benefits would continue to be reduced by $1 for every $1 of earnings above $2,400, as they are now on earnings above $1,700.

Still other changes included in the bill are:

A provision for automatically recomputing benefits to take account of earnings that a beneficiary may have after he comes on the rolls and that would increase his benefit amount;

A provision permitting an unlimited time for filing proof of support for husband's, widower's, and parent's insurance benefits and applications for lump-sum death payments where there is good cause for failure to file these documents within the initial 2-year period provided under the existing law; and

A provision allowing a person to become entitled to disability benefits after he has become entitled to monthly benefits that are paid on the basis of his age.

The bill also tightens up the provisions governing the payment of child's benefits to a child adopted by a retired worker in order to provide safeguards against possible abuse.

SOCIAL SECURITY AND HEALTH INSURANCE FINANCING

Obviously the proposed hospital insurance provisions for the aged and the significant improvements that would be made in social security cash benefits would add to program costs. The bill faces up squarely to the need for providing sufficient funds to pay for these improvements.

It provides sufficient income to pay all the costs of the changes proposed in the present social security program as well as the costs of the proposed hospital insurance program.

Each of the two existing social security trust funds and the proposed new hospital insurance trust fund would be assured not only of adequate short-range income but also of long-range financial soundness.

In arriving at the social security contribution schedules included in the bill, particular attention was given to the effect of social security contributions on the individual taxpayer and the economy as a whole. The bill provides a more gradual attainment of the full rates needed to support the cash benefits than does the present law.

Under present law the rates for employees and employers would go to 4.125 percent in 1966 and 4.625 percent in 1968. Under the bill that is before you, the rates that employees and employers would pay under the cash social security program would not exceed 4 percent until 1969. Moreover, they would not exceed the rates now scheduled for 1968 until the ultimate rate scheduled under the bill—4.8 percent—goes into effect in 1973.

The rates for the self-employed would be held at 6 percent until 1969 and would not exceed the 6.9-percent rate now scheduled for 1968 until the ultimate rate scheduled under the bill—7 percent—goes into effect in 1973.

The separate contribution to finance the new hospital insurance program would also be put into effect under a graduated schedule. The rates are scheduled to begin in 1966 at 0.35 percent each for employees, their employers, and self-employed people and to rise in five steps to 0.80 percent each in 1987.

On the basis of conservative assumptions, the contribution rate would provide adequate income to the hospital insurance trust fund over the entire 25-year period for which estimates were made.

The contribution rates in the bill have been set so as to avoid undesirably and unnecessarily large trust fund accumulations in the near future. Under the bill the social security trust funds would of course increase—that is, income would generally exceed outgo—but the contribution rates are designed to avoid the large increases in the trust funds in the next few years that would have occurred under present law.

Under present law, the law we are now operating under, the combined assets of the old-age and survivors insurance and the disability insurance trust funds would grow from $21.2 billion at the end of 1964 to $32.8 billion by the end of 1969.

Under the bill that is before this committee, the combined assets of the three trust funds supported by payroll contributions—of the two existing funds and the new hospital insurance trust fund—would grow, but only to $23.5 billion by the end of 1969 instead of the $32.8 billion under existing law.

The cost of the voluntary supplementary health insurance program would, of course, be met by contributions made by the participants and the Government.

It would be financed through a separate trust fund but, unlike the other parts of the program, it would be financed on a short-range basis, with the contributions adjusted to the cost.

The contribution rate, under the bill before you, would not and could not under the bill be changed more often than once every 2 years.

The regular social security contribution rates scheduled under the bill provide more favorable treatment for the self-employed than previous schedules, which set the tax rate for the self-employed at about 1½ times the employee rate.

Under the bill, the final self-employed rate for the cash benefits would be somewhat less than 1½ times the final employee rate, and, as I said before, self-employed people would pay for hospital insurance at the same rate as employees and employers.

CHILD HEALTH AND MEDICAL ASSISTANCE

The child health and medical assistance provisions of the bill would carry out recommendations that President Johnson made in his health message. These provisions are also included in S. 970, the Child Health and Medical Assistance Act of 1965, introduced by Senator Ribicoff and pending before your Committee.

Under these provisions a new title of the Social Security Act would be established under which all vendor payments for health care—such as payments to hospitals, doctors, druggists, nursing homes—in behalf of public assistance recipients would be made.

States could include under the title all the recipients of money payments for old-age assistance, aid to the blind, aid to the permanently and totally disabled, and aid to families with dependent children. They could also include medically needy persons who would qualify for these programs if their income and resources were so small that they needed payments for basic maintenance costs—food, clothing, shelter, etc.

The medically needy group could include not only the present recipients of medical assistance for the aged but comparable groups of persons under 65 who are blind, disabled, or dependent children and relatives. The title thus represents a substantial broadening of the existing Kerr-Mills law.

The greatest number of new potential beneficiaries under the expanded benefits would be the 3.2 million dependent children now receiving financial aid and any other children from broken families who need help if their medical needs are to be met.

When these programs are placed under a single new title, States would receive increased matching on a uniform basis for all groups. Increases at least as large as those contemplated by the "eldercare" bill would be available to all States and would apply not only to aid provided in the form of insurance premiums but to all medical costs.

Under the new title, comparable eligibility requirements would apply to all groups and comparable medical benefits would be available to each of them. With States relieved of much of their existing cost of hospital care for the aged through the health insurance provisions of the bill, sufficient State funds would become available in many States together with matching Federal funds to provide significant health care programs for all needy persons on an equitable basis.

By July 1, 1967, a minimum program would be required to include at least some inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, and physicians' services regardless of where they are provided. States could at their option include a broad range of additional services.

The program could be adopted by the States as early as January 1, 1966, and would be the only basis on which vendor payments for medical care could be made after June 30, 1967.

Costs on a full-year basis are estimated at about $200 million, with $100 million being the estimated cost in the fiscal year ending June 30, 1966.

In addition, improvements would be made in the child health programs. The amount authorized to be appropriated for maternal and child health services would be increased by $5 million in the fiscal year ending June 30, 1966, and by $10 million in each subsequent fiscal year.

The same increases in authorizations would be made for the program of crippled children's services. In each of these programs, States would have to show progressive expansion of the availability of services with the objective of making them available to children in all parts of a State by 1975.

Provision would be made for a separate authorization beginning in 1967 for the training of professional health personnel to deal with crippled children, particularly mentally retarded children and children with multiple handicaps. Such training is closely related to the development of university-based mental retardation centers authorized by the Congress in 1963.

A new authorization for project grants to establish comprehensive health projects for children of school and preschool age would be provided.

These health projects would be in areas with concentrations of low-income families, and, while all children in such an area might receive screening, preventive, or diagnostic services, only those children who would not otherwise receive such care would be eligible for treatment, correction of defects, and aftercare.

In addition, grants of $2.75 million per year for 2 years would be authorized to assist States in following up and beginning to implement the comprehensive mental retardation plans that they have been developing under grants made available under legislation enacted in 1963.

Other medical assistance changes in the bill were also included in H.R. 11865 as it passed the Senate last year and were contained in S. 1 introduced this year by Senator Anderson and others.

Among these is the removal of limitations on Federal participation in public assistance for aged persons in mental and tuberculosis hospitals. This was Senator Long's amendment, adopted last year with safeguards to assure that additional Federal funds resulting from it would go into improvement of mental health programs.

CHANGES IN CASH PUBLIC ASSISTANCE

The bill provides for an increase in the public assistance formulas which averages about $2.50 per recipient per month for aged, blind, and disabled recipients and averages about $1.25 for recipients under the program of aid to families with dependent children. This is the same formula which was proposed by Senator Long and adopted by the Senate last year.

The additional Federal funds received under the new formula would be required to be passed on to the recipients. A similar pass-on provision has been included in Senate-passed amendments to public assistance programs on a number of prior occasions. This provision would apply to increases in Federal funds under all the provisions of the bill.

Another provision of the bill permits payments to be made to a third party in behalf of aged persons who are unable to manage money because of physical or mental impairment. This amendment contains appropriate safeguards and is similar to the one which the Congress adopted for the aid to families with dependent children program in 1962.

Senator Douglas' amendment of last year, liberalizing the amount of earnings of old-age assistance recipients which a State may disregard is also included in the bill. Under the amendment a State might disregard $50 of earnings for aged persons earning $80 or more per month.

Furthermore, provision is included authorizing States to disregard the retroactive portion of the increase in OASDI benefits or the child's school-attendance benefits under that program.

A provision of the Economic Opportunity Act which requires compliance by State public assistance plans by July 1, 1965, is rendered inoperative for States which are unable to comply because of State law and have not yet any regular legislative sessions since the Economic Opportunity Act was passed. The bill would take care of the period until the legislature may act for any State in this situation.

A provision is included permitting judicial review of the Secretary's decisions regarding the State public assistance plans or amendments and affording administrative reconsideration of decisions on audit exceptions.

H.R. 6675 also contains a substantial number of other minor changes. Among these provisions is one which, while not increasing the dollar limitations on grants to Puerto Rico, Guam, and the Virgin Islands, will afford some help to these jurisdictions by providing that all their medical care payments would be outside the existing ceilings on cash assistance. Only their medical assistance for the aged program is outside the ceiling at present.

H.R. 6675 is truly a landmark bill. Its passage will be a tremendous step toward preventing insecurity and want among the aged, disabled, widows, and the orphaned.

As a result of this bill, people who are still working will be able to look forward to their retirement years with a sense of security never before posible. The extensions and improvements in our social insurance and public assistance programs that are embodied in the bill would bring new security and hope to millions of Americans of all ages.

Mr. Chairman, I would like to call to the attention of the committee the charts that are attached to this statement and to ask that they be inserted in the record at this point.

The charts are put in capsule form, the major provisions contained in the bill and what it will do.

(The charts referred to follow:)

SOCIAL SECURITY AMENDMENTS OF 1965 (H.R. 6675)

TITLE I HEALTH INSURANCE FOR THE AGED & MEDICAL ASSISTANCE

THREE LAYER APPROACH

1. HOSPITAL INSURANCE PROGRAM (LIKE H.R. 1)
2. VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE PROGRAM (PRIMARILY PHYSICIANS' BILLS)
3. MEDICAL ASSISTANCE-EXPANDED KERR-MILLS PROGRAM

TITLE II OTHER AMENDMENTS RELATING TO HEALTH CARE

1. MATERNAL & CHILD HEALTH SERVICES
2. MENTAL RETARDATION PLANNING
3. PA AMENDMENTS ON MENTAL & TB DISEASE

TITLE III SOCIAL SECURITY CASH BENEFIT AMENDMENTS

1. BENEFIT INCREASES
2. CHILD'S BENEFITS TO AGE 22
3. RETIREMENT PROVISION LIBERALIZATION
4. COVERAGE EXTENSIONS
5. OTHER CHANGES

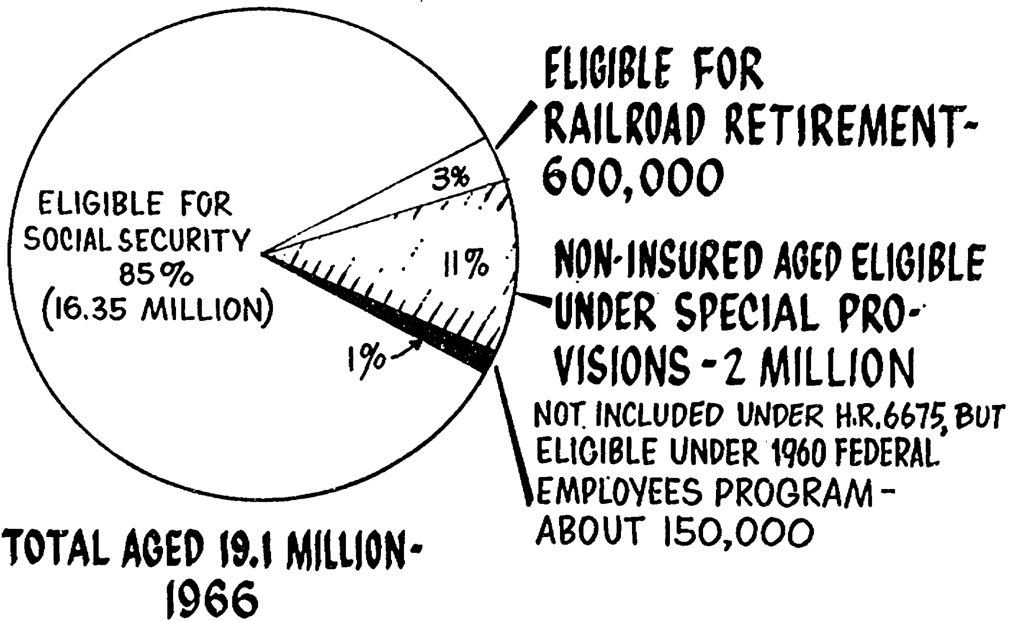
TITLE IV PUBLIC ASSISTANCE AMENDMENTS

1. INCREASED FEDERAL MATCHING
2. PROTECTIVE PAYMENTS
3. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED
4. OTHER CHANGES

HOSPITAL INSURANCE PLAN
Four Types of Benefits

INPATIENT HOSPITAL SERVICES	Up to 60 days per spell of illness Deductible (paid by patient) equal to $40 at beginning of program
POST-HOSPITAL EXTENDED CARE	Up to 100 days per spell of illness after transfer from hospital Less 2 days for each day hospital stay over 20 days (minimum 20 days)
POST-HOSPITAL HOME HEALTH SERVICES	100 home visits in year following discharge from institution, by health workers, under plan established by physician
OUTPATIENT DIAGNOSTIC SERVICES	As required, with a deductible (in each diagnostic study) equal to ½ inpatient hospital deductible

PERSONS 65 AND OVER PROTECTED UNDER HOSPITAL INSURANCE



SUPPLEMENTARY PLAN

Four Types of Benefits

PHYSICIANS' SERVICES	IN AND OUT OF HOSPITAL
PSYCHIATRIC HOSPITAL SERVICES	UP TO 60 DAYS IN A SPELL OF ILLNESS; 180-DAY LIFETIME MAXIMUM
HOME HEALTH SERVICES	UP TO 100 VISITS IN A CALENDAR YEAR
OTHER MEDICAL SERVICES	DIAGNOSTIC TESTS, RADIATION THERAPY, MEDICAL SUPPLIES, AMBULANCE SERVICES, AND RENTAL OF MEDICAL EQUIPMENT

DEDUCTIBLE AND COINSURANCE UNDER SUPPLEMENTARY PLAN

$50 ANNUAL DEDUCTIBLE---
PAID BY BENEFICIARY

PLAN PAYS 80% OF REMAINDER,
PATIENT PAYS 20%

OUT-OF-HOSPITAL EXPENSES FOR TREATMENT OF MENTAL ILLNESS LIMITED TO $250 OR 1/2 ANNUAL EXPENSES, WHICHEVER IS LESS

FINANCING OF 2 HEALTH INSURANCE PROGRAMS

PLAN	SOURCE OF FUNDS	SCHEDULE
Hospital Insurance	Employee & Employer & self-employed General revenues for transitional insured	Each pays 1966-0.35% 1967-0.50% Rising to 0.80 in 1987 EARNINGS BASE 1966-$5,600 1971-$6,600
Supplementary Health Insurance	Beneficiary and Federal Government	Each pays ½ of $6 monthly premium

MAJOR CHANGES IN CASH BENEFIT PROVISIONS

1. 7-percent benefit increase
2. Increase in earnings counted for contribution and benefit purposes
   - $5600 Effective January 1, 1966
   - $6600 Effective January 1, 1971
3. Child's Insurance benefits for child age 18 to 22 attending school
4. Reduced benefits for widows at age 60
5. Disability changes
   - Eliminate long-continued requirement
   - 1st payment for 6th (rather than present 7th) month of disability
6. Liberalization of eligibility for certain persons age 72 or over:
   - 3 quarter minimum
7. Retirement provision changes
   - Withhold $1 in benefits for $2 in earnings
     - For earnings of $1200-2400
     - rather than present $1200-1700
8. Coverage changes
   - Coverage of Physicians
   - Coverage of Tips
   - Exemption of Amish

EFFECT OF CASH BENEFIT CHANGES

PROVISION	NUMBER OF PEOPLE AFFECTED	ADDITIONAL BENEFITS PAYABLE IN 1966*
BENEFIT INCREASE	20,000,000	$1,430,000,000
CHILDREN ATTENDING SCHOOL	295,000	195,000,000
REDUCED BENEFITS FOR WIDOWS	185,000	165,000,000
TRANSITIONAL INSURED STATUS	355,000	140,000,000
DEFINITION OF DISABILITY	155,000	105,000,000
RETIREMENT PROVISION	450,000	65,000,000

*TOTAL ADDITIONAL BENEFIT PAYMENTS IN 1966 $2.1 BILLION.

CONTRIBUTION RATES UNDER PRESENT LAW & UNDER H.R. 6675

(In percent)

EMPLOYER AND EMPLOYEE, EACH

Year	Present law	H.R. 6675 OASDI	H.R. 6675 HI	H.R. 6675 Total
1966	4.125	4.0	0.35	4.35
1967	4.125	4.0	0.50	4.50
1968	4.625	4.0	0.50	4.50
1969-72	↓	4.4	0.50	4.90
1973-75	↓	4.8	0.55	5.35
1976-79	↓	↓	0.60	5.40
1980-86	↓	↓	0.70	5.50
1987 and after	↓	↓	0.80	5.60

SELF-EMPLOYED

Year	Present law	H.R. 6675 OASDI	H.R. 6675 HI	H.R. 6675 Total
1966	6.2	6.0	0.35	6.35
1967	6.2	6.0	0.50	6.50
1968	6.9	6.0	0.50	6.50
1969-72	↓	6.6	0.50	7.10
1973-75	↓	7.0	0.55	7.55
1976-79	↓	↓	0.60	7.60
1980-86	↓	↓	0.70	7.70
1987 and after	↓	↓	0.80	7.80

EARNINGS BASE	
1965	$4,800
1966-70	5,600
1971 and after	6,600

Secretary CELEBREZZE. Mr. Chairman, I apologize for the length of time I have taken but this bill is almost 300 pages long and I found it difficult to really condense it.

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

Senator Smathers?

Senator SMATHERS. Mr. Chairman, I temporarily pass.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. Mr. Secretary, I notice in your statement there are going to be a series of amendments you are going to suggest for this bill. When could you have those amendments, including those so-called technical changes, in written form for submission to the committee so that we can have them for examination?

Secretary CELEBREZZE. We are submitting today the amendment including the other health professions in hospitals, the radiologists and anesthesiologists and so on. I thought it would be presumptuous of me on a bill which is 296 pages long and a bill that will receive extended hearings by this committee to say we will not accept any amendments.

Therefore, I wanted to reserve my judgment on what amendments would be acceptable and what amendments we might suggest after I have heard the testimony from other people.

If there are any further amendments to be submitted they will probably be on minor or technical changes.

I can't conceive of a bill almost 300 pages long without some technical amendments by this committee so I would like to reserve my decision until we have had the testimony before this committee and then I will be most pleased to make my suggestions and also receive suggestions from members of this committee as to what amendments they think are necessary.

Senator WILLIAMS. I wasn't asking you to pass judgment on the amendments which may be suggested by the committee. I am referring to your own statement, in which you said that you are going to have various amendments to suggest. I am wondering what those amendments are and when can we have them before the committee for our consideration?

Secretary CELEBREZZE. The major amendment I placed before the committee this morning, and as far as minor amendments are concerned, as I say, we are studying it and we are giving it thought. The reason I put the phraseology I did in the statement was to convey to this committee, Senator Williams, that we are not taking the position "this is it." We are taking the attitude that this committee may have some amendments and, as a result of what this committee may suggest, we may have further amendments to suggest. The statement was included merely to inform the committee that we are not saying "we accept the bill as it is." I think that is the proper way of doing it so that at the proper time if there are amendments as we analyze it, as the testimony comes in, as we get your reactions to this bill and the other Senators' reactions to the bill, we will be happy to consider those.

Senator WILLIAMS. Then as of the moment you only have the one amendment that you are submitting to the committee?

Secretary CELEBREZZE. Yes.

Senator WILLIAMS. Then at the moment you have no other amendments to suggest?

Secretary CELEBREZZE. Not at the moment and, as I said, Senator Williams, the reason I put that phrase in is that I didn't want to convey the impression to the committee that this was the only amendment we would accept. I wanted to convey to the committee that we are openminded on some other matters.

Senator WILLIAMS. One question that has been raised in connection with the extension of the bill to cover tips, I understand that the employee is supposed to report to the employer within 10 days after the end of the month the amount of the tips.

Secretary CELEBREZZE. That is right.

Senator WILLIAMS. And then the employee becomes liable for the employee's withholding and his own contributions.

Secretary CELEBREZZE. That is right.

Senator WILLIAMS. Now, what happens if the employee reports the amount of the tips but has spent the money and doesn't have it to give to the employer? Is the employer responsible for sending that in or can he say that the money has been spent?

Secretary CELEBREZZE. No, the obligation is upon the employee at the end of the 10-day period to notify the employer that he has had $20 or more in tips. The employer then pays the contribution on that. If the employee doesn't pay his contribution he is in violation.

Senator WILLIAMS. Well, the question is—does the employer send in both his contribution and the employee's contribution, or does the employee send in his own?

Secretary CELEBREZZE. The employer follows the regular pattern that he would for any other employee by sending in both contributions.

Senator WILLIAMS. That is my understanding, he sends in both. My question is this—suppose employee X reports $50 in tips but doesn't have the money to give to the employer to send in; who has the responsibility for the payment?

Secretary CELEBREZZE. The employee.

In other words, Senator Williams, the employer is responsible for reporting and paying the social security tax only for tips reported to him and only if he has funds of the employee from which to pay the employee's taxes.

Senator WILLIAMS. That is the point I want clear. If the employee does not give him the money, the employer is not responsible for sending it in.

Secretary CELEBREZZE. The employer is not responsible. The burden in this case is placed upon the employee.

Senator WILLIAMS. Now, I noticed the limitation on earnings under the present law is $1,200 for social security payments.

Secretary CELEBREZZE. That is right.

Senator WILLIAMS. And the Government takes back a ratio of one for two between that and $1,700 under the present law?

Secretary CELEBREZZE. That is right.

Senator WILLIAMS. And that is raised to $2,400 under this bill?

Secretary CELEBREZZE. Yes, we are adding $700 more. The limit on the $1-for-$2 withholding will be $2,400 instead of $1,700.

Senator WILLIAMS. That has the mathematics of a 50-percent tax on the earnings over the $1,200 in effect?

Secretary CELEBREZZE. Yes, an amount equal to 50 percent of earnings between $1,200 and $2,400 would be withheld from the benefits.

Senator WILLIAMS. And a hundred percent tax on earnings over $2,400?

Secretary CELEBREZZE. It is a hundred percent withholding from benefits for earnings above $2,400.

Senator CURTIS. That isn't correct.

Secretary CELEBREZZE. Over $2,400; we would withhold one dollar for each dollar over $2,400.

Senator WILLIAMS. One hundred percent.

Senator CURTIS. One hundred percent on the benefit, not on the earnings.

Senator WILLIAMS. Whichever way you might want to do it.

Senator CURTIS. He might earn thousands of dollars.

Senator WILLIAMS. That is true, but I mean it reduces his social security benefits dollar for dollar.

Secretary CELEBREZZE. That is right, yes.

Senator WILLIAMS. Which takes it all.

Secretary CELEBREZZE. Yes.
Senator WILLIAMS. All the benefits.
Secretary CELEBREZZE. Yes. On the benefits side.
Senator WILLIAMS. While it is not a hundred-percent tax the mathematics results are the same.
Secretary CELEBREZZE. In other words, for everything over $2,400 in earnings we would deduct dollar for dollar from benefits.
Senator WILLIAMS. Sure.
Secretary CELEBREZZE. Now, under present law, for everything over $1,700 we take out dollar for dollar.
Senator WILLIAMS. This $1,200 was established as the base in what year?
Secretary CELEBREZZE. 1954.
Senator WILLIAMS. There has been substantial change in the purchasing value of the dollar. Has there been any consideration given by the Administration to raising that base to $1,500 or $1,600?
Secretary CELEBREZZE. Yes, we gave it consideration, and the Social Security Advisory Council gave consideration to it. But as you raise the base the taxes have to be raised. So what we have to do is take a sound fiscal position, as I said in my statement, without too much overburdening the economy or the individual or the employer. You can go to any benefit rate you want if you increase the base and increase the tax rate.
Senator WILLIAMS. Well, that is true as to the benefits but the question I am asking is—would the Administration be opposed to raising it to $1,500?
Secretary CELEBREZZE. I don't know that I would be opposed to it because I haven't had it staffed out so I am unable to answer your question.
Offhand, I would say that we would at this time oppose it because it would require a greater tax outlay. You would have to increase your payroll tax by around one-tenth of 1 percent in order to meet the cost.
Senator WILLIAMS. This question, I am sure, will come before the committee before we get through so will you give us a memorandum as to the position of the Administration on the proposal to raise it to $1,500?
Secretary CELEBREZZE. I will submit it for the record.
Senator WILLIAMS. And also one for $1,800.
Secretary CELEBREZZE. I will submit it for the record.
(The information referred to follows:)

The Department of Health, Education, and Welfare believes that the retirement test provision in H.R. 6675 is preferable to increasing above $1,200 the amount of earnings a beneficiary may have in a year without any reduction in benefits.

It is important that the retirement test not intefere with incentives to work. Although increasing the exempt amount of earnings would be quite costly, it would not bring with it a corresponding reduction in the deterrent effect that the retirement test has on efforts of beneficiaries to work. All of the incentives to hold down earnings that now apply around the $1,200 point would continue to apply, but around the new point.

On the other hand, the retirement-test provision in H.R. 6675 would lessen the deterrent to work that admittedly is implicit in the test by increasing from $1,700 o $2,400 the ceiling on the amount of earnings for which there is a $1-for-$2 adjustment. Moreover, the provision in H.R. 6675 has a relatively low cost—

0.04 percent of payroll. If the exempt amount were increased to $1,500 or $1,800 (retaining a $500 span of earnings above the exempt amount for which there would be a reduction of $1 in benefits for each $2 of earning), the cost of the program would be increased by 0.11 or 0.23 percent of payroll, respectively. For these reasons we prefer the provision for liberalizing the retirement test included in H.R. 6675 over any proposal for increasing the annual exempt amount of earnings.

Senator HARTKE. Mr. Chairman, will the Senator yield there just for clarification?

That is not true except for wage earners. It does not apply to people who are receiving their income from dividends, interest, or rents, isn't that true?

Secretary CELEBREZZE. Yes. It applies only to earned income.

Senator WILLIAMS. Earned income, that is correct.

Secretary CELEBREZZE. He can have a hundred thousand dollars a year from other sources, but I am merely talking about earned income.

Senator HARTKE. There is a discrimination against the people who are working for a living at the present time and there is favoritism at the present time in favor of those people who are over 65 who are able to take their income from rent, dividends, and interest, isn't that true?

Secretary CELEBREZZE. Yes.

Senator HARTKE. And so whenever you are making these remarks, I would hope in the future we would make that clear that there is not a $1,200 limitation on those individuals. It is not true all the way across the board.

Secretary CELEBREZZE. No. We are referring to earned income when we say $1,200 or $2,400.

Senator HARTKE. We are referring basically to wages.

Secretary CELEBREZZE. Wages and self-employment income.

Senator HARTKE. That is right.

Secretary CELEBREZZE. Wages and self-employment income.

Senator HARTKE. There is a limitation on those people who have wages but there is no limitation on those who are living off of their coupons.

Secretary CELEBREZZE. That is true, because that was the basic philosophy upon which the social security program was established. It was to insure against loss of wages. On retirement there is no loss of total income.

Senator WILLIAMS. That is correct.

Secretary CELEBREZZE. That was the basic philosophy when adopting the program.

Senator HARTKE. Then the basic philosophy was wrong.

Secretary CELEBREZZE. Pardon?

Senator HARTKE. Maybe the basic philosophy was wrong.

Senator GORE. Will the Senator yield?

Senator WILLIAMS. Just a moment. To put it very simply, a man can have a hundred thousand dollars a year income and if he gets that without working he can still draw social security benefits in full without any penalties, but if he works and earns up to $1,500 he is penalized. That is the simple mathematics of the formula.

Secretary CELEBREZZE. If he works and makes $1,500, some of his benefits are withheld.

Senator WILLIAMS. If he has to work for his money there is a penalty, but if he doesn't have to work for it it is not considered.

Secretary CELEBREZZE. Let's say if he has wages as against investments.

Senator WILLIAMS. It sounds better that way so we will leave it that way but it is still the situation.

Senator GORE. Will the Senator yield?

Senator WILLIAMS. Sure.

Senator GORE. Mr. Secretary, was not a basic social purpose of the Social Security Act the encouragement and promotion of retirement? It seems to me that instead of this being regarded as a penalty, it should be viewed as part of the pattern of social security. We wanted to provide security in old age and retirement, and to make possible comfortable retirement. We want to encourage and promote retirement of people at age 65 in order to make way for employment possibilities for the teeming millions of youngsters coming out of our high schools and colleges.

Secretary CELEBREZZE. Yes.

Senator GORE. So I never regarded this as a penalty on earned income. It is a part of the social security program to promote retirement of people at 65.

Secretary CELEBREZZE. That is correct.

Senator GORE. Does the Department regard this as a penalty upon earned income or as a means of encouraging and promoting retirement?

Secretary CELEBREZZE. The report, which I am sure all of you have read, on the status of the social security program by the Advisory Council on Social Security, that was made this year, goes into the subject on page 72 of the report, and they say:

> The purpose of social security benefits is to furnish a partial replacement of earnings which are lost to a family because of death, disability, or retirement in old age. In line with this purpose the law provides that, generally speaking, the benefits to which a worker, his dependents, and his survivors are otherwise eligible are to be withheld if they earn substantial amounts.

And then it has a whole section on the subject.

Senator GORE. Thank you, Senator Williams.

Senator HARTKE. Mr. Chairman, I don't want to leave this matter. I will have more to say to the committee but the point still remains we have established an antipoverty program which establishes levels above that presently provided by the social security benefits, isn't that true?

Secretary CELEBREZZE. Senator Hartke, you can go as high as you want to in benefits so long as you are willing to provide the contribution base and contribution rates to meet the cost.

Senator HARTKE. Yes.

The only point I make——

Secretary CELEBREZZE. If you want to go to much higher benefits, then you get into the question whether you are overburdening the employee and the employer, so that you have to draw a line somewhere.

Senator HARTKE. I am not asking about it. I just don't want to leave this matter, leave any questions unanswered here, and leave it as though it is settled. The truth of it is we do have an antipoverty program which establishes certain minimum dollar limitations and this dollar limitation is higher under the antipoverty program than

it is under the social security, even the proposal you have before us.

Secretary CELEBREZZE. Even in the antipoverty program there is not any specific amount. The general borderline of $3,000 has been used, but it should not be a fixed amount, because $3,000 in certain areas of this country is not poverty, while in other areas it is poverty.

So you have to take those matters into consideration.

Senator WILLIAMS. I have several other questions, but in fairness to the other members of the committee I am going to suggest we go around the committee and I will withhold these for the time being. I understand, Mr. Secretary, you will be back tomorrow.

Senator RIBICOFF. Mr. Chairman, will the Senator yield at this point to clear that up. I think this is probably one of the least understood provisions of the social security law and I wonder, Mr. Chairman, at this point if Mr. Myers and Mr. Ball would explain to the committee why the tax rate has to rise if you increase the amount of the exemption. I think this is very, very complex, and I think there should be an explanation of it in the record.

Mr. BALL. Mr. Chairman, I would be glad to respond to Senator Ribicoff's request in general, and then Mr. Myers, perhaps, can add some actuarial knowledge to these general points.

The whole concept of the program, of course, as the Secretary said, has been that what you are insuring against under social security is the loss of income that you get from work. It is not an automatic payment for attainment of a given age. Many people work full time beyond 65, and have no more need for a benefit just because they happen to be 65 than they would have had at 55. They continue to work regularly and continue to receive as much in earnings as they ever did. The concept is one of paying a benefit for a loss of earned income when you retire.

Now, if you shift over—you could do it—shift over to a concept of a straight annuity payable at the attainment of a specified age such as 65, the consequences are that we would currently be paying out about $2 billion more in cash benefits, and that the cost of the whole program would be increased by nearly 1 percent of payroll; that is, nearly a half percent each on employer and employee, largely to pay benefits, Mr. Chairman, to people who are continuing to work at regular wages, and have as much income as they have had in the past.

The council that the Secretary referred to felt that it was very important to the proper conservation of the funds of the program—to keep them to use for the best purposes—that the concept of a retirement system rather than a straight annuity system be retained. This whole rather complicated provision of a $1,200 exempt amount, and withholding one for two from $1,200 to $1,700 and so on—this is just an attempt in broad terms to define the group who are no longer largely working in the way they used to work and who, therefore, are a group who need a payment to partially make up for the loss of earnings they have incurred.

The other important point that the council made, and that has been made over the years, is that if you took into account, for purposes of determining whether a person should get a social security benefit, income that he had from savings or from private pensions, you would have set up incentives the wrong way. The idea has been from the beginning that social security should be a base to which

people can add individual savings on their own, and income from private pensions and other arrangements.

Now, if you are going to take away social security benefits because people have saved, you can see that that would be a discouragement or savings and a discouragement of private pensions being built on top of social security.

For these reasons, I think there has been quite a consensus that you do need a test of retirement, but that it should take into account only what people earn from work and should not take into account any income that they might get from savings, dividends, private pensions or other nonwork income.

Mr. Myers may have something to add.

Senator HARTKE. Can I stop just at one point there just to clarify this a little bit so there is no mistake.

At age 72 it does become an annuity?

Mr. BALL. Yes, sir.

Senator HARTKE. So what we have there is a gap of 65 to 72 that is not an annuity.

Mr. BALL. That is correct.

Senator HARTKE. The other point I want to clarify: you say that you provide this income limitation on the theory that the incentive would be the wrong way, this is the negative approach. It is negative to the extent that you would impose limitations upon that unearned income. However, if you provided for the elimination of the present discrimination against wage earners, this would not in any way affect their incentive.

Mr. BALL. That is correct.

If you were to do away with the retirement test entirely, you would not damage incentives. I think the argument against that is not the point about incentives. The point is that the money would be going largely to people who continue to earn as they had in the past.

Senator HARTKE. So at that point you leave really only one question in that item and that is the monetary one.

Mr. BALL. The question, I think, can be summarized as follows: is this the best way to spend $2 billion social insurance funds paying benefits to people who are working and earning just as they did at younger ages, largely.

Senator WILLIAMS. If the Senator will yield—

Senator HARTKE. I would agree with all of them except if you take the word "large," out and I think he has put his finger on it.

In other words, we are talking about really $2 billion according to your figures.

Mr. BALL. Yes.

Senator HARTKE. And all these other arguments can be put aside.

Mr. BALL. If there were no monetary considerations at all involved I think there would probably be no objection to doing away with it.

Senator WILLIAMS. I didn't intend to pursue this point at this time, but even between the age of 65 and 72, the area where this limitation does apply, if a professional man drew a $20,000 fee in 1 month during that calendar year he could draw his social security benefits for the other 11 months, is that correct?

Mr. BALL. You are right on the general point, Senator. But it is a question of when it is earned rather than when it is paid.

Senator WILLIAMS. That is true. But if it is all earned in 1 month he can draw $20,000 plus his social security benefits for 11 months?

Mr. BALL. Yes.

Senator WILLIAMS. And in the teaching profession suppose they are paid on a 9-month teaching professional basis and technically not paid for the remaining 3 months. Therefore can they draw their social security benefits during those 3 months in which they are unemployed and then go back to teaching in the fall of the same year? Is that possible under this bill?

Mr. BALL. Yes, if the contract, I believe the situation is if the contract, actually creates a termination of employment, yes. We don't pay if it is just a vacation situation but if there is a termination.

Senator WILLIAMS. You don't care if it is a vacation or not if the contract reads he is being paid for the 9 or 10 months?

Mr. BALL. Yes.

Senator WILLIAMS. And the 2 months off he can draw the social security benefits?

Mr. BALL. Yes. You are right, Senator.

The CHAIRMAN. Are you through?

Senator WILLIAMS. Yes.

Senator RIBICOFF. I think if you will supply for Senator Williams the actual cost—the tax increase—to raise the minimum $1,500 to $1,800, I think it would be very helpful to the committee, because it is very obvious the committee is going to have to consider this point and we should know what the costs would be when we consider it.

Senator WILLIAMS. That proposal is coming before this committee, and that is the reason I asked him earlier to submit the cost estimates and the administration's recommendations on these various proposals. They were before our committee last year and I am reasonably certain, they will be before us this year.

Mr. BALL. We will be glad to do it.

(The information referred to follows:)

Cost of selected retirement test changes taking into account the changes made by H.R. 6675 in other provisions of the program

Annual exempt amount	Monthly measure of retirement	Adjustment for earnings above exempt amount	Level-cost (percent of taxable payroll)
$1,200 [1]	$100	$1 for $2 to $2,400	0.04
$1,200	$100	$1 for $2 all the way up above $1,200	.07
$1,500	$125	$1 for $2 to $2,400	.13
$1,500 [2]	$125	$1 for $2 to $3,000	.16
$1,800	$150	$1 for $1 above $1,800	.19
Eliminate the test completely			.93

[1] Provision in H.R. 6675.
[2] Passed by the Senate in 1964.

Senator WILLIAMS. I will pass at this time.

The CHAIRMAN. Senator Anderson?

Senator ANDERSON. Mr. Chairman, the question of how to take care of the health costs of the aged has been before the Congress the last few years. We had a bill up in 1960 on which we voted in the Senate. We had one in 1962 and in 1964, and the provisions of this bill which

relate to social security changes are pretty largely what Senator Long put in the bill a year ago, are they not?

Secretary CELEBREZZE. That is correct.

Senator ANDERSON. And the provisions of Senate bill are pretty largely what the Senate voted on a year ago?

Secretary CELEBREZZE. Yes, generally.

Senator ANDERSON. And we have in addition to that, of course, the suggestion of Senator Ribicoff on health care and so forth, but pretty largely this bill as it came from the House was a consensus of suggestions made over a period of years.

Secretary CELEBREZZE. Yes.

Senator ANDERSON. You refer in your statement:

There would still be ample opportunity for continuing growth of the private effort in the health insurance field since the 90 percent of the population who are under 65 would not be affected by the proposed programs.

While the health insurance plans of the King-Anderson as well as the hospital coverage are for persons over 65, isn't it true that younger persons would have lifted a heavy financial burden sometimes as a result of taking care of the aged in their family?

Secretary CELEBREZZE. Yes.

Senator ANDERSON. Wouldn't this relieve them from that burden?

Secretary CELEBREZZE. Yes, I covered that in my opening statement, yes.

Senator ANDERSON. I was interested in one thing. You have a proposal, which was taken out from the House bill, to put back the language of Senate bill 1 this matter which Senator Douglas has frequently raised of radiologists and certain other specialists.

You still support the recommendations on that, do you?

Secretary CELEBREZZE. Yes, we strongly support that recommendation, basically because that is the way payment to hospitals for the services of their medical specialists have been handled for years, and, as I said in my opening statement, we want to follow existing procedures; whatever way the hospitals have been working it that is the way we ought to keep it. Our proposal is adaptable to the variety of existing arrangements.

On the other hand, if the hospitals have been working on it the other way we ought to do it that way.

Senator ANDERSON. There have been some suggestions this might improve the quality of health care, and that the requirement for utilization might help in some instances.

Secretary CELEBREZZE. Yes.

Senator ANDERSON. That has been recommended by the American Medical Association and so forth.

In your statement you refer to hospital insurance tax contribution going into a newly established hospital trust fund, and while I agree with that, would you not agree also that the bill passed by the Senate last year provided for a separate hospital insurance trust fund?

Secretary CELEBREZZE. Yes, the bill passed last year called for a separate trust fund too. The difference is that under this bill there will be a separate tax and it will be reported on the tax withholding form the employer furnishes his employees as a separate item for hospital insurance.

Senator ANDERSON. I am not trying to quarrel with your language. I am only trying to point out that many of these things which are regarded as new proposals are actually things on which the Senate and the House have voted.

Secretary CELEBREZZE. Yes.

May I at this point, Senator, say that many of the things that are in this proposal before this committee today are things that you and other Senators have suggested over the past, practically the past decade, and they were thoroughly analyzed. We had the benefit, at least I had the benefit, this year of having sat in with the conference committee last year of the House and the Senate.

But most of these provisions in the bill are things which you have advocated, Senator, and which Senator Douglas, Senator Long, and other members of this committee have advocated.

Senator ANDERSON. H.R. 6675 doesn't differ much from Senate bill 1 or H.R. 11865 which we passed a year ago in the Senate.

Secretary CELEBREZZE. Not too much difference except you have one additional feature and that is the supplementary health insurance.

Senator ANDERSON. You have one additional feature.

Secretary CELEBREZZE. Yes, but basically, without counting supplementary health insurance with a few minor adjustments, it is the same as the bill passed by the Senate in the last session.

Senator ANDERSON. Could you submit for the record a comparison of those two bills——

Secretary CELEBREZZE. Yes, we have it.

Senator ANDERSON. H.R. 11865 and H.R. 6675 for the record.

(The information referred to follows:)

Summary comparison of provisions of H.R. 6675 with S. 1 and H.R. 11865 as passed by the Senate

Amendment	H.R. 6675	S. 1	H.R. 11865 as passed by the Senate
1. Hospital insurance	Yes	Yes	Yes.
2. Supplementary health insurance	Yes	No	No.
3. Benefit increase	7 percent; $4 minimum in PIA	7 percent	Flat $7 increase in all PIA's.
4. Contribution base	1966, $5,600; 1971, $6,600	1966, $5,600	1965, $5,600.
5. Payment of limited benefits to certain aged people	Yes	No	Yes.
6. Continuation of child's benefits beyond age 18 while attending school.	Yes	No	Yes.
7. Actuarially reduced benefits for widows at age 60	Yes	No	Yes.
8. Benefits for divorced wife or widow	Yes	No	No.
9. Liberalization of retirement test	Yes; $1 for $2 to $2,400; $1 for $1 above $2,400.	No	Yes; $1,500 exempt amount, $1 for $2 to $3,000; $1 for $1 above $3,000.
10. Exclusion of royalties on works copyrighted before age 65 from retirement test.	Yes	No	No.
11. Coverage of physicians	Yes	Yes	No.
12. Coverage of tips as wages	Yes, plus withholding for income-tax purposes.	Yes, plus withholding for income-tax purposes.	No.
13. Addition of Alaska and Kentucky to States that may cover State and local employees under divided retirement system provision.	Yes	Yes	Yes.
14. Extension of period for electing coverage by State and local employees whose group was covered under the divided retirement system provision.	Yes	Yes	Yes.
15. Coverage of certain hospital employees in California	Yes	Yes	Yes.
16. Additional retroactive coverage of nonprofit organizations, and validation of coverage of certain employees of such organizations.	Yes	No	No.
17. Coverage of certain employees of the District of Columbia	Yes	No	No.
18. Increase in gross income in determining net income of farmers	Yes	No	Yes.
19. Exemption from social security of certain religious sects	Yes	No	Yes.
20. Elimination of the indefinite duration requirement from the definition of disability.	Yes	No	No.
21. Payment of a benefit for the 6th month of disability	Yes	No	No.
22. Payment of benefits for 2d disabilities without regard to waiting period only if first period lasted at least 18 months.	Yes	No	No.
23. Automatic annual recomputation	Yes	Yes	Yes.
24. Payment of disability benefits after entitlement to other monthly benefits.	Yes	No	No.
25. Extension of period for filing proof of support and for lump-sum death payment.	Yes	Yes	Yes.

Item						
26. Adoption of child by retired worker	Yes		No		No.	
27. Timing of future advisory councils	Schedules next Council report for 1970 and every 5th year thereafter.		Yes		No.	
28. Preservation of railroad retirement coordination	Yes		Yes		Yes.	
29. Disability insurance trust fund allocation	0.75 percent of wages; 0.5625 percent of self-employment income.		0.67 percent of wages; 0.4875 percent of self-employment income.		0.67 percent of wages; 0.4875 percent of self-employment income.	
30. Reimbursement for military service credits	Yes		Yes		No.	
31. Frequency of trustees' meetings	Permits trustees to meet annually rather than every 6 months.		Yes, same as H.R. 6675		No.	
	Employee and employer, each	Self-employed	Employee and employer, each	Self-employed	Employee and employer, each	Self-employed
32a. Tax rates (OASDI), by calendar years (in percent):						
1965					4.25	6.4
1966–67	4.0	6.0	4.25	6.4	4.5	6.8
1968	4.0	6.0	5.0	7.5	5.0	7.5
1969–70	4.4	6.6	5.0	7.5	5.0	7.5
1971 and after			5.2	7.8	5.2	7.8
1971–72	4.4	6.6				
1973 and after	4.8	7.0				
32b. Tax rates (hospital), by calendar years (in percent):						
1966	.35	.35				
1967–72	.50	.50				
1973–75	.55	.55				
1976–79	.60	.60				
1980–86	.70	.70				
1987 and after	.80	.80				
33. Child's benefits on record of worker not his parent	No		No		Yes.	
34. Liberalization of definition of disability for blind	No		No		Yes.	
35. Relationship between veterans' benefits and increased social security benefits.	No		No		Yes.	
36. Public assistance amendments:						
a. Improvement and extension of Kerr-Mills program	Yes		No		No.	
Prohibition removed on Federal participation in assistance to TB and mental institution patients.	Yes		Yes		Yes.	
c. Federal matching share of assistance increased	Yes		Yes		Yes.	
d. Liberalization of earnings which may be disregarded in determining need of aged assistance recipients.	Yes		Yes		Yes.	
e. Simultaneous payment of OAA and MAA for month OAA recipients enter or leaves hospital or nursing home.	Yes		Yes		Yes.	
f. Protective payment to third party for incompetents	Yes		Yes		Yes.	
g. Disregarding of part of social security benefits in determining need for public assistance.	Yes, but only to extent of retroactive benefit increase and for child's benefit beyond age 18 while in school.		No		Yes.	
h. Administrative and judicial review of determinations	Yes		No		No.	
i. Maintenance of level of State assistance spending	Yes		No		No.	

Comparison of health insurance provisions of H.R. 6675, S. 1, and H.R. 11865 as passed by the Senate in 1964

BRIEF DESCRIPTION

H.R. 6675	S. 1	H.R. 11865
Provides 2 coordinated health insurance programs for the aged: (1) A basic hospital insurance program financed through a special payroll tax; and (2) a voluntary supplementary health insurance program financed through premium payments from participants and matching payments from Federal general revenues.	Provides a program of hospital insurance for the aged financed through increased social security contributions.	Same as S. 1.
ELIGIBILITY		
HOSPITAL INSURANCE		
All people 65 and over entitled to monthly OASI or railroad retirement benefits would be eligible.	Same provision.	Eligibility essentially same as under S. 1.
Also, persons not eligible for such monthly benefits who reach 65 before 1968, or reach 65 after 1967 and have 3 quarters of OASI coverage for each year elapsing after 1965 and before age 65, would be eligible—excluding Federal employees who could have enrolled in employee health plans under 1959 legislation, aliens with less than 10 years of continuous residence, and subversives.	Similar provision. Differs in that retired Federal employees who are or could have enrolled in plans made available under 1960 legislation also excluded.	
SUPPLEMENTARY INSURANCE		
All people age 65 and over who are residents of the United States and who are citizens or lawfully admitted to permanent residence would be eligible to enroll.	No provision.	No provision.

HOSPITAL INSURANCE PROGRAM		
Payment of cost of— 1. Inpatient hospital services (including tuberculosis hospital services) for up to 60 days in each spell of illness with the patient paying a deductible amount of $40 (which would be increased if necessary, but no earlier than 1969, to keep pace with increases in hospital costs). Excludes all physicians' services except those of interns and residents under approved teaching programs.	1. Differs from H.R. 6675 in that services provided by physicians in the field of pathology, radiology, physiatry, or anesthesiology are included, tuberculosis hospital services are excluded, and the deductible amount would be equal to the average cost of 1 day's care.	1. Similar to S. 1 except for benefit duration: Inpatient hospital services for up to 90 days per benefit period with deductible of $10 a day (minimum of $20) for first 9 days, unless beneficiary elects either up to 45 days with no deductible or 180 days with deductible equal to average cost of 2½ days of hospital care.
2. Posthospital extended care services (in a facility which has a transfer agreement with a hospital) for up to 20 days in each spell of illness. Beneficiary could elect an additional 2 days of services (up to a maximum of 80 additional days) for each unused day of inpatient hospital services.	2. Differs from H.R. 6675 in that it provides for up to 60 days coverage. No 2-for-1 provision.	2. Similar provision to S. 1 except services covered only in a facility affiliated with a hospital.
3. Posthospital home health services (such as visiting nurse) for up to 100 visits in the year after hospital discharge.	3. Differs from H.R. 6675 in that it provides for up to 240 visits wth no restriction to posthospital services.	3. Same as S. 1.
4. Outpatient hospital diagnostic services with the patient paying a deductible amount of $20 (subject to increase as in (1) above) for each diagnostic study; i.e., services furnished in a 20-day period by the same hospital.	4. Similar provision. Differs in that a deductible amount equal to the average cost of ½ day of inpatient hospital care would apply to all outpatient diagnostic services furnishd in a 30-day period.	4. Similar to S. 1. Differs in that deductible amount is $20.
POTENTIAL COST SHARING		
No provision.	No provision.	Provision for beneficiaries to bear a part of the cost of each day's hospital care in the event that hospital costs rose more rapidly in relation to wages than assumed in the cost estimates or that the taxable earnings base was not changed sufficiently to keep up with rising earnings levels.
SUPPLEMENTARY INSURANCE PROGRAM		
Payment of 80 percent of reasonable charges or cost, as provided, above a $50 annual deductible, for physicians' services, inpatient psychiatric hospital services up to 60 days in a spell of illness (180-day lifetime limit), home health services up to 100 visits during a calendar year, and a variety of specified medical and other health services.	No provision.	No provision.

Comparison of health insurance provisions of H.R. 6675, S. 1, and H.R. 11865 as passed by the Senate in 1964—Continued

FINANCING

H.R. 6675	S. 1	H.R. 11865
HOSPITAL INSURANCE PROGRAM		
By separate payroll taxes paid to a separate hospital insurance trust fund. Amount of earnings subject to tax would be same as for OASDI, $5,600 in 1966 rising to $6,600 in 1971. The contribution rate, the same for employees, employers, and self-employed persons, is based on estimates of cost which assume that the wage base will not be increased above $6,600 and would be as follows: 1966, 0.35 percent; 1967–72, 0.50 percent; 1973–75, 0.55 percent; 1976–79, 0.60 percent; 1980–86, 0.70 percent; 1987 and after, 0.80 percent.	By allocating to a separate hospital insurance trust fund 0.60 percent of taxable wages under social security paid in 1966; 0.76 percent of taxable wages paid in 1967 and 1968; and 0.90 percent of taxable wages paid thereafter. Allocations of 0.45, 0.57, and 0.675 percent of self-employment income taxable under social security would be made, respectively, in the taxable years 1966, 1967–68, and 1969 and thereafter. Earnings base of $5,600.	By allocating to a separate hospital insurance trust fund 0.60 percent of taxable wages paid in 1965, and 0.76 percent of taxable wages paid thereafter. Allocations of 0.45 and 0.57 percent of self-employment income taxable under social security would be made, respectively in the taxable years 1965, and 1966 and thereafter.
Costs of paying benefits for persons not entitled to monthly OASI or railroad retirement benefits financed from Federal general revenues.	Same provision.	Same provision.
Requires that W-2 forms show the proportion of the total payroll tax withheld which is for financing hospital insurance.	Authorizes Secretary of Treasury to require that W-2 forms show the proportion of the total social security tax withheld which is for financing hospital insurance.	No provision.
SUPPLEMENTARY INSURANCE PROGRAM		
By $3 a month premium payments from enrollees and matching amounts from Federal general revenues paid to a separate trust fund. Where enrollee is currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.	No provision.	No provision.

COMPLEMENTARY PRIVATE INSURANCE

H.R. 6675	S. 1	H.R. 11865
No provision.	Nonprofit associations of private insurers would be authorized to develop and offer for sale to aged persons health benefits plans covering costs not met under the Government program—specifically, plans covering most of the costs of physicians services. These activities of private insurers would be exempt from Federal and State antitrust laws.	Similar to S. 1, but provided for only 1 association of private insurers; provided exemption only from Federal antitrust laws (not State); specified in more detail the required content of approved health benefits plans; assigned Secretary of Health, Education, and Welfare considerably more responsibility for supervising insurance carriers; and provided for official Government endorsement of complementary private insurance policies.

COSTS

HOSPITAL INSURANCE		
About $2,260,000,000 for 1st-year program in full operation (1967), plus $275,000,000 from Federal general revenues for persons not entitled to monthly OASI or railroad retirement benefits. Level cost of 1.23 percent of payroll.	The cost is approximately the same. Level cost of 1.21 percent of payroll estimated on basis of high-cost assumptions used for H.R. 6675.	Cost slightly less (about 0.05 percent of payroll) than S. 1.
SUPPLEMENTARY INSURANCE		
For 1st-year program in full operation (1967) if 80 percent of the eligible aged enrolled, about $840,000,000 to $1,120,000,000; if 95 percent of the eligible aged enrolled, about $995,000,000 to $1,330,000,000.	No provision.	No provision.

ADMINISTRATION

HOSPITAL INSURANCE		
Under the Secretary of HEW who would use appropriate State agencies and private organizations to assist in administration. State agencies under an agreement would be used to determine and certify eligibility of providers to participate. Hospitals and other providers of services could nominate public agencies or private organizations to receive and pay bills in lieu of dealing directly with Government. Secretary could delegate additional administrative functions to designated organizations.	Similar provision. Differs mainly in that Secretary not required to use State agencies in determining eligibility of providers of services to participate.	Sames as S. 1.
SUPPLEMENTARY INSURANCE		
Under the Secretary of HEW who would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments and holding and disbursing funds for benefit payments.	No provision.	No provision.

INCOME TAX DEDUCTION PROVISIONS

The provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income for persons under 65 would be reinstituted for persons 65 and over. A special deduction (applicable to taxpayers of all ages who itemize deductions) of ½ of premiums paid for medical-expense insurance (including certain premiums paid before age 65 for such insurance effective after reaching age 65) would be added. Such special deduction could not exceed $250 per year.	No provision.	No provision.

Senator ANDERSON. You did add a provision that aged people can deduct medical expenses in excess of 3 percent of income and drug expenses in excess of 1 percent. Is it true that in the calendar year 1966 it would be a $170 million gain by that provision?

Secretary CELEBREZZE. That is right; $170 million would be recovered by this provision.

Senator ANDERSON. You also provide for income tax deductions for health insurance premiums not to exceed $250 a year.

What will the cost be to the Treasury on that?

Secretary CELEBREZZE. That was put into the bill by the Ways and Means Committee. That will cost about $88 million. That was the committee recommendation.

Senator ANDERSON. I don't intend to take much time but I do want to remind you that a great many of the insurance companies have been writing about the provision that doubles the situation on disability insurance where you have workmen's compensation involved.

Would you care to supply us at this time or subsequently your reasons for allowing that in the bill or putting it in the bill? It was not in the original bill that was sent to the House a year ago.

Secretary CELEBREZZE. Actually what we do in the bill is adopt basically the same principles that have been adopted by the private carriers. Under the old bill you had to wait 7 months and then there was a question of a determination of whether the disability will be of long-continued and indefinite duration.

Under the bill following the pattern of most private carriers we would say, "You wait 6 months and we will pay you," that is if there is a total disability.

Senator ANDERSON. Well, I have received a number of letters including one from the National Association of Casualty Insurance Agents.

Secretary CELEBREZZE. Are you referring to the workmen's compensation feature?

Senator ANDERSON. The workmen's compensation feature.

Secretary CELEBREZZE. As you recall the workmen's compensation feature was included in the Social Security Act in 1956 and was taken out by Congress in 1958. About 2 percent of those receiving disability benefits under the social security program are also entitled to workmen's compensation. The Advisory Council on Social Security recommended that the Social Security Administration study the problem. I think the House committee in its report requested that we make a report to Congress by December of 1966 and make a recommendation whether there should be a deduction or not. I think that there are many, many problems that arise in it, and the Department is now in the process of studying it.

Of course, on the other hand, the States can also study it because they can reduce workmen's compensation if they wanted to.

On the other hand, the percentage of overlap is rather small.

Now, whether or not it will grow in the future, it hasn't grown very much since the disability features of the social security program were enacted.

Senator ANDERSON. But it does permit the beneficiary to draw workmen's compensation and social security.

Secretary CELEBREZZE. Yes; under the present law he can draw both.

Senator ANDERSON. He can, therefore, get more money by being sick than by working.

Secretary CELEBREZZE. Sometimes you get more money by being on public assistance than by working under State programs.

Senator ANDERSON. I recognize that. I am just worrying whether you are going to make it more difficult.

Secretary CELEBREZZE. Here again—the reason I say this needs thorough study—the committee has advised there are many factors that enter into it. Let's assume at the time you have total disability you were working at a low wage; whereas, previously you had worked at a higher wage.

Let's assume that there will be a change in the level of wages; there will be increases, as there have been in the past. So all these factors have to be considered in coming to the basic conclusion.

Now, as I said, there is nothing to prevent the States from taking social security into consideration in their workmen's compensation laws if they so desire. If offsetting benefits are the road we were going to travel, I would prefer it would be done in that manner rather than have workmen's compensation deducted from social security benefits where we would have a very complex situation of determining when to make the offsets under 50 different State laws. So, I think that the problem is of significant scope to really study it, and the House committee recognized that and asked us to submit a report by December of 1966, and the advisory committee which made its report just recently also suggested that we study this and we are in the process of studying it.

Senator ANDERSON. In your statement you say you anticipate a very high percentage of the aged enrolling in the supplementary plan.

What do you estimate the number to be now?

Secretary CELEBREZZE. Our best estimate is somewhere between 80 and 90 percent.

Senator ANDERSON. Which would give you a very fine volume and, therefore, permit you to handle it in a much more efficient fashion. I don't have any further questions.

The CHAIRMAN. Senator Curtis?

Senator CURTIS. Mr. Chairman, I will ask a few questions and then I will pass so that others may ask questions.

Mr. Secretary, by what year will they reach the maximum tax, dollarwise, under this schedule?

Secretary CELEBREZZE. 1987.

Senator CURTIS. That is the maximum rate?

Secretary CELEBREZZE. That is the maximum rate.

Senator CURTIS. Yes.

Now, you reach the maximum wage base by 1973, will you not?

Secretary CELEBREZZE. We will reach the maximum wage base in 1971. It goes into effect in 1971. It is $6,600.

Senator CURTIS. Now, I have made some calculations based on 1973. What will be the maximum tax levied on an employee in 1973 if he earns the full amount of covered wages?

Secretary CELEBREZZE. Are you talking percentage?

Senator CURTIS. No; dollars.

Secretary CELEBREZZE. Dollars.

In 1973 the rate on the employee will be $353.10, dollarwise; that is, with a rate of 5.35 percent.

Senator CURTIS. According to my calculations, if a young man enters the work force at age 21 next January 1, and these schedules remain the same and he works for 44 years until he is 65, he would pay in $15,469.90; is that correct?

Secretary CELEBREZZE. Well, assuming your mathematics are right.

Mr. MYERS. It sounds correct.

Senator CURTIS. And if his payments were put in a savings account, drawing 4-percent interest compounded quarterly, he would have had an investment in social security of $40,653.54.

Secretary CELEBREZZE. That is right; but you are starting off on the wrong assumption.

Senator CURTIS. What is wrong with my assumption?

Secretary CELEBREZZE. Because you are just taking the retirement benefits. You are not computing in there the benefits in the event of disability and so on.

Senator CURTIS. No; I am talking about cost.

Secretary CELEBREZZE. Are you talking about the cost factor?

Senator CURTIS. I beg pardon?

Secretary CELEBREZZE. Are you talking about the cost factor and not benefits received?

Senator CURTIS. I am not talking about benefits.

Secretary CELEBREZZE. Excuse me, I thought you were talking about benefits.

Senator CURTIS. According to my calculations if his wife worked not for 44 years but 30 years, at the maximum coverage, she would pay in $10,295.50 if she began her work career as of next January. With her interest accumulations, it would amount at the time of her husband's retirement at 65 to $19,293.84. The two of them would have put into the fund, if you credit them with interest, by the time the husband is 65, $59,947.38.

Secretary CELEBREZZE. That is about right.

Senator CURTIS. Now, what was the maximum tax that an employer had to pay for employing somebody when the act was passed 30 years ago; $30, wasn't it?

Mr. BALL. $30.

Senator CURTIS. If a small businessman employed 10 people, his tax then would be $300 or 10 times $30; isn't that correct?

Secretary CELEBREZZE. Right.

Senator CURTIS. What will it cost a small businessman in employer's taxes to employ 10 people in 1973, if they earn the maximum?

Secretary CELEBREZZE. Ten times $353.10; $3,531.

Senator CURTIS. $3,531 is what I get.

How much will a self-employed person have to pay in dollars in social security tax if he earns the maximum in 1973?

Secretary CELEBREZZE. We are including in this the provisions of the present bill?

Senator CURTIS. If this bill is enacted.

Secretary CELEBREZZE. In 1974 he would pay $498.30.

Senator CURTIS. I won't ask you to pass on my arithmetic because it might be wrong. But I calculate that if a farmer or a corner grocer

or a lawyer would earn the maximum, beginning January 1 next year from 21 to 65, he would pay $21,832 in social security taxes.

Were those amounts to be deposited in a savings account at 4-percent interest compounded quarterly it would have an accumulation by age 65 of $59,345. I have likewise estimated that if his wife worked as an employee—not for 44 years but 30, taking the figure from the previous illustration—that the couple's investment in social security plus interest would amount to $78,638.

Mr. BALL. It sounds reasonable.

Senator CURTIS. I want to ask: How about an individual who works——

Secretary CELEBREZZE. I think your statements are true, except that the employer does take some of it off his income tax, so that while he pays the employer tax he gets something back, on the other hand, on his income tax.

Senator CURTIS. That is correct.

Secretary CELEBREZZE. Also, I think if you wanted to draw an analogy you ought to figure how much we pay for automobile insurance and fire insurance and accident insurance, and if we had taken that money and put it in a trust fund or in a bank we might have much more than what you said here.

I see what you are driving at but I think you started off with the wrong philosophy.

Senator CURTIS. I am not driving at anything, but just trying to figure out what it would cost, that is all.

How about an individual who works after he is 65 years of age. By 1973, he would pay this $353 social security tax but if he availed himself of the benefits of the medical portion he would add $36 to that, wouldn't he?

Secretary CELEBREZZE. Yes; $36.

Senator CURTIS. So his payments under this bill, if he availed himself of the medical part for a man over 65, would be $389.10 for 1973.

Secretary CELEBREZZE. That is right.

Senator CURTIS. What is the average age of retirement?

Secretary CELEBREZZE. Sixty-seven.

Senator CURTIS. According to my calculation an individual over 65 who continued to earn in self-employment and availed himself of this $36 contribution and if he made the maximum amount by 1973 he would be paying in $534.30 a year.

Secretary CELEBREZZE. That is a self-employed person?

Senator CURTIS. Yes.

Now, has there ever been a schedule of tax rates set forth for a period of years in the future that has gone into effect without change?

Secretary CELEBREZZE. Under this program?

Senator CURTIS. No, I mean in past years. Has the Congress ever let a schedule of proposed tax rates go into effect or hasn't it always been changed before it reached the end of the schedule?

Mr. BALL. You mean the entire schedule, Senator?

Senator CURTIS. The entire schedule.

Mr. BALL. You are correct. The scheduled rates for some years have gone into effect.

Senator CURTIS. Some years.

Mr. BALL. But the entire schedule—we haven't reached the end of it—it has not gone into effect without change.

Senator CURTIS. Yes.

Under this bill when does your schedule level off and become fixed?

Secretary CELEBREZZE. 1987.

Senator CURTIS. If that schedule does become fixed and remains a permanent schedule it will be the first time it has happened in the history of the Social Security Act, isn't that right?

Secretary CELEBREZZE. The whole schedule.

Senator CURTIS. Now, these past revisions, have any of them been revisions downward?

Mr. BALL. In the rate charged? For a particular year, but not overall——

Senator CURTIS. Not in what they would pay.

Mr. BALL. The ultimate rate has always gone up, Senator.

Senator CURTIS. That is right.

Senator SMATHERS. You are talking about social security now exclusively?

Senator CURTIS. Yes, social security exclusively.

Here is another question and then I am going to yield the floor.

I have quite a few questions. But I will wait until the others have finished. It wouldn't be possible, would it, to try this program for a period of 10 years to determine whether or not it is satisfactory? In other words, to put a termination date in here at the end of 10 years, would it?

Secretary CELEBREZZE. In any bill passed there is an implied termination date in that the bill only lasts as long as Congress wants that to last. So at the end of 10 years, if Congress wants to change it, Congress can change it. They can terminate the whole thing tomorrow.

Senator CURTIS. We couldn't pass a bill here that said the termination date of this is going to be 10 years from now, because the people 55 years old now wouldn't permit the Congress to pass a bill under which they would pay and have it terminate the day they are 65.

Secretary CELEBREZZE. That is right. I agree with that statement.

Senator CURTIS. Yes. Neither would the people 30 years of age or 40 years or any other age. So, because of the scheme of social security—it is here and I am not quarreling with it—we are legislating in perpetuity, are we not?

Secretary CELEBREZZE. Practically, yes.

Senator CURTIS. Just as it would be politically and every other way impossible to put a 10-year termination date, it would be impossible to put any other termination date in here.

That is correct, isn't it?

Secretary CELEBREZZE. I don't think you could get a termination date through the Congress if that is what you are driving at.

Senator CURTIS. That is right.

Secretary CELEBREZZE. But the program is subject to modification from time to time.

Senator CURTIS. Subject to modification, yes. But whatever we do in this field, because you can't put a termination date on it, is binding upon future social security taxpayers, isn't it?

Secretary CELEBREZZE. It certainly is binding on future social security taxpayers.

Senator CURTIS. We by this act are determining what our society will pay in social benefits not only next year but 10 years from now or 50 years from now. We are determining what the load will be of social benefits for taxpayers that aren't even born yet. Isn't that correct?

Secretary CELEBREZZE. Congress made that decision 30 years ago when they adopted the social security bill.

Senator CURTIS. I am not quarreling with you. I just think it is a point worth considering here when we start in on a program to pay hospital and medical bills for people who may be a lot more able to pay their own bills than the rank and file of social security taxpayers.

Secretary CELEBREZZE. That is true, but I think in the great debate in 1930, as I recall it, we went all through this. The Congress considered the same basic arguments that you are presenting today. It was said that social security was going to kill private pension plans, and I showed in my opening statement how the private plans in cooperation with social security now number 34,000. These were all factors considered. I think it is somewhat of a moot question at this date after 30 years.

Senator CURTIS. I don't think so. We are starting a new program, and would you say that someone who has upward of $10,000 a year income in their retirement should have their hospital and medical bills paid at public expense?

Secretary CELEBREZZE. It isn't at public expense. They have contributed to it.

Senator CURTIS. Well, now, how many people are going to get benefits right away?

Secretary CELEBREZZE. There will be about 19.1 million people that are eligible for it.

Senator CURTIS. Yes.

And many of them didn't contribute anything, did they?

Secretary CELEBREZZE. 2 million will be covered under general revenue funds, but the others——

Senator CURTIS. You are starting out a new trust fund and no one has contributed, isn't that right?

Secretary CELEBREZZE. No one has contributed to that trust fund, no.

Senator CURTIS. Well, now——

Secretary CELEBREZZE. But they were part of the system and being part of the system they are entitled to share in the benefits, just as when there is a benefit increase, being part of the system, they are entitled to it.

Senator CURTIS. I won't quarrel about a distinction between those who have been covered under social security and those who have not.

My question is are you advocating that a retired person who has as much as $10,000 a year income, that this program pay his hospital and medical bills as set forth in the bill?

Secretary CELEBREZZE. The basic principle, whether it is $10,000 or whether it is $20,000, and it is a small group of people over 65 years of age who have that much, is that we will not, we do not advocate, we do not subscribe to, any program which must meet a needs test.

Senator CURTIS. How about an income test?

Secretary CELEBREZZE. Or an income test.

Senator CURTIS. Well, now, isn't it true——

Secretary CELEBREZZE. We have had basic experience with Kerr-Mills on a needs test basis and we have had nothing but turmoil over it.

Senator CURTIS. Oh, no. It has just run a few years. It has got to have some improvements but some people have been very materially helped who needed it. But my point is this: Isn't it true of these people who are in their twenties and thirties and forties are paying their own medical bills, aren't they?

Secretary CELEBREZZE. Yes, because they have an advantage.

First of all, they are working and they are entitled to group policies.

Second, their wages and their incomes are much higher than those over 65 so that they can afford to do it.

Senator CURTIS. But they are also buying their homes, aren't they, a lot of them?

Secretary CELEBREZZE. Yes, sir.

Senator CURTIS. Aren't they educating their children? Aren't they carrying a great many burdens that other people do not? I have no objection to taxing these people to pay hospital and medical bills for those of low income, but I cannot understand your reasoning in saying that these people who are burdened down with supporting children, paying for life insurance, buying homes, maybe paying for their own education, educating their children and doing all these other things, should pay a hospital and medical bill for somebody, say, who has an income in retirement of $10,000 a year.

I think this is the crucial question.

Secretary CELEBREZZE. They are entitled to the same benefits when they get to be 65. I have been around this country and I haven't met any young man or woman who is not pleased to have the hospital insurance program. They have aged parents and they are paying off the mortgage and trying to educate their children, and sometimes they have to make a choice.

Senator CURTIS. We have been meeting different people, I think. But now, on this medical insurance question, by what process of reasoning are we going to pay out of the general fund a half of the premium for people who are well able to pay that $36? Is it just because we believe the Government can do it better than people can for themselves?

Secretary CELEBREZZE. No, I think there was established in the record of the last hearings that there was a void here. I think that last year most of the people on your side of the fence started saying we ought to have a system where the individual contributes something to it, and the Government contributes something to it, and many of the bills that I know of which came from your side of the fence have a contribution from the Federal Government. All we have done is taken a hint that you people have given to us and incorporated it in this bill.

Senator CURTIS. I haven't given you any such hint at all.

Secretary CELEBREZZE. That is all we did.

Senator CURTIS. Here we are running deficits all the time, and you set up a Government insurance program, you are going to provide this for $72 a year. Well, that is one decision to make, to put the Government in the insurance business.

Secretary CELEBREZZE. Well, now, no——

Senator CURTIS. I beg your pardon, did you want to say something?

Secretary CELEBREZZE. Yes. You have to look at the total. The Federal Government now is paying for half of what is spent under the Kerr-Mills provision of the law on a matching grant to States. The other half of it is now coming from the State, so that is all taxpayer's money for Kerr-Mills.

Senator CURTIS. For people who need it. And I think we should. I don't think anyone should go without the finest care that can be given, but you tell me why after you put the Government in the insurance business on this $72 a year plan for people who are well able to pay the full $72 a year, you are going to have the deficit increased by paying half of it out of the General Treasury?

Secretary CELEBREZZE. We recoup part of it from upper income people under the amendment to the Internal Revenue Act by going back to the 3 percent floor for medical expenses for older taxpayers.

Senator CURTIS. Are the benefits under this bill taxable?

Secretary CELEBREZZE. The benefits under this bill?

Senator CURTIS. Benefits paid under this bill, are they taxable?

Secretary CELEBREZZE. On the hospital insurance?

Senator CURTIS. Yes.

Secretary CELEBREZZE. On the physicians?

Senator CURTIS. Yes.

Secretary CELEBREZZE. No.

Senator CURTIS. Isn't that going to change this situation for your tax benefit from having to pay out medical bills if you don't have any medical bills? You see 80 percent of your medical bills are going to be paid under this plan. So, what you propose there is a rather moot question. It may apply to 20 percent of a medical bill, but that is all. I don't want to prolong this but I wish you would tell us what the reason is for paying out of the General Treasury, the Federal Government borrowing the money and paying $36 for people who are well able to pay the $36.

Secretary CELEBREZZE. The people who can well pay it are a small minority. It is because we do not want to require most people to meet a needs test; under the Kerr-Mills provisions, about 30 percent of it is going for hospital and medical expenses, and the Federal Government is now paying large amounts of matching funds to the States to provide this protection against hospital and medical expenses though the proposed insurance programs actually will cost less money out of general revenues than if we tried to do it under the Kerr-Mills bill, and I think that it is just a need which has been stressed to us time and time again in hearings.

As I said, the idea came basically from your side of the fence on this, from listening to the testimony, from the bills that were introduced on it. And I presumed there was a need in this area.

Senator CURTIS. That still doesn't answer my question but I wish you would cite the income figures and show us how many of the people over 65 have to have this $3 a month subsidy out of the Federal Government. You can supply it for the record because in fairness to my colleagues I won't take any more time.

I have some questions I want to go into at length when you reappear here concerning this program and its costs.

(The information referred to follows:)

Older people typically have incomes about half as large as the incomes of people under 65 in families of the same size, whereas retirement reduces living costs only about 10 to 15 percent. In dollar terms about half the aged couples have incomes of less than $3,000 a year and about half the aged persons living alone have incomes of less than $1,300. Aged persons living in the homes of relatives of course have considerably less than those who live alone. If all of the assets of persons 65 and over (other than the equity in the home) could be converted to income prorated over the expected life of the holder, the median income would be raised only about 9 percent for couples and about 12 percent for other aged persons.

The $6 per month premium would represent more than 5 percent of income for about half the aged. The program does not cover medicines or drugs which now account for about as much as the physicians services covered under part B. There will remain the deductible and coinsurance provisions, and also miscellaneous medical care.

Senator SMATHERS (presiding). Senator Douglas?

Senator DOUGLAS. Mr. Chairman, I appreciate this and I will try to be relatively brief. I have only one set of questions for this morning.

I want to say to the Secretary that I am greatly pleased that, in your statement and in reply to questions of Senator Anderson, you endorsed the original provision of the King-Anderson bill making reimbursement of the hospital services of specialists in such fields as pathology, radiology, and anesthesiology, and so forth, part of the basic plan benefit structure instead of part of the supplementary plan structure.

I have prepared an amendment on this matter in conjunction with Senator Moss, Senator Neuberger, Senator Hartke, and Senator Javits. I would like to pass it down to you and have you look it over and see whether this amendment meets your recommendations.

Secretary CELEBREZZE. Yes. The administration would favor this amendment and endorse it.

Senator DOUGLAS. You would favor that amendment?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. May I ask two very simple questions. First, if the House provision, striking these services from the basic benefits, is retained, would this compel widespread change in the billing and accounting systems of the various hospitals?

Secretary CELEBREZZE. Yes.

As I said in my opening statement, Senator, I think it would cause some chaos among the hospitals.

Senator DOUGLAS. In a major portion of hospitals are these now included in the hospital services?

Secretary CELEBREZZE. In most of the hospitals. There are some hospitals that do it on a contractual basis or otherwise. Most of the hospitals—yes, the majority of them are included in the hospital.

Senator DOUGLAS. There is a deductible feature in the supplementary benefits.

What effect would the imposition of this deductible feature and these separate billings for anesthetists, X-ray people, and the rest, have on the amount paid by individual patients?

Secretary CELEBREZZE. It would seem to me they would have to pay more under the provisions of the House-passed bill.

Senator DOUGLAS. Would the deductible provision apply to each and every billing or would it apply——

Secretary CELEBREZZE. No, it is a $50 deductible in the calendar year.

Senator DOUGLAS. Not for each service?

Secretary CELEBREZZE. No, for the total service.

Senator DOUGLAS. The $50 deductible applies to all supplementary services taken together in the year?

Secretary CELEBREZZE. They would pay 20 percent and we would pay the 80 percent except for the $50 deductible within the year. So if you go in and you pay $50 again and you have to go back in again in another——

Senator DOUGLAS. It would not be $50 deductible on X-ray treatment and $50 deductible on anesthesia but for the group as a whole?

Secretary CELEBREZZE. No.

Senator DOUGLAS. Nevertheless, both the cost and the difficulty of keeping a record of all these charges would measurably increase the burden which would have to be borne exclusively by the insured patient, isn't that true?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. These services would really be taken out to the amount of the deductible under the supplementary insurance system, isn't that true?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. The present provisions in the House bill would throw these burdens exclusively upon the individual.

Secretary CELEBREZZE. Well——

Senator DOUGLAS. To the degree that the deductible would apply?

Secretary CELEBREZZE. The deductible and the 20 percent coinsurance would be met by the individual.

Senator DOUGLAS. Does this deductible apply to a benefit period or within the year?

Secretary CELEBREZZE. In the supplementary plan it is on a calendar year basis.

Senator DOUGLAS. Calendar year?

Secretary CELEBREZZE. Yes, it would apply to the calendar year.

Senator DOUGLAS. Is it true that the cost of these supplementary services will frequently run to one quarter of the hospital bill?

Mr. BALL. Senator Douglas, I think the total costs of the department of radiology, say, and laboratory testing and so on, runs as much as 20 to 25 percent of the average hospital bill. But the exclusion here is only for the physician's services within the department and that is about 5 percent.

In other words, the technicians' services would be covered under the basic plan, the equipment, the supplies, they would be covered under the basic plan under the House bill. It is just the physician's own services that are excluded.

Senator DOUGLAS. Could the physician take his assistants out with him?

Mr. BALL. Not under the bill. That is the reason why it is such an upset to the way that this is now handled in practically all hospitals. Where the departments are kept together as a single unit, whether it is handled under Blue Cross or under Blue Shield is a difference from State to State, they keep them together, and the billing to the patient is for a laboratory test, it is not distinguished whether it is the technician or the physician.

Senator DOUGLAS. So there would have to be segregation of the physician's services, the charge for the use of the apparatus, and the charge for technicians who are not doctors.

Mr. BALL. Yes. It is the physician that comes out and that is what changes everything from the way it is set up today.

Senator DOUGLAS. I will continue with other questions on this later, but do you have any further comments to make on this clause?

Mr. BALL. I think the Secretary, Senator, has covered it very well; that is, it is mainly that the provision as it was in S. 1 is fully adapted to the way these arrangements between specialists and hospitals are now carried on and would be adaptable to any changes that might be made. The provision in the House bill puts the Government in a position of dictating a particular arrangement which would cause widespread change and not be satisfactory to many of the parties concerned.

Senator DOUGLAS. I have canvassed the hospitals in the State of Illinois on this question and with replies now in from more than 50 percent I find almost complete unanimity in opposition to the change proposed in the House bill, and almost unanimous support for the amendment which some of us have suggested.

I am glad to see the Senator from Indiana here because he is one of the sponsors of the amendment. This, Mr. Chairman, I think, is one of the major issues we should consider.

Senator SMATHERS. All right, Senator Hartke, do you have any questions?

Senator HARTKE. I would just like to take one moment here on one further step in this matter of the earnings limitation and I am sure it is going to come up.

I would like, if you could give us the amount that would be drawn, and what the average earnings are of those wage earners who would draw, between the ages of 65 and 72, if this discriminatory feature were removed.

What I am driving at is I think the impression was left in the earlier replies that in most cases these people were living quite well, and that all you would be doing would be adding onto people's incomes who were doing quite well. I am not saying that this is so or is not so. I certainly doubt it but I would like for you, as soon as possible, to make that estimate to bring it to the committee.

Mr. BALL. I would be glad to do it.

(The information referred to follows:)

EARNINGS OF PEOPLE AFFECTED BY THE RETIREMENT TEST

As indicated in the following table, in January of 1964, there were about 1.9 million of the 14.6 million people age 65 and over eligible for benefits who were directly affected by the retirement test. The 1.9 million fell into three groups. The first group, numbering about 1 million, was composed of people who were earning enough so that they were not getting any benefits at all. About one-half million of these were earning $4,800 or more and another 300,000 were earning between $3,600 and $4,800. About 200,000 were earning $2,400 but less than $3,600; most of these would get some benefits under the provision in the House bill. If the retirement test were eliminated, all of these people could continue to work and get full benefits.

A second group, numbering about 500,000, were earning above $1,200 and were getting some benefits for the year. About 400,000 were earning less than $2,400 and practically all were earning less than $3,600. Most of these people would be able to get additional benefits under the provision of the House bill. If the test were eliminated, all of them, of course, would get full benefits while continuing to work.

The third group among the 1.9 million, numbering about 400,000, were getting full benefits and were earning just under $1,200 a year (between $900 and $1,200). A sizable proportion of these can be assumed to be deliberately holding their earnings to $1,200 or just under that amount in order to get full benefits. These people would not, of course, be benefited by the retirement test change in the House bill. If the retirement test were repealed, many would earn more and therefore would have a higher income, in benefits and earnings combined, than they have now.

An estimated 4.7 million of the 14.6 million did not have any earnings at all. Generally the retirement test does not affect the benefits these people get because most of them cannot work or cannot find work. Another 800,000 earned less than $900 in the year, and also generally were not affected by the test. Finally, 7.2 million—49 percent—were age 72 or over and thus did not come under the operation of the retirement test at all. Thus a total of 12.7 million people—about 87 percent of the 14.6 million people 65 and over who are receiving or eligible for benefits—would not be affected by any change in the retirement test, whatever the nature of the change.

Estimated number of people aged 65 and over eligible for social security benefits by applicability of retirement test and amount of earnings in 1963

[Figures as of Jan. 1, 1964]

	Millions
U.S. population aged 65 and over [1]	17.9
People aged 65 and over eligible for social security benefits [2]	14.6
Eligible workers not subject to the retirement test [3]	7.2
Eligible workers subject to the retirement test [4]	7.4
With no earnings in 1963	4.7
With annual earnings for 1963 below $900	.8
With annual earnings for 1963 of $900 to $1,200	.4
With annual earnings for 1963 above $1,200	1.5
With only part of the benefits payable for 1963 because of the retirement test	.5
With annual earnings for 1963 of—	
$1,201 to $1,700	.2
$1,701 to $2,399	.2
$2,400 to $3,599	.1
$3,600 to $4,799	(5)
$4,800 and over	(6)
With no benefits payable for 1963 because of the reitrement test	1.0
With annual earnings for 1963 of—	
$1,201 to $1,700	(6)
$1,701 to $2,399	(5)
$2,400 to $3,599	.2
$3,600 to $4,799	.3
$4,800 and over	.5

[1] Includes population of the 50 States, District of Columbia, Puerto Rico, Virgin Islands, Guam, and American Samoa.
[2] Includes spouse over age 65 of workers 62 to 65 and fully insured.
[3] Includes workers aged 72 and over, their spouses aged 65 and over, and survivors aged 72 and over.
[4] Includes workers aged 65 to 71, their spouses aged 65 and over (including those of workers 62 to 65 and fully insured), and survivors aged 65 to 71.
[5] Less than 50,000.
[6] Assumed to be zero for purposes of these estimates.

Senator HARTKE. Another thing, Mr. Secretary, isn't it true that by not increasing the $1,200 minimum and increasing the benefits 7 percent you have added still a further penalty on these people? Let me give you an example, and show you how this works.

You take the man who retires at the age of 65 and has a part-time job at a hundred dollars a month.

Now, at the present time his social security benefits have risen but at the same time there is still that low limit of a hundred dollars a month on him as far as his earning capacity is concerned.

Secretary CELEBREZZE. Yes, but we have added $800 at the other end, from $1,700 to $2,400 for which only $1 would be deducted from benefits for every $2 of earnings.

Senator HARTKE. $700, not $800.

Secretary CELEBREZZE. Yes, $700—from $1,700 to $2,400.

Senator HARTKE. Both of these increases were amendments which I sponsored so I did follow them.

Secretary CELEBREZZE. I congratulate you.

Senator HARTKE. I would like to see it removed entirely and I know I am not going to be successful but I think we will raise it considerably above the $1,200. I am not hesitating about that. I know we are going to raise that $1,200 in my own mind but what I am trying to get to is the equity.

Secretary CELEBREZZE. Bear in mind, Senator Hartke, when you do that you will have to change the contribution rates, because you have to get money coming in as well as going out.

Senator HARTKE. I understand that. I am not asking for anything for nothing.

But the point still remains that the amount over $1,200 still is on a matching formula of 50 percent, and in some cases you can have people who actually lose money by going ahead and working more, isn't that true?

Mr. BALL. Senator Hartke, I think it would occur, if at all, only considerably above the $2,400 level that a person could lose by taking a job as against not taking a job. It is true that, if he can limit his work to $2,400, that would be preferable to earning somewhat more. He could not lose in gross income but a person could lose about $2,400 on additional earnings where you have the income tax factor.

You see, up to $2,400, he gets a reduction of only $1 in his benefits for $2 in earnings above $1,200. All the way up to $2,400 you would reduce his benefits only by $600.

Senator HARTKE. Yes, I understand that.

Mr. BALL. And he is getting $2,400 in earnings, so he gains by going to work.

Senator HARTKE. I will go into this in further detail with you at a later time.

Mr. BALL. Yes.

Senator CURTIS. Mr. Chairman, I would like to have, by tomorrow, the total expenditures under social security of the benefits paid for last year and then the total amount paid in benefits the first full year of operation if the bill is passed.

Secretary CELEBREZZE. We can furnish that for you.
(The information referred to follows:)

(The following table shows the benefit disbursements under the present OASDI program in 1964 (in millions):)

Program:	*Benefit disbursements*
Old-age and survivors insurance	$14,914
Disability insurance	1,309
Total	16,223

The first full calendar year of operation of all insurance programs under H.R. 6675 would be 1967 (since the two health insurance programs do not begin benefit operation until July 1966). The benefit disbursements for calendar year 1967, according to the intermediate-cost estimates, for the several social insurance programs that would be amended or added by H.R. 6675 are as follows (in millions):

Program:	*Benefit disbursements*
Old-age and survivors insurance	$19,180
Disability insurance	1,880
Hospital insurance, insured persons	2,192
Hospital insurance, noninsured persons	267
Supplementary health insurance benefits	979
Total	24,498

Senator SMATHERS. Mr. Secretary, thank you.

As I understand it, you will be back here tomorrow at 10 o'clock.

The committee will stand in recess until tomorrow morning at 10 o'clock.

(Whereupon, at 12:20 p.m., the committee recessed, to reconvene at 10 a.m., Friday, April 30, 1965.)

SOCIAL SECURITY

FRIDAY, APRIL 30, 1965

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

The committee met, pursuant to recess, at 10:15 a.m., in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Long, Anderson, Douglas, Talmadge, McCarthy, Williams, Carlson, and Curtis.

Also present: Elizabeth B. Springer, chief clerk.

Senator TALMADGE. The committee will come to order.

Mr. Secretary, I desire to congratulate you on your statement yesterday. It was forthright and clear in all respects. I have a few questions I would like to ask regarding section 303, as you alluded to it in your testimony yesterday and the distinguished Senator from New Mexico also brought up that point and asked some questions about it.

First, let me say that I think the saddest letters that I have received since I have been in the Senate and some of the saddest visitors that I have talked with have been people who thought they were totally and permanently disabled, and doctors also advised them they were totally and permanently disabled and had letters to prove it, yet from a social security standpoint, they were not totally and permanently disabled.

Therefore. I deem it wise and desirable that that phase of it be liberalized. I have received a number of letters, a number of visitors and telephone calls, that inform me if 303 is pased in its present form, in many jurisdictions, I believe 47 out of the 50 States, perhaps, disabled employees would draw more by being ill and not working, when you include and combine their workmen's compensation and social security benefits, than if they were working.

In fact, a diagram or memorandum handed to me which was prepared in October 1962, although there may have been some liberalizations in some of the States since that time, would indicate that it would vary from 67 percent of the average take-home pay in the State of Alaska to 225 percent in the State of Arizona. I would point out that wages and salaries, of course, are taxable, as you know. Social security is tax free, as is workmen's compensation. I would like to ask you for an expression of opinion as to the desirability and wisdom from every standpoint of having a situation where the individual is better off financially when he is ill than he is when working.

STATEMENT OF HON. ANTHONY J. CELEBREZZE, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT SECRETARY FOR LEGISLATION; ROBERT M. BALL, COMMISSIONER OF SOCIAL SECURITY; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; AND CHARLES E. HAWKINS, LEGISLATIVE REFERENCE DIVISION, WELFARE ADMINISTRATION—Resumed

Secretary CELEBREZZE. Senator, I think yesterday I explained that the Advisory Council on Social Security, which made a report recently, asked that a study be made, and the House Ways and Means Committee in their report also directed us to make a study of the extent and effects of the overlap between social security and workmen's compensation and to report by December 1966. I think I stated yesterday that perhaps 2 percent of the disability beneficiaries under social security also receive workmen's compensation, and that there were many factors that had to be considered in connection with this question. This issue has to be studied in depth.

I can't give you an off-the-cuff opinion on it, but let me tell you what some of the basic problems would be.

First of all, if at the time of disability the man has a low-paying job, of course, that would have a bearing upon the amount of benefits he would receive.

Then, if a man is totally disabled as of a certain period, even though under a combination of workmen's compensation and social security disability benefits he may receive more than his wages were, I think we have to give some consideration to the fact that had he not been disabled his wages would have been substantially higher, say, 10 or 15 years later, and to find a way of taking account of that fact.

Another element is that the Congress of the United States in 1958 repealed the offset provision that had been in effect because it presented a great many technical and administrative problems. In certain cases, the offset provision resulted in delays in paying disability benefits because of the slow process, in some instances, of determination under workmen's compensation and because we couldn't move until we knew what the amount of compensation was when the award had been made.

So there are many problems that have to be staffed out and thoroughly considered.

I think the House Ways and Means Committee in its wisdom arrived at the right conclusion—that there is a need for the Social Security Administration to make a thorough study of this question and to report back to Congress by December of 1966.

You also raised a question about the fact that disability benefits under workmen's compensation laws may vary from State to State. In some States the benefits are high, in some the benefits are low; in some States workmen's compensation benefits are paid directly from a State fund, in others the benefits are paid by private carriers. The question is would it be best, if an adjustment is to be made in benefits, to put the burden upon the States to make the offset rather than require an adjustment in contributory social security.

So these are some of the problems which must be faced in connection with an offset provision. I have just gone back now to read the history of the offset provision in effect in 1957 and 1958 to determine why it had been removed. I would like to know more about the reasons the Congress had for repealing the provision in 1958 and to begin consideration of the need for and desirability of such a provision from that point on. But I am sure you are familiar with the fact that the Congress, on the recommendation of both the Ways and Means Committee and this committee, did remove the offset from the Social Security Act.

Senator TALMADGE. Would you like to consider that problem further while we are deliberating on this bill and perhaps submit us an additional memorandum giving your views on it?

Secretary CELEBREZZE. Yes. I will be most pleased while you deliberate to give you a full statement of the history of the previous offset provision and the reasons why it was repealed. Whether or not we can arrive at a final recommendation I don't know, but we will give you a supplementary report on it.

(The information referred to follows:)

DISABILITY OFFSET PROVISION IN THE SOCIAL SECURITY LAW

Many of the details of the disability program enacted in 1956 had their origin in the bill, H.R. 6000, which became the Social Security Amendments of 1950. Although the Senate subsequently deleted the disability insurance benefit provisions from H.R. 6000, the bill as it passed the House contained provisions for the payment of disability benefits subject to an adjustment (commonly referred to as an offset) where the beneficiary was also receiving a workman's compensation benefit for the same period. Under the bill, the disability insurance benefit was to be reduced by an amount equal to one-half of whichever of the two benefits is the smaller.

The Ways and Means Committee in its report[1] stated:

"Payment of disability benefits under the Federal social security program should not restrict or interfere with the continued development of adequate workmen's compensation programs in the United States.

"Workmen's compensation is payable only in approximately 5 percent of all cases of income loss due to permanent and total disability, so that the area of potential duplication is small. Nevertheless, adequate safeguards should be maintained against unwarranted duplication of the two types of benefits. The total of benefits payable under the two programs should not be excessive in relation to the purpose for which the benefit payments are intended.

"The bill provides that an individual, entitled to disability benefits under both programs on account of the same disability for the same period of time, will have his social security disability benefit reduced by an amount equal to one-half of whichever of the two benefits is the smaller. Payment of a portion of the social insurance benefit in such cases is in recognition of the fact that the worker has established a right to some such benefit through his contributions."

SOCIAL SECURITY AMENDMENTS OF 1956

Monthly social security disability insurance benefits were provided under the 1956 amendments to eligible disabled workers between the ages of 50 and 65. H.R. 7225, the bill which later became the Social Security Amendments of 1956, included a provision relating to the adjustment of social security disability benefits where another Federal disability benefit or a State workmen's compensation benefit was payable. Under this offset provision, social security disability benefit was to be suspended if it were smaller than the other disability benefit, or, if larger than the other benefit, it was to be reduced by the amount of that benefit.[2]

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[1] H. Rept. 1300, 81st Cong., 1st sess. (1949), p. 30.
[2] H. Rept. 1189, 84th Cong., 1st sess. (1955), pp. 6, 29.

The Senate Finance Committee, which held hearings on H.R. 7225 in 1956, recognized the problems of the severely disabled worker but did not agree that disability insurance benefits should be provided under the social security system. However, when H.R. 7225 was acted on by the Senate, an amendment providing for disability insurance benefits was adopted on the floor of the Senate. Except for a provision establishing a special trust fund, the amendment followed the provisions adopted by the House of Representatives in the previous year, including the offset provision.

EXEMPTION OF VETERANS' SERVICE-CONNECTED DISABILITIES FROM OFFSET PROVISION

The 1957 amendments (Public Law 85-100) exempted veterans' compensation received on account of service-connected disabilities from the application of the offset provision. In its report,[3] the House Ways and Means Committee stated:

"This offset provision is designed to avoid duplication or unwarranted pyramiding of disability benefits. Your committee believes, however, that the purpose of veterans' compensation is such as to justify disregard of that compensation in the determination of rights to disability insurance benefits under the social security program.

"Your committee believes that persons who are receiving compensation for disability incurred or aggravated as a result of service to their country in its Armed Forces should not be required to give up all or part of the disability insurance benefits which they may have earned under the contributory social security program. Your committee's bill would amend the offset provision in the Social Security Act so that the disability insurance benefits payable under the old-age, survivors, and disability insurance program will not be reduced by the amount of veterans' compensation payments received on account of a service-connected disability."

The Senate Finance Committee in its report on H.R. 6191,[4] omitted the exemption of veterans' compensation from the offset provision. However, the committee noted that this action was taken without prejudice as to the merit of the proposal, stating:

"The offset provision has the desirable objective of preventing duplication between disability benefits payable under OASI and those payable under any other Federal program or under State workmen's compensation laws. Your committee is in complete sympathy with the objectives of the disability payments provided under the veterans' compensation program, and recognizes that considerations underlying this program may suggest that these payments be given special treatment insofar as the social security disability offset provision is concerned. Your committee is also aware that at the time this offset provision was enacted service in the Armed Forces could count toward social security benefits without any contribution on the part of servicemen; since then, service in the Armed Forces has been covered under social security on a regular contributory basis.

"Nevertheless your committee believes that this change proposed in the House-approved bill should be deferred until the Department of Health, Education, and Welfare is able to complete its study of the provision, including an analysis of experience in operating under it after social security disability benefits become payable. The committee will take up this legislation promptly upon receipt of the information from the Department of Health, Education, and Welfare."

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[3] H. Rept. 277, 85th Cong., 1st sess. (1957), pp. 2 and 3.
[4] S. Rept. 455, 85th Cong., 2d sess. (1957), p. 2.

SOCIAL SECURITY AMENDMENTS OF 1958—REPEAL OF OFFSET

The Social Security Amendments of 1958 repealed the offset provision entirely. The repeal of the offset provision was recommended by the House Ways and Means Committee which stated that, "the application of this requirement has produced inequitable effects."[5] The committee went on to state:

"Your committee believes that disability benefits payable under the national social security system should be looked upon as providing the basic protection against loss of income due to disabling illness, and we have concluded that it is undesirable, and incompatible with the purposes of the program, to reduce these benefits on account of disability benefits that are payable under other programs."

In its report,[6] the Senate Finance Committee agreed with the House Ways and Means Committee's view that the application of the offset provision produced inequitable effects, and that the national social security system should be looked upon as providing the basic protection against loss of income due to illness. In discussing the elimination of the offset provision, the Finance Committee stated:

"The committee has given further consideration to the disability insurance benefit offset provision, under which the social security disability insurance benefits are reduced by the amount of any periodic benefit payable to an individual on account of disability under certain other Federal programs or under State workmen's compensation laws. This offset provision was included in the law at the time that the provisions for social security disability benefits were enacted to prevent duplication between the new social security disability benefits and other disability payments pending the development of administrative experience under the new program.

"In the light of experience in the operation of the offset provision, the committee has concluded that it can now be eliminated. Experience with the social security disability provisions indicates that the danger that duplication of disability benefits might produce undesirable results is not of sufficient importance to justify reduction of the social security disability benefits. The committee-approved bill, like the House bill, provides for the elimination of this offset provision."

Senator TALMADGE. I am very sympathetic with this problem and definitely of the opinion that we need some liberalization of total and permanent disability provisions but it seems to me if we get into a field from the social standpoint where one is economically better off not working than when he is—well, I feel we might have a very serious problem as it relates to chronic malingerers. I don't know whether that is economically desirable from an economic standpoint or not. It presents quite a social problem.

Would the Senator wish me to yield? I yield to the Senator from Delaware.

Senator WILLIAMS. In furnishing this list to the committee would you give us a list by States with the dollar amounts showing how the average working wage would compare with the average amount they could receive under the combined payments of workmen's compensation and disability benefits?

[5] H. Rept. 2288, 85th Cong., 2d sess. (1958), p. 5.
[6] S. Rept. 2388, 85th Cong., 2d sess. (1958), p. 11.

Secretary CELEBREZZE. We will furnish that to you, Senator.

(The following comment, explanatory note, and table were subsequently received for the record:)

COMMENT BY SOCIAL SECURITY ADMINISTRATION

The following tabulation compares the benefits payable under both programs to a worker with wife and two children with his take-home pay—deducting from his gross wages the assumed income and social security taxes. This comparison fails to take into account the value of fringe benefits enjoyed by employed workers: health and life insurance, pensions and other benefits which would in a large proportion of the cases more than offset the income and social security taxes he has to pay. It also fails to take into account the effect of changes in pay rates or in the cost of living in eroding the replacement value of the benefits payable to a disabled worker. If the worker continued to be employed, he could expect pay increases that would at least keep pace with increases in costs of living. On the other hand, workmen compensation benefits to a disabled worker (and, to some extent, social security benefits) are related to the pay the worker received before disability and are not raised when earnings rise.

Aside from these considerations, the tabulation gives only a partial picture of the extent of earnings replacement in the dual eligibility situation. Generally a disabled worker who is entitled to benefits under social security and workmen's compensation cannot expect to receive the same weekly benefit amounts throughout the entire period of his disability. For example social security disability benefits do not become payable until after the worker has been disabled for 6 months.

Then, too, dependents' benefits are payable, generally, under social security and under some State laws only while the worker's children if not disabled are under age 18 and unmarried (under H.R. 6675 the worker's children aged 18 to 22 but not his wife would be eligible if they are attending school regularly). In addition workmen's compensation laws, in general, contain provisions limiting the benefit rate, the duration and the total amount of benefits payable. Similarly, the replacement provided by social security is limited as a result of the maximum earnings restriction, which under present law is $4,800, less in the past. (The earnings base would be increased immediately to $5,600 and ultimately to $6,600 under H.R. 6675.) For these reasons and because the social security benefit formula favors workers with below average earnings, generally, the higher the worker's earnings and the shorter the period that his dependents qualify for benefits, the smaller is the replacement value of benefits under both programs.

EXPLANATORY NOTE

The updating of this table which was taken from a Chamber of Commerce of the United States publication presented some problems. In the first place, the data used in the original table on average weekly take-home pay was based on unpublished data provided the chamber by the National Council on Compensation Insurance. We do not have comparative data for a later period. Instead, we used 1963 data on average weekly wage in employment covered by the respective State unemployment insurance laws. These figures are similar to those reported for production workers in manufacturing.

Second, the original table presented data on the maximum weekly benefit payable under workmen's compensation, without regard as to whether the injured worker with average take-home pay could have received the maximum. In about a dozen States the weekly benefit paid for an average worker with a wife and two children would be less than the maximum, and it seemed appropriate for the column in the table to show the actual amount that would be paid to such worker.

Concurrent payment of workmen's compensation and disability benefits under social security system

[Updated table on the basis of H.R. 6675 from Chamber of Commerce of the United States publication, "You Can Help End the Threat to the State Workmen's Compensation System"]

Jurisdictions	Combined workmen's compensation and social security benefits [1]	Average weekly take-home pay [2]	Workmen's compensation weekly benefit for worker with average wages [1]	Combined benefits percentage of take-home pay
Alabama	$83.00	$75.65	$38.00	109.7
Alaska	97.65	133.89	52.65	73.2
Arizona	111.22	90.99	66.22	122.2
Arkansas	80.00	66.01	35.00	121.2
California	97.50	103.50	52.50	94.2
Colorado	77.21	88.90	[3] 32.21	86.9
Connecticut	102.00	97.00	57.00	105.2
Delaware	95.00	99.96	50.00	95.0
District of Columbia	112.67	90.30	67.67	124.8
Florida	87.00	79.78	42.00	109.1
Georgia	82.00	74.78	37.00	109.7
Hawaii	102.61	78.29	57.61	131.1
Idaho	88.00	78.43	43.00	112.2
Illinois	100.00	99.87	55.00	100.6
Indiana	87.00	94.50	42.00	92.1
Iowa	82.00	84.78	37.00	96.8
Kansas	87.00	84.74	42.00	102.7
Kentucky	87.00	81.00	42.00	107.4
Louisiana	80.00	83.36	35.00	96.0
Maine	87.00	75.57	42.00	115.1
Maryland	93.00	84.57	48.00	110.0
Massachusetts	116.00	86.77	71.00	133.7
Michigan	90.00	107.40	45.00	83.8
Minesota	90.00	89.01	45.00	101.1
Mississippi	80.00	67.03	35.00	119.3
Missouri	87.50	90.12	42.50	97.1
Montana	85.00	82.85	40.00	103.2
Nebraska	85.00	80.91	40.00	105.1
Nevada	96.92	102.04	51.92	95.4
New Hampshire	90.00	77.01	45.00	116.0
New Jersey	90.00	98.43	45.00	91.9
New Mexico	83.00	82.96	38.00	100.9
New York	100.00	99.97	55.00	100.0
North Carolina	82.50	70.09	37.50	117.7
North Dakota	96.00	79.24	51.00	121.2
Ohio	94.00	97.81	49.00	96.1
Oklahoma	82.50	83.11	37.50	99.3
Oregon	92.34	90.14	47.34	102.4
Pennsylvania	92.50	88.42	47.50	104.6
Rhode Island	90.00	79.50	45.00	113.1
South Carolina	80.00	68.32	35.00	117.1
South Dakota	83.00	77.44	38.00	107.2
Tennessee	81.00	76.09	36.00	106.5
Texas	80.00	83.51	35.00	95.8
Utah	93.55	84.73	48.55	110.4
Vermont	89.00	77.36	44.00	115.0
Virginia	84.00	77.18	39.00	108.8
Washington	102.74	97.77	57.74	105.1
West Virginia	83.00	89.37	38.00	92.9
Wisconsin	109.00	91.84	64.00	118.7
Wyoming	90.70	81.99	45.70	110.6
Longshoremen's Act	116.00	(4)	70.00	....

[1] Compensation benefits as of September 1964 based upon a worker with a wife and 2 children. Social security benefits based upon average family monthly benefit of $194 in June 1964, recomputed to $195 (or $45 weekly) on the basis of the provisions of H.R. 6675.

[2] Average weekly wage (in employment covered by unemployment insurance for calendar year 1963) less Federal income and social security taxes (4 deductions) computed under current withholding schedules.

[3] After deducting ½ of OASDI disability benefit under Colorado's offset provision.

[4] Figures not available—varies in each State.

Source: Social Security Administration, Department of Health, Education, and Welfare, Apr. 29, 1965.

NOTE.—For further discussion of this chart see pages 903–904 in part 2 of printed hearings.

Senator TALMADGE. Mr. Secretary, did I understand you to say that of the 155,000 additional beneficiaries you anticipate by this liberalized version that only about 2 percent of them would be primary beneficiaries?

Secretary CELEBREZZE. About 2 percent of the total number of disability beneficiaries that we have now would be eligible for both workmen's compensation and social security disability benefits. Under the amendment we believe the percentage would stay about the same.

Senator TALMADGE. Do you have a breakdown as to the types of dependent beneficiaries?

Secretary CELEBREZZE. I will have to ask Mr. Ball on that.

Mr. BALL. Mr. Chairman, you say a breakdown as to the dependent beneficiaries?

Senator TALMADGE. Yes.

Whether it relates to wives or to children.

Mr. MYERS. Mr. Chairman, the figure of 155,000 includes both the disabled workers and the dependents, namely the young children and the wives in those cases where children are present or where the wife is over 62. Approximately half of the 155,000 are the disabled workers, and the other half are the dependents, and in only 2 to 3 percent of these cases would workmen's compensation benefits be involved.

Senator TALMADGE. What was the source of the information, Mr. Myers, on the estimates of 155,000?

Mr. MYERS. These estimates are based on the data that we now derive from the existing program showing the number of dependents of disabled workers by age. Then, making an estimate of the new disabled workers who would come in under this provision, we, by age, can estimate how many additional dependents would be involved.

Senator TALMADGE. In other words, that is an estimate based on actuarial tables instead of actual reports?

Mr. MYERS. You might say that these are actuarial estimates based on the experience under the existing provisions.

Mr. BALL. Mr. Chairman, I might add there that the estimate of the amount of overlap between Workmen's Compensation and disability is based on a recent eight-city study that the Social Security Administration made, and we would not want it to stand as if we were sure that there was just exactly 2 percent nationwide.

I think one thing that the Committee on Ways and Means had in mind in asking for a report from us by December of 1966 was that we would conduct a study that was representative of the whole country and determine how big this overlap is, and to what extent, where there is an overlap, the combined amount of the benefits might be considered excessive. Even in the 2 percent of cases where there is an overlap, many times when you add the two benefits together they are still quite low in relation to the earnings that a person has had.

An important point to emphasize is that the pending legislation liberalizing the disability program does not significantly change the situation from present law. If there is a problem of overlap in these 2 percent of the cases between workmen's compensation and disability benefits, it exists now, and it isn't the pending amendment of the disability program that causes the problem.

Senator TALMADGE. What you are saying is that the law will not be changed in that regard other than the fact that liberalization will affect a greater number?

Mr. BALL. Yes; it will affect a greater absolute number merely because there will be more cases, but we would not expect the percentage of 2 percent to change significantly.

Senator TALMADGE. Do you have any information as to how long the disability period of this estimated 155,000 is expected to last?

Mr. MYERS. The new group that would be brought in would probably be on the disability rolls for an average period of 3 to 6 months. Some of them might be on the rolls for a number of years; others for 1 or 2 months until their disability was no longer total, or in other words, until they recover from it.

Senator TALMADGE. Can you tell us how many workers covered by social security are disabled for a period of more than 6 months but less than 1 year, anyone here?

Mr. BALL. Covered now?

Senator TALMADGE. Yes.

Mr. MYERS. I believe there would be about 50,000 to 75,000 disabled workers, without allowing for their dependents.

Senator TALMADGE. What is the proportion of covered persons under the social security to those persons whose disability is not due to work-connected injuries, but whose disability results from their employment.

Mr. MYERS. Mr. Chairman, I didn't hear that.

Senator TALMADGE. What is the proportion of covered persons under the social security law whose disability is not due to work-connected injuries to those persons whose disability results from their employment?

Mr. MYERS. If the disability results from their employment, Mr. Chairman, then in almost all cases it would be work connected.

Mr. BALL. Mr. Chairman, perhaps a clarifying point here might be that about 98 percent of the cases that are eligible for payments under the social security law have disabilities that are not work connected. The big diagnostic categories for the social security program are chronic illnesses such as heart disease, mental disorders, cancer, stroke, and not conditions that are ordinarily work connected. That is the reason the overlap between the two programs is so small. Only about 2 percent come on our rolls as a result of an injury that would be covered by Workmen's Compensation.

Senator TALMADGE. How many total beneficiaries, both primary and dependent, using the figures that you have estimated, would be added in the same given year to the rolls?

Mr. MYERS. Mr. Chairman, the member would be a little less, about 125,000. This is a group that, as I have indicated, has a very short duration, so that any backlog that would be brought on the rolls would be relatively small.

So, in summary, I would say about 125,000 workers and dependents.

Mr. BALL. Mr. Chairman, it might be helpful to the record at this point to just repeat what this provision in the pending bill would do as far as social security disability benefits are concerned.

The people who are brought on are those who would be totally disabled, just as under present law, but what is dropped is the requirement that we make a prognosis that the disability will last for a long continued and indefinite period.

So the people who are being picked up by this change are those people whose condition is such that there is no question about the fact that they can't work for a 6-month period, and that in the average

case they won't be able to work for another 3 to 6 months, although you can't say that they won't recover at some point. TB, in the early stages of the disease, is one very good example.

Senator TALMADGE. Thank you very much.

Senator Douglas?

Senator DOUGLAS. Mr. Chairman, I prefer to pass for the time being and then raise some questions later.

Senator TALMADGE. Senator Williams, do you have any questions?

Senator WILLIAMS. Yes.

Mr. Secretary, this bill broadens the coverage, as I understand it, by reducing the requirements for coverage from six quarters down to three quarters in order to qualify, is that correct?

Secretary CELEBREZZE. Yes; those of 72 years of age and over.

Senator WILLIAMS. Reduce from six quarters to three quarters.

Secretary CELEBREZZE. Well, it varies. The minimum is changed to three. In some cases, though, even though they are above 72, some will need four quarters and some will need five quarters. But the minimum is three instead of six.

Senator WILLIAMS. How many additional beneficiaries will be brought in as a result of that change?

Secretary CELEBREZZE. I think it was about 355,000.

Senator WILLIAMS. Now, that is approaching the point of full coverage.

How many are left out?

Secretary CELEBREZZE. If this bill is adopted about 1.75 million persons 65 and over will still not get cash benefits under social security.

Senator WILLIAMS. Isn't is going to be a little hard to explain how you can bring one man in with three quarters which would be merely a token payment, and leave out the ones who are so close to it?

Secretary CELEBREZZE. The philosophy of this, as was brought out very ably by Congressman Byrnes of Wisconsin in the Ways and Means Committe, was that here you do have this class of people 72 years and over who do have some coverage, and in order to bring them in, since they did participate to a degree, only to a lesser degree, in the social security program, and since many of these people were either on welfare or were unable to provide for themselves, it would be best to reduce the quarters down to three and cover those 72 years of age.

There are some that require three, some that will require four, and some five, but it all phases out eventually and later on everyone will have to meet the existing requirements.

Senator WILLIAMS. I was not quarreling with that point.

Senator CURTIS. Mr. Chairman, will the distinguished gentlemen yield at that point? I favor this particular section of the bill. I think you might find some cases where the people having less than 6 quarters may have paid more in taxes than many people who qualified, say, with 6 or 7 quarters, or even 13 quarters.

Secretary CELEBREZZE. It is possible.

Senator CURTIS. Also, isn't it true that the employers' tax which is charged off as a tax deduction, and which in many instances adds to the cost of goods, generally goes to the fund and is not earmarked for any particular employee?

Secretary CELEBREZZE. That is right. The general conception of the employer's contribution was weighted for those on the low-income level.

Senator CURTIS. The point is: These people, as all consumers in the United States, have been paying their portion of the employer's tax, both in increased income taxes because of the deduction and also in the cost of goods, plus the further fact it is entirely conceivable that they may have reported some quarters with a higher tax than someone who has just barely covered the quarters with the most minimum.

Secretary CELEBREZZE. That is possible.

Senator CURTIS. I thank the Senator for yielding.

Senator WILLIAMS. Well, Mr. Secretary, I join the Senator from Nebraska. I am not objecting to this proposal. In fact, I think it has merit. But the question that I am raising is: We are approaching the point of full coverage, and I was wondering if you could furnish to this committee what it would cost to extend this to the other 1.6 million; do you have such a figure?

Secretary CELEBREZZE. Yes; we can furnish it for the record.

Senator WILLIAMS. And take into consideration that many of these additional over 72 who are not covered are perhaps beneficiaries under the public assistance programs, and, of course——

Secretary CELEBREZZE. Yes.

Senator WILLIAMS (continuing). To the extent they were covered, this would reduce those costs on another phase of the bill.

Secretary CELEBREZZE. Yes. The whole bill in all its aspects will reduce public assistance costs.

Senator WILLIAMS. So I want you to take these offsetting factors into consideration and supply us with an estimate as to just what it would be should the bill be extended to full coverage.

Secretary CELEBREZZE. We can do that for you for the record.

(The information referred to follows:)

APRIL 30, 1965.

From: Robert J. Myers.
Subject: Cost estimate for blanketing-in all persons aged 65 and over for cash benefits.

In the hearings before the Senate Committee on Finance today, Senator Williams requested information on the cost aspects of blanketing-in all persons in the country aged 65 and over for cash benefits in the same amounts as would be given under H.R. 6675 for the transitional-insured group of persons aged 72 or over. These amounts are $35 per month for all beneficiaries except, that when both husband and wife are eligible, the total family benefit is $52.50. The general principle of the blanketing-in proposal would be not only that it applies to persons aged 65 and over, but also that it would not phase out, as does the transitional-insured provision, and rather would be a permanent one. Accordingly, this blanketing-in provision would be financed from general revenues.

Assuming the retention of the transitional-insured provision in H.R. 6675, this blanketing-in proposal would cover an additional 1.75 million persons as of the middle of 1965, with the annual benefit cost being about $700 million (payable from general revenues). In future years, the number of blanketed-in beneficiaries would slowly decrease to a level of about 1.25 million persons by 1990 (although it should be realized that this type of estimate of a residual group is difficult to make and, therefore, is subject to wide variation). The blanketed-in group would not include any individual eligible for railroad retirement or civil service retirement benefits.

Of the 1.75 million persons who would be blanketed-in under this proposal in the middle of 1965, it is estimated that about 1.1 million are receiving old-age assistance. It is likely that the vast majority of these 1.1 million persons would continue to receive old-age assistance, although at a reduced rate so as to reflect the OASDI benefit. The Federal savings in old-age assistance as a result of taking into account the blanketing-in OASDI benefit would be about $275 million for the first year of operation, so that the net Federal cost of the blanketing-in provision would be about $425 million per year.

ROBERT J. MYERS.

Senator WILLIAMS. As I understand it under the other sections of the bill, they do have full coverage, do they not?

Secretary CELEBREZZE. For hospital insurance.

Senator WILLIAMS. Hospital insurance; that is what I mean.

Secretary CELEBREZZE. In the basic hospital program, we have incorporated the 2 million not under social security with the cost to be paid out of general revenue for that purpose.

Senator WILLIAMS. That is the point. But they are covered under that section of the bill?

Secretary CELEBREZZE. Yes.

Senator WILLIAMS. Yes.

Secretary CELEBREZZE. As an attachment to my statement, I had some charts which show the total coverage under the new bill.

Senator WILLIAMS. If you will furnish this additional information, along with your recommendation as to the advisability of such action, I would appreciate having it here for our consideration.

Secretary CELEBREZZE. Yes.

(See p. 155.)

Secretary CELEBREZZE. A factor that we have in mind is that we can only go so far with costs, and while I am sympathetic to many proposals, we have to be realistic in how high we can go in the tax rate and how high we can go in expenditures.

Senator WILLIAMS. That is true, and that is the reason I am asking you to furnish us with such a figure because it may be higher than we figured and it may be lower, too, when you consider the offsetting factors that we are now under public assistance no doubt taking care of these same problems anyway.

Secretary CELEBREZZE. Yes; we will furnish those to you.

Mr. BALL. Senator Williams, one reason why in the past, at least, this has not been recommended is related to a point that you made. Such a high proportion of the people who would be brought in are getting public assistance, and yet the amount that you would pay them is relatively low; and therefore, most would have to continue to get assistance to bring them up to a minimum level of living. What you really accomplish by putting them under social security is a shift in expenditures from the Federal-State assistance program over to 100 percent Federal financing, if you finance this out of the general Federal revenues, and mostly of the people who are involved still have to be on assistance.

That is one reason why we haven't in the past thought that this was too desirable a change.

Senator WILLIAMS. Of course, but I would take that more as an argument for it than against it, because on the basis that the costs would be pretty much the same, if the costs, as you say, are pretty much the same, we agree there is more dignity lent to the point that they are receiving it as a check on the basis of insurance than it would be just straight charity.

But, anyway, if you furnish the figures we can evaluate both of these points and decide.

Mr. BALL. Yes, we could.

(The information referred to appears on p. 155.)

Senator WILLIAMS. Now, under private pension plans that are negotiated with some of our major companies, and the unions, they have

rather liberal provisions for medical care and hospitalization for their retired employees.

How will this H.R. 6675 provision mesh in with these private pension plans of some of our major companies?

Mr. BALL. Senator Williams, what I would expect would happen in those plans is that the provisions of this bill would be taken into account in future negotiations and the benefits that are provided here would, of course, not be duplicated, but instead the private plans would concentrate on other benefits that are not covered here, such as the deductible, coinsurance, drugs, further extension of the nursing-care area, and so on.

Senator WILLIAMS. Well, those are hopes that you express, as to what might happen and we join in those hopes. But I am speaking of facts assuming that this bill is passed, and we don't pass any additional legislation, and we can't tell what kind of negotiations there will be, how will it mesh in with these private pension plans under the existing law and as those plans stand now, that is my question?

Mr. BALL. I think they would have to be chanced.

Secretary CELEBREZZE. I think, Senator, if we are using the same guidelines or the same reason that we used in the initial pension plan system that at the time the Social Security Act was adopted in 1935. At that time, there were some private employee pension plans. These private pension plans were modified to supplement social security—or social security merely supplemented the private pension plans—and we believe that the same procedure will be followed in the medical aspects, since we do not cover everything; that is, the employers will build on top of the health insurance program as they built on top of the original social security plan.

Senator WILLIAMS. Again we get back to the hope of what will happen in the future.

Is it not true that many of these private pension plans today do exceed in benefits anything that is provided under this bill?

Secretary CELEBREZZE. Oh, yes; there is no doubt about it in some instances.

Senator WILLIAMS. Is it not true that assuming this bill is enacted, many employees who are already covered by private pension plans that are fully paid by their employer would get no benefits under this bill?

Secretary CELEBREZZE. Yes.

Senator WILLIAMS. Is that true?

Secretary CELEBREZZE. On the other hand, you have to recall that many private pension plans of the employers are negotiated by unions, but there are about 70 percent of the working force who are not represented by unions, so that enters into the picture, too.

Senator WILLIAMS. I agree with that point. But the point I am making, or trying to make, is that there are many workers today who are under private pension plans and who, if this bill is enacted as it stands now, will only get the benefit of paying for something that they are now getting for nothing under their private negotiated plans with their employers; is that not true?

Secretary CELEBREZZE. That may be true, except we know from past experience that their total benefits will not be reduced. Their total benefits will be increased because if we absorb part of the health costs under this plan they can negotiate for additional benefits they don't have now.

Senator WILLIAMS. That may well be but there are still, even though the social security law has been in effect for a long time, there are still some private pension plans where, under the last title of the bill which increases social security benefits, employees will get no benefit at all under that increase. This is true because it is meshed in with their private pension plan.

Some companies give them half of the increase, some companies give them nothing. But this is only a hope you are expressing. The point that has been made by some of the workers, and I am trying to establish whether it is correct or not, is that as far as they are individually concerned all they get out of this bill is a privilege of paying for something that they are now getting for nothing; isn't that true?

Secretary CELEBREZZE. I think you will find as a part of the total work force it is a small minority.

Senator WILLIAMS. May be it is a small minority but it is true of employees of some of the major companies. It is true the benefits of this plan will go to the employer and not the employees because if this bill passes it will reduce the costs of the private pension plans now being paid for wholly by the employer. This bill passes part of that load to the employees under the present setup, isn't that right?

Secretary CELEBREZZE. That is right if the private plan is unchanged.

But when you say it is merely a hope that it be changed, I think it is more than a hope. I think it has been based on actual knowledge of what happened under the private pension plans. We think that the same thing will apply here, Senator.

Senator WILLIAMS. I have tremendous respect for you but neither of us can tell what will happen in the future. We can only hope, and there is nothing in this bill that would guarantee that this will be a reality.

Secretary CELEBREZZE. It is a fact that while I haven't evaluated all the contracts, some of the contracts I have seen have a builtin provision to take into consideration the passage of this plan that is before this committee.

Senator WILLIAMS. What would they do in the event that it passes?

Secretary CELEBREZZE. Pardon?

Senator WILLIAMS. They did take it into consideration and in the event the bill passes what consideration will they give to passing on these additional benefits?

Mr. BALL. As I remember it, Senator, for example, in the United Automobile Workers contract there is a specific provision that if the benefits under the Government plan come into being, the employer and the union have already agreed to take into account what has been passed by the Government. They testified on this question in the House, and I believe they will be testifying again before this committee, Senator, and I think their reaction to this situation might be quite helpful to the committee.

Senator WILLIAMS. Yes, but any agreement will have to be the result of future negotiations and not past negotiations.

Mr. BALL. Yes.

I think that realistically you could expect this to become part of a new bargaining situation, and the pressures, of course, would be very strong to improve in areas other than those that would be taken care of by the Government.

Senator WILLIAMS. Perhaps you don't have this information here, but I wish you would furnish it later for the committee, the amount of social security benefits that are currently being sent abroad broken down by number of recipients and countries in dollar volume.

Secretary CELEBREZZE. We have that and we can furnish it for the record.

Senator WILLIAMS. I am sure you can furnish it.

(The information referred to follows:)

Old-age, survivors, and disability insurance—Estimated amount of benefit payments in calendar year 1964 to beneficiaries residing abroad, by country or continent

[In thousands]

Beneficiary's place of residence[1]	OASDI benefit payments
Total	$124,122
Africa	718
Cape Verde Islands	477
Other	236
Asia	7,572
Cyprus	187
Hong Kong	1,002
India	97
Israel	1,352
Japan	3,430
Jordan	190
Lebanon	463
Macao	92
Ryukyu Islands	311
Syrian Arab Republic	88
Turkey	178
Other	182
Canada	16,288
Central American and West Indies	2,068
Bahamas	122
Barbados	225
British Leeward and Windward Islands	296
Costa Rica	106
Dominican Republic	113
Jamaica	648
Nicaragua	97
Trinidad and Tobago	119
Other	342
Europe	84,767
Austria	1,151
Belgium	497
Denmark	819
Finland	609
France	1,771
Europe—Continued	
Germany	$7,856
Greece	11,511
Ireland	3,350
Italy	28,567
Malta	387
Netherlands	606
Norway	3,354
Poland	1,237
Portugal	3,217
Rumania	77
Spain	3,950
Sweden	3,564
Switzerland	1,402
United Kingdom	6,956
Yugoslavia	3,726
Other	160
Mexico	5,130
Oceania	580
Australia	453
New Zealand	110
Other	17
Philippines	5,863
South America	952
Argentina	249
Brazil	236
Chile	92
Colombia	81
Peru	83
Venezuela	104
Other	102
U.S. possessions[2]	189
Canal Zone	185
Other	4

[1] Places with 100 or more persons receiving OASDI benefits at the end of 1964 are shown separately.
[2] Excludes American Samoa, Guam, Puerto Rico, and the Virgin Islands.

SOURCE: Social Security Administration, Division of the Actuary, Baltimore, May 4, 1965.

Senator WILLIAMS. Then can you give us an estimate as to what this amount will be, with the same countries under this particular bill?

Mr. BALL. We can do it.

Senator WILLIAMS. If it is enacted.

Secretary CELEBREZZE. We can do that. Part of this bill won't apply at all.

(The information referred to follows:)

Old-age, survivors, and disability insurance—Estimated amount of benefit payments in calendar year 1966 to beneficiaries residing abroad, under the present program and under the program as modified by H.R. 6675, by country or continent

[In thousands]

Beneficiary's place of residence [1]	OASDI benefit payments under—	
	Present program	Present program as modified by H.R. 6675
Total	$140,000	$155,370
Africa	800	890
Cape Verde Islands	540	600
Other	260	290
Asia	8,540	9,450
Cyprus	210	230
Hong Kong	1,130	1,260
India	110	120
Israel	1,520	1,690
Japan	3,870	4,260
Jordan	210	240
Lebanon	520	580
Macao	110	120
Ryukyu Islands	350	390
Syrian Arab Republic	100	110
Turkey	200	220
Other	210	230
Canada	18,370	20,540
Central America and West Indies	2,330	2,580
Bahamas	140	150
Barbados	250	280
British Leeward and Windward Islands	330	370
Costa Rica	120	130
Dominican Republic	130	140
Jamaica	730	810
Nicaragua	110	120
Trinidad and Tobago	130	150
Other	390	430
Europe	95,610	105,360
Austria	1,300	1,440
Belgium	560	620
Denmark	920	1,020
Finland	690	760
France	2,000	2,200
Germany	8,860	9,800
Greece	12,980	14,280
Ireland	3,780	4,160
Italy	32,220	35,460
Malta	440	480
Netherlands	680	750
Norway	3,780	4,170
Poland	1,400	1,540
Portugal	3,630	4,000
Rumania	90	100
Spain	4,450	4,920
Sweden	4,020	4,430
Switzerland	1,580	1,750
United Kingdom	7,850	8,660
Yugoslavia	4,200	4,620
Other	180	200

Old-age, survivors, and disability insurance—Estimated amount of benefit payments in calendar year 1966 to beneficiaries residing abroad, under the present program and under the program as modified by H.R. 6675, by country or continent—Continued

[In thousands]

Beneficiary's place of residence [1]	OASDI benefit payments under—	
	Present program	Present program as modified by H.R. 6675
Mexico	$5,790	$6,720
Oceania	650	740
Australia	510	580
New Zealand	120	140
Other	20	20
Philippines	6,610	7,630
South America	1,080	1,210
Argentina	280	320
Brazil	270	300
Chile	100	120
Colombia	90	100
Peru	100	110
Venezuela	120	130
Other	120	130
U.S. possessions [2]	220	250
Canal Zone	210	240
Other	10	10

[1] Places with 100 or more persons receiving OASDI benefits at the end of 1964 are shown separately.
[2] Excludes American Samoa, Guam, Puerto Rico, and the Virgin Islands.

Source: Social Security Administration, Division of the Actuary, Baltimore, May 4, 1965.

Senator DOUGLAS. Will the Senator yield?

Senator WILLIAMS. Yes.

Senator DOUGLAS. I wonder if you could furnish us estimates of the pensions received by officers of corporations who are living abroad?

Secretary CELEBREZZE. We will try to get it from the Commerce Department. We wouldn't have it but we will try to get it. I doubt whether we can get that information.

(The information referred to follows:)

CORPORATION PENSIONS RECEIVED BY RETIRED CORPORATION OFFICERS LIVING ABROAD

A check with the Departments of Commerce, Treasury, and State indicates that there is no information available about pensions received by retired corporation officers living abroad.

Secretary CELEBREZZE. The point I was trying to make, Senator, was that the benefit payments under the hospitals insurance plan and under the supplemental program would not be available to anyone living abroad, under the provisions of the bill.

Senator WILLIAMS. I understand that. But to the extent they would benefit under the bill.

Secretary CELEBREZZE. Yes, we can furnish that for you.

Senator WILLIAMS. Now, how many States have fully implemented the Kerr-Mills bill?

Secretary CELEBREZZE. I think it is——

Senator WILLIAMS. That is, fully implemented.

Mr. BALL. Fully implemented, Senator?

Senator WILLIAMS. Yes, that are fully implemented functioning as of last year.

Mr. COHEN. What do you mean by "fully"? There is no State which has taken advantage of every aspect of it. But there are 40 States that have taken advantage of the Kerr-Mills program.

Senator MCCARTHY. What do you mean by "have taken advantage"?

Senator DOUGLAS. It means the extent to what advantage.

Senator MCCARTHY. It does say then that they have not made their full contributions, the Federal Government has paid its full contribution.

Mr. COHEN. The offer on the part of the Federal Government to make matching funds available to the States for some aspects of medical care has been taken advantage of by some 40 States.

Now, the State programs are in quite different stages of development at the present time. There are only, I think, five States which really have what I would call a comprehensive scope of medical care. Those are Indiana, Massachusetts, Minnesota, New York, and North Dakota. They have a rather broad definition of medical care that would take care of almost anything that a needy aged person would need.

But then there are about 11 other jurisdictions which have various major types of services but have some limitation of some type. So in answer to your question, I would say that in terms of the original 1960 law there are really only 5 of some 40 States that have taken full advantage of Kerr-Mills.

Senator WILLIAMS. Then how many States are there that have taken very little, if any, advantage?

Mr. COHEN. Well now, let me just go through this and I think you can get the classification.

There are these five States that have comprehensive medical services.

Senator ANDERSON. Could we have those again?

Mr. COHEN. Indiana, Massachusetts, Minnesota, New York, and North Dakota.

Senator DOUGLAS. We had always thought, if the Senator will excuse me, that Michigan and California were States that had utilized Kerr-Mills to a considerable degree.

Mr. COHEN. California and Michigan are States which I would classify as having a very broad scope of coverage but nevertheless significant limitations.

Senator MCCARTHY. Do you have a figure on the distribution of money under Kerr-Mills that you could give in each case?

Mr. COHEN. Yes, I can give you that.

Senator ANDERSON. Would you mind giving us the category of States and then come back to the money?

What is your second category?

Mr. COHEN. Supposing I put this whole table in the record at this point and I will read them off so you will have them.

Senator ANDERSON. Without objection we will put it in the record.

(The table referred to follows:)

Classification of 42 MAA plans according to comprehensiveness of content and scope of services, Nov. 30, 1964

1. Provide comprehensive medical services,[1] 5 jurisdictions:

   Indiana, Massachusetts, Minnesota, New York, North Dakota.

2. Provide the 5 major kinds of services with significant limitations on 1 or more, 12 jurisdictions:

California	Hosp.[3]	NHC[2]	Prac.	Dent.	Drugs.[3]
Connecticut	Hosp.	NHC	Prac.	Dent.[3]	Drugs.
D.C.	Hosp.[2]	NHC.[2]	Prac.[3]	Dent.[3]	Drugs.[3]
Hawaii	Hosp.	NHC	Prac.	Dent.[3]	Drugs.
Iowa	Hosp.	NHC[2, 3]	Prac.	Dent.	Drugs.
Kentucky	Hosp.[2, 3]	NHC	Prac.[3]	Dent.[3]	Drugs.
Rhode Island	Hosp.	NHC[2, 3]	Prac.	Dent.[3]	Drugs.
Utah	Hosp.[3]	NHC	Prac.[3]	Dent.[3]	Drugs.[3]
Virginia	Hosp.[3]	NHC[2, 3]	Prac.[3]	Dent.[3]	Drugs.[3]
Washington	Hosp.[3]	NHC[2]	Prac.[3]	Dent.[2, 3]	Drugs.[3]
West Virginia	Hosp.[3]	NHC[3]	Prac.[3]	Dent.[3]	Drugs.
Wisconsin	Hosp.[3]	NHC[3]	Prac.[2, 3]	Dent.[3]	Drugs[3]

3. Provide at least hospital care, nursing home care, and practitioners' services, with significant limitations on 1 or more services, 13 jurisdictions:

Arkansas	Hosp.[2, 3]	NHC	Prac.[3]	Dent.[3]	
Colorado	Hosp.[3]	NHC	Prac.	--------	
Idaho	Hosp.[2, 3]	NHC	Prac.[2, 3]	--------	
Illinois	Hosp.[3]	NHC[2, 3]	Prac.[2, 3]	--------	Drugs.[3]
Kansas*	Hosp.[3]	NHC	Prac.[3]	--------	Drugs.
Louisiana	Hosp.[3]	NHC	Prac.[3]	--------	Drugs.[3]
Michigan	Hosp.	NHC[2, 3]	Prac.[3]	--------	
New Jersey	Hosp.	NHC	Prac.[3]	(Dent.[3])	(Drugs.[3])
Oklahoma	Hosp.[3]	NHC	Prac.[2, 3]	--------	
Oregon	Hosp.[3]	NHC[3]	Prac.	--------	
Pennsylvania	Hosp.[3]	NHC[2, 3]	Prac.[3]	--------	
Puerto Rico	Hosp.	NHC[3]	([4])	--------	
South Carolina	Hosp.[2, 3]	NHC[2, 3]	([4])	--------	

4. Provide hospital care and 2 or 3 other major kinds of service, with or without significant limitations on 1 or more, 6 jurisdictions:

Guam	Hosp.[3]	--------	Prac.[3]	Dent.[3]	Drugs.
Maryland	Hosp.	--------	Prac.	Dent.	Drugs.
Nebraska	Hosp.[3]	--------	Prac.[3]	Dent.[3]	Drugs.[3]
New Hampshire	Hosp.[3]	--------	Prac.[3]	--------	Drugs.[3]
Tennessee	Hosp.[2, 3]	NHC[3]	--------	--------	Drugs.
Virgin Islands	Hosp.	--------	Prac.[3]	([5])	Drugs.

5. Provide hospital care and 1 other major medical service, with or without significant limitations on either, 7 jurisdictions:

Alabama	Hosp.[2, 3]	--------	Prac.[2, 3]	--------	
Florida	Hosp.[2, 3]	--------	--------	--------	([5])
Maine	Hosp.[2, 3]	--------	([4])	--------	
North Carolina	Hosp.[3]	--------	--------	Dent.[3]	
South Dakota	Hosp.[3]	--------	Prac.[3]	--------	
Vermont	Hosp.[2, 3]	--------	Prac.[3]	--------	
Wyoming	Hosp.[3]	--------	([6])	--------	

[1] Hospital (inpatient) care (Hosp.), nursing home care (NHC), practitioners' services (Prac.), dental care (Dent.), pharmaceutical services (Drugs) with no significant limitations on conditions needing care or on extent of care.

[2] Significant limitations on conditions for which or circumstances under which care is provided, such as "only for acute illness or injury," "treatment for pain only," "posthospital care only," "after 31st day of care if in a private hospital or nursing home"; ( ) after eligibility for a "primary service."

[3] Significant limitations on extent or quantity of care, such as "up to 30 days per fiscal year," "6 visits per calendar quarter," "after paying 1st $65."

[4] Comprehensive services in outpatient clinics available in all sections.

[5] Home nursing care provided as the "noninstitutional" medical care.

[6] Outpatient clinic and services in doctors' offices as specified.

*Program began Jan. 1, 1964; plan submitted, not yet approved.

Report for period Dec. 31, 1964, to Jan. 31, 1965—activities of the 54 jurisdictions to put into effect the program of medical assistance for the aged

A. Program in effect; 44 jurisdictions:

Alabama.	Kansas.	Oregon.
Arkansas.	Kentucky.	Pennsylvania.
California.	Louisiana.	Puerto Rico.
Colorado.	Maine.	Rhode Island.
Connecticut.	Maryland.	South Carolina.
Delaware.[1]	Massachusetts.	South Dakota.
District of Columbia.	Michigan.	Tennessee.
	Minnesota.	Utah.
Florida.	Nebraska.	Vermont.
Guam.	New Hampshire.	Virgin Islands.
Hawaii.	New Jersey.	Virginia.
Idaho.	New York.	Washington.
Illinois.	North Carolina.	West Virginia.
Indiana.	North Dakota.	Wisconsin.
Iowa.	Oklahoma.	Wyoming.

B. Plan approved; not in effect, 1 jurisdiction: New Mexico.[2]
C. Plan material in preparation, no jurisdictions.
D. Legislation in process to give basis for program or to provide appropriation (1965), no jurisdictions.
E. Interested or intend to use, 1 jurisdiction: Nevada.[3]
F. Need legislation, 6 jurisdictions:

Alaska.[4]	Missouri.[5]	Ohio.[6]
Arizona.[4]	Montana.[6]	Texas.[7]

G. Have authority for MAA; implementation indefinite, 2 jurisdictions:

Georgia, enacted 1961; no funds available.
Mississippi, enacted 1964; no appropriation.

Mr. COHEN. The second classification is 12 jurisdictions that have at least 5 major types of services, such as hospital care, nursing home care, physician services of some sort, dental care, and drugs, but with a significant limitation in one form, such as limiting the number of doctor visits or the hospital service, and that includes California, Connecticut, the District of Columbia, Hawaii, Iowa, Kentucky, Rhode Island, Utah, Virginia, Washington, West Virginia, and Wisconsin.

There are 13 jurisdictions, in the third category, which provide at least 3 major types of services, such as hospital care, nursing home care, and practitioner's services, but with significant limitations on one or more of these services. Those are Arkansas, Colorado, Idaho, Illinois, Kansas, Louisiana, Michigan, New Jersey, Oklahoma, Oregon, Pennsylvania, Puerto Rico, and South Carolina.

Then a fourth category is made up of a group that provide hospital care and two or three other types of major kinds of services with some type of limitation and these are Guam, Maryland, Nebraska,

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[1] Plan not yet approved; new program.
[2] Plan submitted and approved to begin service whenever State appropriation is made and available; in agency budget request for next fiscal year.
[3] Enabling legislation of 1963 was contingent upon amendment of sales and use tax act, which was defeated by majority of voters in June 1963. Will seek new legislation in 1965.
[4] Considered by 1964 legislature; not enacted.
[5] Passed by 1963 legislature; vetoed by Governor.
[6] Considered by 1963 legislature; not enacted.
[7] Passed resolution for constitutional amendment which was ratified by popular vote; may be followed by enabling legislation.

New Hampshire, Tennessee, and the Virgin Islands. Then we have seven jurisdictions which have hospital care and one other type of medical service, and those are Alabama, Florida, Maine, North Carolina, South Dakota, Vermont, and Wyoming. Then we have the following States that have not yet implemented the law at all: Alaska, Arizona, Missouri, Montana, Ohio, and Texas, and then Georgia and Mississippi which have enacted enabling legislation but have not enacted any appropriations to implement it, and I believe also Nevada and New Mexico which are not yet in operation. We expect the New Mexico one to be put into operation soon.

Senator WILLIAMS. I didn't hear you read the State of Delaware.

Senator ANDERSON. Which category is that in?

Mr. COHEN. Well, that is correct. Delaware just came in the first part of this year.

Senator WILLIAMS. First part of this year?

Mr. COHEN. Yes, Delaware just started in operation.

Senator WILLIAMS. The reason I raised that question is that we had quite an argument last year and some officials insisted that Delaware had already implemented the Kerr-Mills and I am trying to get it straight. Because it was my understanding they had not implemented it at all and they are only getting their program underway this year; is that correct?

Mr. COHEN. That is my understanding.

Senator CURTIS. Mr. Chairman, could I ask a very brief question right at this point on these tables?

Senator ANDERSON. Surely.

Senator CURTIS. These tables do not include liberalizations that have been made in 1965 or are under consideration by legislatures still in session.

Mr. COHEN. No, that is correct.

Senator CURTIS. And the general movement has been toward liberalization?

Mr. COHEN. Yes, I would say the general movement is toward improvement. Here and there you find some modification which may not be an improvement, but I would say if you had to characterize the total movement, it has been upward. I would say we had a difficult problem in these last five or six States, some of which have laws but the laws have not been financially implemented.

Senator WILLIAMS. One question: After Delaware's plan is fully operative, as it is submitted this year, in what category will it be?

Mr. COHEN. We don't have that information right now.

Senator WILLIAMS. Could you furnish it for us?

Mr. COHEN. I will look it up and put it in the record for you.

(The information referred to follows:)

STATUS OF MEDICAL ASSISTANCE TO THE AGED PROGRAM

There are 44 medical assistance for the aged programs in effect throughout the country (40 States, District of Columbia, Puerto Rico, Virgin Islands, and Guam). All but one, Delaware, have approved plans. The Delaware program has been in operation since December 1, 1964. Action on the State plan was delayed because of questions related to the implementation of lien provisions under the State

law. The State has submitted a clarifying plan amendment so it is now possible for the Bureau to give formal approval of the Delaware plan. Reports show that the State made its first payments (in behalf of 22 recipients) in January 1965. Latest report available is February 1965 and discloses that there were 69 MAA recipients during that month.

Another jurisdiction, New Mexico, has an approved MAA plan, but it is not in operation. A budget appropriation has been approved for the next fiscal year.

There are three States, Georgia, Mississippi, and Montana, which have the legislative authority, but have not been provided funds to operate MAA programs.

There are six other jurisdictions, Alaska, Arizona, Missouri, Nevada, Ohio, and Texas which need legislation.

Delaware contemplates a comprehensive MAA program, but at the outset it is limited to hospital care, home health care (visiting nurses), and pharmaceutical services.

Senator ANDERSON. Do you see why he asked where Delaware was? It said it came into this this year and the reason he asked is what category will it fit in at the present time.

Mr. COHEN. I will get that information.

Senator DOUGLAS. It is an old aphorism, "If you are lying on the floor you can't fall out of bed." [Laughter.]

Senator WILLIAMS. It is clear there was no implementation of the Kerr-Mills bill prior to this year so far as our State is concerned.

Is that not true?

Mr. COHEN. Yes. I think they took applications in December in the program, and they made the first payments in January. There are very few payments in January.

Senator WILLIAMS. Of 1965?

Mr. COHEN. Of this year, that is correct.

Senator WILLIAMS. Thank you.

Senator ANDERSON. Senator McCarthy?

Senator MCCARTHY. Is distribution under Kerr-Mills an indication of the effectiveness of the scope and program?

Mr. COHEN. First, let me give you the total amount.

The total amount for all States reporting in the fiscal year ending June 30, 1964, in Kerr-Mills, under medical assistance for the aged, was $381 million.

Senator MCCARTHY. Federal money?

Mr. COHEN. No, that is the total Federal, State, and local that were used.

Now, at the time that perhaps you were thinking about, if you took the five States which are large in population and also have the broader scope of the program, of course, the five states are New York, California, Massachusetts, Minnesota, and Pennsylvania, which have about 31 percent of the aged, they are getting about 62 percent of all the Federal funds now.

In other words, because of the ability of the larger states to implement it faster, they are getting twice as much proportionately in Federal funds as their proportion of the aged population.

Senator DOUGLAS. But it is not merely greater financial ability. Some of these states are under very heavy financial burden.

Senator McCARTHY. We are just an average State.

Senator DOUGLAS. But some have a greater readiness to act.

Senator McCARTHY. Well, some of these States like Illinois, particularly, Minnesota, Connecticut, had programs of some sort in operation previously upon which they could more readily build when the Kerr-Mills program was started, so that was one factor that had to be taken into account.

Senator DOUGLAS. I have never been satisfied with the degree to which Kerr-Mills actually was applied in my State. How many people in the last month for which you have figures were receiving benefits under Kerr-Mills in Illinois?

Mr. COHEN. In the last month? There are about a quarter of a million people now in a month who are getting some——

Senator DOUGLAS. That is for the country as a whole?

Mr. COHEN. For the country as a whole.

Senator DOUGLAS. How many in Illinois?

Mr. COHEN. In Illinois, as of January it was 1,086.

Senator DOUGLAS. How many people over the age of 65 are there in Illinois?

Mr. COHEN. Well, I don't know offhand. I would think this amount would represent only a very, very small proportion of the total but that wouldn't be the total factor. You would have to know how many of them were sick and needed hospital care.

Senator DOUGLAS. You must have a figure.

Mr. COHEN. I can give you this figure. There are 5.4 percent of the aged on old-age assistance in Illinois in December 1964, and the recipients who were getting Kerr-Mills were one-tenth of 1 percent of the aged, so you see it was a very small——

Senator DOUGLAS. The total number of the aged in Illinois runs something over a million. Since about a thousand are receiving aid at any one time under Kerr-Mills, you only have one-tenth of 1 percent benefiting. Whereas you have over 5 percent, 50 times as many, receiving old-age assistance, and this despite the fact that many of these are also receiving social security, probably the vast majority of them.

Senator ANDERSON. Senator McCarthy?

Senator McCARTHY. I have no more questions on this point if anyone wishes to pursue it further.

The report of the Advisory Council on Social Security makes rather strong recommendations for including the civil service employees who are not covered under the civil service retirement program in the social security program.

We are waiting for another report, for a report on the civil service retirement program, I understand. But is there any reason to believe that the changes in that program which may be recommended will be so drastic that we ought to delay taking action to include civil service personnel under this program?

Mr. BALL. Well, Senator, the recommendation, as you have said, of the Advisory Council is not really for a basic extension of coverage to Federal employees but rather a transfer of credit arrangement between the two systems for people who don't qualify under the civil service retirement system.

Senator McCARTHY. That is right, right.

Mr. BALL. You may know that the Ways and Means Committee asked the Social Security Administration and the Civil Service Commission to develop a recommendation for them that would be the best that we could recommend, without necessarily taking a policy position on it, and Mr. Macy and I submitted that report, which indicates that this proposal of the Advisory Council would be such a proposal—that it would fit in and do a good job.

Now, I am sure that the Cabinet committee that has been set up to study the whole matter of retirement systems for Federal employees would prefer that action of the Congress to make this change would be deferred until they had had a chance to look into its relationship to all other aspects of retirement for Federal employees.

But if the Congress were to act, I would say this type of plan suggested by the Advisory Council would be the sort that, at this point, we have thought was most practical and from all standpoints probably most feasible.

Senator MCCARTHY. There is no problem with the language, there is no technical problem.

Mr. BALL. No, I would say there are no technical problems.

Senator MCCARTHY. That would cause any difficulty.

My second question, the Council also makes a rather firm recommendation regarding the definition of a child. The exact language is this:

> A child should be paid benefits based on his father's earnings without regard to whether he has the status of a child under State inheritance laws if the father was supporting the child or had a legal obligation to do so.

Is there any reason why we ought to continue this kind of a Balkanization with regard to children in the social security program?

Mr. BALL. Yes, Senator, we have felt that this recommendation by the Council does go in the right direction. It really applies to the social security system much the same sort of definition that the veterans program now has.

Senator MCCARTHY. You didn't recommend it now?

Mr. BALL. No, there are several of the Council's recommendations that the executive branch had not fully evaluated at the time that this bill was put in.

Senator MCCARTHY. Was there any reason for not including it or is there any reason for not including it?

Mr. BALL. There is no negative reaction on our part. It was really a matter of timing. This council report was made very close to the time that this bill was put in.

Senator MCCARTHY. Would you be prepared to accept a single national definition of "child"——

Mr. BALL. We can give you a report on that specific provision if you would like it.

Senator MCCARTHY. So we could have one definition of "child" for the whole country insofar as the social security program is concerned and not 50 different ones.

Mr. BALL. Yes. What the present law says is that if a child is a child for purposes of inheritance under State law, then he is a "child" for social security purposes, whereas this recommendation would provide for paying benefits to a child where the father had been supporting the child and the child in other respects was clearly dependent.

Senator McCARTHY. We could use the definition of a "child" now used in the veterans benefits program.

Mr. BALL. Yes, essentially, but with a requirement that the child have been supported by the worker.

Senator McCARTHY. Thank you.

Senator ANDERSON. Senator Carlson?

Senator CARLSON. Mr. Secretary, it is with some hesitation that I start asking some questions because I have been unable to be in attendance at these hearings and I assume any questions that I may raise have been well covered and I assure you I shall not press them if they have.

I have been interested in this section in the bill which provides for inclusion of people over 72 years of age with coverage of three periods of work. My thought is why not remove any provision for coverage and include the entire group of people who are over 72 and who could not qualify for many reasons?

Secretary CELEBREZZE. First, Senator Carlson, the three quarters is not the whole story. Some over 72 will need four quarters and some will need five quarters. The basic philosophy, as has been brought out by Senator Curtis, was that these people contributed something to the fund, and that they were part of the system, and because of their age they didn't acccumulate sufficient quarters to qualify.

We felt we should incorporate them.

I think the primary objection to blanketing in everyone, if there is an objection, would be that you are largely transferring obligations from the States to the Federal Government, because most of these people now are under the assistance programs where the States and the Federal Government both contribute.

If you blanket them all in then you would merely be transferring part of the obligation from the States to the Federal Government, and the individual himself would gain very little.

I think we have to bear in mind that when are talking about coverage on three quarters, we are talking about $35 a month—$35 would be the benefit under that provision as against the minimum benefit of $44 under the other provisions of the law, so that the individual himself would still need assistance supplementation and gain very little. This provision would be phased out within 4 or 5 years, as we have in past years broadened the coverage of the program and most people would be brought in under the normal program.

Senator CARLSON. Mr. Secretary, I certainly shall not press it any further because I am sure it is in the record.

As I get your statement, these individuals should they be included, and covered completely, all over 72 they no doubt would have to have additional assistance from the old-age assistance programs in addition to that?

Secretary CELEBREZZE. No doubt about it, most of them would.

Senator CARLSON. Thank you very much.

There is another problem that I have received a great deal of mail on and I assume that may have also been discussed and that is in regard to section 303, which deals with disability insurance, and the payments out of workmen's compensation.

Secretary CELEBREZZE. We went into that and we promised to submit a memorandum to the committee on it.

Senator CARLSON. I have a number of questions here and I think I would like to ask them at this time.

Senator ANDERSON. Go right ahead.

Senator CARLSON. I could submit them for the record. There is a little history involved in disability insurance and I want it in the record, and if the Secretary would not mind just for a few minutes.

Secretary CELEBREZZE. Not at all.

Senator CARLSON. I think we ought to discuss this section thoroughly because I do have some problems with it and I know others have.

First, historically previous to the Social Security Disability Act in 1956, what was the estimate as to how many disabled persons over age 50 would come under the program upon its enactment?

If you do not have this available, let's have it for the record. I am trying to build a case history as to the entire program as we go through it.

Secretary CELEBREZZE. We will furnish it for the record.

(See below.)

Senator CARLSON. The next question is how many persons actually disabled did receive benefits under the act in the first year after its enactment. If you do not have that available at this time I do want it for the record.

Secretary CELEBREZZE. We will submit it.

(See below.)

Senator CARLSON. Then, in 1958 the offset provision was removed from the Social Security Disability Act. This allowed a disabled person to receive benefits from the Federal program and also from the State workmen's compensation program.

How many primary beneficiaries received benefits under the Federal program at the end of the first year after repeal of this offset provision, which made quite a change in the program as you well remember.

Secretary CELEBREZZE. Yes.

The average was changed but you want the specific numbers. It was about 2 percent but we can try to work out for you the specific numbers if we have that material available.

Senator CARLSON. I would appreciate it.

Mr. BALL. Senator, that particular change—we will submit the numbers for the record.

(The information referred to follows:)

APRIL 30, 1965.

Memorandum.
From: Robert J. Myers.
Subject: Comparison of disability insurance benefits experience with actuarial cost estimates.

At the hearings before the Senate Committee on Finance today, Senator Carlson raised a number of questions about how the experience under the disability insurance program at various times in the past has compared with the actuarial cost estimates. He also inquired about the effect of the offset provision that was included in the disability insurance program before the 1958 amendments. This offset provision applied to all types of disability benefits, including not only those under workmen's compensation programs, but also veterans benefits and disability benefits under various governmental benefit systems (such as railroad retirement, civil service retirement, and State and local government employee pension systems).

As to the cost estimates for the original provisions, as contained in the 1956 amendments, the actuarial cost estimates that were contained in a committee print of the House Ways and Means Committee dated July 23, 1956, showed

benefit payments of $116 million for 1957 and $379 million for 1958. The actual experience for these 2 years was $57 million and $249 million (the latter figure being somewhat increased by the elimination of the offset provision, effective for benefit payments made in August 1958 and by the addition of supplementary benefits for eligible dependents, effective for benefit payments made in October 1958). Thus, the actual benefit payments in 1957 were only about 50 percent of the estimate, while for 1958 the corresponding figure was 66 percent.

The effect of eliminating the offset provision, as result of the 1958 amendments, may be seen by analyzing the increase in the total amount of disability insurance benefits in current payment status for August 1958 as compared with July 1958—namely, $18.3 million as compared with $15.3 million, an increase of $3 million when in the previous year the average monthly increase was about one-fourth that figure. It should be recognized, however, that only a small part of the higher than normal increase was due to eliminating the offset of workmen's compensation benefits, but rather the major portion of the overlap was for veterans benefits. Only 14 percent of social security benefits reduced because of the offset were reduced because of workmen's compensation payments and the remainder was because of receipt of veterans' pensions.

When the age-50 limitation was removed from the disability insurance program, as a result of the 1960 amendments, the long-range actuarial cost estimates indicated that the actuarial balance of the program was changed from a "surplus" condition, with a positive balance of 0.15 percent of taxable payroll, to a lack of actuarial balance of 0.06 percent of taxable payroll. It was believed that this deficiency was well within the limits of variation to which long-range actuarial cost estimates are subject. This apparently small relative lack of actuarial balance represented a relative lack of balance of 12 percent (as compared with the level employer-employee contribution rate of 0.50 percent). These figures are contained in a committee print of the House Ways and Means Committee dated September 1960.

The estimated disability insurance benefit disbursements for years after 1960 as contained in that report compare with actual experience, as follows (in millions):

Calendar year	Estimate	Actual experience	Ratio (percent)
1961	$802	$887	111
1962	864	1,105	128
1963	924	1,210	131
1964	973	1,309	134

As will be seen, unlike the situation when the estimates and actual experience were compared following the initial enactment of the DI program, the actual exeprience after the 1960 amendments ran significantly ahead of the estimates. As has been stated previously, a considerable amount of this difference resulted from the cumulative effect of disability determination rates (from death and recovery) being significantly lower than the assumed rates used in the cost estimates. On the other hand, it will be recalled that the rates of becoming disabled—and thus the annual number of persons becoming disabled—have been significantly lower than would have been anticipated according to the original cost assumptions (particularly so for women workers).

Inquiry was also made about the changes in the actuarial cost estimates for the DI program that had been made from time to time, as the benefit provisions were changed and as the assumptions were altered to reflect the developing experience. An analysis along these lines has been prepared in actuarial Note No. 3, July 1963 (copy attached). This actuarial note also gives an estimate of what the experience of the DI program would have been if the age 50 limitation had not been eliminated by the 1960 amendments. As will be seen from table 2 of this actuarial note, the DI trust fund would have shown a steady increase in the years after 1960, instead of the decrease that have occurred beginning after 1961.

ROBERT J. MYERS.

ACTUARIAL NOTE NO. 3, JULY 1963—SUMMARY HISTORY OF COST ESTIMATES FOR DISABILITY BENEFITS

(By Robert J. Myers, Division of the Actuary)

This actuarial note presents a brief historical summary of the actuarial cost estimates for the monthly-disability-benfits portion of the old-age, survivors, and disability insurance system. It will trace through not only the changes in the cost estimates resulting from the amended benefit provisions, but also those resulting from changed cost assumptions.

When the disability-benefits program (DI) was enacted in 1956, the estimated level-cost according to the intermediate-cost estimate was 0.42 percent of taxable payroll. Following usual practice, a range of cost estimates was prepared to recognize the inherent variability of such long-range estimates—especially for disability benefits. The low-cost estimate was 0.27 percent of taxable payroll, while the high-cost estimate was 0.57 percent.

In 1958, before the enactment of the 1958 amendments, revised estimates were presented. These showed the estimated level-cost of the program to be decreased to 0.35 percent of taxable payroll. The reasons for this estimated decline in cost were: (a) account was taken of the significant effect of the "offset for other disability benefits" provision (which had previously not been considered) and (b) the estimates of the size of the insured population that would be at risk of becoming disabled were considered more thoroughly and were revised downward (giving greater recognition to the relatively strict eligibility conditions—fully insured, currently insured, and having 20 quarters of coverage in the last 40 quarters preceding disability).

The 1958 amendments considerably liberalized the DI program by eliminating the aforementioned offset provision; by eliminating the requirement of currently insured status; by adding dependents benefits; and by increasing the general benefit level by about 7 percent. At the same time, the 1958 amendments contained a cost-reduction element by raising the maximum earnings base. It will be kept in mind that the 1958 amendments did not change the age 50 requirement for disability benefits. The estimated level-cost of the disability-benefits program, following the enactment of the 1958 amendments, was 0.49 percent of taxable payroll.

In 1960, before the enactment of the 1960 amendments, new cost estimates were made for the DI program. Not only did these reflect the higher earnings levels of recent years, but also the actual operating experience as to the rate of persons becoming disabled and going on the benefit roll. Also, some more reliable information was available as to the number of persons possessing insured status sufficient for them to be eligible for disability benefits if they became disabled. Since the rate of becoming disabled that was actually experienced was about the same for men as had been assumed, and considerably lower for women, a reduction in cost was indicated. The effect of the higher general earnings level also moved the cost in the same direction, and this too was so in regard to the estimates of the insured population, which were lower than previously assumed. As a result, the new cost estimates, prepared in 1960, for the system as it was following the 1958 amendments showed a level-cost of 0.35 percent of taxable payroll.

The 1960 amendments liberalized the program primarily by eliminating the age 50 requirement. As a result, the estimated level-cost of the disability benefits was increased to 0.56 percent of taxable payroll. Congress recognized that this resulted in the disability-benefits program having an actuarial lack of balance of 0.60 percent of taxable payroll (when measured against the level employer-employee contribution rate of 0.5 percent), but the belief was expressed that—considering the variability of cost estimates for disability benefits—this small actuarial deficit was not significant. Further, it was believed that, on the basis of future experience, such adjustments as might be necessary could be made.

The 1961 amendments slightly liberalized the program by raising the minimum primary benefit from $33 to $40 per month and by liberalizing the fully-insured-status requirement in the next few decades of operation. The actuarial cost estimates for the disability benefits were not revised because it was believed that these changes would not produce significant cost increases (and, moreover, there were offsetting factors, such as the higher general earnings level being experienced and the more favorable interest basis on trust-fund investments).

At the end of 1962, new cost estimates were made on the basis of a complete reexamination of all cost factors involved. The major element resulting in higher estimated costs for the disability benefits was that the number of persons continuing on the benefit roll was significantly higher than had been anticipated—or in other words, disability termination rates due to death and recovery were lower than assumed in the actuarial cost estimates. The result of the new cost estimates was to show a level-cost of 0.64 percent of taxable payroll.

Finally, there is presented an estimate of what the experience under the disability-benefits program would have been in the past and of what it will be in the short-range future (based on the cost estimates in the 23d Trustees Report), if the past liberalizations as to providing dependents benefits and as to eliminating the age 50 requirement had not occurred, but rather the monthly benefits continued to be restricted to disabled workers aged 50 to 64. It is, however, assumed that certain other of the liberalizing amendments did occur, such as the elimination of the antiduplication provision with other disability benefits, the general 7 percent increase in benefits in the 1958 amendments, the $40 minimum benefit in the 1961 amendments, and the various changes in the insured-status provisions.

The estimates necessary for the concept considered here are relatively easy to make because the data on actual benefit disbursements are subdivided between primary benefits and supplementary benefits (so that the latter can be dropped out), and further, age data on the beneficiaries are readily available. Certain approximations and arbitrary estimates are necessary in connection with such other items as the railroad retirement financial interchange, the administrative expenses, the military-service-credits reimbursements from the General Treasury, and the interest earnings of the DI trust fund. It is believed, however, that these can be reasonably well approximated, especially considering that they are relatively small items as contrasted with the data on benefit payments and contribution income and so will not have a significant effect on the overall results.

Table 1 compares the estimated disability benefit payments if the original provisions had not been changed, as against the data for the actual operating experience under the program as it has been amended and as it is projected for the future under the present provisions. In calendar year 1962, the actual experience under the prevailing law resulted in benefit payments that were more than $400 million higher than under the original provisions, or an increase of about 60 percent. Relating the benefit cost to taxable payroll, the original provisions would have produced a cost of 0.33 percent for 1962, as against the actual experience of 0.52 percent. In the next 5 years of operation, the absolute amount of benefit payments is estimated to increase under both the actual experience and the original provisions, but the cost relative to payroll is estimated to level off (which may be too optimistic a picture). At the same time, during the next 5 years, the relationship between the experience under the present law and that which would have occurred under the original provisions would be only slightly changed, with the differential increasing from the 1962 figure of 61 percent to about 67 percent by 1967.

Table 2 shows the progress of the DI trust fund under the original provisions. As would be anticipated from the previous discussion, income from contributions significantly exceeds outgo for benefit payments and, together with the substantial interest earnings, results in a rapidly growing trust fund. At the end of 1962, the trust fund would have amounted to $3.4 billion if the original provisions had not been changed, as against the actual figure of $2.4 billion. In the next 5 years, the trust fund would have grown to $5.8 billion if the original provisions had not been changed, whereas the estimate for present law is a decline to $1.6 billion.

TABLE 1.—*Comparison of disability benefit payments if original provisions had not been changed with actual experience*

Calendar year	Benefit payments (in millions)		Benefits as percent of payroll		Increase in cost due to amendments
	Original provisions	Provisions as amended	Original provisions	Provisions as amended	
	Actual experience				
			Percent	*Percent*	*Percent*
1957	$57	$57	0.03	0.03	----------
1958	246	249	.14	.14	1
1959	390	457	.20	.23	17
1960	479	568	.24	.28	19
1961	581	887	.29	.44	53
1962	685	1,105	.33	.52	61
	Estimated experience				
			Percent	*Percent*	*Percent*
1963	$739	$1,206	0.34	0.55	63
1964	765	1,257	.34	.56	64
1965	780	1,291	.34	.55	66
1966	794	1,321	.33	.55	66
1967	810	1,350	.33	.55	67

TABLE 2.—*Progress of DI trust fund if original provisions had not been changed*

[In millions]

Calendar year	Contributions[1]	Benefit payments	Administrative expenses	Railroad interchange[2]	Interest on fund	Fund at end of year
	Actual experience					
1957	$702	$57	$3	----------	$7	$649
1958	966	246	12	----------	25	1,382
1959	891	390	46	−$21	42	1,900
1960	1,010	479	31	−5	57	2,462
1961	1,038	581	35	−5	77	2,966
1962	1,046	685	40	−5	96	3,387
	Estimated experience					
1963	$1,091	$739	$45	−$5	$110	$3,809
1964	1,129	765	50	−5	127	4,255
1965	1,167	780	55	−5	143	4,785
1966	1,202	794	60	−5	162	5,250
1967	1,230	810	65	−5	182	5,792

[1] Including military-service-credits reimbursements from General Treasury.
[2] A positive figure indicates a payment to the Railroad Retirement Account and vice versa.

Senator CARLSON. I would be glad for some discussion on it.

Mr. BALL. I just wanted to make the point that that particular change would not be responsible for any very significant part of the change in the number qualifying from the beginning to the end of 1958. A much more important factor, of course, is the maturing of the program and additional people becoming disabled and being added to the rolls.

As the Secretary developed in an earlier discussion with Senator Williams, the overlap between disability and workmen's compensation

is quite small. Most of the people who have come on social security are not disabled because of work-connected injuries, and our estimate is that the overlap in total is in the neighborhood of about 2 percent; that is, 2 percent of the disabled beneficiaries with social security also get workmen's compensation. And a significant proportion of those 2 percent, even when you consider their combined benefits, still get in a combined amount a relatively low benefit in relation to their past earnings.

Senator ANDERSON. Could I ask you one question there on this?

If that is true would you object to a provision which limited the total of the combined benefits to the earnings prior to the disability? In other words, the real problem, I think, some insurance companies face is that for a long time they have believed that benefits should not be greater than your earning capacity; otherwise, there is no incentive to go back to work.

Mr. BALL. Yes, Mr. Chairman, and we are very sensitive also to that same issue.

As the Secretary said, there isn't a simple and easy solution because of the fact that past earnings, when a person comes on the rolls, are what he was earning up to that time. Now, say he comes on the rolls this year—wages have been rising in the past around 3 to 4 percent a year—and 10 years later he still is a beneficiary. If he had been able to continue at work his earnings would be much larger 10 years later than they were when he first came on. Yet his benefit would be based on his lower level of earnings at the time he came on the rolls.

So it has seemed to us that if we were to adopt a proposal such as you suggest, it would need to have in it the element of bringing that maximum up to date. It wouldn't be fair to keep that disabled worker, say, to a maximum of 90 percent of the wage that he had in 1965, when he first started getting benefits, up to 1975, when he would have been earning considerably more had he not been seriously disabled.

We have been giving thought to a proposal along the lines of your suggestion, Mr. Chairman, that would have this dynamic element in it. As the Secretary said, the Ways and Means Committee asked us to survey this whole question and to determine the size of the overlap problem, and the extent to which the benefits in overlap cases are excessive, and if we can devise a recommendation that is consistent with good policy to make that recommendation. We are considering this proposal as part of that study.

Senator ANDERSON. I do think that is worthwhile.

The only thing I point out to you is that there is some reason for trying to put a situation together where a man is not profiting by being sick.

Mr. BALL. Yes; we believe that. Even though the cases that exist may be less than 1 percent of all social security disability beneficiaries, it is not desirable to have excessive wage replacement even in those few cases if a good proposal can be devised that doesn't introduce more difficulties than it solves.

Senator CARLSON. I appreciate very much the Senator from New Mexico entering into this discussion, because it is a problem I think every member of the committee is concerned with and I don't think I violate any confidence when I state in the executive sessions where we

considered this bill for 2 or 3 days, it was hoped, as we read the House report, that we could get some information on this phase before December 31 of next year, in fact, in time to act on it in this particular bill and I hope that that can be worked out.

Mr. BALL. Senator, the Secretary suggested earlier that we would prepare a memorandum on this whole point during the consideration of this bill.

I would like only to add that it isn't the disability changes in the bill before you that cause this problem. The problem, if it is a problem, exists under the present disability provisions, and the extensions that are proposed in this bill are not what create any difficulty there may be. Actually, there will be some more cases in which overlap occurs, but probably, as a percentage of the total number of disability cases, the proportion would not be significantly greater than the 2 percent that exists today.

Senator ANDERSON. I assure you there are a great many people who do think the problem is accentuated by the language in this bill.

Mr. BALL. I think they have indicated that, Senator. It is not our feeling that the extension of social security disability protection to these additional 155,000 people will significantly increase the proportion of cases in which overlap occurs. It may increase slightly but not significantly.

Senator ANDERSON. If the change in the law doesn't help anything why do you put it in?

Mr. BALL. It helps a great deal.

Senator ANDERSON. That is what I thought.

Mr. BALL. But I am saying it doesn't create a larger overlap between workmen's compensation and social security disability benefits. Many more people will be getting social security benefits, Senator, but a very large proportion of them, for example, will be early cases of tuberculosis that we can't pay now. TB is not ordinarily the kind of disability that involves workmen's compensation, although it may be in some few situations.

By and large, the people that we will be paying as a result of this bill will not be people getting workmen's compensation. In most cases, the people who will be eligible for disability benefits as a result of the change in the disability definition will be receiving only social security benefits.

Senator CARLSON. Again I want to get back to the historical background and the actions we have taken because I think for the record it would be well to preserve it for at least future sessions.

In the act of 1956 we made changes in 1956, and changes in 1958 and we go to 1960 at which time we have the removal of the 50-year limitation from the 1960 act, how many primary beneficiaries did you estimate were under age 50 and would be eligible for benefits, for the record, unless you know, Mr. Myers?

Mr. MYERS. Senator Carlson, I don't have those figures with me here.

Senator ANDERSON. Will you submit them for the record?

Mr. MYERS. I will insert them for the record, Mr. Chairman.

(See p. 170.)

Mr. MYERS. I might mention in general terms, however, that the estimates of the number of additional beneficiaries brought on the

rolls by the various disability changes have, I believe, been quite close to the estimates. In fact, I think some of the early experience was considerably below the estimates.

The only part of the disability experience that has been higher than the estimates has been the estimated length of time the disability beneficiaries would stay on the rolls.

In other words, the actual experience as to termination by death and recovery has been less favorable to the financial operations of the fund than had originally been assumed.

Senator CARLSON. What did you estimate, now, for the record, the cost to be for the additional beneficiaries under the age of 50, and for all beneficiaries under the act, for the record, if you would, please.

Mr. MYERS. Yes, Senator Carlson, I will put this in the record.

The estimates, of course, as you realize, change from time to time as we have made different assumptions after studying the experience. (See p. 170.)

Senator CARLSON. The next question: What was the cost of the program annually prior to the removal of the age 50 limitation, and then the effect of the provision repeal? I don't care, unless you have it.

Mr. MYERS. I do have the figures here that will give you the answer to that, Senator.

The outgo of the disability insurance program in 1960, which was largely before the age 50 limitation was removed, was $568 million.

The next year, 1961, it was $887 million, which was an increase of about 55 percent. Most of this increase was due to the removal of the age 50 limitation. But part of the increase was due to the gradual increase in the benefit roll and to somewhat higher benefit payments as time goes by.

However, I will put in the record some more information on just how much of the cost was due to the underage 50 beneficiaries. (See p. 170.)

Senator ANDERSON. Did the removal of the limitation at 50 years and throwing it wide open throw the disability fund from the black into the red?

Mr. MYERS. Well, Senator Anderson, if this change had not been made, then the disability fund would have had less outgo, and it would not have decreased as it did.

Senator ANDERSON. The question was, did it throw it from the black into the red?

Mr. MYERS. Yes.

Senator ANDERSON. Of course, it did.

Senator CARLSON. Did they not transfer funds or did you not transfer funds from the old-age insurance survivors fund to take care of some disability?

Mr. MYERS. There has been no transfer of funds from the old-age and survivors insurance trust fund to the disability insurance trust fund.

The excess of outgo over income from 1962 on, has resulted in decreasing the assets of the disability insurance trust fund.

In the bill that is before you, the allocation to the disability insurance trust fund would be increased. This is to take care of both this deficiency and of the liberalization in the disability definition.

Senator CARLSON. How much was transferred?

Mr. MYERS. In the bill——

Senator CARLSON. How much above your estimates?

Mr. MYERS. In the bill the allocation for the disability insurance trust fund is increased from the present one-half percent of payroll from the employer and employee combined to three-quarters of a percent of payroll.

Senator CARLSON. How much in dollars?

Mr. MYERS. This increase of a quarter of a percent would amount to about $600 million a year.

Part of this would have been necessary even if the disability insurance trust fund had been in exact balance, because of the increased costs due to the liberalization of the definition of disability, the higher general benefit level, and the payment of child benefits to children attending school. Disability beneficiaries have children who are in school and, therefore, there are more payments with respect to them.

Senator CARLSON. Then we get to the current bill, section 303, what do you estimate the additional cost to be under esction 303 of the bill which, as I understand it, will bring additional beneficiaries upon the disability rolls.

Mr. MYERS. The cost for the various disability liberalizations are 0.05 percent of taxable payroll for the change in definition of disability, which is a dollar figure of around $125 million a year. In addition, there is a small increase because of the children attending school beyond age 18, and because of the increase in the benefit level.

Furthermore, the increased allocation to the disability insurance trust fund would change it from a long-range deficit basis to a long-range actuarial surplus basis of about 0.04 percent of taxable payroll.

Senator CARLSON. As I understand it for additional beneficiaries the amount added would be roughly $125 million for the disabled?

Mr. MYERS. On a long-range basis, for the change in the definition of disability. It would not involve that much cost during the first year but that would be a long-range average dollar cost.

Senator CARLSON. How many additional persons will be on the rolls under section 303?

Mr. MYERS. Immediately there would be 155,000 additional persons, including both the disabled workers and their eligible dependents. That figure would be roughly equally divided between the disabled workers and the beneficiaries.

Mr. BALL. Senator, could I add just one point here to round out the record on the financing history that you were inquiring about?

I think it is significant that at the time of that liberalization, when the Congress made that——

Senator CARLSON. If I may interject there, there was great discussion at the time we passed this section as to the determination of disability and who would determine it.

Mr. BALL. Yes. When the age 50 requirement was dropped, I wanted to bring to your attention that the Congress recognized that for the long run they had not employed sufficient financing. There was a 0.06-percent deficit on the long-range basis that it was always recognized would have to be made up for at some time. That was taken into account of. Yes, sir.

Senator CURTIS. May I add, that 0.016?

Mr. BALL. 0.06.

Senator CURTIS. 0.06, was a deficit of the long range had you not lowered the age, is that correct?

Mr. BALL. No, when they did lower the age the amount that they supplied for the new program was short by 0.06 percent on the long run.

Senator CURTIS. What I want to know is based on the experience under this bill, assuming for hypothetical question purposes that we hadn't lowered the age would the original estimate be satisfactory?

Mr. BALL. More than satisfactory.

Mr. MYERS. Yes, Senator Curtis. I have made a study of the experience that would have occurred under the disability insurance trust fund if the age 50 limitation had not been removed, and there would have been more than ample financing for it.

Before the change was made, the program was estimated to have an actuarial surplus of 0.15 percent of taxable payroll. It was decided then to drop the age 50 requirement and let the actuarial balance swing the other way by this minus 0.06 percent of taxable payroll that Mr. Ball referred to.

Then as the experience later developed, it was a little more unfavorable so that the 0.06 percent deficit increased to where at the present time it is about minus 0.14 percent. The bill in reallocating a quarter of a percent of payroll picks up that deficit, and then picks up the additional cost of the disability definition liberalization and the other liberalization and leaves an estimated surplus of 0.04 percent.

Mr. BALL. That difference, Senator, between the 0.06 percent that was a recognized deficit then and the 0.14 percent at the present time—in other words, that additional 0.08 percent—comes about, as Mr. Myers said earlier, not because more people are becoming disabled than was originally thought—the estimate on that has been very close—but because we didn't have good data on how long disabled people might live. The estimate of the rate of disability related to the determinations that Senator Carlson referred to as having been in dispute at the time the program was established, has not been nearly the problem that was anticipated.

The numbers coming on are just about what were expected. But the length of life of disabled people has been somewhat longer than we estimated at the time, and that has been the cause of this increase from the 0.06 percent deficit that was anticipated to the present deficit of 0.14 percent.

Senator ANDERSON. But since it threw you into the red, have you ever thought about going back to the situation you were in before, put up the 50 limitation again?

Mr. BALL. Senator, it would seem to me that the solution in this bill is much to be preferred to that.

Senator ANDERSON. To raise the rates you mean?

Mr. BALL. The increased allocation to the disability insurance trust fund. Actually for this purpose the only additional amount that is needed over what people thought would be the deficit, in order to put the disability fund on a completely sound basis, is eight one-hundredths of 1 percent. That eight one-hundredths of 1 percent would seem like a very small exchange to make for the protection of people who are disabled and under 50, which is the very time when individuals are

apt to have young children and where total disability is such a devastating thing to the family.

Senator ANDERSON. I am just wondering if you had ever thought of the possibility of going back to where you were when the fund was solvent.

Mr. BALL. I would say we hadn't ever really seriously considered the possibility of recommending putting back the age 50 limitation.

Senator CARLSON. Then following right on that same thought, do I assume that the provisions of this bill in regard to section 802 are recommended by the Secretary and the administration?

Mr. BALL. Yes.

Secretary CELEBREZZE. That is right.

Senator CARLSON. 303, yes.

Then we get to the question, in preparing this amendment for the bill, were the industrial commissions and the compensation commissions of the States considered and consulted in arriving at this decision?

Mr. BALL. Senator Carlson, although, as the Secretary indicated, we support this change, the change was developed in the Ways and Means Committee, and was not in the administration's original proposal.

Senator CARLSON. That was my original question.

Mr. BALL. Yes.

Senator CARLSON. I wondered if it was.

Mr. BALL. We did not carry on any consultations with the industrial commissions on this.

Senator CARLSON. In other words, this amendment is in here, as far as your agency is concerned and the Secretary is concerned, without consultation with the State commissions and the agencies.

What about the insurance industry, were they consulted or were there no consultations on that?

Mr. BALL. Well, let me develop this just a little bit more, Senator.

Although this particular provision was added in the Ways and Means Committee at this time without our having made a recommendation on it, in the early part of President Kennedy's administration we did recommend to the Congress that part of this proposal be put into effect.

We recommended in 1961, I believe, that the prognosis of long continued and indefinite duration be dropped from the definition of disability. To a very considerable extent our reasoning on that proposal was that such a change would bring the social security disability program more into line with what is typically done in private insurance. Under the typical private insurance so-called permanent and total disability policy, the permanency aspect of disability is established on what you might call a presumptive basis.

Under such a policy, an individual would ordinarily be considered to be permanently disabled if his total disability has run for 6 months. Then they start to pay him, and if he recovers they stop paying him. But private insurance carriers don't ordinarily attempt to say whether the disability is going to last on into the future as we have to do under present law.

So, the whole idea really of that original proposal, and then as picked up now in the Ways and Means Committee, was to bring the program closer to the way private insurance operates.

As to your question about consultations with the private insurance industry, there was not at this time a specific consultation with them on it, but a great deal of study went into how private insurance policies handle this problem at the time of that original recommendation.

Senator CARLSON. My only thought is my mail and contacts that I have had indicate concern about this provision, and I have had folks in who say, "Well, we weren't permitted to testify, we didn't know about it" and I am hoping our committee, and I am confident we will, will have witnesses in here on it and again I get back to the statement in the report of the House which says, "You are to report by December 31 on some suggested changes" I sincerely hope the Secretary and the administration, Health, Education, and Welfare will come up with suggestions that are helpful because I think this is one phase I think we ought to check very closely before we act on it.

Secretary CELEBREZZE. Recommendations were to be in 1966, not 1965.

Senator CARLSON. 1966. I hope we get it in 1965 and I hope we get it before we report this bill.

Secretary CELEBREZZE. As I said yesterday, we will try to speed it up.

Senator ANDERSON. Senator Long?

Senator LONG. Mr. Secretary, would you tell me who is not covered under this medicare plan you have here now? You are covering everybody who is under social security.

Secretary CELEBREZZE. Yes. Almost.

Certain Federal employees are excluded—about 150,000; that is because they have their own system, Senator.

Senator LONG. Is that all?

Secretary CELEBREZZE. The 150,000 who were excluded are not covered in this program because after June 1960 they were covered under a continuation of the regular Federal employee program.

Senator LONG. How about people who have never had social security coverage; would they be protected?

Secretary CELEBREZZE. Yes; general revenue would pay their costs.

Senator LONG. Under both programs, both under supplemental and the——

Secretary CELEBREZZE. Under the basic hospital, general revenues will pay the total cost. Under the supplementary they will pay half. In this case it will be $3 on their part and the Federal Government will pay $3 out of general revenues.

Senator LONG. Suppose a person needs 180 days of hospitalization, suppose he is very ill and needs a lot of hospitalization; how much of that could he get in a hospital?

Secretary CELEBREZZE. Well, under the provisions of the basic hospital plan your benefit year starts as of the day you go into the hospital and you are entitled to 60 days. If you leave the hospital, then you have a waiting period of 60 days and then you can return for another 60 days, so it is possible, not continuously, but within the course of a benefit year, that you could get 180 days of hospitalization.

Senator LONG. So——

Secretary CELEBREZZE. Under the benefit year.

Senator LONG. If he were desperately ill and needed hospitalization all year he would be in 60 days, out 60 days, in 60 days, out 60 days?

Secretary CELEBREZZE. That is right.

Senator LONG. Off again, on again Finnegan.

Secretary CELEBREZZE. Yes.

Senator CURTIS. Would you yield for a very brief question?

Senator LONG. I am trying to get the answer to the question first.

Senator CURTIS. Excuse me.

Secretary CELEBREZZE. We would only cover the first 60 days of an illness in a hospital, and then, of course, we can take it from there and pay for a nursing home, a skilled nursing home which has a transfer agreement with the hospital.

Now, in the event at the end of 60 days he is so bad that he still needs hospitalization, if he can't pay it, that is where the third prong of this bill comes into effect—we could pick him up under Kerr-Mills.

Senator LONG. If the State doesn't have a Kerr-Mills program—and some States don't—or if the Kerr-Mills program says a person is not eligible because he owns his own home, then he would be out for 60 days before he could go back in, I take it?

Secretary CELEBREZZE. Yes, but the basic purpose of this bill is not to take care of long-term chronic illness. We are not covering that at all.

Senator LONG. Why do you leave out the real catastrophes, the catastrophic illnesses?

Secretary CELEBREZZE. Well, for the basic reason that this is not intended for those that are going to stay in institutions year-in and year-out, who are primarily receiving custodial care. It was never intended for that purpose. You can't buy a hospital policy that will give you that kind of protection.

Now, the average stay in a hospital here in America is, I think, 7.7 days. Now, there are 60 days of hospitalization covered under the bill, and you can't come up with any plan and finance it soundly if you say to a man if you need 4 years we are going to pay 4 years.

You can't finance it on that basis, and I think we go far enough when we say 60 days.

At that point you leave the hospital if you are able to leave it.

Senator LONG. It seems to me if you take out insurance you ought to take it against the risk that you can't afford to take.

In other words, suppose after age 65 I am ill. All right. I have got enough resources, I can make it for 60 days. But what scares me to death is suppose I am sick all year long and on into the next year?

Now, you have got a plan that is going to insure me for the risk I can afford to take.

Secretary CELEBREZZE. No; not only that.

Senator LONG. But it is not going to insure me for the risk I can't afford to take.

Secretary CELEBREZZE. No; the statistics show that the highest cost for most of the aged actually comes within the first 14 to 15 days of hospital care. We are not trying to solve under this bill, under a health insurance plan, we are not trying to solve the problem of financing long-term custodial care.

Senator LONG. Well, in arguing for your plan you say let's not strip poor old grandma of the last dress she has and of her home and what little resources she has and you bring us a plan that does exactly that unless she gets well in 60 days.

Secretary CELEBREZZE. Yes; if you need it you can go under two plans, you can go under medicare and if that does not provide sufficient protection you can go under public assistance for additional help.

Senator LONG. Strong advocates of your plan are saying, "How shameful it is to make grandma go down there to plead with the welfare about how she is indigent and she can't pay and ask for welfare assistance."

So, it seems to me as though if you are going to have a plan, the first thing you ought to do is she is not going to have to do that, and I just can't understand why you want to pay for the first 60 days and then not pay after the 60 days. It seems to me as though you would be better off to have a bigger deductible and then to see these people on through from that point forward.

Secretary CELEBREZZE. If you go to a higher deductible you are injuring the people you are trying to help. It is the poor people you are trying to help. If you go to a higher deductible they won't be able to afford the deductible.

Senator LONG. Well, you aren't going to injure them all that much because you and I know you can't squeeze blood out of a turnip. Once you put them in a hospital if they haven't got the money to be paid they can't be paid, put it on the cuff and get it back when it can be paid.

Secretary CELEBREZZE. There will be so few cases who really need hospital care more than 60 days. They can be handled under Kerr-Mills, and some 43 jurdisdictions, 40 States, have Kerr-Mills.

Senator LONG. Almost everybody I know of who comes in and says we ought to have medicare picks out the very kind of cases that you and I are talking about where a person is sick for a lot longer than 60 days and needs a lot more hospitalization, $4,000 or $5,000 bill.

Secretary CELEBREZZE. If you come up with a policy, and expect to have it financially sound, that will pay anybody's bill as long as he wants to stay in the hospital, then you will have more people staying in hospitals and you are not going to have enough hospitals to take care of them. I think that when we stretch it to 60 days——

Senator LONG. You are going to have it under either plan in either event we are going to have to build more hospitals.

Secretary CELEBREZZE. Senator, this is a liberal provision, 60 days in the hospital, and then you can leave there and get additional days in a skilled nursing home and leave there and get home care in addition. I don't think that—there may be the exceptional case; there are, no doubt there always are, exceptions; but there are other provisions in this bill, under the liberalization of the Kerr-Mills Act, which could easily take care of that type of case.

Senator LONG. Yes; but if these persons happen to be in such shape that they need to be under an oxygen tent, they need the constant care of a physician, they need to have hypodermics periodically during the day, they need to have blood transfusions two or three times a week, then after that 60 days they are in pretty tough shape.

You ought to be taking care of them.

Mr. BALL. Senator, if I could just enlarge on a couple of points the Secretary made, I think the first reluctance that we have to move in that direction—and also I might say the Advisory Council discussed this at some length, too—is that there are very, very few cases that the professional people think ought to be in a hospital beyond 60 days.

Now, first of all, there aren't very many who are, but even among the group who do stay beyond 60 days there is a strong feeling that quite a significant number really ought to be moved over to an extended care facility.

Now, I am not saying there aren't individual situations such as you have described, but the first point is that there are very, very few of them that ought to be in a hospital that long.

Now, in order to take care of the rare case, you have to insure for more than 60 days—that is offer to cover the care for people beyond 60 days—and there is real fear, real fear, that because of such an offer more people would be staying in hospitals beyond 60 days than are staying today because you offer to pay for it, and really the thought is there ought to be fewer that stay beyond 60 days.

So, the hope was that we could create incentives to move people from the hospital over to extended care. You remember the bill has in it a one-for-two incentive provision where you get more extended care if you don't use up all your hospital care.

So, with an average stay of aged people in hospitals of only 14 to 15 days, it is thought that it is a very rare case that should go beyond 60 and we had a fear of setting up incentives that might encourage unnecessarily long hospital stays.

Senator LONG. Let me just say this: the cost of this thing is going to be at least, even with your 60-day provision, 50 percent more than

it ought to be unless you use this utilization review provision to the utmost.

Mr. BALL. Yes.

Senator LONG. For example, right in Louisiana, we have an extensive charity hospital system and our figures indicate that in these State hospitals the average patient stays 50 percent longer than he does in the private hospital where he is paying the bills himself.

There is no reason why, if you get yourself a committee who have got the courage to be tough about this thing, they couldn't discharge them in the State hospitals on the same standards they use in the private hospitals; it is the same doctors in some cases. But that is how you are supposed to get these people out of there.

Where you have even got a small number, these people in these catastrophic cases, it seems to me that is the first thing you ought to insure.

Mr. BALL. I would say, Senator, speaking at least for myself, after we had developed some actual experience with the administration of this program—with the utilization committee, the other controls that are in the bill under a 60-day provision—and if it was working well, at a later point an extension to some additional days might seem perfectly feasible.

I think there is fear of setting up an incentive for even longer stays by paying for these very exceptional long-term cases at the beginning of a program like this.

Senator LONG. That is all.

Senator ANDERSON. Senator Douglas.

Senator DOUGLAS. I find myself with a great deal of sympathy for the suggestion my friend, the Senator from Louisiana, makes.

If I may indulge in a little history, in 1950 I proposed a substitute for the Murray-Dingell health insurance bill to provide insurance against residual costs above those which would normally be anticipated.

That is the basic purpose of insurance: to insure against the unexpected and extraordinary losses over and above a given percentage of income or a minimum amount.

I found myself shot at from both extremes, because the representatives of private groups objected to any protection and those of the social welfare groups and public groups including some of my friends who are before us here, objected to merely confining attention to residual costs.

I find myself with a good deal of sympathy for the position of the Senator from Louisiana and I hope we can deal with this issue.

I have to leave very soon and I would like to ask a few questions. Mr. Secretary, you have a very capable, very honorable hard-working chief actuary, one of the best public servants we have, who has never been adequately recognized by the Department of Health, Education, and Welfare.

Secretary CELEBREZZE. I have recognized him.

Senator DOUGLAS. By anything more than words?

Secretary CELEBREZZE. I have asked, I have him in every other day in my office asking him questions.

Senator DOUGLAS. You ought to put him up at the very top, grade 19. I mean that, and I am not a personal friend of his.

Senator LONG. Who is that, Paul?
Senator DOUGLAS. Mr. Myers.
I am not a personal friend of Mr. Myers, I have never met him outside of the hearing room.
Senator LONG. You promoted Mr. Cohen, which I approve, and you ought to promote Mr. Myers, I support that motion. [Laughter.]
Senator DOUGLAS. I would like to have you file for the record the actuarial worksheets to justify your estimates under the plan up to 1987, of the benefits, the contributions, and the balances in the fund.
Do I understand that the fund is to run a surplus in the early years?
Secretary CELEBREZZE. You are talking about the total bill now or just the House bill?
Senator DOUGLAS. No, I am talking about the basic plan.
Secretary CELEBREZZE. Basic hospital insurance. Yes, it will run a surplus in the first year.
Senator DOUGLAS. In the first year, but then afterward?
Secretary CELEBREZZE. It keeps on running ahead. It is in balance.
Senator DOUGLAS. And then subsequently?
Secretary CELEBREZZE. Yes. It keeps on.
Senator DOUGLAS. What will be the surplus, if any, by 1987?
Secretary CELEBREZZE. We have it here.
Mr. MYERS. Senator Douglas, the balance in the hospital insurance trust fund in 1990 would be very close to $10 billion, which is about 1 year's benefit payments.
Senator DOUGLAS. This is puzzling to some because you include for benefits the 17 million people now under social security who have never had a chance to make any payments in the past to the hospital insurance trust fund but whose benefits begin immediately.
What actuarial legerdemain enables you to do this?
Mr. MYERS. Senator, it is merely achieved by determining the total benefit cost and calculating a contribution rate over the years that will bring in enough money.
Senator DOUGLAS. Will you furnish for the record the worksheets upon which you base your estimates of the cost for hospital and nursing care benefits the contribution rates and yearly totals, and the balances; not merely the global figures but the detailed worksheets upon which the global figures are based?
Mr. MYERS. Yes, I will be glad to do so.
(The information referred to follows:)

APRIL 30, 1965.

Memorandum.
From: Robert J. Myers.
Subject: Worksheets for actuarial cost estimates for hospital insurance program.

At the hearings before the Senate Committee on Finance today, Senator Douglas requested that certain summary worksheets underlying the long-range actuarial cost estimates for the hospital insurance system that would be established by H.R. 6675 should be inserted in the record. These would give the underlying basis for the summarized figures that appear in the House committee report on the bill. The most important of these worksheets are attached herewith as exhibits. Unfortunately, the actuarial computations and methodology involved are rather difficult to follow because they are, in essence, built up from one proposed plan to another until the final plan of the House bill is reached.

Exhibit A merely presents the global figures for the estimated progress of the hospital insurance trust fund, as displayed in the House committee report. Exhibit B similarly lists the principal underlying assumptions for these actuarial cost estimates.

The various pages of exhibit C trace through the detailed development of the cost estimates. Page 1 shows the global figures for the progress of the trust fund, along with certain auxiliary figures. Pages 2 and 3 show the development of the taxable payroll from which the contribution income is estimated by applying the appropriate tax rates. Pages 4 through 8 trace through the estimated benefit payments and administrative expenses, year by year, as the plan was changed in various respects (such as by the exclusion of the services of certain doctors in the hospitals and such as by changing the size of the deductible). Page 9 tabulates the population eligible for HI benefits in quinquennial future calendar years by age groups and sex. Hospital utilization rates (see p. —) are applied against these age-sex distributions to obtain total days of hospitalization and the result is then multiplied by average daily hospital costs, adjusted to include the cost of the auxiliary benefits (as derived for the initial year as projected to future years by allowing for increasing hospitalization costs).

ROBERT J. MYERS.

[Excerpt from p. 69 of House committee report on H.R. 6675]

EXHIBIT A

TABLE C.—*Estimated progress of hospital insurance trust fund*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	$1,578	$982	$50	$17	$562
1967	2,601	2,192	66	20	925
1968	2,790	2,391	72	34	1,286
1969	2,879	2,607	78	45	1,525
1970	2,983	2,840	85	50	1,633
1971	3,327	3,055	92	55	1,863
1972	3,488	3,280	98	60	2,038
1973	3,929	3,516	105	68	2,414
1974	4,120	3,760	113	77	2,738
1975	4,267	4,028	121	84	2,960
1980	6,123	5,276	158	140	5,018
1985	7,038	6,823	205	236	7,681
1990	9,030	8,754	263	306	9,948

NOTE.—The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not shown in the above figures.

EXHIBIT B

[Excerpt from pp. 54–55 of House committee report on H.R. 6675]

(5) *Assumptions as to relative trends of hospitalization costs and earnings underlying cost estimate for committee bill—H.R. 6675*

As indicated previously, your committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. For the reasons brought out previously, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

Accordingly, for the purposes of the cost estimates in this report, the assumptions as to the relative trend of hospitalization costs as compared with the general earnings level have been modified somewhat as compared with the relatively conservative assumptions recommended by the Advisory Council. The same differential of hospital costs over earnings for the first 10 years is used, but thereafter the assumption is made that these two elements increase at the same rate (rather than having a negative one-half of 1 percent annual differential, as in the Advisory Council recommendations). In other words, the

basis of the hospitalization-cost trends used in the cost estimates of this report are on a more conservative basis than recommended by the Advisory Council and, in fact, are more conservative than those used by the insurance business for its estimates for proposals of this type.

(6) Assumptions as to hospital utilization rates underlying cost estimates for committee bill—H.R. 6675

It should be pointed out that the hospital utilization assumptions for the cost estimates prepared by the Social Security Administration and also those in this report have always been founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for the various past proposals (H.R. 3920 and S. 880, 88th Cong.; the Advisory Council plan; and H.R. 1 and S. 1, 89th Cong.) were the same in all instances. In view of the fact that testimony of the insurance business and the Blue Cross stated their belief that higher utilization would develop (actually, by as much as 40 percent higher in the early years of operation), your committee has adopted higher utilization rates than those used previously by the Social Security Administration. The increase in the early year utilization rates is about 20 percent. Half of this can be attributed to changing the previous assumption of low-cost utilization rates in the early years to the assumption of the intermediate-cost rates then; the latter were previously used only after the program would be in operation for a few years and the beneficiaries would have better knowledge of the benefits available. The other half of the increase in the utilization rates can be said to represent a basic adjustment upward for all future years, which can be viewed as a safety factor.

In other words, the current estimates can be considered to be high-cost ones, as compared with the intermediate-cost ones formerly used by the Social Security Administration. Another factor that may be used to justify the higher utilization rates used in these cost estimates is the somewhat greater amount of hospitalization which might result from the availability of the physicians' services benefits for in-hospital cases made available under the supplementary health insurance benefits program contained in your committee's bill.

(7) Assumptions as to hospital per diem rates underlying cost estimates for committee bill—H.R. 6675

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in actuarial study No. 59 of the Social Security Administration. These per diem costs were in close agreement with what the Blue Cross testimony indicated, although some 13 percent below the estimates of the insurance business. The reason for the latter differential is that the insurance business did not make as large an allowance for a lower average daily cost for persons aged 65 and over and for hospital expenses that are not related to in-patients. The only significant change in the average daily hospitalization cost figures was a reduction by about 4 percent to allow for the exclusion from the hospital insurance system that would be established by your committee's bill of the in-hospital costs arising from the professional services of radiologists, anesthesiologists, pathologists, and physiatrists (the costs for such services would be covered under the supplementary health insurance benefits plan).

Hospital insurance trust fund, House bill

Rate	Calendar year	Contribution[1]	Total benefits and administrative expenses	Administrative expenses	Net income	Interest	Fund increase	Fund at yearend			Railroad contributions		Railroad benefit[2]	
											Rate	(P. 8)	Revised	Original
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
$0.70	1966	1,578	1,033	50	545	17	562	562		4.00	31	29	36	55
1.00	1967	2,601	2,258	66	343	20	363	925		4.00	45	43	77	116
1.00	1968	2,790	2,463	72	327	34	361	1,286		4.00	47	45	82	128
1.00	1969	2,879	2,685	78	194	45	239	1,525		4.00	47	45	80	130
1.00	1970	2,983	2,925	85	58	50	108	1,633		4.00	47	45	91	137
1.00	1971	3,327	3,147	92	180	55	235	1,868		3.90	51	49	94	143
1.00	1972	3,488	3,378	98	110	60	170	2,038		3.80	52	50	97	150
1.10	1973	3,929	3,621	105	308	68	376	2,414		3.70	56	54	100	157
1.10	1974	4,120	3,873	113	247	77	324	2,738		3.60	58	55	103	163
1.10	1975[3]	4,267	4,139	121	128	84	212	2,950		3.50	58	55	105	170
1.20	1976	4,743	4,399	121	344	94	438	3,388		3.50	62	59	106	175
1.20	1977	4,928	4,657	121	271	107	378	3,766		3.50	63	60	106	180
1.20	1978	5,066	4,916	121	150	117	267	4,033		3.50	63	60	106	186
1.20	1979	5,206	5,174	121	32	124	156	4,189		3.50	63	60	106	191
1.40	1980	6,123	5,434	158	689	140	829	5,018		3.50	70	69	106	197
1.40	1981	6,395	5,754	158	641	167	808	5,826		3.50	70	70	106	203
1.40	1982	6,556	6,071	158	485	191	676	6,502		3.50	70	70	106	209
1.40	1983	6,719	6,389	158	330	211	541	7,043		3.50	70	70	106	215
1.40	1984	6,875	6,709	158	166	226	392	7,435		3.50	70	70	106	222
1.40	1985	7,038	7,028	205	10	236	246	7,681		3.50	70	70	106	228
1.40	1986	7,214	7,426	205	−212	239	27	7,708		3.50	70	70	106	235
1.60	1987	8,303	7,823	205	480	251	731	8,439		3.50	79	79	105	242
1.60	1988	8,634	8,221	205	413	274	687	9,126		3.50	80	80	105	250
1.60	1989	8,829	8,619	205	210	293	503	9,629		3.50	80	80	104	257
1.60	1990	9,030	9,017	223	13	306	319	9,948		3.50	80	80	104	265
		1.23											1,602	2,882
	PV, at 3½ percent	81,045	78,613										(.02)	(.04)
	Col. (2) same as P. 6e	9,017	3,816											
	3½ percent of 10 percent of PV of fund		268											
	Total value of benefits and fund		80,697		[4] 6,867	1.23%								

[1] Col. (1) equals rate times col. (4), p. I–1 (except year of change).

[2] Included in cols. (1) and (2). (See note 2.) Amounts are 3 percent of benefits (arbit. $50,000 for 1966).

[3] Benefit equals $4,018, not $4,028 as in report.

[4] From p. I–1 (in billions).

Effective taxable payroll for hospital insurance (SE at EE rate and railroad direct coverage)

[Red rates are for House bill. Level-cost on AS No. 57 utilization rates = 1.17÷1.11=1.05]

Calendar year	A		B			C	
1965							
1966	225.4	0.46	225.4	0.46	0.70	225.4	0.46
1967	270.0		270.0	0.84	0	270.0	.84
1968	279.0		279.0	0.88		279.0	.88
1969	287.9		287.9	0.93		287.9	
1970	298.3		298.3	0.98		298.3	
1971	309.0	1.02	332.7	0.94		336.1	.94
1972	319.6		348.8	0.97		348.8	
1973	330.4		361.2	1.00	1.10	361.2	
1974	341.6		374.5	1.03		374.5	1.03
1975	353.1	1.17	387.9	1.07		387.9	1.07
1976	362.9		399.3	1.10	1.20	424.0	
1977	372.3		410.7	1.13		436.7	
1978	382.4		422.2	1.16		449.7	
1979	391.7		433.8	1.19		462.6	
1980	401.7	1.35	445.2	1.22	1.40	475.8	1.14
1981	411.5		456.8	1.26		516.5	
1982	421.1		468.3	1.30		530.5	
1983	430.6		479.9	1.33		544.8	
1984	440.3		491.1	1.37		559.4	
1985	449.6	1.56	502.7	1.40		573.9	1.22
1986	459.9		515.3	1.44		621.5	
1987	470.6		527.0	1.48	1.60	638.6	
1988	480.6		539.6	1.52		655.3	
1989	491.1		551.8	1.56		672.6	1.28
1990	500.9	1.80	564.4	1.60		689.6	1.31
PU, 3½ percent	6,050		6,570	1.17			

NOTE 1

A~$5,600 in 1966 and no keepup. Taken at (0.9779) of No. 1 p. E with addition of 4.5 for railroad (add only 1½2 (4.5) in 1966).

B~$5,600 in 1966, $6,600 in 1971–90. Same as A for 1965–70. Taken at (0.9779) of No. B with addition of 5.0 for railroad.

C~$5,600 in 1960, $6,600 in 1971, and $800 increase every 5th year. Same as B for 1966–75. Taken at (0.9779) of No. C p. E with addition of 5.3 in 1976–80; 5.6 in 1980–85; 6 in 1986–90 for railroad.

(See note for explanation of contributions.)

[1] No use of this factor in 1966 figs. SE do not contribute in 1966.

NOTE 2

Contributions are calculated by straight multiplication of the effective taxable payroll by the tax rate. For years of change in the rate the multiplication is done by an average rate calculated as follows:

$$R_x = 0.1228 r_{x-1} + 0.8772 r_x.$$

The year 1966 is not considered a year of tax change for our purposes.
Factor of 0.9779 is to change from SE at 1½ee rate to 1.0 ee rate.
The formulas for the taxable payrolls are as follows:
For SE at 1½ EE rate: $T_x = 0.8450 C_x + 0.1443 C_{x-1}$;
For SE at EE rate: $^{*}T_x = 0.8450 C_x + 0.1218 C_{x-1}$.
If we assume that the creditable payroll increases at 3 percent per year then

$$C_{x-1} = \frac{C_x}{1.03}, \text{ and } \frac{^{*}T_x}{T_x} = 0.9779.$$

This factor would not change appreciably if the increase rate were assumed at 2 or 4 percent. Lower or higher increase rates would seem unreasonable for the years 1966–90.

The formula for taxable payroll if SE at EE rate is

$$T_x = 0.8450 C_x + 0.1218 C_{x-1}.$$

For a year of tax increase the contribution would be

$$C_x = 0.8450 C_x r_x + 0.1218 C_{x-1} r_{x-1}.$$

If we assume $1.03 = \frac{C_x}{C_{x-1}}$, then

$$T_x = 0.9633 C_x$$
$$C_x = (0.8450 r_x + 0.1183 r_{x-1}) C_x.$$

If we substitute in the last equations the value of C_x in terms of T_x, we get

$$C_x = (0.8772 r_x + 0.1228 r_{x-1}) T_x.$$

The term in parenthesis could be viewed as an average rate to be applied to the effective taxable payroll.

Mills proposal of Mar. 3, 1965 (committee print of March 1965). Same as H.R. 1 except doctor services[1] out; home health services deliberalized; SE payee rate; extended care benefits modified; earnings base of $5,600 for 1966–70 and then $6,600

[Red figures are revised estimates (see reverse of p. 6e) obtained in April 1965]

Rate	Calendar year	(1) Contributions	(2) Eligibles		(3) Transitional insured		(4) Railroad		(5) Total		(6) Net income	(7) Interest	(8) Fund increase	(9) Fund at yearend	(10) i
			B	E	N	E	F	I	T	S					
0.90	1966	2,029		944		34	76	55		1,033	996	26	1,022	1,022	4.00
.90	1967	2,430		2,075		67	77	116		2,258	172	35	207	1,229	4.00
.90	1968	2,511		2,275		65	82	123		2,463	48	40	88	1,317	4.00
.90	1969	2,591		2,492		63	86	130		2,685	−94	40	−54	1,263	4.00
.90	1970	2,685		2,727		61	91	137		2,925	−240	34	−206	1,057	4.00
1.00	1971	3,320		2,946		58	94	143		3,147	173	33	206	1,263	3.90
1.00	1972	3,488		3,174		54	97	150		3,378	110	39	149	1,412	3.80
1.00	1973	3,612		3,414		50	100	157		3,621	−9	42	33	1,445	3.70
	1974			3,664		46	103	163		3,873					3.60
	1975			3,927		42	105	170		4,139					3.50
	1976			4,186		38	106	175		4,399					
	1977			4,443		34	106	180		4,657					
	1978			4,701		29	106	186		4,916					
	1979			4,958		25	106	191		5,174					
	1980			5,216		21	106	197		5,434					
	1981			5,532		19	106	203		5,754					
	1982			5,845		17	106	209		6,071					
	1983			6,160		14	106	215		6,389					
	1984			6,475		12	106	222		6,709					
	1985			6,790		10	106	228		7,028					
	1986			7,182		9	106	235		7,420					
	1987			7,573		8	105	242		7,823					
	1988			7,965		6	105	250		8,221					
	1989			8,357		5	104	257		8,619					
	1990			8,748		4	104	265		9,017					

NOTES

[1] Radiologist, anasthesiologist, pathologist, physiatrist.

Col. 1 based on payroll B from p. I–1.

Col. 2: 96 percent of col. 2, p. 6d. Reduced by 4 percent due to elimination of RAPP.

Col. 3: $\left(\frac{0.84}{0.86}\right)^{1} \times 1.08 \times 0.96\,^{2} \times \frac{400{,}000}{1{,}615{,}000\,^{3}} \times (1.03)^{t-1965\;4} \times$ col. 4, p. 1 (2d factor=10 percent increase due to utilization, −2 percent increase due to reduced home health.)

Adjustments to col 3:

[1] 1 day deductible.
[2] RAPP.
[3] Population of transitional.
[4] 3 percent increase, 1 year.

Col. 4: $110,000,000 increased 5.7 percent for 5 years, 4.35 percent for 5 more years, 3 percent thereafter (based on 10 percent above RRB estimate for 1st year. see Niessen memo of Feb. 12, 1965). This assume that "RRA only" beneficiaries will stay constant at about 600,000 (but see Niessen memo of Mar. 26, 1965).

A better estimate would be $73,000 initially because "dual beneficiary" should be left out. Later years based on reduction in "RRA only" beneficiaries from Niessen memo of Mar. 26, 1965. Red figures in col. 4 are determined by multiplying the black figures by $\frac{73}{110}\times 0$ percent from Niessen memo.

Mills proposal of Feb. 23, 1965 (same as H.R. 1, except home health services deliberalized and 90 days of hospital with $100 deductible)—Earnings base of $5,600 for 10 years, increase of $600 every 5th year (No. 6)

Tax rate	Calendar year	Payroll			Contributions	Benefits and expenses	Net income	Interest	Fund increase	Fund at yearend				Keeping up every 5th year
		New	Old		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
	1965													
0.90	1966	221.3	230.3	0.43	1,992	983	1,009	26	1,035	1,035		4.00		0.43
.90	1967	271.5	278.3	.78	2,444	2,161	283	38	321	1,356		4.00		.78
.90	1968	280.7	287.6	.82	2,526	2,370	156	48	204	1,560		4.00		.82
.90	1969	289.8	297.1	.87	2,608	2,596	12	52	64	1,624		4.00		.87
1.00	1970	300.4	306.7	.93	2,961	2,841	120	56	176	1,800		4.00		.93
1.00	1971	311.4	316.6	.97	3,114	3,069	45	59	104	1,904		3.90		.90
1.00	1972	322.2	326.2	1.01	3,222	3,307	−85	58	−27	1,877		3.80		.94
1.00	1973	333.3	336.1	1.06	3,333	3,556	−223	52	−171	1,706		3.70		.98
1.20	1974	344.7	346.1	1.10	4,038	3,817	221	52	273	1,979		3.60		1.01
1.20	1975	356.5	356.5	1.15	4,278	4,091	187	58	245	2,224		3.50		1.05
1.20	1976	356.5	389.4	1.12	4,673	4,360	313	68	381	2,605		3.50		1.01
1.20	1977	356.5	400.5	1.16	4,806	4,628	178	78	256	2,861		3.50		1.04
1.20	1978	356.5	411.5	1.19	4,938	4,897	41	84	125	2,986		3.50		1.07
1.20	1979	356.5	422.7	1.22	5,072	5,165	−93	85	−8	2,978		3.50		1.09
1.20	1980	356.5	433.6	1.25	5,203	5,433	−230	81	−149	2,829		3.50		1.12
1.20	1981	356.5	470.6	1.22	5,647	5,762	−115	77	−38	2,971		3.50		1.07
1.20	1982	356.5	482.8	1.26	5,794	6,089	−295	71	−224	2,567		3.50		1.10
1.20	1983	356.5	494.4	1.30	5,933	6,417	−484	59	−425	2,142		3.50		1.13
1.40	1984	356.5	506.9	1.33	6,952	6,745	207	55	262	2,404		3.50		1.15
1.40	1985	356.5	518.5	1.36	7,259	7,073	186	63	249	2,653		3.50		1.18
1.40	1986	356.5	561.2	1.33	7,857	7,481	376	72	448	3,101		3.50		1.12
1.40	1987	356.5	575.7	1.37	8,060	7,889	171	84	255	3,356		3.50		1.15
1.40	1988	356.5	589.7	1.41	8,256	8,297	−41	88	47	3,403		3.50		1.18
1.40	1989	356.5	604.1	1.44	8,457	8,705	−248	84	−164	3,239		3.50		1.29
1.40	1990	356.5	618.0	1.48	8,652	9,113	−461	73	−388	2,851		3.50		1.22
	PV, at 3½ percent					[1] 76,168								

[1] Does not include PV of 1 year's benefit payments as 1990 trust fund (nor factor of TF not being fully invested).

NOTE.—Col. 2 from p. 6c for years 1966–75 by taking out low-cost adjustment in early years and increasing by 10 percent for utilization and reducing 2 percent for deliberalization of home health. Same basis used after 1975. (See red figures, p. 3d.)

Short range—H.R. 1 (same as 6b, except col. 2 is 0.84/0.86 times col. 2 on 6b to get 1 day deductible) (2 days, 1 day deductible)

AS No. 59

Calendar year	Contribution [1]	Benefits and administrative expenses	Net income	Interest	Fund increase	Fund at yearend	4 percent
1966	1,328	[2] 818	510	15	525	525	
1967	1,994	[2] 1,799	195	18	213	738	
1968	2,135	[2] 2,601	134	24	158	896	
1969	2,545	[2] 2,221	324	33	357	1,253	
1970	2,690	2,465	225	45	270	1,523	
1971	2,769	2,700	69	51	120	1,643	
1972	2,850	2,946	−96	52	−44	1,599	
1973	2,935	3,211	−276	46	−230	1,369	
1974	3,021	3,468	−467	31	−436	933	
1975	3,106	3,788	−683	8	−675	258	

[1] From sheet D. Amount computed as described in heading is increased by 2 percent for 1966, 1½ percent for 1937, 1 percent for 1968, and ½ percent for 1969.

Calendar year	Federal cost for hospital insurance (A)	If no blanketing-in savings: Federal (B)	If no blanketing-in savings: State (C)	If blanketing-in savings: Federal (D)	If blanketing-in savings: State (E)	If blanketing-in savings: Net Federal cost (F)
1966	125	$50	$60	$90	$110	$35
1967	255	120	130	200	230	55
1968	250	130	140	205	235	45
1969	245	140	150	215	245	30
1970	240	150	160	225	250	15

NOTES

(A) = (4), p.2 [1] $\times \frac{1750}{1615} \times \frac{.84}{.86} = 1.0584$ (where 1st factor from reverse of p. 1 and 2d factor allows for 1-day deductible, instead of ½ day).

(B) and (C) from p. 28, AS No. 57 (since hospital insurance plan has about same cost).

(D) and (E) based on (B) and (C), plus $\frac{180-100}{260} \times (A)$ and $\frac{215-115}{260} \times (A)$, respectively. (See p. 28, AS No. 97 for factors.)

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Long range—H.R. 1 (same as p. 3c, except col. 1 reflects tips and S.E. doctos and col. 2 is multiplied by 0.84/0.86 to give benefits for 1-day deductible). Red figures assume wages and costs remain at same levels after 1975

Calendar year	Contributions [1] (1)	Benefits (2)	Administive expenses (2A)	Net income (3)	Interest (4)	Fund increase (5)	Fund at year end (6)	Jan. 1965 (7)	Interest rate (8)	No ½-percent decrease (9)
1966	1,325	725	------	590	16	606	606	------	4.00	------
1967	1,937	1,575	0.49	382	25	387	993	------	4.00	------
1968	2,035	1,709	.64	326	39	365	1,358	------	4.00	------
1969	2,400	1,851	.68	549	58	607	1,965	------	4.00	------
1970	2,500	2,005	.72	495	80	575	2,540	------	4.00	------
1975	2,729	2,657	.86	72	136	------	4,320	------	[2] 3.50	------
1980	2,946	2,969	.91	−23	165	------	5,166	------	[2] 3.50	3,044
1985	3,148	3,252	.93	−104	183	------	5,692	------	[2] 3.50	3,418
1990	3,373	3,525	.94	−152	193	------	5,975	------	[2] 3.50	3,799
1995	3,633	3,683	.91	−50	209	------	6,525	------	[2] 3.50	------
2000	3,913	3,720	.86	193	261	------	8,185	------	[2] 3.50	------
2005	4,162	3,683	.86	479	372	------	11,620	------	[2] 3.50	------
2010	4,392	3,730	.76	662	547	------	16,930	------	[2] 3.50	------
2015	4,576	3,977	.78	599	769	------	23,445	------	[2] 3.50	------
2020	4,732	4,381	.82	351	1,002	------	30,241	------	[2] 3.50	------
2025	4,864	4,749	.88	115	1,223	------	36,991	------	[2] 3.50	------
2030	4,980	4,995	.90	−15	1,473	------	44,053	------	[2] 3.50	------
2035	5,072	5,127	.91	−55	1,743	------	52,016	------	[2] 3.50	------
2040	5,156	5,207	.91	−51	2,059	------	61,394	------	[2] 3.50	------
1975	2,729	2,657	.97	72	136	------	4,320	------	------	------
1980	2,946	3,044	1.08	−98	------	------	4,926	------	------	------
1985	3,148	3,418	1.08	−270	------	------	4,704	------	------	------
1990	3,373	3,799	1.13	−426	------	------	3,546	------	------	------

[1] From 1965 H.R. 1 contributions page.
[2] In 1971.

NOTE.—PV to 2040: 3.50 percent, 3.25 percent, and 3.75 percent.

Intermediate estimate of eligible population (24th T.R.)

Sex and age	1965 (1)	1970 (2)	1975 (3)	1980 (4)	1985 (5)	1990 (6)	1995 (7)	2000 (8)	2005 (9)
Male:									
65 to 69	2,689	2,957	3,394	3,808	4,033	4,364	4,266	4,040	4,218
70 to 74	2,031	2,194	2,422	2,796	3,134	3,350	3,649	3,582	3,394
75 to 79	1,322	1,463	1,603	1,790	2,088	2,360	2,538	2,774	2,725
80 to 84	662	802	900	1,000	1,129	1,330	1,514	1,636	1,790
85 plus	252	394	519	617	708	812	961	1,114	1,227
Total:									
65 plus	6,956	7,810	8,838	10,011	11,092	12,216	12,928	13,148	13,354
68 plus	5,185	5,853	6,568	7,473	8,456	9,354	10,220	10,612	10,625
70 plus	4,267	4,853	5,444	6,203	7,059	7,852	8,662	9,106	9,136
72 plus	3,560	4,097	4,631	5,247	5,949	6,574	7,301	7,746	7,910
75 plus	2,236	2,659	3,022	3,407	3,925	4,502	5,013	5,524	5,742
80 plus	914	1,196	1,419	1,617	1,837	2,142	2,475	2,750	3,017
Female:									
65 to 69	3,248	3,606	4,075	4,579	4,861	5,260	5,130	4,841	4,966
70 to 74	2,512	2,879	3,211	3,654	4,123	4,382	4,687	4,603	4,344
75 to 79	1,527	1,986	2,289	2,579	2,952	3,358	3,581	3,852	3,753
80 to 84	722	1,024	1,359	1,587	1,805	2,087	2,382	2,542	2,753
85 plus	255	497	765	1,057	1,280	1,503	1,756	2,039	2,224
Total:									
65 plus	8,264	9,904	11,699	13,456	15,021	16,590	17,536	17,877	18,040
68 plus	6,139	7,654	9,247	10,487	11,927	13,223	14,352	14,915	14,911
70 plus	5,016	6,386	7,624	8,877	10,160	11,330	12,406	13,036	13,074
72 plus	4,129	5,351	6,479	7,563	8,629	9,718	10,602	11,233	11,436
75 plus	2,504	3,507	4,413	5,223	6,037	6,948	7,719	8,433	8,780
80 plus	977	1,521	2,124	2,644	3,085	3,590	4,138	4,581	4,977
Male and female, 65 plus	15,220	17,804	20,537	23,466	26,113	28,806	30,464	31,023	31,314
As percent of total population, 65 plus	88.2	88	90.8	92.6	93.7	94.6	95.2	95.9	------------

DERIVATION OF CURRENT AVERAGE DAILY HOSPITAL COSTS

1963.—AHA average daily cost=$38.91 or 0.87×$38.91=$33.85 for aged +3 percent for administrative expenses=$34.87.

Estimated 1966=$38.91×1.055³=$45.68.

For aged, estimated 1966=$45.68×0.87=$39.74-$39.20. $39.20+3 percent for administrative expenses=$40.38.

Estimated 1964=$38.91×1.05=$40.86.

For aged, estimated 1964=$38.91×1.05×0.87=$35.55.

Projection of "$33.85 for 1963" rate for short-range cost estimate; 1966=(1.027)³ (1.03)³ ×$33.85=$40.06; 1967=(1.027)⁴ (1.03)⁴×$33.85=$42.38. $40.38×0.83=$33.52; $40.38×0.937/1.09=$34.71.

Derivation of hospital daily cost figures for long-range estimate, plus adjustment for "60-day, ½-day deduct" versus "45-day, no deduct," plus adjustment for supplementary benefits

Year	Increase factor, u_t		
	*		*Factor*
1965	$1.027^2 \times 1.037 = 1.065 \times 1.027$	$= 1.094 \times 35.764^*$	$= 39.13$
1966	$1.027^3 \times 1.044 = 1.101$	$= 1.131$	40.45
1967	$1.027^4 \times 1.051 = 1.138$	$= 1.169$	41.81
1968	$1.027^5 \times 1.057 = 1.176$	$= 1.208$	43.20
1969	$1.027^6 \times 1.064 = 1.216$	$= 1.249$	44.67
1970	$1.027^7 \times 1.071 = 1.257$	$= 1.291$	46.17
1975	$1.0135^5 \times u_{1970} =$	1.380	49.35
1980	$0.995^5 \times u_{1975} =$	1.346	48.13
1985	$0.995^5 \times u_{1980} =$	1.312	46.94
1990	$0.995^5 \times u_{1985} =$	1.280	45.75
1995	$0.995^5 \times u_{1990} =$	1.248	44.65
2000	$0.995^5 \times u_{1995} =$	1.217	43.54
2005		1.187	42.46
2010		1.158	41.41
2015		1.129	40.38
2020		1.101	39.38
2025		1.074	38.40
2030		1.047	37.45
2035		1.021	36.52
2040		.996	35.61

*This column represents the increase effect of the supplementary benefits (over No. 2).

*$\$34.87 \times \frac{0.80}{0.78}$ [\$34.87 from sheet C-2 and $\frac{0.80}{0.78}$ from memo of July 1964].

See the following:

$u\frac{1}{t}$ = increase factor for hospital cost alone.

$$\frac{u\frac{1}{t}}{u^1} = \frac{u_t + 1.07}{1.10} = \frac{u_t}{1.177}.$$

NOTE.—1.07 is factor to adjust for supplementary benefits; 1.10 is factor to indicate average, long-range effect of varying "hospital cost-wage" differential.

Over No. 2.—1965 factor (1.037) is ratio of 1st year supplementary benefit costs to hospital costs (AS No. 57); 1970 factor (1.071) is same ratio for level costs.

Eligible population times utilization rate for 45-day maximum

Sex and age	Utilization rate [1]	1965 (1)	1966 (2)	1967 (3)	1968 (4)	1969 (5)	1970 (6)	1975 (7)	1980 (8)	1985 (9)	1990 (10)
Male, 65 to 69	2.13	5,728	5,840	5,966	6,071	6,183	6,298	7,229	8,111	8,590	9,295
Male, 70 to 74	2.23	4,529	4,603	4,675	4,748	4,819	4,893	5,401	6,235	6,989	7,471
Male, 75 plus	3.75	8,385	8,700	9,018	9,338	9,653	9,971	11,333	12,776	14,719	16,883
Female, 65 to 69	1.77	5,749	5,876	6,003	6,130	6,255	6,383	7,213	8,105	8,604	9,310
Female, 70 to 74	2.70	6,782	6,982	7,179	7,376	7,576	7,773	8,670	9,866	11,132	11,881
Female, 75 plus	3.46	8,664	9,356	10,050	10,747	11,439	12,134	15,269	18,072	20,888	24,040
Total		39,837	41,357	42,881	44,410	45,925	47,462	55,115	63,165	70,922	78,830
Administrative room rate		39.34	40.81	42.27	43.85	45.46	47.10	50.79	49.16	47.53	46.63
Benefits and administrative expenses		1,567	1,688	1,813	1,947	2,088	2,235	2,799	3,101	3,371	3,629
Acreage utilization rate		2.62					2.67	2.68	2.69	2.72	2.74

[1] From AS No. 57, intermediate rates, multiplied by 0.937 to change from 60-day to 45-day maximum.

NOTE.—Eligible population from previous table.

Senator DOUGLAS. I will have great confidence in whatever you do because after watching you very closely for 30 years, I think you are one of the finest public servants we have.

Mr. MYERS. Thank you, Senator.

Senator DOUGLAS. Now criticism is frequently made that this measure gives benefits immediately to the some 17 million people who are now retired or semiretired under social security, who, except for a small number, will not contribute to the fund, but who receive these benefits, and that, therefore, you are taxing the young people to support these older people.

That cropped up in the questioning yesterday.

Now, may I ask this: When private companies institute pension plans are they able to confine benefits to those now contributing or will they extend benefits to either (*a*) past employees or (*b*) those who are in the terminal years of employment? Or will they exclude those who have left the employ of the company and those in the terminal years who would have a chance to contribute to the pension fund for only a few years?

Mr. BALL. Senator, I think the common practice is that for employees who are still in the employ of the employer but near retirement the employer picks up the cost of past service credits for such employees and this is quite similar to what social security does in the cash benefit area by rationalizing this deficit of contribution of older persons is coming from the employer's share of the contribution.

Senator DOUGLAS. Is this not called an accrued liability in actuarial language?

Mr. BALL. Yes.

Senator DOUGLAS. And if a pension system were to be instituted which confined benefits to those who in the past had made contributions sufficient to pay the whole cost of benefits, how many years would it be before any adequate benefits could be paid?

Mr. BALL. I would think, Senator, you would probably always be trying to catch up, because even though the time you took the action you would think that in 35 or 40 years the accumulation would be sufficient to pay benefits that were reasonably related to wages, wages would have gone up in the meantime. Employer private pension plans are constantly also under the necessity of liberalizing the benefits to keep up with future wages.

Senator DOUGLAS. If you did not meet these accrued liabilities—or sometimes they are called unearned annuities—and confined the benefits simply to those who had made sufficient contributions to pay for their benefits at retirement, would it not mean that the system could really not become effective for 20, 25, or 30 years?

Mr. BALL. Oh, yes.

Senator DOUGLAS. And wouldn't there be a tremendous popular uproar against a system which would not really take effect for a long period of time?

Mr. BALL. It wouldn't be doing its job.

Senator DOUGLAS. Hasn't this been the experience, with the private plans, too, that they have found it necessary and wise to blanket in those who are, say, in the last year of employment——

Mr. BALL. Yes.

Senator DOUGLAS. Or in the second to the last year of employment? And sometimes they have to take in past employees, isn't that correct?

Mr. BALL. Yes, sir, I believe some of the collective bargaining plans when they have added health protection, for instance, have given it to those already retired.

Senator DOUGLAS. Now, tears have been shed about people in their forties and fifties, bringing up families and so forth, being required to contribute for the support of the health care of their elders who are not making any contribution because they are not employed.

Is it not true that this plan will benefit not merely those over the age of 65, but their children and their grandchildren?

Mr. BALL. Yes.

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. Do not most of those over the age of 65 have children in their forties and fifties?

Secretary CELEBREZZE. Yes.

The way they benefit is that it takes the burden off the child of having to pay these hospital costs and at the same time, of course ——

Senator DOUGLAS. Do not the majority of these children in their forties and fifties in turn have children whom they are trying to educate?

Secretary CELEBREZZE. Yes.

Senator DOUGLAS. And bring up?

Secretary CELEBREZZE. Yes, that is one of the greatest burdens, to have children in school and then if the parents become sick (and under certain conditions, under State laws the child is responsible for the bills of the parents or to take care of the parents) then you have a choice sometimes between educating your children or paying the hospital.

Senator DOUGLAS. They are caught in this cruel dilemma. If they take care of their parents, in a very large percentage of cases they must neglect their children. If they take care of their children's needs, they have to neglect their parents.

Secretary CELEBREZZE. That is right.

Senator DOUGLAS. And by removing this burden from the shoulders of those over the age of 65 you are actually lifting the burden on their children in their forties and fifties and permitting them to concentrate on their own children, isn't that true?

Secretary CELEBREZZE. That is right.

And, of course, you would have complete hospitalization coverage in that this plan takes care of the old folks and while the young person is working he is carrying his group policy where he is working, so you have complete hospital insurance coverage for the whole family.

Mr. BALL. Senator Douglas, on that same point, as Senator Curtis developed yesterday, this proposal is really intended as a long-term solution or partial solution to this problem of high medical costs in old age so that we ought to look not only at the situation of young people now and parents now, but those who are in their middle years or are young people who will have the security of knowing that when they become 65 and are retired this protection will be there for them, and they will not have to make further payments.

Senator DOUGLAS. If this were a voluntary plan as some of our friends propose, how many youngsters, when they enter the working

force at the age of 20, would begin to make contributions to a fund to provide hospital and nursing care for them when they reach the age of 65?

Mr. BALL. I would think not very many.

Senator DOUGLAS. I can tell you how many, only those who would drink warm milk and wear rubbers on a hot day in the summer time. [Laughter.] Isn't this a case where the actuarial tables and the collective judgment of the people is superior to the anticipations of the individual?

Mr. BALL. There is also the point, I think, Senator, about the employer contribution in a voluntary system. If very few young employees would voluntarily do this, it is difficult for me to see how a voluntary system could get the advantage of an employer contribution

Senator DOUGLAS. And as a matter of fact, wouldn't people wake up to the high medical and hospital and nursing costs of old age just about the time they reach 55 or 60?

Mr. BALL. When their own parents would need it.

Senator DOUGLAS. By that time it would be too late for them to accumulate the funds to protect themselves adequately in their old age, isn't that true?

Mr. BALL. That I think is about the size of it.

Senator DOUGLAS. Now, some technical questions and I will try to wind up.

On the Kerr-Mills bill, States still have the right to accept or reject the Kerr-Mills plan, do they not?

Secretary CELEBREZZE. That is correct.

It is voluntary with the States.

Senator DOUGLAS. If they accept, however, what must they do under Kerr-Mills?

Secretary CELEBREZZE. There is a broadening of what they must do under the bill and I am going to ask Mr. Cohen to address himself to it because he helped draft that particular provision.

Mr. COHEN. Under the present law, the only requirement on scope of medical care is that the State must have some form of institutional care and some form of noninstitutional care, at its choice.

In the new bill, as reported out by the House Committee on Ways and Means, they must have at least five types of medical care.

In other words, the committee was impressed, I think, with the argument that a number of States have an inadequate scope and they included as their five items inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physician services.

Then they gave the State complete freedom of choice on such things as dental services.

Senator DOUGLAS. Is there any minimum duration?

Mr. COHEN. No, not on the number of visits or duration of hospital care.

Senator DOUGLAS. It is left up to the States?

Mr. COHEN. That is correct. But they didn't——

Senator DOUGLAS. What about the type of means test which the States could impose?

Mr. COHEN. Yes. They did not put into the bill a specific means test or income test, but they did put this in in an attempt to deal with

that fundamental problem; namely, that before you could get Federal funds you must provide for taking care of the medical care needs of all needy persons—aged, blind, dependent children, and the disabled—for whom you had determined a need to get cash benefits, and then that you had to deal with all of them on an equitable basis.

In other words, you couldn't be more liberal with regard to an income test for one group than for the other.

In other words, you have to provide the five types of medical service, you have to take in the four types of groups getting cash assistance, and then you have to provide for the same income test and the same scheme of medical care to all of them before you go beyond the level of people who are receiving cash assistance.

Senator DOUGLAS. Now, I am not quite clear in my mind how you are going to administer the hospital and nursing home benefits.

Are you to do this directly through the Department of Health, Education, and Welfare or are you to do it indirectly through such organizations as the Blue Cross?

Secretary CELEBREZZE. Let's take the two plans. Let's take first the basic plan.

Senator DOUGLAS. Let's take the basic plan.

Secretary CELEBREZZE. Under the basic plan the hospital, or group of hospitals, can nominate an intermediary to act for them, whether it be Blue Cross or private insurance, they can nominate an intermediary so that we have a buffer between the hospital and the Federal Government.

Senator DOUGLAS. Would you take private insurance companies?

Secretary CELEBREZZE. Yes, in certain instances they can designate private insurance companies to act for them.

Under the supplementary plan, to the extent possible (the words "to the extent possible" were put into the law) we must enter into a contract with an outside organization, either an insurance company or Blue Shield and so on to handle this program for us.

Senator DOUGLAS. You are not to do it directly?

Secretary CELEBREZZE. No.

At the time that the bill was under consideration they didn't have the words "to the extent possible" in the bill, which made it absolutely mandatory that the Secretary of Health, Education, and Welfare contract out.

My suggestion at that time was that that puts you in a position where you have to enter into a contract where the other fellow is holding all the cards, or you might find yourself in a position where no company would come in and want to handle the program and under the law the program would then die of its own weight.

So we recommended putting into the law, "to the extent possible," but it is the intention to enter into private contract to handle this program for us.

Senator DOUGLAS. May I ask, how many private insurance companies are there which write policies for doctor's surgical services in old age?

Mr. BALL. Quite a large number of them.

Senator DOUGLAS. There are many hundreds of them?

Mr. BALL. Yes.

Mr. COHEN. Yes.

Senator DOUGLAS. Probably many thousands?

Mr. COHEN. No, it is less than a thousand, I think.

Mr. BALL. 700 or so.

Senator DOUGLAS. Well, some of you who have been students of the British system of health insurance which began with Lloyd George and Winston Churchill in 1911——

Secretary CELEBREZZE. In both instances——

Senator DOUGLAS (continuing). And there the administration was carried on under the so-called benefit societies, non-profit-making benefit societies.

Now, they had grave troubles in administration because there were so many intermediaries between the Government agency and the beneficiaries.

Mr. COHEN. This does not follow that principle of the British system, though, Senator. I think we have learned very greatly from that. That is what we call a form of contracting out, under the British system. This system might be called a system of a fiscal intermediary. It is quite different. The carrier does not determine the types of benefits. The types of benefits are determinded by the statute here. There would be only one statutory type of benefits.

Senator DOUGLAS. Who would make out the checks to the individual hospital?

Mr. COHEN. Well, the checks would be made out by the fiscal intermediary.

Senator DOUGLAS. By the fiscal intermediary?

Mr. COHEN. By the fiscal intermediary.

Senator DOUGLAS. And you would reimburse them.

Mr. COHEN. We would reimburse them but it would have to be in accordance with the statute and in accordance with the regulations and contract made by the Secretary. It would not be, as it was, by the friendly societies, determined by them. The intermediary would become an agent, in effect, of the Federal Government in carrying out the statutory requirements under this law.

Senator DOUGLAS. Have you anywhere a detailed explanation of the role of Blue Cross and Blue Shield which are nonprofit making agencies, and the role of the private insurance companies in the administration both of the basic benefits and the supplementary benefits?

Mr. COHEN. We could put that in.

Senator DOUGLAS. This question is very important, I think, and I suggest your memorandum be circulated to members of the committee so that we can study it before we have to act.

(See p. 204.)

Mr. COHEN. I would like to direct your attention to the fact that in the bill there are two separate sections that relate to the role of these fiscal intermediaries in the basic plan and the supplementary plan. That is in section 1816, if I remember correctly, and in the supplementary plan in section 1842, and the best—the House committee report did attempt to in some detail, Senator, to characterize the different provisions that would be applicable for administration in these two sections, and I think if you read that that is about the best there is. It begins as I recall——

Senator DOUGLAS. It is very hard to detect the meaning of these provisions from a study of the bill. I would like a memorandum made available to members of the committee.

Mr. COHEN. Yes, we would be glad to furnish it.
We will be glad to do that.
(The information referred to follows:)

ROLE OF FISCAL INTERMEDIARIES IN THE ADMINISTRATION OF THE PROPOSED PROGRAM OF HEALTH INSURANCE FOR THE AGED

Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs under H.R. 6675 would rest with the Secretary of Health, Education, and Welfare. However, the bill provides for the participation of private organizations in administration of the proposed programs. The major function of these organizations would be to make payments in accordance with the law and regulations for the covered services rendered to beneficiaries of the programs by hospitals, physicians, and others. In addition, these organizations could, under the terms of their contracts with the Secretary, perform certain related administrative functions.

Under H.R. 6675, private organizations would not underwrite the health benefits; the Federal Government would assume the underwriting risk. They would not design the package of benefits; the benefits would be specified in detail in the law. Their participation in administration would enable the programs to benefit from their experience in providing reimbursement for health services and from the relationships they have established with hospitals, physicians, and others who furnish health care. In addition, the participation of such intermediaries in administration of the health insurance programs would have the effect that providers would be dealing directly with private organizations instead of the Federal Government.

The bill specifies the requirements private organizations would have to meet to qualify as fiscal intermediaries, the manner of their selection, requirements to be included in their contracts with the Secretary, and the duties they would perform. The provisions regarding fiscal intermediaries under the hospital insurance program and under the supplementary program differ somewhat, reflecting the differing natures of the two programs.

ROLE OF PUBLIC OR PRIVATE ORGANIZATIONS UNDER THE HOSPITAL INSURANCE PROGRAM

Under the hospital insurance program, groups of hospitals or associations of hospitals, on behalf of their members, could nominate an organization to act as a fiscal intermediary between providers and the Federal Government. Similarly, other providers of services would have fiscal intermediaries. This arrangement would permit the same organizations that now reimburse hospitals and other providers of services to perform a similar function under the hospital insurance program.

Providers could nominate a National, State, or other public or private agency or organization. The Secretary would be permitted to enter into agreement with a nominated organization only if he finds that this would be consistent with effective and efficient administration and that the organization is able and willing to assist in the application of safeguards against unnecessary ultilization of covered services, and only if the organization agrees to furnish him with necessary information it gathers in carrying out the agreement.

A hospital may be a member of an association whose nominated organization or agency had been selected as a fiscal intermediary but the hospital would not be required to work through that intermediary and could instead elect to receive payment from another intermediary which has been selected (provided that the other organization or agency agrees), or could elect to deal directly with the Secretary.

The organization or agency serving as a fiscal intermediary under the basic plan would, under agreement with the Secretary, determine the amount of payments due upon presentation of provider bills and make the payments. These payments would be made on a reasonable cost basis as defined in the bill and spelled out in regulations.

The agreement may include provision for the agency or organization to perform one or more of certain administrative duties other than the payment function. These duties would include providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers,

making audits of provider records, and performing related functions. The Government would provide advances of funds to the agencies or organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

ROLE OF CARRIERS UNDER THE SUPPLEMENTARY HEALTH INSURANCE PROGRAM

Under the supplementary health insurance program, the Secretary would be required, to the extent possible, to enter into contracts with carriers under which the carriers would perform specified administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations.

The Secretary would be permitted to enter into contracts with carriers without regard to provisions of law relating to competitive bidding. However, he could enter into such a contract only if he found that the carrier would perform efficiently and effectively and if the carrier met such requirements as to financial responsibility, legal authority, and such other matters as the Secretary found pertinent. According to the report on H.R. 6675 by the House Committee on Ways and Means, it was the committee's intent that the Secretary should, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance.

The functions of carriers would include: Determining the amounts of payment due physicians and others who provide covered services, and making the payments; auditing records of providers; determining whether providers meet the utilization review requirements under the program; assisting providers to develop procedures relating to utilization practices, and studying the effectiveness of such procedures; assisting in the application of safeguards against unnecessary utilization of covered services and in the establishment of review groups outside hospitals; serving as a channel of communication of information relating to the program's administration; and otherwise assisting in the administration of the supplementary plan.

The contracts between the carrier and the Secretary would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable. When payment under the program is on a charge basis, the carriers would also have to take action to assure that the charge on which the reimbursement is based is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment to the physician, the reasonable charge would have to be accepted as the full payment. In determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services. The carrier would also have to maintain the necessary records and furnish needed information and reports to the Secretary and, in addition, would have to establish procedures for fair review of beneficiary complaints regarding disallowed requests for payment and requests where the amount of payment is in controversy.

The contracts would be for a term of at least 1 year, and could be made automatically renewable. A contract would provide for payment of the carrier's cost of administration (including advances of funds for such purposes), as the Secretary determined to be necessary and proper for carrying out the functions covered by the contract. The Secretary could terminate a contract, after reasonable notice and opportunity for a hearing, if he found that the carrier had failed to substantially carry out the contract or was carrying it out in a manner inconsistent with the efficient administration of the supplementary health insurance program.

The bill defines a carrier with which the Secretary could contract as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition would include a health benefits plan duly sponsored or underwritten by an employee organization. With respect to hospitals, extended care facilities, and home health agencies, the definition also includes

a public or private organization which is nominated by providers of services and which participates in administration of the hospital insurance plan. In addition, a State welfare agency which buys into the program for aged welfare recipients could act as the carrier for its recipients (if it met the other conditions of participation as a carrier).

Senator DOUGLAS. Mr. Chairman, I must leave. I would like permission this morning to have included in the record a statement which I have prepared on the effect of the amendment I have offered along with Senators Moss, Neuberger, Hartke, and Javits on hospital outpatient diagnostic benefits.

Senator ANDERSON. Without objection that will be done.

(The statement referred to follows:)

THE EFFECT OF THE DOUGLAS AMENDMENT ON HOSPITAL OUTPATIENT DIAGNOSTIC BENEFITS

The costs of the services of hospital based specialists, such as radiologists and pathologists, should be reimbursable under the basic hospitalization plan where these specialists are paid by the hospitals. The effect of the House bill—which omits this provision—on outpatient diagnostic benefits is particularly unfortunate.

As presently worded, H.R. 6675 purports to provide outpatient hospital diagnostic benefits. An eligible individual would receive tests and related services—other than those performed by physicians—that hospitals ordinarily furnish to outpatients for diagnostic study. The deductible applicable to this benefit is $20 for diagnostic services furnished to the patient by the same hospital during a 20-day period.

How would this arrangement operate in actual practice? The most common hospital outpatient diagnostic studies involve either radiological examination or laboratory tests. Under H.R. 6675, the hospital would be reimbursed only for its costs exclusive of the compensation of physician specialists, presumably for the supplies, salaries of technicians, and overhead attributed to the services rendered. Without including any fee for the radiologist to interpret the X-rays or the pathologist to report on the laboratory tests, the hospital's reasonable costs are often likely to exceed the $20 deductible figure. Hence, most of the eligible aged would have to pay out of their own pockets all of the costs of the outpatient diagnostic services they receive in hospitals.

The alleged compensatory factor is that the eligible aged outpatients who have elected the voluntary medical coverage can have the physician's fee paid by the supplemental medical insurance. Technically, this is correct, but practically it is all but meaningless. The deductible under the voluntary supplemental medical plan is $50 per calendar year. Therefore, if reimbursable expenses of less than $50 are incurred by the patient in the calendar year he will receive no benefit for these specialist services under the medical insurance plan. In fact, the hospital deductible of $20 is added to the medical deductible of $50 to produce an effective deductible of $70. Moreover, the voluntary supplementary insurance plan would cover only 80 percent of the patient's bill above the deductible.

The amendment which I have introduced with Senators Moss, Neuberger, Hartke, and Javits would revert to the language and intent of the Anderson bill, H.R. 1. It would restore coverage under the basic hospitalization plan of the services of medical specialists in the fields of radiology, pathology, physiatry, and anesthesiology, where the hospital provides them among its usual hospital services. The eligible patient may then receive both the testing and the services of radiologists and pathologists in the hospital outpatient diagnostic facilities. The hospital would be compensated under the basic plan and the medical specialists would receive remuneration through the hospital under the arrangement to which they are accustomed. The patient would face only a $20 deductible, not a possible $70 out-of-pocket payment plus 20 percent of the bill above the deductible.

Omission of this amendment would unnecessarily impose an added hardship on aged beneficiaries. It should be adopted.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. Mr. Chairman, may I say, Mr. Secretary, that I have a number of questions here, I feel are all pertinent to this matter.

We are making a rather far-reaching decision. I assure you and the very capable men sitting with you that none of these are intended to harass or ridicule in any way what anyone has proposed.

I do not think I can get through, and I mention that now so that the chairman can take such action as he thinks best.

But I will proceed, as long as it is the pleasure of anybody.

Senator ANDERSON. Let's go on a while, if it is agreeable with you.

Senator CURTIS. Now, a question concerning the problem that our country has faced in connection with medical and hospital care for the aged. The problem is not that we do not have adequate medical facilities and a high quality of medical services available in the country. It isn't that, is it?

Secretary CELEBREZZE. Well, there is to a degree.

There are shortages.

Senator CURTIS. Oh, yes.

Secretary CELEBREZZE. In the application of the medical services and in the facilities. There are some shortages.

Senator CURTIS. We have a very fine system of medicine, don't we?

Secretary CELEBREZZE. Yes, I think we have one of the best in the world.

Senator CURTIS. We have the finest systems of medicine in the world.

Secretary CELEBREZZE. There is no doubt. It has some shortcoming too but in comparison with other systems——

Senator CURTIS. But we do not approach this as an emergent nation that needs to lift its health standards or anything like that by building a better medical system.

Secretary CELEBREZZE. No. But as I say, we have a good system but there is room for improvement and I am sure you will agree, Senator, that anything as years go by has to be improved.

Senator CURTIS. Oh, yes.

The real problem is that quite a number, and I won't try to fix the number because we will disagree on that, of our people over 65 cannot avail themselves of the fine medical system that we have because they lack the resources and the property and the income, isn't that right?

Secretary CELEBREZZE. That is right.

Senator CURTIS. I think we agree on that.

Here is my first question, and no doubt Mr. Myers will be the one to answer it. This relates to the OASI existing law only, not the disability, and I confine my question to those beneficiaries now on the rolls. What portion of the benefits that they have already received, plus the expected benefits that they will receive have they or their primary benefits paid for?

Mr. MYERS. Senator Curtis, of course as you realize the amount that has been paid by the employer and the employee varies widely for individual cases. Some have paid extremely little, and some have paid somewhat more, but on the average I believe about 10 percent of the actuarial value of the benefits that have been received or may be expected to be received in the future by those on the rolls are represented by the combined employer-employee taxes.

Senator CURTIS. Now, about 10 percent of what our present beneficiaries have received and are expected to receive in the balance of their days has been paid by the employer and the employee both.

Mr. MYERS. Yes, Senator Curtis.

Senator CURTIS. Yes, and some of the self-employed would be a little below that, and I am not trying to fix an exact figure. Your 10 percent figure serves my purpose very well.

Mr. MYERS. Yes, the self-employed would be below that, both because of the lower contribution rate for the self-employed as compared with the combined employer-employee rate and also because the self-employed have been covered only since, 1955 in the case of farmers, or 1951 in the case of other self-employed persons.

Senator CURTIS. Confining it again to OASI and not disability and not including the hospital medical that is in this bill, but so far as the aged persons are concerned and the secondary beneficiaries, what will be—you say it is about 10 percent now—what will it be in the next 10 years. It will vary in degree, isn't that right?

Mr. MYERS. Yes, Senator Curtis. If we considered new cases coming on the rolls, the figure is higher than 10 percent, and if we take, as you indicate, new cases coming on the roll in the next decade this proportion will gradually increase.

I would say that for new people coming on the rolls now this ratio might be in the neighborhood of 15 percent.

The next 10 or 15 years it will move up to 20 to 25 percent.

Senator CURTIS. Yes.

So were I to ask the question, were I to ask my first question 10 years from now, the answer might be 20 or 25 percent of the benefits that are received are paid for by the employer and the employee combined or by the self-employed.

Mr. MYERS. Yes, that is correct.

Senator CURTIS. Because you say it is about 10 percent now.

Mr. MYERS. Yes.

Senator CURTIS. So as of now we have a system that about 90 percent of what people receive is paid by others, those coming up who look forward to the time when they get benefits, and the employer?

Mr. MYERS. That is correct.

Senator CURTIS. Yes.

Now, I asked a question at the close of our hearing yesterday to see how big a jump we are making by this legislation before us. I asked what were the total expenditures under OASI and under disability insurance for the last full year, which would be 1964, and what it would be the first full year if we passed this bill.

I have your memorandum here.

Has that been inserted in the record? If not, I ask that it be inserted.

Senator ANDERSON. I am informed that it was placed in the record of yesterday at the place it was requested by you.

(See p. 148.)

Senator CURTIS. Briefly it shows this, does it not, that in 1964 the amount of benefits paid out was about $16.223 billion, isn't that right?

Mr. MYERS. That is correct, Senator Curtis.

Senator CURTIS. It will take a while to get this program in motion, so the first full year that this bill will operate, so far as benefits are concerned, is calendar 1967.

Mr. MYERS. That is correct.

Senator CURTIS. And you estimate there that the benefits paid out in 1967 will be $24.498 billion?

Mr. MYERS. Yes, Senator Curtis.

Senator CURTIS. So if this bill is passed, the amount paid out in social benefits which were old-age and survivor and disability in 1964 and which for 1967 will include those two plus the hospital insurance and the supplementary health benefits will be increased roughly by a little over $8 billion.

Mr. MYERS. There would be an increase from 1964 under the present program, and the new program as envisaged by the bill in full operation in 1967.

Senator CURTIS. Yes, if we didn't pass this bill it will be some higher anyway.

Mr. MYERS. Yes. Under the present law in 1967, the corresponding figure would be about $18.8 billion without any change in present law.

Senator CURTIS. Yes.

Those figures are valuable to me for all future purposes but I want to mention in connection with one idea right here, if we pass no bill we will increase our expenditures from 1964 to 1967 by about a couple of billion dollars.

If we pass this bill as the House passed it we will increase our payment of the social benefits by about $8 billion.

How much is the minimum old age benefit paid now to a primary beneficiary?

Mr. MYERS. The minimum benefit paid to a primary beneficiary who retires at age 65 or later is $40 a month. If the beneficiary retires at age 62 it would be $32 a month.

Senator CURTIS. We will take 65 for our purpose here.

What is the minimum widow's benefit?

Mr. MYERS. Under the present law it is likewise $40 a month where the widow is the only survivor.

Senator CURTIS. You may not want to pass on this particular thing right now, but if we are going to increase our social benefit expenditures by $8 billion it seems to me that these poor people who are getting only $40 a month, ought to have more than a $4 increase. That is what they would get under this bill, wouldn't they?

Mr. MYERS. That is correct, they would get a $4-a-month increase under this bill.

Mr. BALL. Senator, could I comment on that?

Senator CURTIS. Yes.

Mr. BALL. That is under the cash benefit increase. The hospital insurance basic benefit would provide for those at the minimum, as well as those at the maximum, protection that has an actuarial value of about $11 a month, and in addition the offer of the supplementary plan amounts to another $3 for the beneficiary.

So you could say that for these people——

Senator CURTIS. Of course, all people will get that.

Mr. BALL. Yes; my only point is this, that those at the minimum will be gettting about the equivalent of $18 a month if you look at the provisions in general, the total provisions.

Senator CURTIS. Yes.

My point is this: We have a system that by the very facts of it the people, as of now, have paid 10 percent of the cost of the benefits. It

has run 30 years, and the poor people, the person who had to work for small wages, or had to leave the work force early, or the widow who became a widow a long time ago before her husband built up a nest egg, we are paying them $40 a month. I have had a feeling that this system has been in the old-age retirement business for a long time, that one of its first obligations would be to make a reasonable success of that, and I don't think it has.

Mr. BALL. Senator, on the question of the minimum benefit I would like to make this point: The people who receive as low as $40 a month are really not to be equated with low wage earners, but with people who have only part of their earnings covered under the social security system, since we compute——

Senator CURTIS. They didn't decide that.

Mr. BALL. No; but what I am suggesting, for example, is that doctors, for instance, might have part of their income under social security, and part not. Many of them have been partly covered, so $40——

Senator CURTIS. Has an analysis been made of who gets the smallest?

Mr. BALL. Yes. But as we have looked at the question of who gets the very low benefits, it is partly a result of people who have been unemployed a lot or sick a lot but it is also——

Senator CURTIS. Do you have any statistics on that?

Mr. BALL. I would be glad to submit a memorandum on this.

(The material referred to follows:)

FACTORS ASSOCIATED WITH LOW BENEFIT AMOUNTS

This memorandum is based on a study of the social security employment history of a 1-percent sample of workers who became entitled to old-age benefits in 1962. The results of the sample indicate that the smaller the benefit amount, the less likely was the worker to have had regular employment over an extended period.

Many of the workers entitled to a benefit of less than $65 a month, particularly those entitled to the minimum benefit ($40), apparently had only marginal attachment to the covered labor force. About half of those entitled to the minimum and nearly one-fourth of those with benefits of $41 to $64 had less than seven quarters of coverage during the 11-year period 1951–61. One-fifth of the former and one-eighth of the latter had had no covered work at all after 1950.

Among all workers getting the $40 minimum, 1 in 12 earned his insured status in the last 2 years before entitlement. Among those 65 and over, one-fourth earned their insured status in the last 2 years before entitlement.

Thus, the beneficiaries with relatively small benefits included relatively large proportions of workers of two types: Those whose covered employment had ceased over a decade ago, and those who had earnings credited only within the last 2 years before entitlement.

Only about one-tenth of those workers with benefits of less than $65 had extended employment at very low earnings—that is, worked in 7 to 11 years at earnings levels of less than $1,200 in every one of these years and, of course, for these people, too, their covered earnings may be only a part of total earnings. Thus, for those who got benefits of less than $65, short-term or irregular employment was much more characteristic than regular employment at very low earnings.

Generally, workers who got benefits ranging from $40 to $64 had been out of covered employment for many years just before they started getting benefits or had been in covered employment a very short period of time overall.

Senator CURTIS. Well, I have the great opportunity of living in a small town where you know everybody, and the people who are drawing $40 a month include the women who had worked long and hard

washing dishes in the cafe and the well-to-do people are drawing a sizable social security benefit.

They could get along if they didn't have any, and none of them have paid more than 10 percent of the costs of the benefit.

Mr. BALL. The only point I am making, Senator, is, if you take a very low average wage, say a person who earns only $1,200 a year, a hundred dollars a month, way under minimum-wage laws, he gets a benefit today not of $40 but a benefit of about $60. I am not saying that some of those benefits ought not to be increased, but I am saying you also would be increasing benefits at those minimum levels, to a very considerable extent, for Federal employees who have had part-time jobs on the side, for certain State and local employees who are only partly covered, and so forth. As you look into the future, many steps have been taken—broadening the coverage, and the disability freeze—to get out of the wage record these elements that have reduced average earnings.

Senator CURTIS. You are dealing now with the question of offset in reference to the same individual sharing in more than one federally subsidized retirement program.

Mr. BALL. Well, I am merely dealing with——

Senator CURTIS. A smart young man can qualify for five federally subsidized retirement programs if he starts out to do it.

Mr. BALL. I am really dealing with——

Senator CURTIS. Of course, he will have to get himself elected to Congress along the way, but he can——

Mr. COHEN. Lots of smart people have done it.

Senator CURTIS. In less than 30 or 35 years he can qualify for five federally subsidized retirement systems, so even if the political tides are running against him, he can get four.

Mr. BALL. I think it is not quite right to equate $40 minimum benefit received with a low wage rate, that is all I am saying.

Senator CURTIS. But you would say this, everybody who did work for very meager wages have a little benefit.

Mr. BALL. Yes; but if a person works regularly under social security even at very low wages, he would get substantially more than $40. If he worked at regular low wages under the program, say at minimum wages——

Senator CURTIS. I am not unmindful if you raise the $40 you would have to raise those just near $40 a little bit, too.

Mr. BALL. Yes, but——

Senator CURTIS. What I am saying is we have what is supposed to be a social program that taxes our economy to pay a benefit, and the recipient has paid 10 percent of it and it doesn't meet the social need the country is faced with.

I will go on to something else.

Secretary CELEBREZZE. If I may add, people getting $40 a 10-percent increase in the bill, instead of a 7-percent one—we go from $40 to $44.

Senator CURTIS. We are going to increase this by $8 billion.

Secretary CELEBREZZE. But I think you have to look at it——

Senator CURTIS. And the poor are going to get $4 a month.

Secretary CELEBREZZE. You have to look at the total picture of social security.

Are we meeting a social need? Of course, we are not meeting all social needs. But when you start in 1935, when this program first went into effect, the graph line will show downward trends in the percentage of the people 65 years and over who are on public assistance.

In other words, since the program has been in effect there is a downward trend in the percentage of old people on public assistance and as these others gain more quarters and qualify for more benefits there will continue to be a downward trend.

Senator CURTIS. Well, there are other factors that entered into it. I said a bit ago I had the privilege of living in a small town where you know everybody, and these people are not turning to old age assistance, they are turning to self-denial, that is what they are doing.

Secretary CELEBREZZE. Yes, that is true.

Senator CURTIS. And the wealthy people are getting a big benefit that they paid 10 percent on.

Secretary CELEBREZZE. They are doing the same thing for want of medical care. Rather than go on assistance programs they deny themselves medical care, that is their pride.

Senator CURTIS. They don't all deny it. There are some facts about that. I think if you get in your car and visit a hundred hospitals and ask them who has a hard time paying their bill, when they leave the hospital, they are going to tell you it is the family man who is supporting a lot of kids and carrying on everything else.

Well, now, going to another subject, Mr. Secretary, on pages 26 and 27 of your statement yesterday you made the point that the schedule of tax rates under the proposed bill would be less severe on employees and employers and the self-employed through 1968 than are the tax rates under the present social security law.

While this point is correct with respect to tax rates, is it not true that the dollar effect on employers and employees as well will be far greater during the earlier period of this bill than at the present time?

Secretary CELEBREZZE. For those earning more than the present maximum, that would be true, yes.

Senator CURTIS. Yes. Because the tax rate now is multiplied by $4,800, and it will go next year to $5,600, and ultimately to $6,600.

Secretary CELEBREZZE. Yes.

Mr. BALL. Senator, I am not sure I understood your exact characterization of the increase prior to 1968. The tax would not be much more, but for the people who earn above the average, as the Secretary said, it would be some more when you take the wage base into account. Perhaps the exact figures here might be worth putting in.

Senator CURTIS. Well, I think when this thing gets in full motion, the employee, as I pointed out yesterday, will pay about $353 a year, and the maximum he can pay now is $198.

Mr. BALL. Not under present law, Senator. I thought you were comparing——

Senator CURTIS. Yes, under the present law. What is the maximum paid this year?

Mr. BALL. The maximum is $172 for the employee alone this year.

Mr. COHEN. No, $174.

Mr. BALL. $174.

Mr. COHEN. But then in 1966 the maximum would be $198.

Mr. MYERS. That is right.

Mr. COHEN. In 1968 under the present schedule on $4,800 the maximum would be $222.

Senator CURTIS. When you hit that $6,600, say, about 1973, what is he going to pay? I think you will find it is $353.

Mr. MYERS. In 1973 under the bill, the maximum that the employee woud pay under the combined program is $353.10.

Senator CURTIS. Yes, that is right.

Now, according to my calculations, employees and employers would each have to pay $222 in the social security taxes in 1968, those covered by the maximum.

Mr. MYERS. Under present law, that is correct.

Senator CURTIS. Under present law.

Under the proposed bill, they would have to pay $262 in 1968.

Mr. MYERS. In 1968 it would be, the maximum employee tax would be, $252.

Senator CURTIS. $252?

Mr. MYERS. $252.

Senator CURTIS. Well, now, if this bill is passed, by 1968 the employee and employer will pay about 66 percent more in dollars than they are paying, than they would pay under existing law.

Mr. MYERS. This is for an employee who is making $5,600 a year or more?

Senator CURTIS. Yes.

Mr. MYERS. Who, at present, pays only a maximum of $4,800?

Senator CURTIS. Yes.

Mr. MYERS. In 1968, the $5,600-and-over employee and his employer will pay 45 percent more in dollars than they are paying this year under present law, and 14 percent more than they would be paying in 1968 under present law.

Senator CURTIS. What is the average medical expenditure for persons over 65?

Senator ANDERSON. Both for people hospitalized and those people who are not.

Senator CURTIS. It is an average.

Senator ANDERSON. Give it both ways.

Secretary CELEBREZZE. In 1962 private spending for health care averaged $120 per person under age 65, and $208 per person age 65 or over. This is from a survey published by the National Health Survey in May of 1964.

Senator CURTIS. Now, my office this morning contacted Mrs. Lenore A. Epstein.

Mr. COHEN. Yes.

Senator CURTIS. Of the Division of Research and Statistics, and she recited an estimate for 1961 of $315 per person 65 years and over, including both public and private care.

Mr. BALL. That is correct for public and private expenditures.

Secretary CELEBREZZE. I gave you the private expenditures.

Senator CURTIS. Now, the cost goes up between 5 and 6 percent a year, is that right?

Mr. BALL. It has been, yes.

Senator CURTIS. So that estimate was based on 1961 ——

Mr. COHEN. That is correct.

Senator CURTIS. If it goes up between 5 and 6 percent a year or 5 percent, it would make an expenditure of $364 on an average for people over 65, public and private care both, for 1964.

Mr. COHEN. That is about right.

Mr. BALL. Yes, that is right.

Senator CURTIS. All right.

I do not want to have these figures exaggerate, so instead of $364, we will take $360.

How soon will we have 20 million people over 65?

Mr. MYERS. In the middle of 1966, we will have about 19 million, and in another 3 years, by the middle of 1969 or the beginning of 1970, we will have 20 million.

Mr. BALL. Senator Curtis, if I could interrupt for just a moment, the chairman asked me if we could give that figure for the people who have been hospitalized as against those who had not.

Senator CURTIS. Yes, surely.

Mr. BALL. For the married couples—we have it by family size here—for married couples, the cost, if they were hospitalized, would be $938 a year, and for the nonmarried men, $820, and for the nonmarried women, $703.

Senator CURTIS. Well, the reason I am moving up to the point of time when you will have 20 million of aged is to make the arithmetic easier.

Mr. BALL. Yes.

Senator CURTIS. If the average medical expense for a person over 65 is $360, we will assume that does not change at all until that day not far from now when we have 20 million of them, according to my calculation, 20 million times $360 is $7.2 billion.

Mr. COHEN. That is correct, $7.2 billion.

Mr. MYERS. That is correct.

Senator CURTIS. I think we agreed on the fact that the cost of medical care for 20 million people would be $7.2 billion on the average, based upon this average figure.

Secretary CELEBREZZE. If you are using the figures for 1957, when they reach 20 million, you have to build in a continuing 6-percent increase, because that is the way the hospital costs have gone up. So it will be a little over $7 billion.

Mr. BALL. We have also assumed in the estimates that there would be greater utilization of services, so you can move it up further.

Senator CURTIS. So it will cost more than $7.2 billion.

Mr. BALL. That is total expenditures for the aged.

Senator CURTIS. I am going to prove my arithmetic in another way. Is it generally accepted that people over 65 have about twice as much medical expenses as those under, on the average?

Secretary CELEBREZZE. Approximately, that is about right.

Mr. COHEN. I would say it is a little bit more than twice.

Mr. BALL. Roughly.

Mr. COHEN. For simple calculation it is quite sufficient.

Senator ANDERSON. Aren't the figures one and three-quarters?

Mr. BALL. For expenditures in hospitals it is about two and three-quarters to one for those over 65 as compared to those under 65. But, if you take all types of care and include public spending, which goes

to a very considerable extent to the aged in assistance, and so on, I think the ratio is a little more than 2 to 1.

Senator CURTIS. Is it true that we spend about $36 billion for medical care in this country?

Mr. MYERS. That is a figure for, I think, several years back.

Senator CURTIS. It is more than that, and 10 percent of our people are over 65, and they spend twice as much, so they spend 20 percent of $36 billion which comes out $7.2 billion.

Mr. MYERS. That is right.

Senator CURTIS. So our answer ——

Mr. BALL. Everything is consistent.

Senator CURTIS. I want to know what have you based as the expenditures under this bill after it is enacted and it gets into full operation, how much a year?

Mr. MYERS. Senator Curtis, from a memorandum I furnished you this morning, the result of adding up the last three figures in the table on the bottom of the page would give you a figure of about $3.3 billion.

Senator CURTIS. So this bill is going to provide about half of what is being spent now?

Mr. MYERS. Yes.

Senator ANDERSON. $3.3 as against $7.2.

Mr. MYERS. Might I correct the figure, it is $3.4 billion, under the bill—so it is a little less than half of the $7.2 billion figure.

Senator CURTIS. I want to go to another subject. This relates to section 404 of the bill. I think it is about page 275. That section begins with line 10, page 275, and it continues over to page 278.

Mr. COHEN. Yes.

Senator CURTIS. Rather briefly what is the purpose of section 404?

Mr. COHEN. You are talking about the administrative and judicial review of the Secretary's decision in connection with public assistance?

Senator CURTIS. That is right.

Mr. COHEN. Yes.

Under the existing law, and the court cases, the one or two that there have been, there is no express provision for judicial review of the Secretary's decisions with regard to disapproval of State public assistance plans, including public assistance and Kerr-Mills, and this provision was put in by the House Ways and Means Committee to permit the State, in any case where a State wishes, to take exception to a Secretary's final decision and go to court.

Senator CURTIS. The questions I have here are to develop a point so that we can see the procedure and see what is lacking in the House language, if anything.

Turning now to the part that begins on page 275, about line 15, and continuing through line 11, page 276, am I right in interpreting this language to mean it provides procedures and time limits within which procedures are to take place for a State to ask for, and the Secretary to reconsider, a finding of nonconformity by the Secretary?

Mr. COHEN. That is correct, Senator Curtis.

Senator CURTIS. Now I notice in this language that there are a certain number of time limitations within which certain steps in this procedure must be completed. There are 90 days for this, and 60 days for that, and so on. Of course, I recognize that even these can be extended by mutual consent. However, assuming that there are no

extensions, what is the maximum elapsed time which would occur from the submission of a State plan to the Secretary that he must affirm, modify, or reverse his original determination?

Mr. COHEN. Well, I think, if I understand your question correctly, he has to make the determination, the initial determination, in 90 days, except that there may be an extension. But you take 90 days.

Then a State must file its notice of dissatisfaction in the court within 60 days, so that is 150 days. And then such hearing must be held within not less than 20 to 60 days, so if you added the 60 on that, that would be 210 days before that process can be completed.

Senator CURTIS. I figure that somewhere in there you get 270 days.

Secretary CELEBREZZE. You have the last 60 days in which the Secretary then has to make the determination, so you may put that on.

Senator CURTIS. Yes.

I would like to get this clear. Suppose a State submits a revised public assistance plan to the Secretary on December 31. As I read the language, the Secretary within 90 days or roughly by the end of March of the next year, must make a determination as to whether it conforms to the requirements for approval under the various titles, is that correct?

Secretary CELEBREZZE. That is correct. He has 90 days within which to do it.

Senator CURTIS. Yes. Unless, of course, by mutual agreement it is extended.

Secretary CELEBREZZE. Yes.

Senator CURTIS. If a State is not satisfied with the Secretary's determination, it must, within the next 60 days or roughly by the end of May, file a petition with the Secretary for reconsideration; is that correct?

Secretary CELEBREZZE. That is right.

Senator CURTIS. Now, when you receive such a petition for reconsideration, and I am directing my attention here to line 3 on page 276, the Secretary must notify the State of the time and place at which a hearing will be held for reconsidering the issue, and it goes on to say that the hearing must be held not less than 20 days nor more than 60 days after the Secretary has notified the State of the date of the hearing; is that correct?

Secretary CELEBREZZE. Yes.

Senator CURTIS. Now go back to lines 3 and 4. How soon after you receive a petition from a State for a reconsideration must you set a date for hearing? As I read the language, the Secretary conceivably could let a year or 2 or 3 years go by before a date for such hearing is set by the Secretary.

Secretary CELEBREZZE. There is no time limitation on the time of the setting of a hearing on the bill.

Senator ANDERSON. Mr. Secretary, you did not recommend this provision, did you? Is this the so-called Congressman Curtis provision?

Secretary CELEBREZZE. Yes.

Mr. COHEN. Yes.

Senator CURTIS. Understand I am not critical of them. I want to make sure what this does, and if it needs any further amendments——

Secretary CELEBREZZE. The Senator is correct. At the time for setting a hearing there is no time limitation as to the Secretary setting a hearing.

Senator CURTIS. There would be no objection to fixing a reasonable time, would there?

Secretary CELEBREZZE. No; providing it is also put in there that by mutual agreement that date could be extended, because sometimes the Secretary is ready to go ahead with the hearing and the State is not prepared yet or vice versa, so I have no objection to that.

Senator CURTIS. According to the majority report of the House Ways and Means Committee on page 131:

These provisions are designed to assure that the States will not encounter undue delays in obtaining Federal determinations on acceptability of proposed State plan material under the public assistance programs.

Since a given number of days are specified for each of the other steps in the procedure, it would rather seem that maybe something ought to be done with that point.

Secretary CELEBREZZE. Yes. The primary purpose, as I understand it, of this section is if you have an arbitrary Secretary who rules the way he wants to rule, and you have no right to appeal from his decision, you are stuck with it. This is more of a protection for the State than anything else, and we have no objection to it. As a matter of fact, we have hearing procedures now under our system, under our public assistance program.

Senator CURTIS. Now a few questions, and I am going to move along just as fast as I can, a few questions about section 303. Generally this section relates to what?

Secretary CELEBREZZE. Disability benefits.

Senator CURTIS. Do you have any plan to increase your staff and personnel to implement this section properly?

Mr. BALL. Senator, there would be an increased workload as a result of that change, and if the bill were to pass we would certainly have to have more people to make these determinations and do the other work connected with the proposed changes in the disability program.

As you know, the actual determinations of disability in the first instance are made for us under contract by State agencies, and it would be an additional workload for them, too.

Senator CURTIS. Do you have an estimate of the increased cost?

Mr. BALL. Of the administration of that section?

Senator CURTIS. Yes; of section 303.

Mr. BALL. I am not sure whether I have that right here or not.

Secretary CELEBREZZE. I may add, Senator, within the past year or year and a half we have cut down substantially the time necessary for making the determination through more geared-up procedure.

Senator CURTIS. That estimate may be put in later.

Mr. BALL. Thank you, sir.

(The information referred to follows:)

The additional continuing cost per year of administering the disability insurance benefit provisions as they would be modified by section 303 of H.R. 6675 is expected on the basis of preliminary estimates to be about $15 to $20 million.

Senator CURTIS. In order to implement section 303, how did you propose to check on, first, the propriety of the disability?

Mr. BALL. Senator, the job of making the initial determination as to whether a person is totally disabled, will be somewhat easier than it is under present law. As I indicated, the State agencies will con-

tinue to make the initial determination. But, in making those determinations they will not have to do one thing that they are required to do today, that is, they will not have to make a prognosis of how long the disability is going to last—whether it is expected to be of long-continued and indefinite duration.

Just as is done today, there will be development of medical evidence, and in some cases vocational evidence, and the decision will be made by the State agency and reviewed by us.

Senator CURTIS. Do you have any particular plans in determining the accuracy of the medical examination?

Mr. BALL. Well, the administrative procedures would be really just the same as today. The way the medical determinations are handled under present law is that the individual, first of all, submits himself what evidence he has of his disability. The burden of submitting medical evidence is first on him, and such evidence may be in the nature of records from his own doctor, hospital records, sometimes veterans' records and so on; and then the State agency examines the question of whether they can make a determination on that evidence alone or whether there are questions which may need further clarification. In a significant proportion of the cases, maybe 40 to 50 percent, we purchase a specialist-type examination under present law related to developing further medical evidence.

Now, in this provision I would think it would not be necessary in as high proportion of the cases to have such detailed development and such specialist exams because we would not have to make this long-continued and indefinite duration determination.

So more often than not, the evidence that would be submitted in the first instance would be sufficient.

Senator CURTIS. Is the implementation of this section 303 to take place from Baltimore or from the regional office?

Mr. BALL. Well, it would be implemented in the same way as now. If I could just take a minute, Senator, I could describe the procedure that we have under present law. An individual files his application with one of the local district offices of the Social Security Administration, and there is where he applies, and there is where in the first instance he submits the evidence, as I have described.

Then that case moves over to a State agency, and they do what I described, and then it is reviewed by the Disability Division in Baltimore, and we would operate the same way under this.

Senator CURTIS. Do you consider that the rehabilitation has a place in the disability program under the Social Security Act?

Mr. BALL. Yes, indeed, Senator. The law requires, and we have faithfully executed, a referral to the vocational rehabilitation agency of cases applying for Social Security disability benefits. There is a gross screening that takes place by the vocational rehabilitation people in connection with making the disability determination which indicates any possibility of rehabilitation.

Senator CURTIS. Has this been done in the past?

Mr. BALL. Yes, indeed, Senator.

Senator CURTIS. Did not the Secretary issue a bulletin in the summer of 1962 stating that 80 percent of the primary beneficiaries are never rehabilitated?

Mr. BALL. Were not rehabilitable?

Senator CURTIS. Yes.

Mr. BALL. That is right, Senator. The referral is made. However, these people have been so severely disabled—as I have indicated, we have had to make a determination that their disabilities are of long-continued and indefinite duration—that when the State rehabilitation agency looks at the case and talks with the individual they come to the conclusion in a high percentage of cases that it is really not practical to attempt to rehabilitate them. Up until now most of the cases referred by us have been what you might call cases of permanent disability.

Senator CURTIS. But 20 percent is quite low, is it not?

Mr. BALL. No.

Senator CURTIS. Some very, very much disabled and handicapped people do wonderful things these days.

Mr. COHEN. Senator, we have another bill pending before the Senate, S. 1525, to increase the funds and to expand the authorization of the Vocational Rehabilitation Administration to help the severely disabled, the very point you are making.

Senator CURTIS. Yes.

My next question leads to that point. State workmen's compensation administrators tell us that since the repeal of the offset provision from the social security law they have encountered a great deal of resistance to rehabilitation from injured employees who are receiving both workmen's compensation and social security benefits.

Mr. BALL. They have not brought that to my attention, Senator. It is a very small number, and I would certainly like to have them—I would certainly like to know about that.

Senator CURTIS. Well, in other words, if somebody is getting one benefit there might be just a little bit more effort to rehabilitate than if they are getting two; isn't that right?

Mr. BALL. Well, I might say, Senator, that I would like to know about any cases of people refusing rehabilitation because of the receipt of social security benefits, since there is a provision in the law for the termination of social security benefits under those circumstances.

Senator ANDERSON. You do not have any such information now?

Mr. BALL. No.

Senator ANDERSON. Where does your information come from?

Senator CURTIS. It is not published in statistical form. It is just an opinion that is expressed by State administrators now and then that because of the two systems, where somebody gets more money being disabled than they could earn going back, they have lost their incentive for rehabilitation.

Mr. BALL. I would, without having any cases to my knowledge, be willing to agree, Senator, that in the very, very few cases where this takes place, it might well be a disincentive to rehabilitation.

Senator CURTIS. But the incentive should always be toward rehabilitation. Even if the victim is discouraged and thinks it cannot be done, it will do something to him as an individual if he can accomplish it.

Mr. BALL. We are strongly in favor of everyone who can possibly benefit from rehabilitation services getting those services and being restored to gainful employment, and of limiting the payment of cash disability benefits to people who cannot return to work.

Senator CURTIS. Now, the Advisory Council had something to say about this, didn't they? I think they said it would be desirable to prevent any excessive payment resulting from dual entitlement to whatever extent they may occur.

Mr. BALL. That is correct, Senator.

Senator CURTIS. You agree with that?

Mr. BALL. Yes, Senator; and they indicated also that in those cases where the combined payment was excessive, the majority thought that it would be desirable for the adjustment to be made by the workmen's compensation system, which, of course, can be done.

Senator CURTIS. Do you recognize in broadening the social security disability program an increase in the present duplication between the social security program and the workmen's compensation State programs?

Mr. BALL. Well, in absolute numbers, there is no question about that because we will be paying more cases and obviously there would be some increase in the number that were duplicative.

We do not believe, however, that this 2-percent overlap would be significantly increased.

Senator CURTIS. Does the disability program under social security provide the same types of benefits that the State workmen's compensation provides?

Mr. BALL. Well, it provides one type that is the same. But workmen's compensation provides certain other types, too. They provide benefits for partial disability and they provide benefits for medical care.

Senator CURTIS. They both relate to medical benefits.

Mr. BALL. They provide medical benefits but they also provide temporary cash benefits and they provide for partial disability benefits. Where the two are similar, is where workmen's compensation pays for those who are injured and have a permanent and total disability.

Senator CURTIS. And something about safety services, too.

Mr. BALL. Yes.

Senator CURTIS. Now, the Federal benefit under social security is a cash benefit?

Mr. BALL. That is correct, Senator.

Senator CURTIS. Only?

Mr. BALL. That is correct, Senator.

Senator CURTIS. Do you anticipate that continued duplication between the social security program and the workmen's compensation may lead to either the abolishment of workmen's compensation or a substantial curtailment of its activities?

Mr. BALL. I would not say that the area of duplication that has existed before or would be brought about by this change would be of that character or seriousness at all, Senator.

Senator CURTIS. How many people of our working force are covered by workmen's compensation?

Mr. COHEN. I would say about two-thirds of the working force are covered by State workmen's compensation.

Senator CURTIS. I cannot see that the duplication would be so narrow.

Mr. COHEN. Here is the point: As you said, there are at least six different types of benefits provided by State workmen's compensation. There is temporary total, temporary partial, permanent total, permanent partial, medical, and rehabilitation. Now we are only talking about one of those many different types of benefits, which is the so-called permanent total, so that there are, as Mr. Ball says, tremendous other areas in workmen's compensation that we are not talking about.

Mr. BALL. Turn it the other way, too, Senator, and that is that of the people who will become more or less permanently and totally disabled in this country, very few are in that condition because of a work-connected accident or an occupational illness. Most of our cases who are permanently and totally disabled are disabled because of a chronic illness—heart disease, stroke, cancer, or mental illness, and these conditions did not come out of the work connection that workmen's compensation covers.

Senator CURTIS. Now, about two-thirds of the benefits paid under workmen's compensation laws go for disability income benefits; is not that right?

Mr. BALL. Yes.

Mr. COHEN. Although that may be the temporary as well, which we are not dealing with at all.

Mr. BALL. Oh, yes.

Mr. COHEN. I mean the bulk of the numbers of cases that workmen's compensation handles are the temporary total and the temporary partial, which are not involved in this area that we are discussing at all. That would still be an exclusive role for them, and the benefits there certainly need to be improved.

Senator CURTIS. Would not the major cost to the employers under workmen's compensation programs diminish or disappear?

Mr. COHEN. No sir; I do not see that.

Senator CURTIS. While social security insurance covers people who are chronic but are not occupational, it also covers those occupational.

Mr. COHEN. I happen to remember that 80 percent of workmen's compensation is medical costs. We are not even talking about that. So there is 80 percent of the employers' contribution that would still continue under workmen's compensation. I see no substantial curtailment, and certainly no abolition, of workmen's compensation that could be envisaged by this.

Senator CURTIS. Under social security, you will take care of all workmen's compensation?

Mr. BALL. Only, Senator, where they are totally disabled, and only where they have been totally disabled for a period as long as 6 months.

As the Secretary was saying, most workmen's compensation is for short-term, temporary disability and much of it even for partial disability, so there is not a large degree of overlap at all.

Senator CURTIS. Of course, that is one of the changes you are making here now. At the present time under social security for one to get disability payments they have to show evidence they are totally disabled, and that they expect it to continue throughout their life.

Mr. BALL. Yes; more or less.

Senator CURTIS. What is the situation if the doctors say that the individual is totally disabled and he will be totally disabled for 9 months; does he get social security?

Mr. BALL. He would get social security for the 3 months. He would still have to be disabled for 6 months before we would pay.

Senator CURTIS. All right. What if he said he is totally disabled and will be so for 2 or 3 years. He would get 2 or 3 years, less 6 months?

Mr. BALL. Yes.

Mr. COHEN. All I was saying, Senator, to make it clear, is that the man who loses his finger in an accident—the man who has, even though a permanent disability, one which is only partial—he is not covered by the social security program. That would still be exclusively workmen's compensation. That is why I say the workmen's compensation is not in its basic character adversely affected, and by no means could it be said that this would result in an abolition of workmen's compensation.

Senator CURTIS. Now, the U.S. Department of Labor, Bureau of Labor Statistics, has often contended that the greatest factor in the reduction of industrial accidents over the years has been the need to reduce the workmen's compensation costs.

Secretary CELEBREZZE. To reduce the workmen's compensation?

Senator CURTIS. The incentive for employers to do everything in the world to promote safety has been to reduce costs.

Secretary CELEBREZZE. Of course——

Senator CURTIS. But to the extent that that is taken over by social security and not as a direct cost on him, it will lessen it, won't it?

Secretary CELEBREZZE. I doubt it. I think every plant—every employer that I know or ever talked to—is concerned with the safety of his employees. He is concerned with that from a humanitarian point, but also because his rates in many instances are set by the number of accidents that happen in his plant, so I do not think there is any employer who would not take this into consideration; the safety features, and conditions in his plant.

I do not think that this bill would have much of a bearing on it because it would have very little, if any, effect on workmen's compensation.

Senator CURTIS. Here is something that is not a question but it is an answer to something you put in, made a point of, and I want to show the other side.

This idea of handling the services of radiologists and pathologists and anaesthesiologists and——

Mr. COHEN. People engaged in physical medicine.

Senator CURTIS. In the House bill under the supplemental health——

Mr. COHEN. That is right.

Senator CURTIS. And you are recommending that they go on the hospital bill.

Secretary CELEBREZZE. We are recommending that we handle it in the manner in which it is usually handled, on whatever basis the hospitals handle it. Most of them do have it under the hospital bill, and some of them do not. What we say is: Let us handle it the way it is handled today.

Senator CURTIS. Well, I am not disputing your right to your position on that, but the point is they are in a bit different category than most of the hospital employees; are they not? The radiologists and pathologists are physicians of the highest order; are they not?

Secretary CELEBREZZE. Yes; no doubt about it.

Senator CURTIS. And much of the advance in the cause and cure of disease have come from these people; hasn't it?

Secretary CELEBREZZE. Well, they have contributed.

Senator CURTIS. Yes; a great deal.

Mr. Chairman, I would like to read portions from a letter that I received from one of Nebraska's outstanding physicians who is the radiologist at one of our leading hospitals. Among other things, he says:

> In adopting H.R. 6675, the House did correct a very serious defect in H.R. 1 and S. 1, the King-Anderson bill, in that physicians' services and radiology, pathology, anesthesiology, and physiatry were removed as hospital services and the professional services of all physicians are now covered under the voluntary insurance section of the bill. I am well aware that there are certain elements who believe, particularly in the area of hospital administration, that these doctors' services should be called hospital services rather than medical services. I would urge you not to vote to reinstate the provisions of H.R. 1 and S. 1, which have removed the practice of medicine from the King-Anderson bill.
>
> I would urge you to continue to support the premise that radiologists, anesthesiologists, pathologists, and physiatrists are all members of the medical profession. As you know, radiology and the other branches of medicine mentioned above, are acknowledged branches of medicine with approved speciality examining boards. They also have representation in the scientific assembly of the American Medical Association and they are recognized as a medical specialty within the Armed Forces, Veterans' Administration, and the U.S. Public Health Service. At the present time and in the foreseeable future, medical practice is interdependent and, in order to maintain a high level of patient care, the health team must be balanced. If the services of radiologists and the others are legislatively defined as "hospital services," desirable young physicians will not enter these branches of medicine. Seventy percent of patients with cancers are treated at least in part by radiologists. An estimated 25 percent of all important decisions in patient care are based on the specialized diagnoses of radiologists. It was recognized in the report of the President's Commission on Heart Disease, Cancer, and Stroke, that diagnostic radiology is expanding at the rate of from 12 to 20 percent per year, while the number of radiologists is increasing at the rate of 5 percent per year and 25 percent of the residencies training radiologists are vacant. These are vacant primarily because of the threat imposed by legislation that define physicians, professional services, and radiology as "hospital services." The interest of the patients are of paramount importance and should lead to enactment of legislation that supports full availability of services in all branches of medicine and does not legislatively destroy radiology, pathology, anesthesiology, and physiatry. Therefore, H.R. 6675, as passed by the House, merits support.

Senator CURTIS. I am not going to take any more time.

Secretary CELEBREZZE. I am sure, Senator, there will be some expert testimony on this very question from the American Hospital Association.

Senator CURTIS. All the testimony this committee gets is expert.

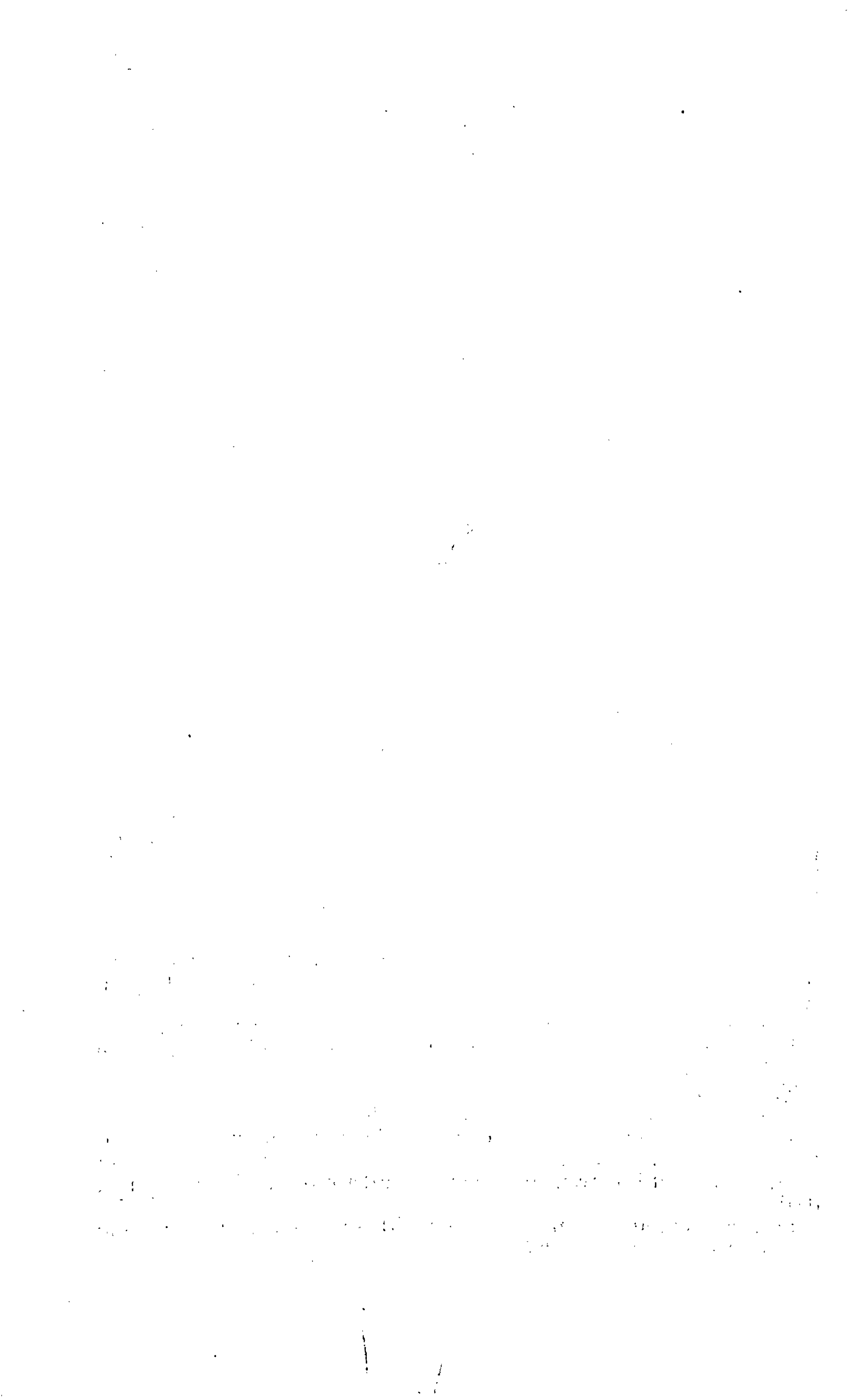
I want to thank the witnesses and my very distinguished chairman for his patience in letting me go on.

Thank you.

Senator ANDERSON. Thank you very much.

We will continue again on Monday. We appreciate very much the testimony given, Mr. Secretary, by you and by all the members of your staff. I think it is extremely fine and we all appreciate it a very great deal.

(Whereupon, at 1:10 p.m., the committee recessed to reconvene at 10 a.m., Monday, May 3, 1965.)



SOCIAL SECURITY

MONDAY, MAY 3, 1965

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Clinton P. Anderson presiding.

Present: Senators Anderson, Talmadge, McCarthy, Williams, Carlson, Bennett, Curtis, and Dirksen.

Also present: Elizabeth B. Springer, chief clerk.

Senator ANDERSON. The committee will be in order.

Our first witness this morning is the Honorable Aime J. Forand, a longtime Member of the House, a distinguished friend of both Senator Carlson and myself while he was in the House, and now as the time comes closer more distinguished than ever.

We are very happy to have you before us, Aime.

Senator CARLSON. I would like to express my personal appreciation for having Mr. Forand as our first witness. It does bring back pleasant memories of a past association.

Mr. FORAND. Thank you very much, gentlemen.

It is a pleasure for me to be back to say "hello" to some old friends, and I am glad to see that you are both alert and active.

Senator ANDERSON. You can always trust the Scandinavian contingent.

STATEMENT OF HON. AIME J. FORAND, FORMER REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. FORAND. It is a long while since we served together. Now I am on the sidelines, just watching your operations.

Mr. Chairman, I suppose for the record I should identify myself. I am Aime J. Forand, former Member of Congress from Rhode Island. I am the author of the original bill to provide medical care to the elderly under social security, a bill I introduced in 1957.

I appreciate very much the invitation to appear before your committee, Mr. Chairman, to give me one more opportunity to express briefly my sincere hope and my confidence, that this committee will promptly and favorably report out this bill which I consider humane legislation long overdue.

All of us for many, many years, have been speaking about the need of medical care for many of the senior citizens. Even the AMA admitted years ago that there is need. I think that our principal difference was in the approach to the financing of such a system.

I was fortunate, indeed, to have a dedicated group of people make a long study of the various approaches to the financing of social security. They came up with a unanimous agreement that the best and most appropriate way to finance medical care for the elderly was under the social security system.

The bill before you today, H.R. 6675, encompasses many different titles, I imagine. I haven't had an opportunity to read the bill, but I have read excerpts in the newspapers but the basic principles that I advanced are incorporated in this bill, and the bill goes much further.

I have no objection to that. In fact, I applaud the action of the Ways and Means Committee in reporting out such a bill.

I can tell you very frankly that I shall not be eligible for benefits under this bill being a retired Federal employee. But at no time was I interested in my own position. My dedication was for the health and welfare of our senior citizens, and that is one reason why shortly after I retired from Congress I yielded to the pressure coming to me by way of over a thousand letters from every part of the country, asking me to lead a movement to organize the senior citizens, and in the fall of 1961, with a group of about 12 dedicated men and women, we organized the National Council for Senior Citizens, which has now grown to a membership of some 1,400 to 1,600 affiliated clubs representing a membership in excess of 2 million. That there is need for this type of legislation is beyond any doubt, and the situation is really pathetic when you get right down to the base. When I retired from Congress I had an accumulation of hospital bills that had been sent to me by people all over the country, that must have been 12 inches high, and another pile about 8 or 10 inches high representing doctor's bills.

In many instances the doctor's bills had been turned over to collection agencies and these collection agencies were ruthless.

I know from my own personal experience the difficulty that many of these people have had, and still have. Many times we hear it said that, oh, you should prepare for your old age, you should save some money.

Gentlemen, I am one of a family of 16 children, and when just after I passed my 13th birthday my dad became totally blind. One daughter was working and bringing home $8 a week to support that family. My father was a loom fixer in a cotton mill and you can appreciate that on his wages and the size of family we had, it was not possible for him to accumulate a great deal of wealth. The truth of the matter is that when he died his total financial assets were $80.32. So, I have had the experience, I know what struggle is. I had to leave school in the seventh grade to go to work, and I worked in a cotton mill for $4.19 a week.

That is one reason why I feel that I can speak on this subject and speak perhaps with a little bit of weight.

Another is that I did welfare work. I was commandant of the State soldiers' home in Rhode Island and chairman of the board, and chief of the division of soldiers' relief for 2 years.

There I had many, many veterans of all wars, way back to the Civil War, and the pathetic conditions that I found in those homes were something that was heart rending in many instances.

Those were men who couldn't afford to accumulate wealth and also support their families.

I could go on and discuss many of these pathetic cases, but I know your time is limited and I don't want to be hindering the passage.

The demand for this type of legislation, as you know, is nationwide and I am not going to go into details as to statistics because I am sure you have had that, but I do plead with you to see to it that no undue delay is brought about on this particular piece of legislation, and give the elderly that which they so justly deserve, because they are the ones who really built this country, and had no opportunity in many instances of accumulating sufficient wealth to take care of their needs in their old age.

The big idea is dignity instead of humiliation, and if I were to make recommendations to you as to any changes to be made in this particular bill, I have two in mind. One is that I think the deductible of $40 could be cut down to $20, because many of these people who are going to be the beneficiaries of this type of legislation are people who are living on their social security checks, and in many, many, instances drawing the minimum.

I remember in 1957 or 1958, that the Secretary of Health, Education, and Welfare testified before the Ways and Means Committee that there were, out of some 12 million recipients of these benefits, approximately 2 million who were getting the minimum, and out of that 2 million, 600,000 of them had to seek old-age assistance to supplement the meager amount of money they received from social security to live on, which, to me, is proof that if a medical catastrophe should have stricken any of these people, I don't know what would have happened. They would really have become dependent.

Who wants and who is going to pay for this? Of course, under the social security system all workers and all employers are going to pay for it. But let's keep in mind this fact, that we are going through this tax, we are going to relieve many of the young families who now have children to put through school, and have elderly parents to take care of. The elderly parents may be stricken, stricken ill, to the point where the children will not be able to get the education because the family will be struggling to meet the medical bills of the older people.

There is so much that could be said on this but, as I have said before, I don't want to take up too much of the time of the committee, but I do want to thank you for having permitted me to appear before you, and I do urge most forcefully, the prompt and favorable report of this bill.

Thank you very much, Mr. Chairman.

Senator ANDERSON. Mr. Forand, you said there were two factors you would like to be changed. One was the deductible. What was the other one?

Mr. FORAND. Thank you for calling my attention to that.

The second is they have eliminated the radiologists and anesthetists, and so forth from the House bill and I would urge that be restored.

Senator ANDERSON. As in the Douglas amendment?

Mr. FORAND. As a part of the hospital coverage.

Senator ANDERSON. I see.

Thank you.

47-140—65—pt. 1——16

Senator Carlson?

Mr. FORAND. Thank you.

Senator CARLSON. No questions.

Senator CURTIS. Mr. Chairman, I want to say I am very sorry to miss the statement by my former colleague and longtime coworker on the Ways and Means Committee. I shall read the record.

Mr. FORAND. Thank you very much. It is nice to see you.

Senator ANDERSON. Thank you very much, Mr. Forand, we appreciate your being here a great deal.

Mr. FORAND. Thank you.

Senator ANDERSON. At this point, there will be inserted in the record a statement by Mrs. Lillian Allan, secretary of a senior citizens club in New Jersey, National Federation for Social Security.

(The statement referred to follows:)

STATEMENT BY MRS. LILLIAN ALLAN

My name is Mrs. Lillian Allan. I am the secretary of a senior citizens club in New Jersey—National Federation for Social Security (Hudson County Branch). This club was organized 7 years ago with one goal in mind—medical care for the aged through social security.

I am also speaking today on behalf of 50,000 older Americans from New Jersey whose clubs are affiliated with the New Jersey Council of Senior Citizens.

Senior citizens resent being thought of as statistics. Each one is an individual, with individual problems. One fear they have in common is sickness.

They don't mind this comparison, as I have voiced it many times. An older American is like an old car. It breaks down here and there. If the repair is taken care of right away there is a lot more mileage and use in the old car. So it is with our elderly. The pressures of life show, and sickness attacks the weakest part of their bodies. Between the ages of 40 and 65 they develop heart trouble, high blood pressure, arthritis, diabetes, ulcers, etc., due to pressures at work. So they hand out money for doctor and medicine just to be able to keep on working.

But—once they reach the age of 65 and they must retire—the pressure doubles. There is no group insurance. Their income is cut, and they have to move to cheaper rooms. Worry and fear bring on high blood pressure, heart attacks, strokes and ulcers.

The doctors did the oldsters no favor by adding 20 years to their lives. Like the old car, the human body deteriorates with age. The doctors keep them alive with their antibiotics and pills. So, in giving the oldsters longer life, they have the responsibility of taking care of them—not with operations—but with the gentle, loving care of a family doctor. He decides when his patient must go into the hospital.

Our purpose is to keep the older American out of the hospital by preventive medical care. But—when he has to go into the hospital—it should be with the thought that he is not a charity case. So, as the representative of 50,000 older Americans of the New Jersey Council of Senior Citizens, I ask that you release the medicare bill (H.R. 6675) for the floor vote by the Senate.

The following are extracts from letters I have received from senior citizens. These are people I know, who speak the truth and do not exaggerate. These statements are greatly condensed. If necessary, I could supply names and addresses of all these persons—and many more with similar stories to relate.

1. "Mrs. Allan, I have a house, but very low social security. I have to draw from the bank for living expenses. I am very sick, but won't call the doctor because I do not have money in the house for doctor and medicine. In a few days I will get my social security check. Then I will call the doctor or go to his office."

2. "Mrs. Allan, since I had the stroke, I am too weak to go to a doctor for physical therapy treatments. Could you get these treatments for me at home? I can't pay much, but I am willing to pay something. I have a house and low social security. I take in boarders to stretch my living expenses."

3. "Mrs. Allan, I am paying $14 a week for physical therapy treatments for my broken shoulder. How long can my savings last?"

Senator ANDERSON. Mr. Cruikshank.
You are known to most of us. Will you identify yourself for the record, please?

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO

Mr. CRUIKSHANK. Thank you, Mr. Chairman, Senator Anderson.

My name is Nelson H. Cruikshank and I am director of the Department of Social Security of the American Federation of Labor and Congress of Industrial Organizations. My office is located in the headquarters building of the AFL–CIO, 815 16th Street NW., Washington, D.C.

Mr. Chairman, and gentlemen, I have a statement here copies of which I believe have been distributed to the members, and with your permission, I would like to have this inserted in its entirety in the record and then in the time that is available to me I should like to summarize it and comment on it orally if that is agreeable to you, Mr. Chairman.

Senator ANDERSON. Without objection that will be done.

Mr. CRUIKSHANK. I am appearing this morning representing the AFL–CIO, in support of H.R. 6675, the Social Security Amendments of 1965.

We appreciate always the opportunity to appear before this committee to present our views, particularly in this case on a series of amendments to the Social Security Act which are of the most far-reaching, we believe, since the social security program went into effect some 30 years ago.

I am not going to attempt to analyze in detail all the complicated and interrelated provisions of this comprehensive measure.

My purpose is rather to give you in the brief time available, the major reasons why the AFL–CIO, representing some 13½ million wage earners and their families, and reflecting, we believe, the views of millions more, wholeheartedly supports H.R. 6675 and why we urge this committee and the Senate to grant it speedy and favorable consideration.

There are six main reasons why we support this bill.

1. It provides basic health benefits for the aged, financed through contributory social insurance.
2. It provides for contributions from general revenues toward health insurance coverage, without the imposition of a means test.
3. It provides substantial increases in cash benefits to social security recipients.
4. It increases the amounts of earnings insured under the system—
   (a) By raising the wage base; and
   (b) By including earnings received in the form of tips.
5. It provides adequate and equitable financing for both the broadening of existing social insurance programs and for the newly inaugurated ones.
6. It provides improved standards and broadened coverage for State programs of medical assistance for needy persons.

The first two of these stated reasons are especially important to us, not only because of the immediate protection afforded nearly 19

million people, but because of the acceptance of the basic principles they reflect. The extension of the proven principle of contributory social insurance to meet major health costs is of far-reaching and historic significance. Nearly every other industrial country in the world took this step years ago.

Of almost equal significance is the recognition that it is appropriate to use funds from general revenues to help pay the costs of health insurance without the application of a means test. This bill takes this important step in two areas:

(*a*) By meeting during the early years of the program the costs of benefits under the basic plan for those not covered by social security or railroad retirement; and

(*b*) By matching the $3 monthly premium for each individual enrolling in the supplementary plan.

If this bill did nothing more than establish these two principles, while at the same time translating them into concrete benefits, as it does, it would merit our wholehearted support.

This, of course, it not to say that the bill is a perfect instrument or that it cannot be improved. I shall, in fact, have some suggestions to make which we believe are necessary if this measure, when enacted into law, is to meet its worthy objectives.

The AFL–CIO has long supported and still supports the basic health insurance programs for the elderly embodied in S. 1, introduced by the distinguished member of this committee, Senator Anderson, in which he was joined by 44 of his colleagues in the Senate, including 5 other distinguished members of this committee.

There were two basic reasons for our support over the last several years for a measure of this kind. The first is the well-known fact that incomes decrease sharply with old age and retirement. The second is the equally demonstrable fact that the incidence of costly illness increases with age.

In my formal statement I summarize statistics that I am sure are familiar to the members to support those two main reasons.

The point really is we feel a program that covers the major costs of hospitalization and other related costs meets a most important risk because there is a high correlation between hospitalization and large total medical expenses. Those older people who are hospitalized in a given year are the very ones who have the big expenses. These data are supported by a 1963 survey of the aged and various other studies that have been made over the period of years when measures like the Anderson bill (S. 1) have been up for consideration.

In short we think that this underwriting of the contingency of a hospitalized illness and the alternate method of meeting the medical needs in case of a hospitalized illness is a very important measure and this is the reason we have, over the years, been supporting what is now the basic program as it was introduced by Senator Anderson and his colleagues.

But the bill before you, as you, of course, know, goes far beyond these protections. We are glad that it does. It proposes a voluntary supplementary insurance plan which would cover physician's services, home services, hospital services in psychiatric institutions and numerous other medical and health services in and out of medical institutions. The two together comprise a far more comprehensive protection than that contemplated in H.R. 1, and in S. 1.

We note that, ironically enough, some of the forces who have appeared before you in the past and have appeared in opposition to H.R. 1 are in some degree responsible for this broadening of the protection that is afforded in the measure before you. They are responsible because of a basic shift in position that has taken place over the last several years.

At first the opposition that was offered to a proposal of this kind was based on the contention that it went way too far. Nothing like this was needed. Then there was a middle period during which it was acceptable to the opposition to provide care on a public assistance basis, for those who were in need and were in a position to prove their need by the imposition of a means test.

Finally, within the last year their ground has shifted to where they say that the bill which originally they said went way too far and wasn't needed, now didn't go near far enough.

Well, there was, of course, not complete coverage proposed in S. 1 but we did feel it offered the most important and the most needed coverage. But the public has taken their criticism at its word and consequently these provisions of the supplementary program or the enrollment program or the voluntary program, as it is variously referred to (sometimes called the third layer of the cake) has been added, and we are glad that it has been added.

Now, while a combination of these two plans does indeed provide far more comprehensive protection than that envisaged in the previous plans there are some matters that cause us concern.

The first is what we consider a reduction in the benefits of the basic plan as contrasted with the proposals of H.R. 1 and S. 1. This latter measure (as well as its King-Anderson and Forand bill predecessors) provided that all services furnished to an inpatient of a hospital, by the hospital, including services in the fields of pathology, radiology, psychiatry, and anesthesiology would be covered among the basis inhospital services. Under the terms of H.R. 6675, that part of such services that is provided by a physician would be excluded from the basic hospital benefits. Coverage would be limited to partial reimbursement for the physician's fee under the terms of the supplementary program.

In our view, this change results in a substantial reduction in benefits under the basic plan, as a result of shifting coverage of hospital-based specialists' services from the basic program to the supplementary program. Instead of full coverage for these services, the individual would be entitled only to reimbursement subject to the $50 overall deductible for 80 percent of the specialists' fees. And he would be entitled to this only if he were enrolled in the supplementary program.

In actual fact the benefits in the basic plan would be further reduced under this provision because, as a result of changing the terms under which payment for these services could be made, the cost of hospital-based specialists' services could be expected to rise sharply—both for beneficiaries and nonbeneficiaries.

Experience with existing plans such as Blue Cross has demonstrated that the total cost to patients, or third-party payers, for these hospital-based specialists' services is substantially smaller when these services are provided as part of total hospital services than when they are provided by the specialists charging on a fee-for-service basis.

We do not pretend to be experts in the intricacies of hospital administration. However, we are impressed by the arguments put forward by the American Hospital Association and others, pointing out that the provisions of H.R. 6675 would constitute an unfortunate form of governmental interference with medical practice and would result, in some instances, in the Federal Government encouraging and, in some instances actually forcing hospitals to change their present arrangements with specialists, to arrangements that are substantially less desirable from the point of view of the patient and the public.

At this year's midwinter meeting of the executive council of the AFL-CIO, the council stated:

> The King-Anderson bill, introduced in this Congress as H.R. 1 and S. 1, constitutes an eminently constructive program. * * * The AFL-CIO executive council enthusiastically supports its passage in its present form. If any modifications are to be made, we urge that covered health benefits be as broad as is economically feasible and consistent with the maintenance of standards of high quality care.

In the line with that policy statement, we urge your committee to restore the provisions of S. 1 relative to the coverage of the services in the field of pathology, radiology, psychiatry, and anesthesiology.

We also have two major concerns about the supplementary enrollment program. The first relates to the deductible and coinsurance provisions. While the proposal to match the $3 premium for each enrollee is a generous one that should encourage nearly universal participation, we are also aware that the requirement of a $50 deductible and the out-of-pocket payment of 20 percent of the patient's bills (above the deductible) will, for a majority of older persons, constitute a real hardship. For some, it may be insuperable.

Our second concern relates to the quality of medical care to be provided. In this area we have considerable experience, since the type of protection contemplated parallels that in a great many of our negotiated health and welfare plans. We have learned that when we provide payment for medical services, we have not by any means solved all the problems. In fact, the existence of such a plan, while solving some problems, in some cases raises others.

We have seen that under some plans, there has been an escalation of physicians' fees. There has been unnecessary surgery performed. There has been a lack of any guarantee that all medical and surgical procedures were performed by the best qualified men available. In some cases patients have been hospitalized in a hasty and superficial manner without any clear-cut indication or without prior study of what could have been done on an ambulatory basis.

These experiences have not by any means convinced us that we should drop these plans, as they accomplish a great deal on the positive side. They do so much good, they meet so important a part of the problem for people when they are ill. For the same reason we don't believe that just because there are potential problems, which we frankly recognize, that the Government should then for that reason hesitate in instituting the new broad programs because the only alternative is to leave these elderly people without the protection or to institute rigid controls on the practice of medicine. We are not proposing, of course, that either one of these alternatives should be taken.

We also note that the bill does provide procedures to minimize the risks as much as possible without instituting controls. In part, the responsibility is placed upon the National Medical Review Committee, which is authorized to study the utilization of hospital and other medical care and services, to keep a careful watch over the way in which covered care and services are used, and to monitor the administration of both the basic and the supplemental plans.

We point out in our statement that the potential dangers that we put our finger on here are no different from the dangers that exist on the currently widespread health insurance plans that now cover some 80 percent of the working population of the United States during their working years.

The difference is that in this program it will operate in a goldfish bowl and we think that is an important difference. The people, consuming public, the medical profession and the Government will know what is going wrong if it does go wrong. If there are abuses they will be in a position to indicate corrective actions.

Now, in this whole area also of the quality of care, our experience has been with negotiated plans that one of the most effective ways to assure quality is through group practice, group practice tied with prepayment and we trust that this measure will encourage this kind of group practice.

The accomplishment of group practice plans are gradually attracting increasing support among our membership and where they have accepted group practice and prepayment tied together, it has clearly enhanced the quality of medical care.

Now, we believe there are provisions in the bill as written to protect the group practice plans that are in existence in this country. We believe that they could perhaps be made more explicit. If there is any question about that they should be made more explicit.

We are also in support of the other provisions of the bill: The changes in the definition of disability, the 7 percent increase in benefits, the inclusion of tips as taxable earnings, the two-step increase in the contribution and benefit base are all very important.

However, the wage base has not kept pace with rising wages, and we point out that if it were to keep pace and cover the same proportion of full-time earnings that was covered in 1935 the wage base would have to go about $18,000. So, good as this measure is, it is going only halfway in this direction.

We point out also that there are a number of other improvements that could be made. We would not want any Member of the Senate or of this committee to believe that we are under the impression that good as this measure is that it is a great radical far-out improvement. There are many other things that could be done to our social security system, all good, all constructive. We could face up to this matter of earlier retirement, which is being forced on so many people because of automation and the rationalization taking place in the industrial process, but we are not urging these now, because our position is—the position of my organization and those we represent—that the most immediate threat to the economic security of older people is the threat of high cost illness. We give that a priority in our social security legislative program, and this bill gives it a priority, and, therefore, it is consistent with our position that this bill should be

adopted with only those changes, with one real change that I have suggested.

We note also the extensive improvements in the public assistance program, the extension of care to children, with a broadening of the child health programs. These are excellent programs and we trust the administrative arrangements that have been so constructive here and the lessons we have learned in the application of high quality medical care can be carried over into this broadened program.

We note also the moneys that will be released as the States are relieved from the burden of the high cost of medical care for their older citizens is by this bill channeled to an improved and extended Kerr-Mills approach.

This, we think is practical and sound, and we are fully in support.

Gentlemen, this Nation under the President's leadership is fully committed to a war on poverty. The major provisions of H.R. 6675 would provide the most effective weapons yet provided for winning that war because they would prevent the occurrence of poverty.

Finally, Mr. Chairman, and gentlemen, let me note that we appear before this committee today in a spirit of deep gratification and with a measure of pride.

We are proud of the many years of effort we have devoted to a program which now appears to be on the threshold of reality. We could say, in all modesty, that the Nation has caught up with us, that our position has been vindicated.

But whatever pride we feel is secondary to our gratification that the Nation is taking this historic stride toward the ultimate goal of assuring the security and well-being of all the people. At a time of unparallel national prosperity, the American people, through their Government, have dedicated themselves to those who are still in need.

The effects of the bill before you will be felt in all the generations ahead; and its most valued product will be human happiness and human dignity. We urge you, therefore, to advance this worthiest of all causes, and we are confident that you will.

Thank you, Mr. Chairman.

(The full statement of Mr. Cruikshank follows:)

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO

My name is Nelson H. Cruikshank, and I am director of the Department of Social Security of the American Federation of Labor and Congress of Industrial Organizations. My office is located in the headquarters building of the AFL-CIO, 815 16th Street NW., Washington, D.C.

I am appearing this morning, representing the AFL-CIO, in support of H.R. 6675—the Social Security Amendments of 1965. We appreciate the opportunity to appear before this committee to present our views on what we consider the most far-reaching proposals for the improvement of the economic security of American families through the mechanism of social security since the enactment of the original social security program 30 years ago this summer. The bill you are considering represents arduous labor and painstaking thought over a period of nearly a decade by thousands of citizens in every State, officials at every level of government, members of the medical professions, and by both Houses of the Congress. Its enactment would bring to practical realization the hopes and dreams of millions of citizens who have labored in support of a better way to meet the needs of the elderly, the children, and others with special needs.

I shall not attempt to analyze in detail all the complicated and interrelated provisions of this most comprehensive measure. My purpose is rather to give you, in the brief time available, the major reasons why the AFL–CIO, representing some 13½ million wage earners and their families, and reflecting, we believe, the views of millions more, wholeheartedly supports H.R. 6675 and why we urge this committee and the Senate to grant it speedy and favorable consideration.

There are six main reasons why we support this bill.

1. It provides basic health benefits for the aged, financed through contributory social insurance.
2. It provides for contributions from general revenues toward health insurance coverage, without the imposition of a means test.
3. It provides substantial increases in cash benefits to social security recipients.
4. It increases the amounts of earnings insured under the system—

   (*a*) By raising the wage base; and
   (*b*) By including earnings received in the form of tips.

5. It provides adequate and equitable financing for both the broadening of existing social insurance programs and for the newly inaugurated ones.
6. It provides improved standards and broadened coverage for State programs of medical assistance for needy persons.

The first two of these stated reasons are especially important to us, not only because of the immediate protection afforded nearly 19 million people, but because of the acceptance of the basic principles they reflect. The extension of the proven principle of contributory social insurance to meet major health costs is of far-reaching and historic significance. Nearly every other industrial country in the world took this step years ago.

Of almost equal significance is the recognition that it is appropriate to use funds from general revenues to help pay the costs of health insurance without the application of a means test. This bill takes this important step in two areas: (*a*) by meeting during the early years of the program the costs of benefits under the basic plan for those not covered by social security or railroad retirement, and (*b*) by matching the $3 monthly premium for each individual enrolling in the supplementary plan.

If this bill did nothing more than establish these two principles, while at the same time translating them into concrete benefits, as it does, it would merit our wholehearted support.

This, of course, is not to say that the bill is a perfect instrument or that it cannot be improved. I shall, in fact, have some suggestions to make which we believe are necessary if this measure, when enacted into law, is to meet its worthy objectives.

The AFL–CIO has long supported and still supports the basic health insurance programs for the elderly embodied in S. 1, introduced by the distinguished member of this committee, Senator Anderson, in which he was joined by 44 of his colleagues in the Senate, including 5 other distinguished members of this committee.

There were two basic reasons for our support over the last several years for a measure of this kind. The first is the well-known fact that incomes decrease sharply with old age and retirement. The second is the equally demonstrable fact that the incidence of costly illness increases with age.

The mechanisms of private insurance and negotiated health and welfare plans have been very useful in providing protection for people during their working years when ill health is less frequent. The situation that comes with advancing age is quite different. Not only do workers have the higher health costs associated with old age, but these costs come at the time when their incomes are greatly reduced because they are no longer employed. It is now generally recognized that the great majority of the aged do not have adequate health insurance, mostly for the reason that they are unable to pay the premiums for such protection. Older people have, on the average, only about half as much income as younger people living in family groups of the same size. A recent survey of social security beneficiaries reveals that about half of them have practically nothing in continuing retirement income, other than their meager social security benefits. About four-fifths of these aged beneficiaries were found to be dependent on social security as their major source of income. While the protection of private pension plans will expand in future years, at the present,

only 15 percent of the retired have current income from such plans and even for these, the amount from social security is generally larger than the private pension payment.

At the very time of life when these people are experiencing these drastic reductions in income, they find themselves faced with health care expenditures much greater than those confronting younger people. In fact, total health care expenditures for the aged are twice as high and, in the case of expenditures for hospitalization, the ratio is 2.75 to 1. These older people have to go to the hospital more often and have to stay longer than those in their younger years.

Few older people escape the hazard of the cost of a hospitalized illness. In fact, 9 out of 10 of those who reach age 65 will be hospitalized at least once during their remaining years, and most of them will experience a hospitalized illness 2 or more times.

A program that covers the major costs of hospitalization and other related costs meets a most important risk because there is a high correlation between hospitalization and large total medical expenses. Those older people who are hospitalized in a given year are the very ones who have the big expenses. This is shown by the fact that in 1962, medical care costs for all aged couples averaged about $442. The medical expenses of those aged couples with one or both members hospitalized during the year average $1,220.

These data, obtained in the 1963 survey of the aged, a study conducted by the Social Security Administration in cooperation with the Bureau of the Census, also show that for nonmarried elderly people, the average medical expenses in 1962 were $270, whereas for those who were hospitalized, the averaged was $1,038. These figures are now 3 years old. Both the averages and the differentials would be even higher today.

The costs of an ordinary illness which can be cared for in the home are easier to budget for and payment is less difficult to arrange for. The costs accompanying a hospitalized illness are not postponable, are usually of a more emergency nature, and cannot be budgeted for on a retirement income. It was for these reasons that we felt and still feel that a measure that provided a mechanism whereby the costs of hospitalized illness could be spread over the entire working population and through the working years for those covered under the program was a good measure, meeting a major and serious problem. It provided against the costs of inpatient hospital services, posthospital extended care services, home health services, and outpatient hospital diagnostic services for almost the entire population upon attainment of age 65.

But the bill before you goes far beyond these protections. We are glad that it does. It proposes a voluntary supplementary insurance plan which would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions. The two together comprise a far more comprehensive protection than that contemplated in H.R. 1 and S. 1.

For these welcome changes we are to a large degree indebted, ironically enough, to certain forces that testified in opposition to H.R. 1 and its predecessors from the start, and to their grudging change in tactics over the years.

When proposals were first introduced in the Congress to provide health insurance to cover mainly hospitalization and related costs, those who appeared in opposition based their case on the claim that there was no need. Eight years ago they were saying that most of the aged were relatively well to do and that the growth of private insurance was so rapid that it could be expected to cover the entire population within a few short years.

By 1960, however, there was already a shift in this position. There was a recognition that some of the elderly were unable to meet the cost of illness and that for those who were medically indigent, a Federal-State program, built on the principle of public assistance, could meet the need.

The Kerr-Mills program, designed to meet this part of the problem, failed, however, to recognize two important facts. The first was that it was important to prevent dependency, as well as to help meet it after it occurred. It failed to recognize that for a great many of the elderly their dependency was caused by the cost of their illnesses.

Finally, within the last year, those who once denied there was a need at all have not only recognized the need for Federal action, but acknowledged that the need went beyond covering the costs related to hospitalization. Their criticism of H.R. 1 was that it did not go far enough. They, therefore, proposed a much broader spectrum of benefits, although they were completely impractical

as to the method of financing them. However, the public took them at their word and recognized that the protection afforded should be much more comprehensive. The House of Representatives responded to this expression. The result is the combination of a basic social insurance plan and a supplementary voluntary plan now embodied in the bill before you.

While the combination of these two plans does indeed provide far more comprehensive protection than that envisaged in any of the previous proposed plans, there are some matters that cause us concern. The first is a reduction of the benefits in the basic plan, as contrasted with the proposals of H.R. 1 and S. 1. This latter measure (as well as its King-Anderson and Forand bill predecessors) provided that all services furnished to an in-patient of a hospital, by the hospital, including services in the fields of pathology, radiology, physiatry, and anesthesiology would be covered among the basic in-hospital services. Under the terms of H.R. 6675, that part of such services that is provided by a physician would be excluded from the basic hospital benefits. Coverage would be limited to partial reimbursement for the physician's fee under the terms of the supplementary program.

In our view, this change results in a substantial reduction in benefits under the basic plan, as a result of shifting coverage of hospital-based specialists' services from the basic program to the supplementary program. Instead of full coverage for these services, the individual would be entitled only to reimbursement subject to the $50 overall deductible for 80 percent of the specialists' fees. And he would be entitled to this only if he were enrolled in the supplementary program.

In actual fact the benefits in the basic plan would be further reduced under this provision because, as a result of changing the terms under which payment for these services could be made, the cost of hospital-based specialists' services could be expected to rise sharply—both for beneficiaries and nonbeneficiaries. Experience with existing plans such as Blue Cross has demonstrated that the total cost to patients, or third-party payers, for these hospital-based specialists' services is substantially smaller when these services are provided as part of total hospital services than when they are provided by the specialists charging on a fee-for-service basis.

We do not pretend to be experts in the intricacies of hospital administration. However, we are impressed by the arguments put forward by the American Hospital Association and others, pointing out that the provisions of H.R. 6675 would constitute an unfortunate form of governmental interference with medical practice and would result, in some instances, in the Federal Government encouraging and, in some instances, actually forcing hospitals to change their present arrangements with specialists, to arrangements that are substantially less desirable from the point of view of the patient and the public.

At this year's midwinter meeting of the executive council of the AFL-CIO, the council stated:

"The King-Anderson bill, introduced in this Congress as H.R. 1 and S. 1, constitutes an eminently constructive program. * * * The AFL-CIO Executive Council enthusiastically supports its passage in its present form. If any modifications are to be made, we urge that covered health benefits be as broad as is economically feasible and consistent with the maintenance of standards of high quality care."

In line with that policy statement, we urge your committee to restore the provisions of S. 1 relative to the coverage of the services in the field of pathology, radiology, physiatry, and anesthesiology.

We also have two major concerns about the supplementary enrollment program. The first relates to the deductible and coinsurance provisions. While the proposal to match the $3 premium for each enrollee is a generous one that should encourage nearly universal participation, we are also aware that the requirement of a $50 deductible and the out-of-pocket payment of 20 percent of the patient's bills (above the deductible) will, for a majority of older persons, constitute a real hardship. For some, it may be insuperable.

Our second concern relates to the quality of medical care to be provided. In this area we have considerable experience, since the type of protection contemplated parallels that in a great many of our negotiated health and welfare plans. We have learned that when we provide payment for medical services, we have not by any means solved all the problems. In fact, the existence of such a plan, while solving some problems, in some cases raises others.

We have seen that under some plans, there has been an escalation of physicians' fees. There has been unnecessary surgery performed. There has been a lack of any guarantee that all medical and surgical procedures were performed by the best qualified men available. In some cases patients have been hospitalized in a hasty and superficial manner without any clear-cut indication or without prior study of what could have been done on an ambulatory basis.

These experiences have not by any means convinced us that we should drop these plans, as they accomplish a great deal on the positive side. They have, however, convinced us that we should exercise every effort to see that they are so structured and administered as to encourage high-quality medical care.

Likewise, we don't believe, just because we recognize that there are some potential problems, that the Government should hesitate in instituting this new broad program for the aged. We think the plan should go forward because the only alternatives are (1) to continue to leave the elderly without adequate protection, or (2) to set up rigid controls over the practice of medicine. It must be assumed that physicians under this new program will act in accord with the best traditions of their profession; and that those few who may abuse the new program for private gain will be subjected to the disciplines of the profession.

We note also that the bill provides procedures to minimize the risks as much as possible without instituting controls. In part, the responsibility is placed upon the National Medical Review Committee, which is authorized to study the utilization of hospital and other medical care and services, to keep a careful watch over the way in which covered care and services are used, and to monitor the administration of both the basic and the supplemental plans.

Essentially, as we see it, the function of this review committee is based on the principle of disclosure. This principle has been effective in other areas in assisting nongovernmental groups in their efforts at self-discipline.

Whatever problems are involved in establishing this broad new program are essentially no different from those in prevailing systems of nongovernmental health insurance. The difference—and it is a big difference—is that this new system will operate in a goldfish bowl. Not only the medical profession, but the public and the Government, will be aware of any abuses that may occur.

The institution of the new health programs will place new responsibilities on all the interested voluntary organizations, on Government and on the medical profession.

Organizations of consumers of medical care and service, like our own, will be called upon to educate the public in what they should expect in terms of high-quality medical care.

The Government, and especially the administrative agencies designated under this bill, will have the responsibility of keeping clear the flow of information about the way the program is operating. Any abuses that may develop will have to be referred to those who are in a position to correct them.

Those in the medical profession will have the additional responsibility of implementing its own high standards and policing its own members. It will also have the responsibility of assisting the private organizations and the consumers' groups and the general public in understanding what high-quality medical care means and how best to utilize the services of this new program in order to obtain it.

Physicians organized in medical groups are today giving prepaid medical care to several million people enrolled in group practice plans. These physicians work as teams and pool their varied professional skills for the best care of the patient in return for regular payments on an agreed basis. These plans achieve substantial economies through bringing the various specialties together in one place and through efficient joint use of supporting personnel and expensive equipment. They assure quality of medical care through professional review of the qualifications and performance of medical staff.

The accomplishments of group practice plans are gradually attracting increasing support among trade unions. Not only from our own interest but because of their value as yardsticks against which the efficiency and costs of other methods of providing and paying for medical care can be evaluated, we believe it essential that this bill and the Secretary's administration of it clearly authorize and foster the continued existence and development of these plans, and especially their methods of compensating physicians on other than a fee-for-service basis. We believe this is authorized under the present bill, but we would welcome any technical improvements which would make this aspect more explicit. We also believe the record should make clear the intent of the Congress for the guidance of the administration in this regard.

We also welcome the extensive liberalizations and improvements in our basic old-age, survivors and disability insurance system contained in this measure. With increased cash benefits and broadened coverage, the program will more nearly meet the needs of the great majority of working people who look to it for protection against loss of income due to old age, death, or disability.

The changes in the definition of disability and in the payment period are essentially technical changes which will enable the program to meet better the objectives originally contemplated by the Congress when it established the disability program in 1956.

The 7-percent increase in benefits, with a minimum of $4 monthly increase for all retiring at age 65, especially timely and welcome.

The inclusion of tips as taxable earnings and for computation of benefits would correct a long-standing injustice affecting about a million workers. These earnings are now subject to income taxes but excluded from the protection of social security.

The two-step increase in the contribution and benefit base from $4,800 to $5,600 and then to $6,600 is not only important as a means of financing the broader program. It provides for keeping benefits more nearly in line with rising earnings. Our social security system is important to average and above-average earners as well as to those with low earned incomes.

Over the years, the limitation on earnings for taxes and for the computation of benefits has failed notably to keep pace with increases in earnings. As a result, the protection provided under the system for those in the higher wage brackets has signficantly deteriorated.

As the recent Advisory Council on Social Security pointed out, for example, a man who was earning $3,000 in 1940 had all of his earnings counted, and as he looked forward to retirement in 1965, could expect to get a benefit that would equal 21 percent of his earnings. However, a man who was earning $3,000 in 1940, if his earnings rose in proportion to the general increase throughout the Nation, is making about $13,000 in 1965. Under the $4,800 ceiling now in effect, his benefit would equal not 21 percent of his earnings, but about 11 percent. About two-thirds of the regularly employed men now have earnings have this $4,800 maximum. If the essential wage-related character of the system is to be preserved, it is imperative that the earnings base keep pace with the general rise in earnings. The two steps provided in this measure are welcome, but even the second step goes only about half way toward the goal of covering all the earnings of most men working full-time in covered employment.

While these liberalizations, along with others proposed in the bill, represent substantial improvements in the protection afforded by our social security system, they are, in fact, quite modest. Even with their enactment, there will still be serious gaps in the wall of defense against destitution.

For one thing, they leave untouched the problems that arise out of the growing threat of enforced early retirement. In the last year, more than half of the men applying for social security benefits were retiring before age 65, accepting the consequent actuarial reduction in benefits. No one believes that with the average primary benefit currently awarded—about $88 a month—very many of these men are retiring of their own free will. What is undoubtedly reflected here is an indirect effect of automation and other factors causing the displacement of workers. If the economic system is forcing men and women to retire earlier, then the social security program will have to be adjusted to meet the facts of modern life. At the very least, the amount of the actuarial reduction should be reduced. This was specifically called for by the AFL-CIO executive council's statement on legislative goals last November, and stressed at a national legislative conference in January.

Other improvements come readily to mind. One that is clearly called for is to add additional dropout years in the computation of the average wage. This would result in an average wage more nearly reflecting current earnings, with the result that the full effect on benefits of the increased wage base would not be delayed for so long as it will be under the bill in its present form.

We believe, also, that in the case of a retired couple, when the husband dies, the widow should get a benefit equal to the primary insurance amount, rather than 82½ percent as provided under present law.

The general increase in benefit amounts should also go much beyond the modest 7 percent provided in H.R. 6675. The 7 percent barely keeps pace with the rise in living costs since the last general increase provided in 1958. It does not permit the retiree to share in the advancing standard of living which other

segments of the population have enjoyed during the last 7 years. The Advisory Council on Social Security recommended a general benefit increase averaging 15 percent.

These improvements are all desirable. However, the position of the AFL-CIO is that the most serious threat to the economic security of the elderly today is the high and unpredictable costs of illness. Measures to meet this threat hold first priority among our goals for social security legislation. H.R. 6675 reflects the same priority. Our wholehearted support of this measure is, therefore, consistent with our policy.

We support, also, those provisions of the bill that would extend the child health programs, those for maternal and child health and crippled children. These have demonstrated how programs under the auspices of Government can provide high-quality medical care. We urge that maximum use be made of this experience, and that the administrative arrangements under which they have been conducted be utilized in the development of the new programs for children, wherever possible. In undertaking a substantial extension in the quantity of medical care provided, those involved must not lose sight of the paramount importance of its quality.

The health insurance programs of this bill will relieve the States from the major part of the heavy financial burden they are now carrying in their efforts to meet, on an assistance basis, the costs of illness for their elderly. We welcome the provisions of this bill which would combine additional Federal aid with the State funds thus freed to provide a more adequate, less restrictive and, we hope, higher quality medical care for all those people, including children, for whom no other provisions now exist.

This Nation, under the President's leadership, is fully committed to a war on poverty. The major provisions of H.R. 6675 would provide the most effective weapons yet devised for winning that war, for they would prevent the occurrence of poverty and need, as well as alleviate its irreducible remnants.

In conclusion, Mr. Chairman, let me note that we appear before this committee today in a spirit of deep gratification and with a measure of pride.

We are proud of the many years of effort we have devoted to a program which now appears to be on the threshhold of reality. We could say, in all modesty, that the Nation has caught up with us, that our position has been vindicated.

But whatever pride we feel is secondary to our gratification that the Nation is taking this historic stride toward the ultimate goal of assuring the security and well-being of all the people. At a time of unparallel national prosperity, the American people, through their Government, have dedicated themselves to those who are still in need.

The effects of the bill before you will be felt in all the generations ahead; and its most values product will be human happiness.

We urge you to advance this worthiest of all causes, and we are confident that you will.

Senator ANDERSON. Thank you Mr. Cruikshank.

Senator Carlson?

Senator CARLSON. Mr. Cruikshank, I appreciated very much your statement and I think you might well state that your organization and you personally have been in the forefront of a program of this type for many, many years and I do appreciate your statement here this morning.

I was interested in your thought here in regard to the stepup and increase in the contribution of benefit base from 4,800 to 5,600 and then 6,600 and then you kind of look forward to the day when they might get to 13,000.

Now, I would like to ask just one question, and I don't know whether you have given this any thought: assuming, and I assume all of us agree, we must have a sound financial program no matter what the costs are, what about the pressures that are going to be coming to Congress in the future to reduce the age from 65 to 60, and 55 to 50, where do we get to as to future costs?

Mr. CRUIKSHANK. Well, sir, I don't know where we will get. I do know that we are faced with the basic problem, and it is too bad almost that it is a problem, isn't it, because we are faced with the situation that with the enormous productive capacity of our industrial system and the skill of our workers, that the amount of goods and services that are necessary to the country, even including our enormous defense needs can be produced by the devotion of a smaller number of hours or a smaller number of weeks or a smaller number of years to the industrial process.

Our essential problem is the way the release of this time is distributed, it seems to me. As long as we can produce with fewer number of hours the amount of goods and services that are needed we have the real question as to how we distribute it better.

I think obviously we are going to have to lengthen the period of education and training down at the bottom, the bottom of the age scale, and this will be good because our technological processes mean that people are going to have to have longer periods of training. So, part of that, part of that increment that we get out of this, I think, is going to be longer periods of education.

Then we are going to have, I believe, a shorter workweek which will take part of that. We are going to have paid vacations for people in the middle period of their working lives. We have some of that now in some of our wage and hour agreements. We are going to have perhaps a sabbatical year. We have a sabbatical 6 months now in the steel industry contract. We are going to have, as I say, vacations during the year. We are going to have all of these methods that will take up the slack.

The question is how you distribute the load of the working population among the nonworking population, the nonproducing population.

Now, part of this, I think, is going to be that people can leave the productive—that is the area of production for the marketplace at an earlier time. I hope it won't mean that they just vegetate. We have had a fine example of our dedicated friend, Mr. Forand, here this morning, who is retired but who is productive, and carrying on useful work in society. We have got to find all of these ways.

Now, whether we do all of this by the social security mechanism or not, I think we are going to have to do part of it that way. We are going to have to adjust our social security system to this basic fact that we can produce all the needed goods and services in modern technological society with less hours, less months, less years given directly to it.

But social security, I believe, will have to bear part of that load, sir.

Senator CARLSON. Mr. Cruikshank, I certainly appreciate your statement. You are one man who has worked and lived with this field and is well qualified to speak on it. I could not help but think as you were looking forward to the future of this Nation's productive capacity and its workers the good book reads something like this, where there is no vision people perish.

You have that vision and I hope we will be able to meet it when the time comes.

That is all.

Senator ANDERSON. Senator Talmadge?

Senator TALMADGE. Mr. Cruikshank, I thank you for your statement which was lucid and forthright and to the point.

We received some testimony from the Secretary of Health, Education, and Welfare and members of that Department staff last week to the effect that it would cost, I believe, $600 million a year to vouch all of those persons of 72 years of age under social security.

As you know, this bill reduces the coverage from six quarters to three quarters for eligibility at that age.

Some of the most pitiful letters that I receive are from individuals who lack only a few days having sufficient quarters for coverage. Of course, the requirements are purely arbitrary in the first instance.

Do you have any information as to the cost, if we vouched all of those 72 years of age and older under social security bearing in mind the offset that we would have in public assistance?

Mr. CRUIKSHANK. No, Senator Talmadge, I don't have anything different from the figures that were presented to you by the Secretary. I think those estimates are undoubtedly accurate.

We would have no objection, of course, to blanketing in these people under the social security system's provided the costs were met out of general revenues. We do not think it is advisable or fair to the people who have paid a payroll tax to put that additional burden on them since, as you pointed out, it would relieve other burdens of the State and the Federal Government. We do not believe it would be fair to provide that relief to the tax burdens in the other areas and put that on a system primarily financed by the payroll tax.

Senator TALMADGE. Of course, that is what you are doing when you change an arbitrary formula of six quarters to another arbitrary formula of three quarters.

Mr. CRUIKSHANK. You are doing it to a certain extent, yes, Senator, you are. These matters have always been a matter of compromise and you have to draw the line somewhere, of course, and wherever you draw it there will be some people who will almost make it and some who will just barely make it, and the concentration of our examination to the borderline cases always makes it appear that the system is less just than in fact it is.

Senator TALMADGE. Thank you very much.

No further questions.

Senator ANDERSON. Senator Bennett?

Senator BENNETT. Pursuing this same subject, aren't you doing it today for everybody who qualified for old-age assistance by blanketing those now over 65 into the medical program assuming this is going to be paid out of future contributions to the medical program fund?

Mr. CRUIKSHANK. Well, you are, of course, making an additional benefit retroactive under the system, which we have always done whenever Congress has given us an increase in benefits. They have made these cash benefit increases retroactive.

We do this also in private plans every day, we improve the system and then to the extent at all possible we share that with the present retirees. We did it when disability protection was added to the social security system in 1956. We picked up some disability cases reaching back as far as 1940. We do it in workmen's compensation in the States. As cash benefits are increased or a State adds medical care

provisions to their workmen's compensation programs, those benefits usually are available to those who have been under the system as well as to those who come under it after the improvements are added.

Now, of course, there is this distinction. The people who are not eligible under social security or railroad retirement are under this proposal just as I suggested provided the benefits, but they are paid out of general revenues.

Senator BENNETT. Well, to me this is largely semantics with respect to the people who are now 65. We blanket one group in, and say we are doing it because they have earned certain benefits in the past under another system and, therefore, it is retroactive inclusion and then we take another group and say, if you can earn three quarters by the time, if you are over 72 we will put you in that route but if you can't earn three quarters we put you in another route. So that in effect that—in effect we are saying today everybody over 65 is going to get medical benefits from here on out for which they themselves have never made a specific contribution to any specific fund, and we set up the fiction that a certain section of these are going to be paid for out of the general revenues and the others are going to be paid for when and if the new fund we set up becomes solvent under what we call the level premium assumption.

But the fact is that nobody who is 65 when this bill passes will have paid a penny for the services he or she could get out of it. We rationalize they have earned certain rights because they qualified for other services, but isn't that about the actual fiscal fact of the situation?

Mr. CRUIKSHANK. Well, that is a description of it, Senator, yes. But I think one of the factors we need to bear in mind is this is all a temporary arrangement. We hold to the basic principles of the system and because this group will diminish gradually, and we are not making a permanent distortion of our social insurance approach by making an interim arrangement of this kind to take care of the people who have not paid into this particular fund.

But it is true, we are, of course, as you say, providing benefits to people who have not contributed to this specific fund. But this is the mechanism of social insurance. We do it all the time, we do it under our private arrangements. We do it in our negotiated plans; we do it when we extend Blue Cross programs to people who are working in a plant, and we do it when we institute a pension plan. We take people who are 64 years and 6 months of age and we give them the full pension rights by the system of past service credit.

Now, they haven't had the wage reduction to compensate for that benefit but this is the very mechanism of our whole social insurance approach which is carrying on also into our private arrangements or you could say the private arrangements are carrying over into our public arrangements. It is characteristic of the whole mechanism of social insurance. It is unavoidable.

Senator BENNETT. That is why I think we might as well, as Senator Talmadge suggests, accept this as a kind of unavoidable adjustment and take care of these people without another fiction that they suddenly qualify with three quarters instead of six.

Mr. CRUIKSHANK. We are not objecting to their qualifying. We just feel that those who have not participated in the system in order to maintain the integrity of the system, their benefis should be paid,

as this bill provides, for the medical benefits for those who have not participated in the social security system be paid out of general revenues.

Senator BENNETT. No other questions, Mr. Chairman.

Senator ANDERSON. Senator Curtis?

Senator CURTIS. Mr. Cruikshank, the Secretary and his experts testified last week, that so far as present beneficiaries are concerned the system is about 10 percent contributory.

Would you agree with that?

Mr. CRUIKSHANK. I haven't seen the figure that low but if the Secretary and his experts said that, I wouldn't quarrel with it, sir.

Senator CURTIS. Yes.

Mr. CRUIKSHANK. For the present beneficiaries have paid about 10 percent.

Senator CURTIS. We are operating about 10 percent contributory and 90 percent of the benefits are paid by others.

Would you agree with that?

Mr. CRUIKSHANK. I wouldn't quarrel with it, with that figure.

Senator CURTIS. And the record will also show that I asked the question, What would it be 10 years from now? Ten years from now it will be about 20 or 25 percent contributory and about 75 or 80 percent of the benefit will be paid by others. Would you agree with that?

Mr. CRUIKSHANK. I wouldn't quarrel with it; no sir.

Senator CURTIS. Now, how high do you think the Congress should ever fix the withholding tax? Is there any limit as to how high we should go?

Mr. CRUIKSHANK. Well, sir; I wouldn't attempt at this time to look into the future and to say that there is any appropriate figure which should be applied to that future time, because I don't think that in a dynamic society such as ours, that it is possible to say that any portion of earnings should be allocated one way or another. These changing ways surprise all of us.

I look back, for example, to the time when I was a boy, raised in a family of a small businessman, middle-class community, I suppose you would say, in northern Ohio, and I look at the amount of our family budget that was allocated to travel and enjoyment and it was very small.

My father had a car, we would take one or two trips a year, and I suppose the whole business of vacations and travel wasn't over 2 to 3 percent of our budget.

Now, people in ever less affluent circumstances than we enjoyed will pay $80 a month payments on an automobile and think nothing of it. The cost of travel, the amount that they will travel, the amount of vacation, that would have been impossible in 1912 to looking forward to see in a productive society such as ours the fact that families in very ordinary circumstances would allocate 20 percent perhaps of their incomes to travel and vacation. That would have seemed preposterous.

When the Social Security Act was passed 30 years ago this summer, I don't suppose anybody would have thought we could have allocated to it, out of our wage payments, anything like the proportion that we are, both in social security and private arrangements, health and welfare plans and pension plans, to the matter of security in old age.

Partly we didn't anticipate the size of the problem then, and more we didn't anticipate the productivity, the productive capacity of our industry and our whole system.

I think that will expand the amount that will be applied to education, the amount that will be applied to leisure activities, the amount of our earned budget that will be applied to security in all ages, I don't believe are predictable.

If we just rid ourselves, for example, if we could see a peaceful world some day look what would be released, look at the capacity that would be released, the wealth that would be produced, that we could apply to other things, so I don't say—we can't look into the future and say this is a reasonable figure at any time.

Senator CURTIS. There has been considerable discussion about not going beyond the 10 percent combined payroll tax. You do not share that?

Mr. CRUIKSHANK. I don't think there is anything magic about the 10 percent but I always ask the question 10 percent of what? This bill contemplates going a little bit over 10 percent. But it only carries the wage base to $6,600. Improving the wage base to something comparable to what it was relative to 1935 and you could stay well under 10 percent and finance all the benefits in this bill.

Senator CURTIS. Do you believe that there are people over 65 who are well able to pay their medical bills or to buy private insurance?

Mr. CRUIKSHANK. Yes; I think there are, but I think also they would want to take measures to insure that fortunate position they are in.

Senator CURTIS. They would like the benefits, you say?

Mr. CRUIKSHANK. Well, I think that there are people today who are able to take care of their own medical bills, but there are not many of them that can be assured that they are going to always be able to provide those a year from now or 5 years from now or 10 years from now. People's circumstances change in dramatic and sometimes catastrophic fashion.

Senator CURTIS. There will be about 19 million of them that will not be contributory at all, isn't that right?

Mr. CRUIKSHANK. In the early years people won't have contributed.

Senator CURTIS. I just had the staff compute here, that in 10 years' time the maximum an employee could pay to the medical portion of this bill under social security would be a total of $307.50. So the individual who comes under this bill at age 55 now in 10 years would pay $307.50 into the medical fund.

Now, do you know what the average cost of a day in a hospital is?

Mr. CRUIKSHANK. It runs between $35 and $40.

Senator CURTIS. Yes.

So, in 10 years' time an employee will pay in about a little less than the cost of 10 days' hospitaliaztion.

Mr. CRUIKSHANK. Well, of course, Senator, in the 10 years, in the early part of the program this may be true. This is true of any insurance program in its early start. Suppose a life insurance company starts business today and it establishes its legal reserve and starts collecting premiums, starts selling policies and collecting premiums. This relates to your question. You could take the first 6 months of

the operation of that life insurance company and you can say all of these beneficiaries have only paid, say, 1 or 2 percent and all of the costs of the benefits they receive.

As years go on it would be a little more and a little more, but that is the very basis of the operation of any insurance system, when it starts the people who get benefits in the early period of its operation have not paid at all. It would be in the instances I cited by way of example, there would be some people who perhaps just made the first payment of their premium and might get $10,000, $15,000, or $20,000 in benefits.

Senator CURTIS. I won't take the time of the committee to discuss the comparison between what people have come to talk about a social insurance and ordinary insurance. There are a lot of differences there. In social insurance you have to judge the program. We have a program that has gone on for 30 years, and the beneficiaries are 10 percent contributory at the present time. Ninety percent of the load is carried by others. We are going to have medicare provisions to some 19, and soon 20 million people, and without being contributory. The person who works for 10 years will contribute less than the cost of 10 days in a hospital bed.

The point I am wishing to make is this: that we have a system here where those who are producing pay for those who have passed the age of production. I am not challenging the justice of that in certain limits, but nevertheless that is what we have here, isn't that right?

Mr. CRUIKSHANK. Yes, of course, that is right.

Senator CURTIS. That is all.

Mr. CRUIKSHANK. And I would only comment since you asked me that while there are many differences between private insurance, nongovernmental insurance, and social insurance there are also many likenesses and I think you have just described one of the likenesses. The money comes in. All the benefits of any insurance operation or most of them, are paid out of current premium payments, so this is one of the points where it operates most like insurance.

Senator CURTIS. Well, any State in the Union can run an insurance company like that—but I won't take time to answer it. But there is a vast difference between what people have come to term as social insurance and our system of private insurance, but we have a lot of witnesses to hear and I won't press the latter part of it.

Senator ANDERSON. Senator Dirksen?

Senator DIRKSEN. No questions.

Senator ANDERSON. If there is no objection, I will send you two short questions about catastrophic illness and you answer them for the record.

Mr. CRUIKSHANK. Yes, sir.

Senator ANDERSON. Thank you very much.

Mr. CRUIKSHANK. Glad to do so, Senator.

Senator ANDERSON. That is all then.

(Senator Anderson's question and Mr. Cruikshank's answers follow:)

Question 1. You expressed concern about the $50 deductible and coinsurance provisions in the bill and said that for the majority of old people this would constitute a read hardship. A suggestion has been made that the proposal should focus on "long-term catastrophic illness" after he has used up a substantial part of his income. This would require a person to pay even more than the amount of

the deductible and coinsurance under H.R. 6675. Which do you believe is the preferable approach—basic coverage of health expenses before the person uses up a substantial part of his income, or so-called catastrophic coverage after the person has used up a substantial part of his income?

Answer 1. We are concerned primarily with two things in any health insurance program. First, ready accessibility without barriers of any kind between the patient and the services—whether they be services of an institution, such as a hospital, or of medical personnel, like those of the physician. This is the basis of our reservation about deductibles. They constitute even more of a barrier when combined with a coinsurance feature. Secondly, we feel a primary purpose of a health insurance program is to prevent destitution and indigency rather than to meet it after it has arisen. The requirement that a person covered by a health insurance plan must use up more of his own resources as a condition of eligibility tends to defeat this basic purpose. It also would mean that many persons would tend to put off seeking medical care with the result that what, if treated in its early stages, might be a minor ailment, amenable to less extensive—therefore, less costly—treatment, might become a more serious illness. In such cases, neither the welfare of the beneficiary nor the objective of economy would be served.

Question 2. Do you believe that H.R. 6675 would, as it is now and without any change, cover "long-term catastrophic illness"?

Answer 2. The protection afforded under H.R. 6675 as now written covers the most frequent and therefore most likely medical cost of a catastrophic nature for most people.

In the case of hospital care, 60 days hospitalization for each spell of illness meets the needs of about 95 percent of the hospital cases. And probably, the other 5 percent includes some who could be given some less costly type of care. Beyond the really necessary hospital stay, the care that is usually needed is custodial care, not medical care. The maximum hospital stay provided in H.R. 6675 would ordinarily cover almost all the costs of a serious hospitalized illness of the kind that frequently total $2,000 to $2,500. Costs of this magnitude are indeed catastrophic to all but a tiny fraction of the elderly. It is also to be noted that in contrast to most private insurance, there is no lifetime limitation on this protection.

Senator ANDERSON. Our next witness is Mr. Schlotterbeck.

Senator CURTIS. Mr. Chairman, our next witness, Dr. Karl Schlotterbeck, I am very happy to welcome here today.

About in 1953 and 1954 Dr. Schlotterbeck served as a staff director of a subcommittee of the Ways and Means Committee upon which I served, making a study of social security. This staff report is still read and quoted by many people. Those who agree as well as those who disagree with these proposals, nevertheless recognize the product of his work and I want the record to so state.

Senator ANDERSON. Thank you, Senator Curtis. I hope the committee will keep up its good practice of keeping questions relatively short because we have done very well.

Mr. Schlotterbeck, will you identify yourself for the record, please?

STATEMENT OF KARL T. SCHLOTTERBECK, MANAGER, ECONOMIC SECURITY DEPARTMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. SCHLOTTERBECK. Mr. Chairman, my name is Karl Schlotterbeck. I am manager of the economic security department of the Chamber of Commerce of the United States.

I would like to thank Senator Curtis for his words of welcome and it is a pleasure to be here.

I am speaking today on behalf of the national chamber expressing its views based on policies established by a majority of its members.

We have studied carefully the many provisions in this omnibus social security bill, H.R. 6675. In presenting the views of the national chamber on some of these provisions, I will take up first "Proposed Revisions of Title II of the Social Security Act."

The national chamber endorses several of these proposed revisions of title II, of the Social Security Act, including:

1. *Cost-of-living benefit increase.*—The last general benefit increase became effective in January 1959. Since then, the cost of living has risen slightly more than 7 percent. The proposed cash benefit increase of 7 percent, with a minimum increase of $4 monthly at the lowest benefit level, is needed so that these benefits may continue to serve as a "floor of protection."

2. *"Transitional" old-age benefits.*—One provision in this bill would establish a new minimum benefit of $35 a month payable to women now 71 or older, and men now 74 or older, who have limited social security coverage. This is a reasonable provision as a transitional device to extend benefit protection to those of advanced age who were unable to acquire sufficient quarters of coverage to establish regular eligibility for benefits.

However, the proposed benefit amount of $35 a month will not serve as a "floor of protection." We see no reason in logic or in principle for initiating this benefit at anything less than the regular minimum of $44 a month provided for in this bill.

3. *Extension of social security coverage.*—This bill would extend coverage to self-employed physicians, interns, and to certain employees of State and local governments.

For 17 years the national chamber has urged Congress to extend social security coverage to all noncovered occupations and groups, both employed and the self-employed. This policy has been reexamined and reaffirmed frequently; and, at our most recent annual meeting, on April 28, it was determined that no change be made in the chamber's position.

We urge Congress to be as diligent in extending social security benefit protection and tax coverage to all employees of the legislative, executive, and judicial branches of the Federal Government—the largest single group of workers now not under social security—as the Congress has been in extending coverage to those many millions who were not its employees. There are more than 2 million such Federal employees without protection of social security.

4. *Increased tax support for both social security programs.*—The cost-of-living benefit increase and the transitional benefit will cost about $1.5 billion the first full year. Provisions in H.R. 6675 indicate the clear intent of the House of Representatives to finance fully these additional costs by increases in taxes. Because these benefit increases will be received by some 20 million, young and old, we believe that the additional benefit costs should be shared by all covered workers. This can be achieved by an increase in the tax rate, only.

The bill also provides for improvement in the financial support of the social security disability benefit program which is now seriously out of balance. This is a sound and badly needed adjustment in the financing of the disability program.

This bill, H.R. 6675, contains other revisions of title II which we believe are unsound or not needed, including:

1. *Widows' benefits at 60.*—Widows are entitled to benefits equal to 82½ percent of the benefit amount their husbands would have received. They are able to draw a full benefit at age 62, without any actuarial reduction of the benefit.

The bill proposes that widows be able to draw benefits at age 60 with an actuarial reduction, to compensate for their drawing benefits 2 years earlier.

If the present provision for the amount of benefit to a widow is reasonable as a floor of protection, a provision for a reduced benefit will obviously make their benefit inadequate.

2. *The social security work test.*—The bill would substantially alter the present work test. Thus, a retired beneficiary, presumably retired, would be able to be more fully employed, earn more on a job, and still get social security retirement benefits.

The continued easing of the work test will inevitably change the basic purpose of social security, which has been to provide a partial replacement of job income loss upon retirement from active employment.

This proposal is a step in the wrong direction.

3. *Change in eligibility for disability cash benefits.*—Section 303(a)(1) and (2) of this bill would make a fundamental change in the conditions of eligibility for disability benefits by deleting the requirement that the disability must be of "long, continued, and indefinite duration, or likely to result in death" and substituting for this a "duration of 6 months."

Perhaps this change in the conditions of eligibility would appear relatively innocuous. However, it inevitably will result in more individuals qualifying for both workmen's compensation and for a social security disability benefit. Many such individuals would consequently receive more in tax-free income than they earned in take-home pay while working. This will, of course, seriously hamper effective rehabilitation of such persons, and is not in their best interests.

In its report to the House of Representatives, the Ways and Means Committee recognized that this revision would be a further encroachment by social security in the area of workmen's compensation. The committee directed the Social Security Administration to make a study of the extent of such duplicate benefits and the impact on the 50-State workmen's compensation systems, and to report its findings by the end of 1966. Because the consequences of this proposal are potentially adverse, it would seem prudent at this juncture to forgo any change in the present conditions of eligibility for permanent and total social security disability benefit—at least, until such report has been made to the Ways and Means Committee. We urge Congress to delete this section from the bill. (There is attached to this testimony a more detailed statement about this section of H.R. 6675.)

Senator ANDERSON. Would you like to have it printed at this point with your remarks?

Mr. SCHLOTTERBECK. If it may be added to my statement, it is attached to it.

Senator ANDERSON. All right.

Mr. SCHLOTTERBECK. In this connection we urge Congress to restore in title II of the Social Security Act, the provision to offset workmen's compensation against social security disability cash benefits. The

principle of an offset is recognized in the present bill in the provisions under both plan A and plan B. The offset is sound in the latter (see 1862(b)), and is equally sound in the former.

PROPOSED REVISIONS OF PUBLIC ASSISTANCE

Certain provisions in the bill require the States to consolidate their programs of vendor payments for medical care for those on public relief. Additional Federal financial support would be provided.

Any State which will pay for health and medical care to medically indigent persons—whether elderly, blind, permanently and totally disabled, or dependent children—will also receive the same Federal financial support.

The national chamber endorses in principle both the proposal for consolidation of vendor payment programs, as well as for medical assistance programs for the medically indigent, regardless of age. However, the chamber believes that no greater Federal financial support is needed.

NEW PROPOSALS

H.R. 6675 proposes to establish two new programs—plan A and plan B—in the health and medical care fields. The national chamber agrees that some of the retired elderly have a problem of paying for needed hospital and related care. However, the chamber opposes the methods, in both plans A and B, by which such care would be paid for.

Plan A—Medical benefits

By the provisions in this bill, plan A would pay for a certain amount of hospital care, outpatient diagnostic services, and home health care to all persons 65 and over. These services would be available, whether the individual has retired completely from active employment, has only partially retired, or is working full-time and earning the best pay in his life.

The national chamber has always endorsed the social security purpose of providing a partial replacement of job-income loss due to retirement or to premature death of the family breadwinner. Such job-income loss established a presumptive need for help. The chamber has also endorsed public assistance monthly payments to elderly people, families with dependent children, the blind, and permanently and totally disabled whose need for help is proven.

In the case of plan A, however, hospital and related care will be paid for people 65 and over who are neither proven to be in need, nor presumed to be in need, but who in fact are known to be working regularly, completely self-supporting and, hence, no more in need of help than all other employed, self-supporting families and individuals under 65.

Plan A will establish a new principle—certainly a precedent—which will give rise to the valid question, why should it be restricted to people 65 and over, when there are million of younger people, similarly working full time, not in need, cannot be presumed to be in need, but who also may have to pay for hospital care?

The basic problem plan A is designed to meet—insufficient income of some retired people to pay for needed hospital care or to buy health

insurance—can best be met through the existing social security cash benefits program, rather than by inaugurating a vast new benefit program of services.

Plan B—Supplemental benefits

This proposal would establish on a voluntary basis a supplementary package of benefits available to persons 65 and over. Plan B would pay 80 percent of a patient's bill (after a $50 deductible) for selected health and medical care services, including physicians' and surgical services in a hospital, clinic, office, or in the home; diagnostic X-ray and laboratory tests, and so forth.

Half the cost of this plan would be financed by monthly payments of $3 by each elderly person who chose to participate, and the other half by a subsidy from the general funds of the Treasury.

This proposal has the admirable feature of freedom to each individual to participate or not. However, half the financial support would be financed like public relief with "means test money"—that is, from the general funds of the Treasury—but no means test would be applied. The national chamber believes this is unsound and it should be rejected.

Thank you, Mr. Chairman, that completes my statement, Mr. Chairman.

(The attachment referred to follows:)

ATTACHMENT TO TESTIMONY OF KARL T. SCHLOTTERBECK ON H.R. 6675
SECTION 303(a) (1) AND (2), H.R. 6675

Among several important changes in the present Social Security Act, H.R. 6675 would amend the definition of disability. Section 303(a)(f) and (2) of H.R. 6675 would amend sections 216(i) and 223 of the Social Security Act which define disability as follows:

"Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to be of long continued and indefinite duration."

The amendment proposed in H.R. 6675 would delete the underlined portion of the above definition.

The proposed amendment would not change the present requirement that a disability continue for 6 months before the individual is eligible to draw social security disability benefits. It would provide that an individual no longer would have to be suffering a permanent total disability in order to draw cash benefits, but that he could draw benefits for a temporary disability that prevented his working for 6 months or more.

The national chamber is concerned about the impact which the proposed new definition of disability would have on the State workmen's compensation systems and on the thousands of individuals who are receiving and who will receive cash benefits under those systems.

Social security cash disability benefits have duplicated workmen's compensation paid for permanent and total disability since 1958 when Congress removed the provision from the act requiring that social security disability payments to an individual be reduced by the amount of workmen's compensation received by him.

Duplication of cash benefits gives rise to serious concern and poses several problems. For example:

1. Duplication of benefits removes the economic incentive to an injured worker to rehabilitate himself. In 47 States, injured workers now may receive more money, tax free, for staying home than they were earning on the job before they became ill or injured. According to State compensation administrators and insurers there has been increasing difficulty in persuading injured employees with duplicate benefits to accept rehabilitation and return to work.

2. Providing disability payments under social security for job-connected injury and disease adds unnecessary costs to social security.

3. Encroachment by social security is hampering efforts to improve the State workmen's compensation systems where improvements are needed. Faced with sharply rising costs and the duplication of benefits, employers in several States have supported legislative proposals to reduce workmen's compensation benefits by the amount of social security disability benefits.

The additional duplication which will result if section 303(a)(1) and (2) remains in H.R. 6675 will greatly increase the problems enumerated and hamper efforts to improve the protection for the workers through the workmen's compensation systems.

Preservation of our State workmen's compensation systems is important because:

1. They serve as the basic means of providing effective medical, rehabilitation, and loss-of-income benefits for work-connected injuries and illnesses. The 54-year history of these systems has been one of constant improvements (40 States legislated improvements in their workmen's compensation laws between 1961 and the end of 1964).

2. State workmen's compensation systems provide a major incentive for this country's continuing progress in assuring job safety. The fact that plant safety is rewarded by lower workmen's compensation premium rates gives employers a powerful economic incentive, in addition to their humanitarian motivations, for reducing on-the-job accidents. Private insurance carriers who provide workmen's compensation coverage contribute vitally to accident prevention by providing effective safety engineering and "loss control" services.

Both the frequency and the severity rates of injury in private enterprises currently are more than 50 percent lower than in the years 1937–41. This record may be compared with the fact that in the last 10 years no overall improvement has occurred in the incidence of job injuries among civilian employees of the Federal Government and that total direct injury costs have risen nearly 50 percent. President Johnson has challenged Federal agencies and departments to match the safety record achieved by employers.

This sharp contrast between private enterprise and Federal experience demonstrates the advantages to workers under experience-rated workmen's compensation with its inherent incentives to employers to provide progressively improved working conditions.

3. Rehabilitation of disabled employees reduces costs for both the employer and his insurer. Consequently, this cost-savings opportunity is a strong incentive to achieve rehabilitation.

4. Workmen's compensation customarily provides swift and certain payment to those who are injured on the job. Most workmen's compensation income payments begin within 2 weeks following an injury, and medical care begins immediately in most cases.

Again we stress that Congress recognized the need to avoid duplication of benefits when it added the disability provision to the social security law in 1956. The provision included a clause which recognized workmen's compensation as the basic system for compensating injured workers by requiring the Social Security Administration to deduct workmen's compensation payments. An amendment eliminating the "offset" was rushed through Congress in 1958, without public hearings, creating the problem of duplicate benefits which section 303 will intensify.

The House Ways and Means Committee recognized the merit of avoiding Federal duplication of workmen's compensation medical benefits by inserting in H.R. 6675 an offset provision in both plan A and plan B.

Although the House Ways and Means Committee report provides no estimate of the costs involved or the extent of cash benefit duplication, its concern with these problems is indicated by the fact that it ordered the Social Security Administration to study the significance of overlapping cash benefits under the two programs and to report back by the end of 1966. It is not clear why the committee approved section 303(a) (1) and (2) which will greatly increase the overlap of cash benefits, without waiting to learn the results of the investigation it ordered.

Workmen's compensation has a constructive and vital role in our economic and social system and it should be maintained and strengthened. Congressional action which will adversely affect workmen's compensation should not be undertaken without careful study prior to legislative action.

Section 303(a) (1) and (2) should be eliminated from H.R. 6675. In addition legislation should be enacted to restore the workmen's compensation "offset"

provision in title II of the Social Security Act. Such action will help maintain and even accelerate progress in reducing on-the-job accidents and returning injured workers to their jobs.

Senator ANDERSON. Thank you, Mr. Schlotterbeck. I would just ask you a question as to this last point you make here. You say—

Plan A will establish a new principle—certainly, a precedent—which will give rise to the valid question—why should it be restricted to people 65 and over.

Is that not a pretty well-recognized figure for retirement?

Mr. SCHLOTTERBECK. Well, I was referring there, Mr. Chairman, to those 65 and over who are continuing to work full time. They are self-supporting.

Senator ANDERSON. Yes. But isn't that a fairly recognized figure, the 65 figure?

Mr. SCHLOTTERBECK. It is recognized by some, but some do not, and they continue to work.

Senator ANDERSON. In the chamber of commerce, would you recognize American Telephone & Telegraph as a fairly large employer?

Mr. SCHLOTTERBECK. Yes.

Senator ANDERSON. Does it have a retirement at 65 policy?

Mr. SCHLOTTERBECK. American Telephone & Telegraph? I do not know, sir.

Senator ANDERSON. Talk to the chairman of the board. He is a very efficient and able man. People are worrying about the fact he may have to retire because he has reached the age, or will soon, the age of 65.

I must say I am very much interested in one of the things you say here about this retirement situation or rather the disability situation where you get possible double benefits, and I am not certain as to what I am going to think about this finally because I am tempted to believe, as you believe, maybe this ought to be postponed until 1966, but actually it is not a very large question, is it? The biggest item that I have had from the standpoint of correspondence, maybe because I have been in the insurance business, but I have had a stack of mail on this, but very little on anything else. But actually what portion of compensation awards are for partial disability?

Mr. SCHLOTTERBECK. I could not answer you, Mr. Chairman.

Senator ANDERSON. It is about 25 percent.

Mr. SCHLOTTERBECK. It is not the size that is concerning people. It is the principle of having two benefits for the same disability, with the result that they could have more in tax-free income than they used to earn when they were working, and that would seriously discourage rehabilitation.

Senator ANDERSON. This applies only after 6 months. Have you any idea what portion of disability pay is for under 6 months and how much is for over 6 months?

Mr. SCHLOTTERBECK. I would be glad to supply it for the record.

Senator ANDERSON. Ninety-eight percent under 6 months and only 2 percent over. So we are dealing with only 2 percent of all cases. It is not a large amount.

I think the principle is important, and I am not so sure it is what I want at the present time.

Mr. SCHLOTTERBECK. If the principle is important it makes no difference that it is 1 percent.

Senator ANDERSON. Yes; I agree with you. It is a strong question. Thank you.

Senator Williams.

Senator WILLIAMS. No questions exactly, but regarding the suggestions made that private industry should insist on its officials retiring at 65, that is not true with the Government as an employer, is it?

Mr. SCHLOTTERBECK. No. I believe that there is not a mandatory retirement age for people in the Federal Government.

Senator WILLIAMS. Of course, if they are forced out of industry at 65 they can run for the Congress and serve as long as they live if they can get elected.

Senator ANDERSON. Senator McCarthy.

Senator MCCARTHY. Mr. Chairman, thank you.

On the question of the double compensation to which you have made reference, is your objection to the double compensation or to the fact that a man may be compensated in excess of what he was otherwise earning or is it to the effect that this income is tax free?

Mr. SCHLOTTERBECK. Well, I think there are several reasons, Senator. Part of it is dealt with in the attached statement that I have, but it is in part that with two benefits that are both tax free the man may, I am not saying it is always the case, he may, receive more in income, if it is tax free, than he used to earn when he was last working.

Now, to the extent that rehabilitation is possible, it would seem obvious that if you can get more by being disabled there is an incentive to continue to do so.

Senator MCCARTHY. It would be more acceptable to you if we made the excess above his ordinary income taxable?

Mr. SCHLOTTERBECK. Well, I would prefer that you ask that question of some who will be here later who are more knowledgeable in the workmen's compensation area and who have, as employers, experience with problems of encouraging some of these people to be rehabiliated.

Senator ANDERSON. Actually, Mr. Schlotterbeck, the real objection is, is it not, if a man becomes injured and gets more money than if he returns to work, it is a temptation there at least to delay in returning to work?

Mr. SCHLOTTERBECK. Particularly if there is rehabilitation involved there, and in that case a real incentive to get him to do so.

Senator ANDERSON. At least it is a question that needs some discussion, I am sure you would admit.

Senator MCCARTHY. I have no further questions.

Senator ANDERSON. Senator Carlson.

Senator CARLSON. Mr. Chairman, I was just trying to check the testimony last week of Secretary Celebrezze when we discussed this problem. Section 309, as the chairman, Senator Anderson, has mentioned, is one that gets us a lot of mail, and I think the record will show, and I have the transcript here, that we went into it rather thoroughly, and I believe that the Secretary mentioned that he was hopeful that he could get some information up to our committee so that we might act previous to the House provision which suggested that a report be in by December 1966, and I share that view.

I appreciate your statement on it. It is one problem that is giving me some concern. Thank you very much.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. Dr. Schlotterbeck, is there a retirement requirement so far as the medicare provisions of this bill are concerned?

Mr. SCHLOTTERBECK. No, there is no work test in the Medicare program.

Senator CURTIS. And that includes both the original medicare part and the supplemental health benefits.

Mr. SCHLOTTERBECK. That is correct. It is everyone 65 and over whether they are fully retired, partially retired, or working full time.

Senator CURTIS. Some lawyers, for instance, reach their maximum income after 65. Under this bill, if it is passed, as passed by the House, they might or might not have considerable wealth, perhaps have the highest income of their lives, and they would get the free hospital and medical benefits of this bill, would they not?

Mr. SCHLOTTERBECK. That is right.

Senator CURTIS. And to get the medical benefits they would have to pay $3 a month.

Mr. SCHLOTTERBECK. Three dollars a month matched by $3 a month from Treasury for plan B.

Senator CURTIS. Six dollars a month is the premium. I do not know whether it is adequate or not, and I do not know whether anybody else does, but half of that is subsidized by the Federal Treasury——

Mr. SCHLOTTERBECK. That is correct.

Senator CURTIS. Is there anything in your statement you offered for the record that pointed up what are the true facts as to the financial position of people over 65? Have you gone into that?

Mr. SCHLOTTERBECK. No, we have not in preparation for these hearings. I would like to say in that connection, Senator, that the distinction I was trying to make was between doing something for people who have retired and those who have not, who are working full time. And, if I might, I would like to quote the first Commissioner of Social Security, Mr. Altmeyer, who is recognized as one of the outstanding experts in the social field. He appeared before the Ways and Means Committee in 1949 and I would like to quote him here:

> I think we have to bear in mind that the purpose of social insurance, whether social security or unemployment insurance or any other kind of insurance, is to insure against a portion of the wage loss. If the person has not retired and has not suffered a wage loss, then under social insurance he should not receive benefits.

So the distinction I was making was doing something for those who had retired and those who were continuing to work full time, although they are 65.

Senator CURTIS. I understand that, and I think it is a real point here. This medical and hospital thing does open it up so that an individual not anywhere near in need, may have unlimited assets and the highest income of his life, is going to benefit from a program that is going to be paid primarily by the producers of the country and the general consumers, isn't that correct?

Mr. SCHLOTTERBECK. That is correct.

Senator CURTIS. Now, based upon your previous study, and we will have to keep this brief, but could we accurately assume that all people over 65 are unable to pay their own hospital medical bills or to buy insurance for it?

Mr. SCHLOTTERBECK. No, you could not make that assumption.

Senator CURTIS. There is a sizable portion who can't without hardship?

Mr. SCHLOTTERBECK. That would be correct.

Senator CURTIS. Wouldn't that be right?

Mr. SCHLOTTERBECK. That is correct.

Senator CURTIS. And it is also true there are a great many people under 65 to whom the cost of illness is an exceedingly heavy burden, isn't that correct?

Mr. SCHLOTTERBECK. That is right.

Senator CURTIS. Has there been any study carried on along that line, on the income and resource status of the people over 65?

Mr. SCHLOTTERBECK. Yes, there have been some studies. I believe the statistics have been introduced in the record of the hearings here last year and in the Ways and Means Committee also. They would show that there are people under 65 and, incidentally, they might be working full time, who would find it difficult to even buy health insurance.

Senator CURTIS. And many of the costs that families must bear, such as payment of life insurance, installment payments on homes, medical care for the mother and father, and medical care for the children, education for the children, a great many of those burdens do not fall upon people past 65, isn't that true?

Mr. SCHLOTTERBECK. That is correct.

Senator CURTIS. Yes. That is all, Mr. Chairman.

Senator ANDERSON. Senator Dirksen.

Senator DIRKSEN. No questions.

Senator ANDERSON. Thank you very much, Dr. Schlotterbeck. We are always happy to have you come in.

Senator WILLIAMS. I did want to ask one question. The suggestion has been made that many of the private pension plans today, as operated by many of our companies, already exceeded in benefits anything that is provided under this bill. It is pointed out that the enactment of this bill will not extend to the employees of those companies any benefits other than that of paying for something they are getting for nothing now. Would you care to comment on that, and to what extent you think that may be allowed.

Mr. SCHLOTTERBECK. Would you read that question back to me, Mr. Reporter?

Senator WILLIAMS. Well, the question was based on the premise that many companies today have a pension plan for their employees under which the benefits far exceed anything that is provided under this bill and, therefore, this bill will give them no additional benefits. The point has been made that under those circumstances those employees only get the privilege of paying an additional tax under this bill when, in reality, they will reap no benefits.

Mr. SCHLOTTERBECK. I could not answer that. I would have to see the provisions of the private pension plan because they do vary in the way they integrate the private benefits with social security.

Senator WILLIAMS. That is all.

Senator ANDERSON. Thank you very much.

Mr. Dikovics.

Will you identify yourself for the record, please, and also the person with you.

STATEMENT OF LESLIE J. DIKOVICS, CHAIRMAN, SOCIAL SECURITY COMMITTEE, COUNCIL OF STATE CHAMBERS OF COMMERCE; ACCOMPANIED BY ROBERT C. GRESHAM, ASSISTANT DIRECTOR, COUNCIL OF STATE CHAMBERS OF COMMERCE

Mr. DIKOVICS. My name is Leslie J. Dikovics. I am assistant controller of Walter Kidde & Co., Belleville, N.J., and I am chairman of the Social Security Committee of the Council of State Chambers of Commerce. I appear before you on behalf of the 31 State chamber organizations listed at the end of my statement.

I have with me Mr. Robert C. Gresham, who is assistant research director of the Council of State Chambers of Commerce.

In respect to the hospital and medical care benefits, the organizations on whose behalf I appear are now—and for many years have been—firmly convinced that adequate medical care should be available to all the aged. They have long believed that this is a sound and desirable goal which can be attained without drastically altering the existing social security program.

We are opposed in principle to providing, as a matter of right, services as distinguished from cash benefits under the Social Security Act. If services are provided rather than cash benefits, Congress will be deciding for these individuals how part of their monthly old-age benefit must be spent.

The organizations for which I speak oppose the practice as well as the principle of providing services rather than stipulated cash benefits because they believe that to do so is equivalent to writing a blank check for what are in fact unpredictable future costs.

Full and complete medical care should be provided those aged members of our society who cannot reasonably pay for such care themselves. It is neither a sound nor an equitable alternative to provide partial protection for all of the aged in our society regardless of their ability to pay for such protection themselves. The medical assistance for the aged programs have made great strides toward meeting the medical needs of the medically indigent aged. The continuing expansion of private health insurance coverage and MAA programs, coordinated and strengthened along the general lines of H.R. 6675, make it unnecessary and unwise to enact the OASDI hospital and the supplementary medical care insurance proposals contained in the bill.

Contrary to the general belief that the public understands and favors the basic elements of social-security-financed medicare, an Opinion Research Corp. survey published last month shows that almost two-thirds of the public favor Government medical coverage only for the needy, not for everyone over age 65. Almost three-fifths of the public favor a requirement that those people who apply for Government medical services make a statement under oath as to the amount of their income. Further, a majority of the public favor State-developed and State-administered programs rather than a federally controlled program.

OASDI FINANCING PROVISIONS OF H.R. 6675

The OASDI financing provisions of H.R. 6675, apart from the provisions to finance hospital care, are intended to pay the cost of the additional OASDI benefits provided in the bill and to improve the actuarial status of the trust fund, These provisions would raise the taxable wage base from $4,800 to $5,600 in 1966 and to $6,600 in 1971. At the same time, under these provisions, the tax rates for the years 1966 through 1972 as provided in existing law would be reduced for both employee and employer. And it would not be until 1973 that the rate in the bill would exceed the rate provided in existing law.

The existing and proposed rate schedules follow:

OASDI tax rate on both employee and employer

[In percent]

Year	Under present law	Under bill
1966	4.125	4.0
1967	4.125	4.0
1968	4.625	4.0
1969-70	4.625	4.4
1971-72	4.625	4.4
1973 and later	4.625	4.8

These provisions would have the effect over the next 7 years (1966–72) of saddling covered workers who earn an average of more than $5,090 a year with all the costs of the added OASDI benefits in the bill and with a larger share of the cost of existing benefits than under present law. We question the equity of this shift in the OASDI tax burden.

Under the financing provisions in the bill, a covered worker earning an average of less than $5,090 a year over the next 7 years would have his total OASDI tax liability reduced below what it would be under existing law. Over the same period, those workers earning more than an average of $5,090 a year would have their tax liabilities increased. For example, the worker earning the maximum taxable wages ($5,600 from 1966 through 1970 and $6,000 in 1971 and 1972) would pay during those 7 years 16 percent more in OASDI taxes than he would under existing law.

Social Security Administration records indicate that 69 percent of all workers in covered employment will earn less than $5,100 in 1965. Thus if H.R. 6675 is enacted, it will result in Congress having provided additional OASDI benefits and, at the same time, having reduced the OASDI tax burden on a substantial majority of covered workers.

We urge you to reject the proposal to expand the taxable wage base. To the extent that benefits are to be increased, we recommend that these changes be financed through increases in the tax rates. This certainly would be more equitable and proper than an expansion of the taxable wage base.

Disability insurance benefit provisions: The social security disability program is intended to cover severe disabilities that are indeterminate in duration. "Disability" is presently defined as inability to engage in any substantial gainful activity because of a mental or

physical impairment which can be expected to result in death or be of long-continued and indefinite duration. Section 303 of H.R. 6675 would drastically alter these requirements by making benefits available to any covered worker who has been totally disabled for 6 months, even though the disability is not permanent.

For the reasons that follow, we urge you: (1) To eliminate section 303 from the bill and (2) to reintroduce the State workmen's compensation offset concept which was removed from the Social Security Act in 1958.

We urge this so that financial incentives for rehabilitating and returning the disabled worker to self-supporting status will be strengthened.

Thousands of disabled workers today are receiving more tax-free income from social security disability benefits combined with State workmen's compensation benefits than they were earning before they became ill or were injured. Section 303 would add many more thousands to this number. When tax-free social insurance benefits exceed earning power there is little incentive for a disabled person to accept the risk, pain, and struggle involved in attempting to become self-supporting again.

A matter of equal concern is the impact of Federal disability payments on State workmen's compensation programs. Legislative proposals have been offered in several States (Colorado, Florida, Maryland, and Minnesota) to reduce workmen's compensation benefits by the amount of OASI disability benefits payable to a disabled worker. If other States follow this direction and section 303 of this bill is enacted, we believe it will be only a matter of time until State workmen's compensation programs are destroyed.

If that happens, a major impetus for this country's remarkable achievements in occupational safety will be destroyed also. Workmen's compensation insurance costs are based on the actual loss experience of industry groups and of individual employers. This gives the employer a direct financial incentive to improve safety on the job. If workmen's compensation costs are absorbed into the social security program, employers without safety programs and those whose employment is hazardous would pay no more than those employers who have adopted safety programs or who have less hazardous employment. We strenuously object to any action which could have an adverse effect on safety programs and on the remarkable downswing in disabling accidents that has taken place over the last three decades.

The reenactment of a workmen's compensation offset to disability benefits would be entirely consistent with the offset proposed in section 1862(b) of title XVIII. This section provides that no payments shall be made for health items or services to the extent that payments have been made, or can reasonably be expected to be made, for these services under a workmen's compensation law or plan of the United States or a State.

In summary, we urge your committee to improve the medical assistance for the aged program and to reject both the OASDI hospital insurance proposal and the supplementary medical care insurance proposal. We recommend that any additional OASDI cash benefits that are provided be financed by an increase in the OASDI tax rate rather than through expansion of the taxable wage base. We

urge elimination of section 303 of the bill and we urge the adoption of a provision to offset State workmen's compensation payments against OASI disability benefits.

Gentlemen, the following State chamber organizations listed here have endorsed this statement:

Alabama State Chamber of Commerce.
Arkansas State Chamber of Commerce.
Colorado State Chamber of Commerce.
Connecticut State Chamber of Commerce.
Delaware State Chamber of Commerce.
Florida State Chamber of Commerce.
Georgia State Chamber of Commerce.
Idaho State Chamber of Commerce.
Illinois State Chamber of Commerce.
Indiana State Chamber of Commerce.
Kansas State Chamber of Commerce.
Kentucky Chamber of Commerce.
Maine State Chamber of Commerce.
Michigan State Chamber of Commerce.
Mississippi State Chamber of Commerce.
Missouri State Chamber of Commerce.
Montana Chamber of Commerce.
New Jersey State Chamber of Commerce.
Empire State Chamber of Commerce (New York).
Ohio Chamber of Commerce.
Oklahoma State Chamber of Commerce.
Pennsylvania State Chamber of Commerce.
South Carolina State Chamber of Commerce.
Greater South Dakota Association.
East Texas Chamber of Commerce.
South Texas Chamber of Commerce.
West Texas Chamber of Commerce.
Lower Rio Grande Valley Chamber of Commerce (Texas).
Virginia State Chamber of Commerce.
West Virginia Chamber of Commerce.
Wisconsin State Chamber of Commerce.

Thank you, gentlemen.

Senator ANDERSON. When you point to the basic elements of social security and medicare, and so forth, and that an Opinion Research Corp. survey published last month shows that almost two-thirds of the public favor Government medical coverage only for the needy, was that survey financed by the American Medical Association?

Mr. DIKOVICS. Not to my knowledge.

Senator ANDERSON. Not to your knowledge?

Mr. DIKOVICS. I am not aware of who financed the survey.

Senator ANDERSON. Well, if you found out the American Medical Association financed it, would it somewhat change your opinion?

Mr. DIKOVICS. Who financed it, sir, I do not think would change my opinion. I think the nature and depth of the survey would be of more significance.

Senator ANDERSON. Do you think it would have more significance than the outpouring of votes in November of 1964?

Mr. DIKOVICS. I cannot answer that question. Medicare was only one of many major issues in the 1964 election.

Senator ANDERSON. Thank you.

I am concerned from the standpoint of figures where you say that thousands of disabled workers today are receiving more tax-free income from social security disability benefits combined with State workmen's compensation benefits than they are earning before they became ill or were injured. Do you have a figure showing about how many, because we are all going to be interested in that question—Senator Williams and I were talking about it, I know he is interested—do you have any idea how many are receiving this now?

Mr. DIKOVICS. I do not have available the number that are presently receiving it.

Senator ANDERSON. You say thousands of workers today are receiving more income. That is a positive statement. Have you any figures to back it up?

Mr. DIKOVICS. I do not have those with me, sir.

Senator ANDERSON. Can you find them?

Mr. DIKOVICS. The exact number?

Senator ANDERSON. Would you try to get them?

Mr. DIKOVICS. I can get them and make them available for the committee.

Senator ANDERSON. Because 98 percent of all the cases are eliminated from the beginning because they do not last 6 months, and it is only 2 percent that goes over 6 months. Would that involve thousands of these workmen, do you imagine?

Mr. DIKOVICS. It could very well, we have a substantial number in just the one State of New Jersey. I do not have available, as I say, the numbers for all the States, but we can make that information available for the committee.

(The following was later received for the record:)

COUNCIL OF STATE CHAMBERS OF COMMERCE,
Washington, D.C., May 4, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Senate Finance Committee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR BYRD: Yesterday, during the hearings on H.R. 6675 (Social Security Amendments of 1965) Senator Anderson asked this council's witness, Leslie J. Dikovics, if he could supply for the record the number of persons who are simultaneously collecting social security disability benefits and State workmen's compensation payments.

The following will be of interest in this regard:

The March–April 1965 issue of Journal of American Insurance reflects that a Social Security Administration study in 1963 revealed that 7 percent of 825,000 claimants for OASI disability benefits, or 57,750 persons were already receiving State workmen's compensation payments. The Journal pointed out that if the 7-percent ratio still obtains, then there are some 63,000 persons currently receiving duplicate benefits.

The House Ways and Means Committee report on H.R. 6675 estimates that an additional 155,000 workers and dependents would become immediately eligible for OASI disability benefits should section 303 of the bill be enacted. Among these potential claimants of disability benefits, there certainly would be a substantial number who would already be collecting State workmen's compensation.

The 1965 report of the Advisory Council on Social Security acknowledges the existence of the duplicate payments problem and states that " * * * it would be desirable to prevent any excessive payments resulting from dual entitlement to whatever extent they may occur."

With expressions of my esteeem,

Sincerely,

EUGENE F. RINTA, *Executive Director.*

Senator ANDERSON. This takes in the totally disabled. It does not involve partially disabled, and partially disabled are a large share of all cases that come in.

Mr. DIKOVICS. I beg your pardon, sir.

Senator ANDERSON. Partially disabled people are a large share of workmen's compensation cases. Not so many of them run 6 months.

Mr. DIKOVICS. The House Ways and Means Committee report indicated that this provision, the disability provision, would add some 155,000 more workers for coverage by providing in effect payments for a partially disabled.

Senator ANDERSON. I think you have a point here that is going to be carefully studied, I can assure you of that, because many people are interested in it.

You then say that a matter of equal concern is the impact of Federal disability payments on State workmen's compensation programs, and then you say legislative proposals have been offered in several States to correct this. Have any of them ever been adopted?

Mr. DIKOVICS. One has been adopted, Minnesota.

Senator ANDERSON. In Minnesota?

Mr. DIKOVICS. Yes, sir. I believe Colorado also.

Senator Bennett.

Senator BENNETT. No questions.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. Are you an actuary?

Mr. DIKOVICS. No, sir.

Senator CURTIS. Directing my questions to the point that you made that here new benefits are added to the social security program, and increased benefits are added at a time when a majority of covered workers will pay less in taxes, that would be over a period of the next 6 or 7 years?

Mr. DIKOVICS. Yes, sir.

Senator CURTIS. It would be possible, would it not, to combine an increase in the wage base and a raise in the tax rate and accomplish the result that all covered workers would pay some increased tax at a time when benefits are being added and benefits are being increased, would it not?

Mr. DIKOVICS. That would be possible, Senator.

Senator CURTIS. But the combination they worked out here where there is an actual reduction in the rate does establish the principle that we are adding benefits and increasing benefits at a time that the tax is being lowered for a majority of the workers.

Mr. DIKOVICS. Yes; and we feel that it is an inequity of shifting that burden from one group actually to a much smaller group, and that while changing the tax base at the same time as raising the tax rates would be some improvement, it still would in that case provide a shift from the lower wage earner to the higher wage earner.

Senator CURTIS. I think that is all, Mr. Chairman.
Senator ANDERSON. Senator Dirksen.
Thank you very much. We appreciate your being here and we appreciate the information you have given us.
Mr. DIKOVICS. Thank you, Mr. Chairman.
Senator ANDERSON. Mr. Bernstein.

STATEMENT OF PHILIP BERNSTEIN, CHAIRMAN, COMMITTEE ON SOCIAL ISSUES AND POLICIES, NATIONAL SOCIAL WELFARE ASSEMBLY

Mr. BERNSTEIN. My name is Philip Bernstein, and I am the executive director of the Council of Jewish Federations and Welfare Funds, and chairman of the Committee on Social Issues and Policies of the National Social Welfare Assembly, the central planning and coordinating organization of the social welfare field.

I appear today as spokesman for 19 organizations, National, State, and local, and more than 80 individual leaders in the fields of welfare, health, and education, who are offering their testimony jointly in the interests of your time and because they are in substantial agreement regarding this bill.

Their names are listed in the statement which I should like, with your permission, to enter in full into the record.

Senator ANDERSON. Without objection that will be done.

Mr. BERNSTEIN. I may note that some of these organizations in addition to this statement are also entering into the record, through correspondence with the chairman, supplementary statements of their own.

You will note that these agencies are as varied as the American Association of Homes for the Aging, community chests and councils in a number of cities, the Council of Jewish Federations and Welfare Funds, the National Jewish Welfare Board, the Executive Council of the Episcopal Church, the National Federation of Settlements and Neighborhood Centers, the National Urban League, the National Board of Young Women's Christian Association, and the others listed in our statement. I might note also that in addition to the 19 organizations which have associated themselves in this statement, others, such as the Family Service Association of American have joined in support of previous proposed legislation now embodied in the basic plan of this bill, but whose governing boards have not met in time to act on the present bill, H.R. 6675.

Let me say then at the outset for these organizations and individuals, that we urge favorable action by the Senate Finance Committee on H.R. 6675. We regard it as a landmark measure to help meet the health needs of older citizens, the health needs of children, to aid others with special health needs, and to strengthen the basic social security system.

With regard to the major provisions, may I say we welcome incorporation into the social security system of hospital care, extended care, outpatient diagnostic services, and home care benefits.

This bill, we believe, is the result of long experience and study which have brought the conviction that these needs cannot be met by the traditional system of voluntary and commercial insurance. We be-

lieve it sound that this bill would use the time-tested contributory social insurance system in which workers and employers contribute during their productive years for care which is most costly in the later years when the income of these people is much reduced, for care to which they are then entitled as an earned right, subject to the determination independently by a physician that is actually needed. We believe, therefore, that this measure will thereby help to remove a primary cause of poverty and dependence.

Secondly, we welcome the voluntary program of supplementary health benefits to cover a major share of doctor bills and related costs as a new approach, to assist the aged in their health needs. We would stress that in order to achieve these purposes it will be highly important to maintain adequate safeguards that will assure the highest standards of medical practice.

Therefore, we commend the inclusion in this bill of a National Medical Review Committee with a continuing cooperation of the health professions and the Government; and we believe that there should be a close review, and continuing review, of the experience with regard to fees, utilization, quality of service, and participation of prepayment health plans.

Having said that favorably, we would urge two changes in the bill with regard to the basic and the supplementary plans. One has been brought to you this morning, and that would deal with the special services on an anesthesia, radiology, pathology, and physiatry. These services are now in hospital programs. We believe they belong in hospital programs, and that they belong in the hospital insurance program as a part of the basic entitlement. To exclude them deprives elderly patients of a prepaid right to an important aspect of hospital care which is now available to other patients, and constitutes therefore an arbitrary demand on hospitals to restructure their internal administration.

We would urge this committee to incorporate in H.R. 6675 the provisions that were in S. 1 for such services.

Senator ANDERSON. Would you recognize that as the substance of the Douglas amendment?

Mr. BERNSTEIN. Yes.

Senator ANDERSON. He supported that.

Mr. BERNSTEIN. And our second concern is with the deductibles. It is a fact that the older people are, in large proportion, people of low incomes, and for such people the deductible provision will be a major and, for some, indeed an insuperable hardship. That certainly will be true for many single individuals, and where an aged couple both require hospital care and medical care, it will be even more serious.

We recognize that the bill does provide that public welfare agencies can make payments for such persons. But we know, too, that this involves a costly and a time-consuming means test investigation. And we know from our association with these people, that those who are most sensitive regarding their own dignity and their own decency, their own sense of independence and their own integrity, often will not go through a means test, and would rather deny themselves the medical attention they need, sometimes at the very peril of their health and of their lives.

Now, on the other provisions, may I briefly say that we welcome the changes in the social security provisions that will improve the benefits and the coverage in the system. It will more adequately meet the needs of the beneficiaries, and will reduce the need for supplementary public assistance.

We welcome likewise the extension of the two child health programs, the maternal and child health and the crippled children's program which have demonstrated their ability to provide the highest services.

Finally, we regard the more adequate medical assistance program in the bill as essential for people whose needs are not met by the other provisions of the bill, and we strongly commend those provisions that would combine the additional Federal aid with the freed State funds to provide more adequate, less restrictive, and high quality medical care.

In sum then, Mr. Chairman, no bill in history, we believe, has done as much to extend health care to the most vulnerable groups in America, and we believe that its enactment will be an historic forward step for our entire Nation. Thank you very much, Mr. Chairman.

(The prepared statement of Mr. Bernstein follows:)

TESTIMONY PRESENTED BY PHILIP BERNSTEIN, CHAIRMAN, COMMITTEE ON SOCIAL ISSUES AND POLICIES OF THE NATIONAL SOCIAL WELFARE ASSEMBLY IN BEHALF OF A GROUP OF VOLUNTARY ORGANIZATIONS AND INDIVIDUAL LEADERS IN THE HEALTH AND WELFARE FIELD

My name is Philip Bernstein. I am executive director of the Council of Jewish Federations and Welfare Funds and chairman of the Committee on Social Issues and Policies of the National Social Welfare Assembly, central planning and coordinating organization of the social welfare field.

Today, I appear as spokesman for approximately 19 organizations (listed at the end of this statement) and more than 80 welfare leaders speaking as individuals (also listed) who have requested me to present the following joint statement in their behalf:

We the undersigned—associated with the voluntary health and social welfare field—wish to urge, either in behalf of our organization or speaking from our personal experience, early favorable action by the Senate Finance Committee on H.R. 6675, the Social Security Amendments of 1965.

This is indeed a landmark measure bringing to the point of practical realization the hopes and aspirations we have long held for a better answer to the health needs of our older citizens, our children, and other persons with special needs, and for other improvements in the basic social security system.

The incorporation into our social insurance system of provisions for hospital, extended care, outpatient, and home care benefits for the aged is the culmination of a long period of study as to how best to meet a need which clearly cannot be adequately answered either within the traditional system of voluntary or commercial insurance or through the provisions of public assistance for the needy. This program, utilizing the time-tested mechanism of contributory social insurance, permits workers and their employers to pay during their productive years for the costly care they are increasingly likely to need in their later years. The provision of these benefits as an earned right, subject only to the independent determination of a physician that they are needed, opens up new vistas of health security for our older citizens and will remove a primary cause of poverty and dependence among this growing group in our population.

The proposed voluntary program of supplementary health benefits to cover a major share of doctors' bills and related health cost is also welcomed as a new approach to assisting the aged in a primary area of health need. We note that this program, while utilizing the services of nongovernmental organizations experienced in this field, is essentially a governmental program in which costs are shared by the patient and the Government itself. We therefore urge that, even while recognizing the personal and professional character of the

doctor-patient relationship, adequate safeguards be maintained to assure the highest standards of medical practice. We commend the inclusion of a National Medical Review Committee as a means of assuring continuing cooperation to this end between the health professions and the Government and urge their close review of experience with respect to fees, utilization, quality of service, and participation of prepayment health plans.

Two changes in the provisions of the bill with respect to the basic and supplemental plans are strongly urged.

The first relates to the inclusion within the basic hospital insurance plan of those specialist services, specifically those related to anesthesia, radiology, and pathology, which have traditionally been a part of hospital service. To exclude these services from the basic entitlements of the hospital insurance program not only deprives elderly patients of the prepaid right to an important aspect of hospital care available to other patients, but constitutes an arbitrary demand upon hospitals to restructure their own internal administrative arrangements for this particular group of patients. We therefore, urge the committee to incorporate in H.R. 6675 the provision of S. 1 with respect to this type of service.

Our second recommendation relates to all the payments required of beneficiaries prior to the receipt of benefits under both these programs; i.e., the deductible provisions. The low income of a majority of older persons makes this a major and, for many, an insuperable hardship. We recognize that public welfare agencies are authorized to make this payment in behalf of the needy aged. But this raises once again the inhibiting and costly question of a means test investigation and seems unnecessarily cumbersome where other govermental programs are involved. We, therefore, strongly urge the elimination of all deductibles.

We welcome the many improvements in the benefits and coverage of the social insurance program which will more adequately meet the needs of all beneficiaries and reduce the extent to which supplementary public assistance is required.

We also welcome the extension of the two child health programs, those for maternal and child health and crippled children, which have so fully demonstrated their ability to provide under governmental auspices the highest quality of service to children, and the addition of a new program of school health services for impoverished children.

No bill in history has done as much as H.R. 6675 to extend the provision of health care to our most vulnerable groups on a basis of objective entitlement. Convinced that the best answer to poverty and need are those measures that prevent its occurrence, we regard this as an historic forward step. At the same time we believe that for those groups of people and those particular health needs not totally answered by the other provisions of H.R. 6675, a more adequate medical assistance program as provided in the bill is essential. The provisions of basic hospital benefits and the voluntary supplementary health plan for the aged will relieve States from the present heavy financial burdens they are carrying in meeting these needs on an assistance basis. We strongly commend the proposals in H.R. 6675 which would combine additional Federal aid with these freed State funds to provide a more adequate, less restrictive, high-quality medical care for all those persons, most particularly children, for whom no other provisions now exist. In the current war on poverty no investment can pay larger returns than that we make in the health of all our people, including our children.

ORGANIZATIONS

American Association of Homes for the Aging, Lester Davis, executive director.

Community Chest and Council, Bridgeport, Conn., Bernard Green, chairman, Social Legislation Committee.

Community Services Committee AFL-CIO, Essex West Hudson Labor Council, Newark, N.J., Alfred W. Wagner, director.

Community Service Council, 615 North Capital Avenue, Lansing, Mich., Gerald K. Wyman, coordinator, Project on Aging.

Council on Community Services of Plattsburg and Clinton County, John W. McTerman, chairman, Legislative Committee.

Council of Jewish Federations and Welfare Funds, Philip Bernstein, executive director.

Council on Social Work Education, Katherine A. Kendall, executive director.

Executive Council of the Episcopal Church, Gregory D. M. Maletta, associate secretary, ministry to the aging.

Florence Crittenton Association of America, Inc., Mary Louise Allen, executive director.
Maryland State Conference of Social Welfare, M. Shakman Katz, president.
Massachusetts Conference on Social Welfare, Mrs. Oliver Cope, president.
National Association of Social Workers, Lansing-Jackson (Michigan) chapter, Manfred Lilliefors, chairman, legislative committee.
National Council for Homemaker Services, Betty Hale Andersen, executive director.
National Federation of Settlements & Neighborhood Centers, Gladys Duppstadt, secretary for social education and action.
National Jewish Welfare Board, Sanford Solender, executive vice president.
National Urban League, Whitney Young, executive director.
Planned Parenthood Federation, Elsie Jackson, R.N., field consultant.
National Association of Social Workers, Knoxville, Tenn., area chapter, Charles E. Gebtry, chapter chairman.
Young Women's Christian Association, national board, Mrs. Lloyd J. Marti, president.

INDIVIDUALS

Martha D. Adam, director, nursing services, National League for Nursing.
Martha F. Allen, national director, Camp Fire Girls, Inc.
Clara M. Allen, executive director, Social Work Vocational Bureau.
Philip Booth, lecturer, School of Social Work, research associate, Bureau of Public Health, economics, School of Public Health, University of Michigan.
W. H. Bulkeley, West Hartford, Conn., vice president, Connecticut Printers, Inc.
Eli E. Cohen, executive secretary, National Committee on Employment of Youth.
William E. Cole, professor of sociology, University of Tennessee.
Eleanor Connolly, consultant, government liaison unit, National Tuberculosis Association.
Clement E. Constantine, executive director.
Gilbert Convers, assistant national director, American Council for Nationality Services.
Thomas J. Cooley, executive secretary, New Britain, Conn., Community Chest.
Fred M. Cox, assistant professor of social work, University of Michigan.
Fred Delliquadri, dean, Columbia University School of Social Work.
Rex M. Dye, campaign associate, Massachusetts Bay United Fund.
Irving Engelman, director, Division of Public Welfare, New Jersey Department Institutions and Agencies.
Virginia S. Ferguson, planning consultant, Health Services.
Robert L. Foust, executive director, Durham, N.C. Community Planning Council.
Sidney Hollander, past president, National Social Welfare Assembly.
Merl C. Hokenstad, Jr., associate executive director, United Community Services, Sioux Falls, S. Dak.
Frank A. Maloney, executive director, North Shore United Fund, Salem, Mass.
W. T. McCullough, executive director, Welfare Federation of Cleveland, Ohio.
John H. Moore, social welfare consultant and dairy farmer.
Robert Morris, professor of social planning, Brandeis University.
A. A. Morse.
Estelle M. Osborne, director of services to State leagues, National League for Nursing.
Mrs. Savilla Millis, Simons, executive director, National Travelers Aid Association.
Donald A. Trauger, associate director, Epidemiology and Statistics Division, National Tuberculosis.
Harleigh B. Trecker, dean, School of Social Work, University of Connecticut.
T. E. Wintersteen, associate director, planning, United Community Services, Knoxville.
Mildred Fairchild Woodley, board member, sundry National, State, and local social welfare agencies of voluntary character.
Walter Johnson, associate professor of social work.
Arnulf Pins, associate director, Council on Social Work Education.

Senator ANDERSON. Thank you for your statement, not only for yourself but for the organizations and individuals you represent here this morning.

Senator Williams.

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Bennett.

Senator BENNETT. I just have one question for clarification. When you say you believe the requirement for deductibles be eliminated, do you include both of them, both the 20 percent and the $50?

Mr. BERNSTEIN. Yes.

Senator BENNETT. Have you got any idea as to how much this would increase the cost of the program?

Mr. BERNSTEIN. No, we have not figured the costs. But in consideration of the total costs, which include the cost of investigations for a means test, we believe that our proposal is feasible. We believe that the financial provisions in the bill, based on the best expert testimony we have received, are conservative, and we believe that the system could be developed to absorb such costs feasibly.

Senator BENNETT. Of course, this question of the application of a means test for people who have to look to public assistance for help in handling these deductibles is entirely—this is an intangible. You have no measure of the cost of the means test either. You are free to say this will be an unnecessary burden, and you try to equate it against the tremendous burden that would fall in terms, I think, of hundred of millions, maybe billions of dollars if the total—what you are proposing is the total medical care of everybody over 65 be assumed by the Federal Government for a premium of $3 a month. That is what you are proposing.

Mr. BERNSTEIN. This is an insurance system to which the people increasingly will be contributing. We are discussing here the initial phases, in a transition program. We believe that the purpose of the long-range program, to the extent possible, should be prepayment by people for benefits that they will receive later in life, and should minimize elements of the means test. We believe that the reconsideration of this element is deserving of the committee's attention.

Senator BENNETT. Wasn't there a deductible in the King-Anderson bill?

Mr. BERNSTEIN. Mr. Anderson can answer that better than I can.

Senator ANDERSON. There was.

Senator BENNETT. There was. That is all I have to say.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. The sum deductible does eliminate all the cost of processing a very small claim, isn't that right?

Mr. BERNSTEIN. Yes.

Senator CURTIS. Thousands or millions of very small claims.

Mr. BERNSTEIN. Well, it remains to be seen as to what the extent would be, but I would say unquestionably that such income would cover some of the expense. Our question is whether that is the best way of providing the income.

Senator CURTIS. That is all.

Senator ANDERSON. Thank you very much for your appearance.

Mr. BERNSTEIN. Thank you.

Senator ANDERSON. Mr. Zagri.

Mr. ZAGRI. Yes. Thank you, Mr. Chairman.

Senator ANDERSON. Thank you.

STATEMENT OF SIDNEY ZAGRI, LEGISLATIVE COUNSEL, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

Mr. ZAGRI. Mr. Chairman and members of the committee, my name is Sidney Zagri. I am legislative counsel for the International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America. On behalf of the general executive board and General President Hoffa, I wish to express my appreciation for the opportunity of being heard on the problem of financing an adequate hospital and medical care program for America's senior citizens. The Teamsters' position here is of crucial significance to the welfare of its 1,780,000 members as well as its families, totaling over 5 million men, women, and children.

Our international union's historic position has been in favor of the King-Anderson bill, before that the Forand bill, and even before that more comprehensive systems of hosiptal and medical insurance for our senior citizens.

Although we have one of the finest health and welfare programs in America for our members during their working years, our actuaries tell us that the cost for a program of health care after 65 would be prohibitive, that even with the broad base of 1,780,000 members, and so we welcome the proposals of H.R. 6675 insofar as they go in covering the health needs, the hospital needs of our senior citizens.

Each of these members and his family is covered by a comprehensive health and welfare program negotiated by the union with management, covering the bulk of his medical needs during his working years. However, the moment he retires, health and welfare benefits come to a halt—at a time in his life when he needs them the most. His income has been reduced to about 25 percent of his former earnings yet his medical expenses will be doubled or tripled. Our actuaries tell us that the premium for retirees, even with the board base of 1,780,000 members, would have to be at least two and a half times as great as that of our active members.

A cost item of this magnitude cannot be negotiated effectively as it would place the employer who is not paying the fringe benefit at a further competitive advantage. For this reason, the employer-employee contribution, in order that they be uniformly applied to all employers and in all industries, must be legislated.

For these reasons we support a comprehensive medicare program and therefore are in complete accord with the objectives of H.R. 6675 but have serious reservations concerning some of the means proposed.

The purpose of my remarks this morning is to raise points where we have reservations, where we think there is need for strengthening or improvement.

Our questions arise in three major areas:

1. Does the bill protect the retiree from the bilking practices of the medical profession—overcharges, unnecessary operations, uncalled for stays in the hospital, et cetera, which has been the experience under Teamster and other private health and welfare insurance programs? And I will expand somewhat on this point in just a moment, from our experience in New York City and the United Mine Workers'

experience, and other labor unions, in the area where doctors have charged sums sometimes double the amount provided for in the insurance program, charging the patient separately, creating unnecessary admissions to the hospital to collect on insurance fees, removing organs because there was a dollar sign and so forth. This is documented by a detailed study of Columbia University and Montefiore Hospital, and I will document this in just a moment. But this is the kind of question that I am raising: Does this bill provide the necessary machinery to curtain, to curb and protect the individual from this type of practice. I am afraid it does not. I am afraid that it provides that administrative machinery based upon traditional and customary lines, which is a little bit like the fox watching the henhouse, and I would like to have the committee bear with me a moment while I raise the second point.

2. Does the bill assure that the neediest of the retired citizens will receive the medical services and medical facilities that the bill seeks to provide him, or will the benefits go primarily to those who were already protected under private group insurance plans or individual private insurance plans.

3. What guarantees will the individual have in terms of maintenance of a quality standard of medical care consistent with the capabilities and resources made available to the practitioner through the progress of medical sciences?

The bilking practices of the medical profession as presently experienced under private insurance plans will continue under the administration provisions of H.R. 6675.

What bilking practices do I refer to? Let me take a page out of the book of Teamster experience in the field of health and welfare administration. In New York City, 1 out of every 16 residents is covered by a Teamster negotiated health and welfare plan; last year the fund paid out nearly $20 million for doctor and hospital bills on behalf of its members.

In 1962 the Teamster health and welfare fund in conjunction with Columbia University and the Montefiore Hospital conducted an audit of quality and the cost of medical care as reflected in the medical records of 406 hospitalization cases of Teamsters and their families. In the 3 months prior to being interviewed, 48 percent of the families paid physicians' fees outside the hospital. While in the hospital, 74 percent of the cases paid extra fees in the cases of hysterectomies; and with reference to medical care, extra charges were assessed in 40 percent of all cases. With reference to admissions, the report found that 20 percent of the admissions were unnecessary. With reference to 60 hysterectomies, 33 percent were unnecessary and 10 percent were questionable. With reference to 13 caesarian sections, 50 percent were considered unnecessary. With reference to out-of-pocket expenses beyond coverage, we found the following:

1. For all medical care, 17 percent.
2. For drugs, 77 percent.
3. For doctor's care, 52 percent.

Quality of medical care was reported as follows:

1. One-fifth of the patients had received poor care.
2. Another one-fifth had been given only fair care.
3. One-fifth of the hospital admissions had been unnecessary.

In a fifth of the general surgical cases, there appeared to be unjustified delays in performing the surgery. The quality of the surgery in 20 percent was labeled "poor" and 26 percent was "fair."

There were instances which substantiated many of the grave charges made from time to time against the medical profession: ghost surgery (operations performed on normal organs); fee splitting; instances of outrageous charges; a higher proportion of unnecessary admissions in the proprietory (profitmaking) hospitals.

The sharp practices and the inadequate medical care exposed by the Columbia University-Montefiore Hospital study is not limited to the Teamsters Union nor to organized labor but is found quite generally wherever insurance payments act as a stimulus to medical malpractice.

With a dollar sign placed upon each organ in the human anatomy, dramatic differences between the number of operations that take place for the removal of a specific organ under insurance plans and among the uninsured can be demonstrated: The welfare and retirement fund of the United Mine Workers of America managed to slash the rate of appendectomies for its beneficiaries by 59.4 percent after it set up its own group practice teams of salaried doctors. No wonder that "chronic remunerative appendicitis" is a standard quip among physicians. The Health Information Foundation study discovered that while only 5 out of 1,000 uninsured persons have their appendix removed every year, the annual appendectomy rate for the insured is 11 per 1,000. The big difference cannot possibly be attributed to medical reasons alone. If it were, death rates from ruptured appendixes among those without health insurance would be appalling.

Equally open to question is the differential in the tonsillectomy rate. Hospitalization rates for children up to the age of 17 for tonsillectomies are 30 per 1,000 for insured families as compared with only 9 per 1,000 for the uninsured. This higher rate is particularly deplorable in view of the fact that the value of this operation for the adenoids in children is seriously questioned by reputable medical authorities except in a certain restricted number of cases in which certain health conditions exist.

A study made by Dr. Osler L. Peterson of the Harvard Medical School shows that, while one Blue Cross plan in the United States has a rate of 12.3 hospital admissions for tonsils and adenoids per 1,000 subscribers, the rates for such admissions are only 3.6 per 1,000 persons in England and 0.25 per 1,000 in Sweden. In other words, the child in the United States under Blue Cross plan has 49.2 times a greater chance of having his tonsils removed than he has in Sweden.

Dr. Peterson states:

> I believe that the lower rate of Sweden and England represents more discriminating use of this operation.

Dr. Peterson finds it lamentable that the natural inclination of many suregons to rush their patients into the operating room should be spurred by the bait of insurance payments.

SOLUTION

What solution does H.R. 6675 propose? The report of the bill issued by the Ways and Means Committee (pp. 45 and 46) calls for a continuation of the present system and recommends "that benefits under the supplementary health insurance benefits program should

be administered by the private sector—private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians."

As the testimony of Walter J. McNerney, president of the Blue Cross reveals, Blue Cross would like to do the whole job and become a medical behemoth administering the program for the Federal Government. He stated in executive hearings before the House Ways and Means Committee this year that—

> The medical profession is still quite antsy about * * * manipulation from the outside. The same profession, although it doesn't always welcome it, is at least fairly used to dealing with an agency such as ours * * *.

Representative Martha Griffiths, a member of the House Ways and Means Committee, has pointed out the Blue Cross is so closely tied up with hospitals and doctors that it perhaps would not engage in sufficiently stringent regulation. Mrs. Griffiths, noting that 17 percent of Blue Cross board members were doctors, said:

> I think it would be very difficult to get into the situation where you are having a doctor reviewing the prices charged by doctors and of which they are profiting. There should be someone who is far removed from any possible charge by the public that doctors are reaching into the taxpayers pocket and getting rich.

H.R. 6675 directing the doctors to supervise the fees of other doctors may be comparable to the situation where the hens were afforded protection by assigning the fox to watch the henhouse. It is quite clear that the president of Blue Cross is suggesting a cozy arrangement between the doctors and Blue Cross in the scheduling of fees, et cetera.

RECOMMENDATIONS

1. That the ascertainment of costs and fees be left within the exclusive jurisdiction of the Secretary of Health, Education, and Welfare and that his discretion to delegate this responsibility be limited to that of a public agency authority.

2. That all fees be fixed on the basis of prevailing rates in the areas for specific operations and other medical services.

3. That no reimbursement for doctor's fees be paid—and this is very important—unless the doctor certifies that the bill presented represents the total charge for his service. Any misrepresentation on this score will constitute a misdemeanor and be subject to criminal prosecution.

4. A fixed fee be established for the doctor's certification of a patient to a hospital, nursing home, or home care. As you know, under this bill, no one can go to a hospital or nursing home unless he would be certified. We do not know, no one has estimated the size of the bonanza that medicare promises for America's doctors, but two figures hint at it: the total cost of health care for Americans over 65 was more than $5 billion last year. Blue Cross, Government, and private insurance witnesses testified before the House Ways and Means Committee that the bill surely would increase the use of hospitals by the aged; estimates are varying from 10 to 40 percent in the first years.

5. Utilization review committees provided for in this bill—to check

on abuses of administration as well as longevity of hospital stays—and this is very important—because we have 2½ more times need than we have hospital beds, and if the needy of this country are going to get into hospitals, we are going to have to have a speedier rotation system, and we cannot have that kind of bilking where the doctor will use the full term of the insurance to keep people in there in order to sastisfy their particular financial necessities, not patient-doctor. So therefore I say that the committee reviewing these long stays or longevity stays should be comprised of doctors outside of the hospital, preferably a special committee of the county medical society or the deans of the local medical schools or a combination of the two.

Unfortunately, the gentlemen's agreement among doctors, particularly on the same hospital staff, would impose certain serious limitations on the utilization review committees' effectiveness. It is common knowledge that in malpractice suits it is almost impossible to get one doctor to testify against another even though privately physicians may agree that certain doctors may have been criminally negligent. In a recent article in the Nation magazine, Selig Greenberg states:

> Regardless of how flagrant a case may be, it is almost impossible to get one doctor to testify against another. Covering up one another's mistakes * * * seems to be the unwritten rule even though all physicians are pledged by their code of ethics to expose the misdeeds of their professional fellows.

To have the doctors regulate the doctors is to establish a conflicts-of-interest situation which is entirely untenable and inconsistent with the basic concepts on which all of our regulatory agencies operate. It is like appointing all railroad men on the Interstate Commerce Commission, or appointing Mr. Stanton of CBS and Mr. Sarnoff of NBC as members of the FCC, or Jimmy Hoffa and George Meany as members of the NLRB.

I say this is inconsistent, an inconsistent approach, to regulation and should not be in this bill.

What assurances does the bill provide that the neediest of the retired citizens will receive the medical services or facilities that the bill seeks to provide for him?

Senator ANDERSON. Can I stop you for just one second there?

Mr. ZAGRI. I beg your pardon?

Senator ANDERSON. Can I stop you for just one second there. You said this should not be in the bill. You were discussing the utilization review committee?

Mr. ZAGRI. I do not object to that.

Senator ANDERSON. You are not objecting to that; you want somebody besides them.

Mr. ZAGRI. I should have made it clear, the provision in the bill that permits private agencies to be financial intermediaries between the Government and the beneficiary under the part 2 of the bill to be revised to preclude the use of private, the private sector, to act as intermediaries between the Government and the patient in order to get the fox out of the henhouse.

Senator ANDERSON. I was not exactly clear.

Mr. ZAGRI. Yes. So far as review committees, we think this is excellent, but we think this should be composed of men separate and apart from the hospital where the review is taking place.

Senator ANDERSON. Thank you.

Mr. ZAGRI. Now, of the 17 million aged citizens who would qualify under plan 1, it is estimated that 13 percent will be hospitalized during the coming year. This means that there will be a vast increase in the number of hospital beds that will be needed to take care of the problems arising from this bill. This raises the question of the spreading of the medical facilities—hospitals, nursing homes, et cetera, where the needs exist. Hospitals and other facilities have been developed to take care of those citizens who could afford medical insurance or had other resources and to a degree the charity cases.

Existing facilities will continue to be filled by those cases. The poor who will be covered by this bill for the first time will find it difficult to have their needs taken care of unless some type of rotation system is developed which will enable the "newcomers" under this bill to have some equality of opportunity in being admitted.

Because of the limited number of hospital beds and nursing home beds, and current figures indicate that the national need is at least 2½ times as great as the number of beds, it will become necessary to review the most effective utilization of existing hospital beds and other medical facilities. I say that the existing facilities will continue to be filled by the individuals who have today paid for these under private insurance plans or out of their own pocket, because at the present time all these beds are full, and the doctors who are members of the staff will seek preferential treatment for their own patients.

The distribution of medical facilities in medical care and doctors is completely in disproportion to the need, because under the Adam Smith law of supply and demand, the doctor goes where the dollars are, so the needy of the country will still be without beds unless we can find some method of effectuation of rotation of the use of existing supply with some allocation possibly to those in greatest need who have the need but have no connection to get their particular needs satisfied.

What good is a bill? What good is the allocation of funds and a plan unless there is some facility to take care of them, and in this connection we have several amendments to the bill that we feel might help along this line.

The provision that the doctor first certify a patient to a hospital, and he must remain in there for 3 days, and then he may be certified to a nursing home, and from there he may be certified to home care, should be revised, so that the doctor will have it within his discretion to designate whether an individual should go to a hospital in the first place or go to a nursing home or have home care. There may be many cases where the individual could be taken care of at home, and there is no use cluttering up much needed hospital beds or nursing beds if the doctor finds that adequate medical care and therapy could be handled on that basis. But under this bill he would still have to go through

the redtape of first being sent to the hospital, remaining there 3 days, and then designated to the proper institution or home depending on what the doctor thought was best.

I say let us eliminate that step of a 3-day requirement in order to maximize the utilization of hospital beds.

Also there is a question of costs. Your nursing home beds would cost 25 percent of what inpatient hospital cost care would cost. Why not economize in this area if the result will be just as good or possibly better in some cases?

You may have the nursing homes in areas where there are no hospital facilities. You may have medical care especially under the requirements of the bill which may be quite adequate, but no hospital facilities. Why go through the rigmarole of assigning the patients first to the hospital?

Senator ANDERSON. Of course, a great many of the cases that go to hospitals are in very serious shape, and the facilities for testing of all kinds and probably emergency treatment are best in the hospital.

Mr. ZAGRI. That is right. That is why I say leave it to the discretion of the doctor rather than have some bureaucratic redtape say that this patient must go to the hospital for 3 days.

Sixty percent of the senior citizens, or approximately 10.5 million, with incomes of less than $1,000 per year will be hard pressed to meet the deductibles under plans 1 and 2 of the proposed bill. It is estimated that an average American couple over the age of 65 spend $312 a year on medical expenses other than hospital. Under part 2 of the plan, the average member would be obligated to pay the following:

Deductible	$50
20 percent of the $312 which is the average medical charge outside of hospital care	62
Deductible for diagnostic	20
Deductible for hospital	40
Blood ($20 for 1st 3 pints)	60
Extra fees for radiologist, pathologist, anesthesiologist, physiatrists	100
Total	332

This does not include the cost of medicine on an outpatient basis which averages approximately $25 a month or $300 a year.

It is clear from the above that the average retiree would be required to spend between 20 and 45 percent of his annual income in support of medical and hospital bills under parts 1 and 2 of the proposed bill.

Are we not, in effect, saying these citizens should be covered under Kerr-Mills? But what assurance do we have that Kerr-Mills States will afford this type of protection in the light of previous experience? Two-thirds of the recipients of Kerr-Mills benefits live in California, New York, or Massachusetts. Almost 90 percent of Kerr-Mills funds are spent in California, New York, Massachusetts, and Michigan. This means that the other 35 States with Kerr-Mills programs spend less than 10 percent of available Kerr-Mills money. It has been estimated that at the present rate of coverage it would take until approximately the year 2000 before the indigent population among our senior

citizens would be covered under Kerr-Mills. Of course, H.R. 6675 liberalizes Kerr-Mills. Yet, there is no assurance that States will be interested in expending sums necessary to provide their share of funds to comply with the new standards of medical care provided for in Kerr-Mills.

If the Federal Government is sincere in its desire to provide Kerr-Mills benefits to the senior citizen who is indigent—and that is over 60 percent of all senior citizens—then why not have the Federal Government provide for these needy in the first place without the deductions and the 20 percent requirements which are presently part of plan 2?

RECOMMENDATIONS

Eliminate all deductions and the 20 percent of the total bill under part 2 for all senior citizens with incomes of $1,000 a year or less.

THE DOUGLAS AMENDMENT

The Douglas amendment would repeal the present restriction contained in H.R. 6675 on the allocation of the hospitalization benefits as payment for the services of the anesthesiologist, pathologist, radiologist, or other medical specialist attached to the hospital.

As the bill stands now, each of these doctors would have to bill the patient separately. This will add approximately $100 to the patient's bill since these services constitute approximately 25 percent of hospital costs and the average hospital bill for a person over 65 will be about $400.

It is indeed an irony that this restriction, which calls for Federal intervention in relations between hospital and doctor should be sponsored by the AMA.

The exclusion of the services of these specialists from the basic hospitalization plan would cause a disruption of hospital accounting methods.

In recent years, most radiologists, pathologists, and other specialists have accepted an arrangement that puts them under hospital administration. The bill, as it presently stands, would discourage hospitals from making arrangements that would draw these specialists into a comprehensive medical center. "In the long run," says Eugene D. Morris, administrator of Edward Hospital of Naperville, Ill., "it would reduce the hospital to little more than a nursing home." Senator Douglas, of Illinois, points out that under this proposal a pathologist who was a private entrepreneur and not under the administration of the hospital "can't go into a medical staff meeting and tell Dr. Feesplitter that 25 percent of the tissue he removed was normal * * *. The pathologist has this freedom to criticize because he is paid by the hospital, and his responsibility is to the hospital."

The provision also would create an administrative quagmire as every specialist in the hospital presented his separate bill to the patient, and as the hospital figured out the percentage of laboratory

charges, for example, to be billed by the pathologist. "I have seen an estimate made by the director of a major hospital in the East," says Senator Moss, of Utah, "that radiologists on that hospital staff would have to issue about 3,000 separate bills per month."

At this point I would like to introduce as an exhibit (exhibit I) a policy statement of a member committee of doctors and other medical specialists in New York City who have summarized the arguments in support of the Douglas amendment.

THE HARTKE AMENDMENT FOR A DRUG STAMP PLAN

It has been estimated that the average cost of drugs will be as much as $25 a month for the person over 65. It is an anomaly that the Kerr-Mills program includes the outpatient cost of drugs but under part I and part II of this bill the retiree must pay for drugs at the regular retail price.

Senator Hartke's amendment does not do anything to upset the present situation of drug manufacturers. It does not pursue the question of the enormously high markup between manufacture and retail outlet on the cost of drugs. It deliberately avoids both of these matters. It does not hurt drug manufacturers. It helps them. If the Hartke amendment is accepted, there will be fewer and fewer persons walking around with prescriptions in their pockets which they cannot afford to have filled. There are no anticipated problems in administration because the groundwork for this kind of operation has already been laid with the food stamp plan. The Secretary would simply set a level of income below which persons would be assisted with coupons which paid for 75 percent of drug costs.

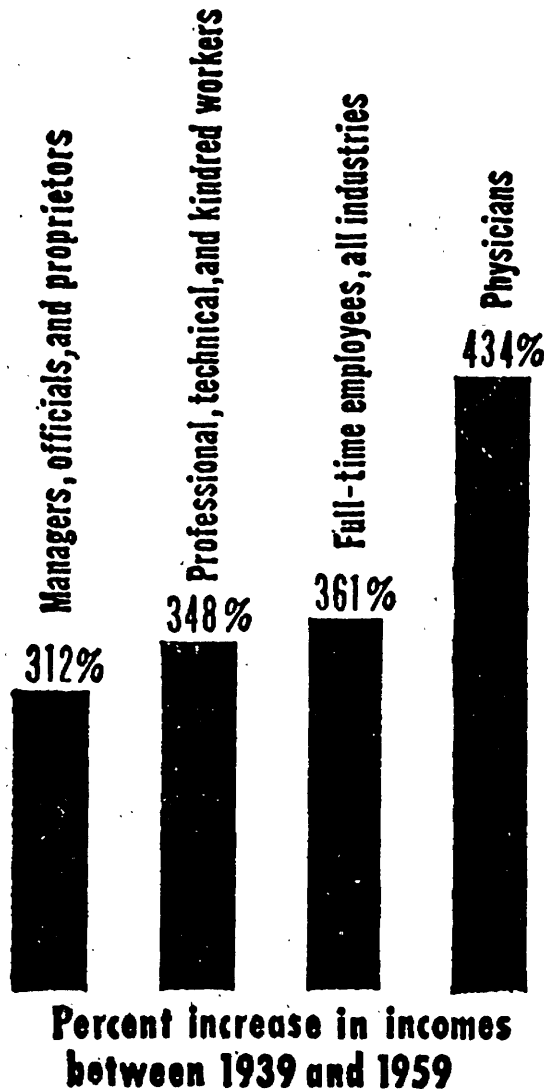
Part II of the proposed bill calls for a reevaluation of the amount of the deductibles and the premium for the purpose of adjusting to the rising cost of hospital and medical care.

The most recent study of the Columbia University Montefiore Hospital—the 1964 study, we have two studies, 1962 and 1964—in our 1964 study it was flatly stated there would be an increase in the cost of the hospital and medical insurance from 50 to 75 percent in the next 2 years. This is due to the increasing charges made both by hospitals and by the medical profession.

Compare these skyrocketing costs with the paltry increases in social security benefits which for most of the aged population would be their only source of income. Projecting costs on the basis of these figures, we find that deductibles would have to be increased by 50 and 75 percent, as well as the premiums. In other words, instead of having a $100 deductible 2 years from now and so on.

In a comparative study of increase in incomes of the medical profession with that of other professional groups between 1939 and 1959 indicates the following, and here we have a chart which indicates that all the other professions had increases in income ranging from 312 to 361 percent, but the physicians' incomes soared during the same period to 434 percent.

(The chart referred to follows:)



Percent increase in incomes between 1939 and 1959

These tremendous increases are partially due to the population explosion and the limited numbers of doctors available to take care of the ever-increasing medical problems.

It is clear from the above that Congress has one or two choices:

(1) Either the Federal Government absorb the increased cost out of payments from the general fund or increases in the social security tax, or

(2) Exercise more direct control over the pricing practices employed by doctors where Federal benefit payments are concerned.

We do this in many other fields. When we lay out money we tend to set up certain limits on how the money is to be spent. There is nothing unusual about that.

Finally, I agree with the Long proposal that the bill cover catastrophic illnesses by extending the period of hospital and nursing home care.

The third major segment of our approach is not really criticism, but calls upon the Secretary of Health, Education, and Welfare must be given the affirmative responsibility of improving the quality of medical care in this country consistent with the high standards of research and of our medical capability.

We have long boasted of having the finest medical system in the world. It is true that the United States has surpassed all nations in terms of medical research. We have the highest quality of medical care for the few. But when it comes to medical services for the masses, the United States is lagging far behind the rest of the Western World.

The real test of the adequacy of a medical system is to be determined by whether we are using the tools placed at our command by the remarkable advances of medical science as well and as effectively as we know how.

The fact is that a number of countries with poorer economic resources than ours consistently outrank us in some of the most dependable measurements of health status. Infant mortality has always been considered the most accurate index of a nation's progress in the health field. Ten countries have a lower infant death rate than the United States. The rate for Sweden, the lowest, amounts to less than 60 percent of ours. Sweden also has a mortality rate among mothers in childbirth that is nearly 15 percent lower than in this country and an average life expectancy that is 3 years longer. In 10 other nations there is also a higher life expectancy at birth than in the United States. In the Netherlands, the general death rate is 20 percent lower for men and 10 percent lower for women than ours.

I wish to introduce at this point exhibit II, which demonstrates that the best research in medicine takes place here in the United States, the best teaching hospitals are here in the United States, but that the benefits of our medical advances are distributed very unevenly within the community and that the United States ranks below at least 12 other countries in terms of health status as measured by several objective criteria. We rank No. 12 among the civilized nations on earth by several standards such as infant mortality, and others; we rank 12th among civilized nations on earth in terms of the infant mortality rate and the other indexes of the health status of our people, and the President's Commission on Catastrophic Diseases, Stroke, Cancer, Heart Disease, the need to more fully utilize our total capability to bridge the gap between research and practice, to reeducate our doctors, set up a medical complex of regional and local bases to bridge the gaps between what we know and what we do, and our National Review Committee here should work very closely with the recommendations and with the machinery proposed in President Johnson's excellent report on catastrophic illness and its cure in America.

As exhibit III, I would like to introduce a chart, which provides comparative figures in nine stages demonstrating the distribution of licensed physicians. This chart demonstrates that residents of California, Connecticut, Maryland, and New York have 2½ times as many available doctors as do residents of Alabama, Mississippi, and South Carolina. It seems reasonable to assume that there is a positive correlation between the number of licensed physicians and the average per capita income of a State. Of course, the distribution of physicians goes to the heart of the problem on medical care. An overloaded physician doesn't have time to do proper diagnostic work or to treat patients. At best, he can simply turn them out as sausages being ground out in a sausage factory. But as the Columbia Montefiore Hospital report on Teamster members indicated, even in New York City, the quality of medical care is quite inferior.

The recommendations of the Chairman of the President's Commission on Heart Disease, Cancer, and Stroke calls for a retraining of doctors, updating their knowledge on the latest medical discoveries and techniques.

The bill provides for a National Medical Review Committee and a utilization Review Committee at the local level.

The National Review Committee provided for in this bill has a major responsibility for improving the quality of medical care and to this end it should coordinate its efforts with the projected regional and local diagnostic and treatment centers designated to unite the worlds of scientific research, medical education, and medical care as recommended by President Johnson's Commission on Heart Disease, Cancer, and Stroke.

(The exhibits referred to follow:)

EXHIBIT I

POLICY STATEMENT RE EXCLUSION OF SERVICES OF MEDICAL SPECIALISTS FROM MEDICARE

We urge the inclusion as hospital benefits in Federal medicare legislation of the services of radiologists, pathologists, anesthesiologists, and physiatrists for the following reasons:

1. The anticipation of older people that they will receive comprehensive hospital services will be shattered when they find that the pathologist, radiologist, anesthetist, and physiatrist are not covered and are sending him separate bills.

2. The fact that these services will be partially covered by a supplementary health insurance program does not resolve the problem. There will be a $50 deductible and the older patient must still pay 20 percent of all doctor bills including these four specialists—radiology, pathology, physiatry, and anesthesiology, plus $3 per month.

3. The total cost of hospital and medical care, already a matter of national and local concern, will skyrocket because of this change.

4. If this pattern is established it is unlikely that the Blue Cross plan will be able to continue its comprehensive coverage for the rest of the population. Inevitably, hospital insurance for all the people will in due course be stripped of these basic hospital services.

5. In the best hospitals in city, State, and country, one basic reason for the advances in medical care and an ability to do miracles and apply the fruits of research to patient care has been the full-time salaried system where outstanding physicians freely contract with the hospital to work for adequate salaries and devote their time to supervision of quality of patient care, education, and research. The radiologist and pathologist have been at the heart of the system, joined ever increasingly by surgeons, internists, and other medical specialists. If the pathologist and radiologist will not become private practitioners with the potentially enormous incomes from the captive populations hospitals produce for them, this will make the lot of the full-time internist or surgeon with reasonable salaries untenable. In the long run, the full-time system which this society will need increasingly if the quality of hospital care is to be safeguarded, will be set back 30 years by this regressive step.

6. The legislation under consideration, in order to provide basic assurances, makes a strong avowal that the Government will not interfere with the provision of hospital and medical care and in the organization and administration of hospitals. The removal of these specialists' services is contrary to this purpose and tends to dictate a nationwide pattern prescribed by the Federal Government.

7. As a matter of principle this legislation should not affect existing arrangements of any type between hospitals and physicians.

In the interest of the older people so that they will receive what they have been promised; in the interest of preserving what is best in hospital care; in the interest of quality and economy—the services of the radiologists, pathologists, anesthesiologists, and physiatrists should be restored to H.R. 6675 as covered hospital services.

EXHIBIT II

Criteria of comparison

1. Accessibility to medical care.
2. Experience of patients as evidenced by their favorable or unfavorable attitudes to medical profession.
3. Vital statistics. Life expectancy and infantile mortality data from international sources.
4. Successes in medical research.

I. ACCESSIBILITY TO MEDICAL RESEARCH

The case of the aged.

A. Experience in social-insurance countries

(*a*) In countries with a comprehensive system of social insurance, the aged are, of course, included in access to medical services. Such countries include Australia, Bulgaria, Ireland, New Zealand, Norway, Sweden, the Soviet Union, and the United Kingdom.

(*b*) In some countries the aged make no contribution after reaching retirement age but enjoy a wide range of medical benefits which include general practitioner, specialist, hospitalization, essential medicines, laboratory services, dental services, and—in some cases—transportation.

Countries with medical for aged programs which require no further contributions after reaching retirement age include in Western Europe, Belgium, France, Italy, and Portugal. In Eastern Europe, Albania, East Germany, Hungary, Poland, Rumania, aud Yugoslavia. In Africa, Libya has such a program in operation.

(*c*) A number of countries have a program of medical services to the aged but require old people to keep up contributions. Such countries include: Austria, Bolivia, Chile, Greece, Luxembourg, Mexico, Nicaragua, Panama, Paraguay, and Spain.

In countries with comprehensive schemes of medical service medical attention is, of course, within reach of all persons including the aged. In other countries with social insurance schemes medical benefits are available to all who have been insured workers. In some cases other aged persons will qualify as dependents of insured workers and can enjoy medical benefits by this means.

B. The experience in the United States

This committee has heard frequent detailed evidence that many aged persons lack medical care here because they cannot afford to buy it at going rates. The initiation, and continued expansion, of the Kerr-Mills program gives abundant proof of the contention that many aged persons are priced out of the market for the medical care they require at this time in this country.

II. ATTITUDES OF PATIENTS

A. Experience in a social-insurance country

The British National Health Service began in 1948 in a hostile atmosphere. Doctors threatened to go on strike. The conservative press was most bitter.

Twelve years later, the British Medical Association surveyed the system, assisted by the Royal College of Surgeons and other medical associations. In the course of this study, the medical profession called upon the very conservative paper, Daily Telegraph, to assist them in a public-opinion survey. The Telegraph utilized the Gallup organization to do this. The survey turned up the following striking facts:

In typical British fashion, persons interviewed were divided into upper and lower class.

(*a*) Are you satisfied with the medical service as now provided? Upper class say "yes," 92 percent, and "no," 8 percent. Lower class say "yes," 87 percent, and "no," 13 percent.

(*b*) Do the services provided offer value for money? Despite the rising costs of medical care 83 percent of the upper class and 80 percent of the lower class declared themselves satisfied they were getting value for money.

(*c*) About 80 percent of both groups felt that their medical service doctor gave them adequate time, and the same proportion thought the doctor was quite willing when they asked him to visit them at home. This was not a restricted survey. It covered the whole country—rural areas as well as cities, poor as well as rich. Of a thousand persons interviewed 525 were women and 475 were men. Thirty-three percent of the interviewees were aged persons—those who most need to use the service.

B. Experience in the United States

An AMA study shows 44 percent of patients dissatisfied with their doctors, and 32 percent looking for a new doctor. In addition, we note insurance against a malpractice suit costs a California doctor over $800 a year and costs a British doctor $6 a year. This is a very practical measuring rod.

III. VITAL STATISTICS

A and B. Experience in social-insurance countries and in the United States.

Expectation of life at birth—males

Country	Year	Number of years
Norway	1951-55	71.11
Netherlands	1953-55	71.00
Sweden	1957	70.82
Israel (Jewish population)	1959	70.23
Denmark	1951-55	69.87
New Zealand (European population)	1950-52	68.29
England and Wales	1959	68.10
Canada	1955-57	67.61
Northern Ireland	1957-59	67.44
Czechoslovakia	1958	67.23
Australia	1953-55	67.14
West Germany	1958-59	66.67
United States	1958	66.40

Source: Statistical Office of the United Nations, Demographic Yearbook 1960, 12th edition, 621 pages, New York: United Nations, 1960.

Expectation of life at birth—females

Country	Year	Number of years
Norway	1951-55	74.70
Sweden	1957	74.29
Netherlands	1953-55	73.90
England and Wales	1959	73.80
Canada	1955	72.92
Australia	1953-55	72.75
United States	1958	72.70

Source: Statistical Office of the United Nations, Demographic Yearbook 1960, 12th edition, 621 pages, New York: United Nations, 1960.

Infant mortality rates,[1] 1959

Country	Rate
Sweden	16.6
Netherlands	16.8
Norway	18.7
New Zealand (excluding Maoris)	19.9
Australia	21.5
England and Wales	22.2
Switzerland	22.2
Denmark	22.5
Finland	23.6
Czechoslovakia	25.8
United States	26.4

[1] Deaths under 1 year per 1,000 infants born alive. (Excludes European population of Federation of Rhodesia and Nyasaland.)

Source: World Health Organization, Epidemiological and Vital Statistics Report, 14, No. 6, 1961.

On infant mortality rates the United States ranks 11th. Of the 10 nations with a lower infant mortality rate than the United States, 9 of these 10 are countries with social insurance schemes of medical attention. On expectation of life of male, United States ranks 13th. In the 12 countries where a man has a better expectation of life all 12 countries have social insurance schemes for medical care.

On expectation of life for females the United States ranks seventh. The six countries with better statistics are all countries with social insurance schemes for the provision of medical services.

These statistics indicate that there need be no loss of medical efficiency if the payment of medical bills is organized through a social insurance approach. The infant mortality rate is generally regarded as a very sensitive index of the health status of a people. This is because the rate can be directly changed by improving living and sanitation standards, by better maternal care and by more careful supervision of a child during its first year of life. The United States ranks 11th amongst the nations with an infant mortality rate of 26.4 per thousand.

However, within the United States there are marked and serious differences between the infant mortality rates in place to place and from group to group.

For white Americans the rate is 23.2. For nonwhite Americans the rate is 44. Nonwhite rates range from 29 in Minnesota to 72.8 in New Mexico. In some States the infant mortality rate of nonwhites is rising. In Pennsylvania it rose from 43 to 47.7 in the period from 1954 to 1958. (Source: Vital Statistics of the United States, vol. 1, 1958) Prof. David Rutstein, head of Department of Public Health of Harvard University Medical School writes "it is clear that the statement 'We are the healthiest nation in the world' is not supported either by analysis of life expectancy or of infant mortality. Indeed, there are no data to justify the statement."

IV. SUCCESSES IN MEDICAL RESEARCH

A and B. Experience in social insurance countries and in the United States.

The Nobel Prize for medicine and physiology is the acid test of the best medical research going on in the world. The greatest names in the laboratory have always found their way finally onto the Nobel Prize list.

In some years, more than one man is named to a prize. Either independent study has reached the same end or teamwork is involved. In the table below, all scientists receiving awards have been counted equally whether receiving a full or a shared prize.

Nationality of recipients of Nobel medicine awards

	1901-37	1943-62	Total
United States	6	20	26
Britain	6	6	12
Germany	8	2	10
Denmark	3	1	4
Switzerland	1	3	4
France	4	0	4
Austria	3	0	3
Sweden	1	1	2
Italy	1	1	2
Belgium	2	0	2
Canada	2	0	2
Netherlands	2	0	2

NOTE.—Australia, Portugal, South Africa, Argentine, Spain, Russia, and Hungary have each named 1 prizewinner.

The superiority of American medical research is beyond question. Since awards were resumed in 1943, the United States has 20 out of 38 prizewinners. This is a percentage of 52.6. The general superiority of the graduate school of medicine in the United States is implied by such figures as these. All of these awards have been won in competition with the Sorbonne, Vienna, MacGill, London and Edinburgh. It is an amazing achievement.

CONCLUSIONS

With the best research and the best teaching hosiptals American medicine appears to distribute the gifts of life and health unevenly in the community.

Vital statistics of the United States do not reflect the demonstrated superiority of medical research and teaching hospital efficiency.

The high cost of medical care is a factor in poor doctor-patient relationships here.

The best medical care in the world is available in America, to the rich and, also, to those who enjoy it through the armed services, through veterans' hospitals, and as special patients of research hospitals.

For a large body of Americans, another standard of medical care is provided. This is less frequent care in less well-staffed and equipped hospitals. To these people fewer doctors are available, and those who are available are frequently foreign-trained doctors of limited experience. The recipients of this lower, or second, standard of American medicine, about two-fifths of our society, are receiving less medical care than would be available to them in a country with a social-insurance plan for the provision of medical services.

EXHIBIT III

Distribution of licensed physicians—Some comparative figures in 9 States

State	Population [1]	Number of licensed physicians [2]	Potential patients for each doctor	Median family income [3]
Alabama	3,266,740	2,708	1,206	$3,937
California	15,717,204	31,396	500	6,726
Connecticut	2,535,234	4,882	519	6,887
Maryland	3,100,689	5,450	568	6,309
Mississippi	2,178,141	1,712	1,272	2,804
New Jersey	6,066,782	8,954	677	6,786
New York	16,782,304	37,350	449	6,371
South Carolina	2,382,594	1,983	1,201	3,821
Tennessee	3,567,089	4,166	856	3,949
Total	55,596,777	98,601		

[1] Source: Bureau of Census 1960 report.
[2] Excludes Federal physicians. Source: AMA Directory Reporting Service, "Quarterly Table of Distribution of Physicians," Jan. 25, 1965
[3] Source: Bureau of Census 1960 report.

NOTE.—If physicians were distributed throughout these 9 States equally on the basis of population, there would be 564 patients for each doctor.

Mr. ZAGRI. Gentlemen, I thank you for your patience, and I trust that at least some of these recommendations will be given serious consideration.

Senator ANDERSON. I thank you very much for a very interesting and informative presentation. I am sure Senator Hartke, who is here, is very pleased by your commendation of his amendment. I will let him ask the first question.

Senator HARTKE. I do not want to ask questions. I want to thank you for your fine words. I think he understands the proposals very well, and I am hopeful you will persuade the rest of the members, you do not have to persuade me.

Mr. ZAGRI. We will be working on it.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. Just one question. On the basis of your studies, how many days in the hospital will the average 65-year-old person experience a year?

Mr. ZAGRI. Fourteen days.

Senator CURTIS. Fourteen days?

Mr. ZAGRI. Yes; that is, 13 percent of our 17½ million will be in hospital beds during the coming fiscal year, 1966–67. It is estimated that of the 13 percent to go there there will be an average stay of about 14 days.

Senator CURTIS. Then it would be less than 1 day per person.

Mr. ZAGRI. One day per person? You are talking about the total 17 million?

Senator CURTIS. Two days, one-seventh of them would be there for an average of 14 days, and there would be a total average of 2 days.

Mr. ZAGRI. You are talking about the 17 million?

Senator CURTIS. Yes.

Mr. ZAGRI. That is the estimate for the first year or so, yes.

Senator CURTIS. Is it your contention that 60 percent of the people who need hospitalization cannot get in because of lack of beds?

Mr. ZAGRI. Not 60 percent.

Senator CURTIS. You said the need was 2½ times the availability.

Mr. ZAGRI. This is the estimate by the figures of the U.S. Public Health Service, that we have 2½ times, the need is 2½ times, as great as the availability of beds. I personally did not make the survey, but these are the figures of the U.S. Public Health Service.

Senator CURTIS. That is all, Mr. Chairman.

Senator ANDERSON. As to the overcrowding of hospitals, I am interested in your concern about that.

Mr. ZAGRI. I am sorry.

Senator ANDERSON. As to the overcrowding of hospitals, I am very much interested in what you say about that but even if the aged use as much as 25 percent more hospital space for hospital care, it is now estimated there will be room for them because we are using at present about 76 percent of capacity, the aged account for about 20 percent of the use so that even if there is an increased use of 5 percent on the part of the aged it will not be too bad but I do understand we are all concerned with the adequacy of care received by all the people, not only for the aging.

Mr. ZAGRI. Right. You will find oftentimes the overcrowding happens to be in areas where there are a few hospitals, you see, and I have a chart here which indicates the distribution, for example, of doctors—this is exhibit No. III—and while if we had even distribution you would have 564 patients for each doctor in these States cited here, there are 9 States, but we find that in the poorer States, for example, Alabama, with a distribution, there is the number of 1,206 patients per doctor; Mississippi, 1,272 patients per doctor; in South Carolina, 1,201 patients.

Now, the same type of disproportion could be found within any given community, in the poorer areas, because, unfortunately, the doctor follows the dollar sign, and this is not only true of the doctor, this happens to be the standard by which we live and our way of life, in our society.

Senator ANDERSON. Thank you very much.

We will meet again tomorrow morning at 10 o'clock.

(Whereupon, the committee recessed, to reconvene at 10 a.m., Tuesday, May 4, 1965.)

SOCIAL SECURITY

TUESDAY, MAY 4, 1965

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

The committee met, pursuant to recess, at 10:15 a.m., in room 2221, New Senate Office Building, Senator Carl T. Curtis presiding.

Present: Senators Hartke, McCarthy, Williams, and Curtis.

Also present: Elizabeth M. Springer, chief clerk.

Senator CURTIS. The chairman has been detained but has asked that I open the meeting and preside until Senator Hartke arrives.

We will not wait any longer. A number of the members of the committee have been called to the White House for a briefing.

The first witness that we will call is Zalmen J. Lichtenstein.

If you would come forward and have a seat there and give your name to the reporter and tell us who you represent and then you may proceed in your own way.

You are allotted 10 minutes.

STATEMENT OF ZALMEN J. LICHTENSTEIN, EXECUTIVE DIRECTOR OF THE GOLDEN RING COUNCIL OF SENIOR CITIZENS

Mr. LICHTENSTEIN. Mr. Chairman, my name is Zalmen J. Lichtenstein. I am the executive director of the Golden Ring Council of Senior Citizens. This is a voluntary position.

The Golden Ring Council is a nonpartisan, nonsectarian, nonprofit organization. I am accompanied to these public hearings by representatives of senior citizens clubs, railroad trainmen retirees, community, church, trade union groups, Italian-American and Hungarian-American Golden Ring clubs.

We are grateful to the chairman of this distinguished committee for giving us an opportunity to testify.

Right at the outset, Mr. Chairman, we would like to say that the senior citizens of America are for the Mills bill, so modestly called the Social Security Amendments of 1965. In reality this is history-making legislation—a far-reaching measure which, for the first time, establishes alongside social security, a new system of health protection for our elderly citizens and children; in addition it introduces many valuable improvements in the basic social security system. We appeal to you today for favorable and speedy action on this vital legislation.

This bill, Mr. Chairman, is to a large extent, the realization of the hopes and aspirations of the American elderly and their families.

We support this bill because, underneath it all, is the recognition by our Nation of the senior citizens lifetime of toil; underneath it all is the recognition of their contribution to our Nation and its prosperity. In addition to this, it enhances the dignity and self-reliance of the elderly person.

Father Joseph M. Becker, S.J., of the Institute of Social Order at St. Louis University, once wisely said:

> The use of a means test, even a liberal one, automatically divides the citizens into two groups—the successful and the unsuccessful. The opportunity to receive benefits without wearing the public badge of failure constitutes the most appealing characteristic of social insurance.

We ask this distinguished committee which has so much valuable and progressive social legislation to its credit whether "the public badge of failure" is to be the just reward of otherwise self-supporting senior citizens when they become ill.

That is why we are for the Mills bill, H.R. 6675, covering hospitalization and nursing home protection through the social security system.

The senior citizens accept also the supplementary medical insurance plan which will cover fees of physicians, surgeons, home care and similar services.

Of course, this bill would be even more to our liking if a few provisions would be altered.

The senior citizens would like to see a provision added to the voluntary supplementary insurance covering expenses for drugs which, in the bill before you, is only covered by social security entitlements while hospitalized. Drugs are a burdensome expense item in the very limited budget of the senior citizens.

We would be even happier if social security hospitalization would also include, as was proposed in the original King-Anderson bill, full payments for radiology, biology, anesthesia, etc. These important services are currently part of the hospital services now normally rendered to inpatients.

We are indeed grateful for the proposed 7-percent increase retroactive to January 1, 1965. We would be more happy if Congress would grant a higher increase, let's say, 15 percent. This proposed one has already been eaten up by higher rents, fare increases, new sales taxes, etc.

We are concerned about the railroad trainmen retirees, who are part of our organization. We would not like to see them excluded from receiving the increased benefits.

Now, Mr. Chairman, permit us to bring to your attention a problem faced by elderly families where the wife is younger than 65. These families will have to pay for and hold on to the Blue Cross insurance, in addition to the $3 monthly payment for the supplementary insurance. This places a double burden on them.

Despite these shortcomings we—as a senior citizens' organization that has been promoting health care through social security for many years—state again that we wholeheartedly support the Mills bill, incorporating health provisions, increase in benefits and a number of improvements.

We most earnestly trust that the Congress of the United States will make history in 1965. This year we observe the 30th anniversary of the Social Security Act, initiated by the late great President, Franklin

D. Roosevelt, in the era of the New Deal. This year, 1965, under the leadership of our great President, Lyndon B. Johnson, in a new era—the era of the Great Society—we trust we will see a new landmark—the health insurance program.

To wind up this testimony, we would like to tell you, if we may Mr. Chairman, and distinguished members of the committee that our situation is somehow similar to the poor chap in Gogol's story, "The Overcoat," which is now being played in the movie houses of the United States.

This honest clerk had his lifelong dream realized when he finally got a new overcoat. It was not perfect, by any means—one sleeve too long, the other one too short; too tight on one side. But he was delighted anyway because he finally had gotten a new overcoat to warm his body. And so, we are indeed delighted with this new "overcoat" which we, hopefully, will finally get, thanks to the labors of the House Ways and Means Committee, the Senate Finance Committee, and all Congressmen and Senators involved.

We know that the longer sleeve could be shortened, the shorter one could be lengthened, and the back could be loosened up. But this "overcoat" is basically made of good American material and, we can assure you, Mr. Chairman, that this overcoat, will warm the bodies and souls of millions of senior citizens and their families.

The ending of Gogol's story is not a happy one. Someone steals the overcoast from the poor chap's shoulders. But in our case, we trust the ending will be a happy one.

We pray that the legislative and executive bodies of our great land, the hospitals and their administrators, the physicians and their organizations, the social welfare professions and the senior citizens and their children will combine their efforts to protect our newly acquired "overcoat"—the health security system.

Thank you, Mr. Chairman.

Senator CURTIS. Thank you, Mr. Lichtenstein.

Where is your residence?

Mr. LICHTENSTEIN. I am from New York.

Senator CURTIS. Where is the Golden Ring Council of Senior Citizens located?

Mr. LICHTENSTEIN. Mr. Chairman, the Golden Ring Council of Senior Citizens is a national organization with clubs in the States of New York, Pennsylvania, New Jersey, Florida, Ohio, Illinois, California, and a number of other States; and we are here 52 distinguished senior citizens starting from the age of 65, and ending with 1 gentleman who in 3 years will be 90.

Senator CURTIS. Yes.

Mr. LICHTENSTEIN. And these senior citizens are supporting wholeheartedly our testimony.

Senator CURTIS. When was it organized?

Mr. LICHTENSTEIN. It was organized 10 years ago exactly. Our club No. 1 in Brownsville, N.Y., just had its 10th anniversary. Now, we organized ourselves in support of the original Forand bill, the Forand bill.

Senator CURTIS. Now, I want to ask you, have you always had this exact title, Senior Citizens Golden Ring Council?

Mr. LICHTENSTEIN. Right, Mr. Chairman.

Senator CURTIS. Are you affiliated with any other organization?

Mr. LICHTENSTEIN. We are affiliated with the National Council of Senior Citizens. In fact, in 1961 we were one of the chartered members of this organization.

Senator CURTIS. Now, one more question: Where is your national headquarters that we may have it for the record?

Mr. LICHTENSTEIN. The national headquarters are our own, the Golden Ring Council in New York, 25 East 78th Street.

Senator CURTIS. Thank you very much. I will turn the chair over to Senator Hartke, who is now present.

Senator HARTKE. Thank you, Senator Curtis, for presiding and filling in for us. I have no questions, sir. I have reviewed your statement and I think it is a fine statement and I want to commend you for your giving of your time to come here today.

Mr. LICHTENSTEIN. Thanks a lot, Mr. Chairman.

Senator HARTKE. The next witness will be Miss Julia Thompson, the American Nurses' Association, Inc.

We are delighted to have you with us and you may proceed in any way you care to.

STATEMENT OF JULIA C. THOMPSON, DIRECTOR, WASHINGTON OFFICE OF THE AMERICAN NURSES' ASSOCIATION

Miss THOMPSON. Mr. Chairman and members of the committee, I am Julia C. Thompson, director of the Washington office of the American Nurses' Association. I am accompanied by Miss Henrietta Dabney, who is an economist on the staff of our New York headquarters.

I can read my prepared statement within the limits of my time.

Since 1958 this association has supported the principle of extending the social security system to provide health insurance and our older citizens. H.R. 6675 proposed to do this, and more, and we urge early and favorable action on this legislation by the Senate Finance Committee. However, we do have some comments on the bill as it comes to you from the House of Representatives and some recommendations for changes.

The American Nurses' Association believes that nursing services should be an integral part of any prepaid health insurance program whether under governmental or voluntary auspices and that these services should be provided on a full or part time basis, according to the need of the patient. Nursing is an essential component of modern patient care and must be available if the benefits of medical science are to be attainable.

In the past, when we have testified on other proposals that would have provided health insurance for the aged, we have requested that both private duty nursing and part-time nursing care in the home, furnished through an organized community health agency, be included as benefits in such programs.

Section 1861(b)(5) specifically excludes from coverage the services of a private duty nurse. This association believes that some provision for payment for private duty nursing by a registered nurse should be included. For those seriously ill, such intensive care is often essential to recovery. Increasingly, in the past several years, insurance carriers have included private duty nursing as a covered benefit in their major

medical expense programs. There are safeguards in the bill to prevent overutilization of services such as the provision for a utilization review committee and the fact that need for a service must be certified by a physician. We recommend that payment for private duty nursing service be included in H.R. 6675. As a further assurance against overutilization, we also recommend that a registered professional nurse, such as the director of nursing services or her delegate, share with the physician the determination of the need of a patient for private duty nursing.

We are gratified that in H.R. 6675, in both the basic plan and the voluntary supplementary insurance program, provision is made for payment for home health services, including nursing care. These services as a benefit under the basic hospital plan can contribute to decreasing the length of hospitalization and under the voluntary program, when hospitalization is not indicated, will make more comprehensive the care available at home.

We endorse the definition of a home health agency in H.R. 6675 as one "primarily engaged in providing skilled nursing services and other therapeutic services." A very essential provision appears in the bill which is that policies of the home health agency "shall be established by a group of professional personnel, including one or more physicians and one or more professional nurses."

One benefit under the home health services provision is the part-time or intermittent services of a home health aid. The report from the Committee on Ways and Means states that the duties of the home health aid would be camparable to those of a nurse's aid in a hospital. Further, H.R. 6675, in defining home health services and home health agency, makes clear that the home health aid services would be administered by a certified public health agency or hospital which provides nursing care in the home.

A home health aid we believe is an unlicensed worker who can assist the ill, disabled, or infirm with personal care under supervision of a registered professional nurse, preferably a public health nurse. Her assistance cannot be substituted for essential professional services, but can be given in combination with them. Responsibility for determining the proportion of health aid visits to nursing visits should rest with the health care agency. Flexibility in planning services is essential to enable the agency to provide the range of home health services according to the priority of patient needs.

In section 1864(a), the Secretary of the Department of Health, Education, and Welfare is authorized to use a State agency for the purpose of determining whether an agency is a home health agency. We recommend that the State agency responsible for certifying this be the department of health. It is legally entrusted with and empowered to protect the health of the citizens of a State and is the one agency in every State whose services are provided under qualified medical and nursing direction.

Section 1861(e)(5) states, "provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times." We are in complete agreement with the first part of this paragraph. However, the use of "or" in the second part implies that the service of either a registered professional nurse or a licensed prac-

tical nurse is acceptable at some time during the 24-hour period. We believe that any hospital providing services for the actuely ill should have professional nurses on duty 24 hours a day.

The Standards for Hospital Accreditation of the Joint Commission on Accreditation of Hospitals, January 1964 edition, states on page 10, under III Nursing:

B. PERSONNEL

1. There must be an adequate number of licensed, graduate, registered nurses to meet the following minimum requirements:

(a) Director of the department;

(b) Assistants to the director for evening and night services;

(c) Supervisory and staff personnel for each department or nursing unit to insure the immediate availability of a graduate, registered nurse for bedside care of all patients at all times.

Although the licensed practical nurse makes a significant contribution to patient care, she cannot function in place of a registered professional nurse. The laws governing nursing practice in most States prohibit the practical nurse from performing unless under the supervision of the registered professional nurse. Therefore, we recommend that section 1961(e)(5) be amended to provide that registered professional nurses be on duty at all times in hospitals providing services to persons eligible under this legislation.

We support the provision in section 1861(j) that the extended care facility should have in effect a transfer agreement with one or more hospitals that are participating in providing services under this legislation. Such an arrangement would facilitate transfer between hospital and extended care facility when the transfer is medically appropriate and provide for the exchange of essential information necessary to plan and provide care for patients.

Section 1861(k)(2) provides for a utilization review plan for both a hospital and an extended care facility. This we agree is desirable to insure the best use of these facilities and their services. However, the section provides that the utilization review committee may be "composed of two or more physicians, with or without participation of other professional personnel." We believe that professional nurses, who are responsible for planning and directing the nursing care of patients, both in hospitals and extended care facilities, and who are in a continuing sustained contact with patients have much to contribute to any consideration of the utilization of these facilities and the services provided. Therefore, we suggest that it is extremely important that section 1961(d)(2) be amended to provide that the utilization review committee be composed of physicians and registered professional nurses.

It is customary in hospital insurance programs to provide payment for such specialist services as those given by radiologists, pathologists, anesthetists, and physiatrists. We join with others in being concerned that in H.R. 6675 payment for these services is excluded from the basic plan. While other hospitalized patients will have these services paid for through their hospital insurance program, the elderly will be denied this important coverage in their basic hospital plan. Furthermore, should this provision remain, the burden on hospitals will be increased because they will have to make special administrative

arrangements for the group of patients eligible for benefits under this legislation. Therefore, we urge this committee amend H.R. 6675 to provide for payment for specialists services under the basic plan.

Because nursing service will form such a vial part of the total program we recommend that registered professional nurses be appointed to all National and State advisory councils and review committees.

Two statements that will be useful to institutions and agencies providing nursing services, to governmental advisory bodies, and to the certifying State agency are the American Nurses' Association's standards for organized nursing services, 1965, and the National League for Nursing's criteria for evaluating the administration of a public health nursing service, 1962. We request that these statements be made a part of the record.

This committee is considering a bill to provide health insurance coverage for the aged. The responsibility for the successful carrying out of a key phase of this vital program rests ultimately on the shoulders of our Nation's hospitals and their employees. Yet more than one-half of all hospitals in this country are voluntary nonprofit organizations who may exclude their employees from the benefits of the very program for which they are responsible.

The liberalization of the nonprofit coverage provisions, as set forth in title III, section 316, are essential to the correction of past inequities and the American Nurses' Association urges their adoption. To prevent further inequities, we believe that the only satisfactory solution is the compulsory coverage of nonprofit organizations.

Under the present voluntary coverage provisions, the employees of a nonprofit organization are covered under social security only if the employing organization files a certificate waiving its exemption from coverage. Some nonprofit organizations have erroneously reported their employees for social security purposes without ever having filed a waiver certificate. Their error may go undetected for years and result in irreparable harm to the employees.

For example, in November 1963 the nurses in a nonprofit voluntary hospital in Florida learned for the first time that their employer had neglected to file a waiver certificate in 1957, the year the hospital first reported its employees. The resulting patchwork of coverage for the employees of this hospital is incredible. Their earnings in 1957 and 1958 were credited because the statute of limitations barred correction of records. Earnings in 1959 could not be credited because the hospital had obtained a refund in 1962. Credit for earnings in the first 6 months of 1960 was possible if neither hospital nor employees had obtained a refund. Earnings for the last half of 1960 and all of 1961 could not be credited to their account under any circumstances. Coverage of 1962 earnings was impossible unless the hospital requested that the waiver certificate be predated to January 1, 1962, and the Internal Revenue Service honored that request.

Section 316 would permit an employer to elect coverage retroactively for a period up to 5 years, rather than 1 year as at present. By making its waiver certificate sufficiently retroactive, employee earnings already reported erroneously would not be stricken from the record. Liberalization of the present law is essential to correct the error without damage to the employees.

In its report the House Committee on Ways and Means stated this bill would "resolve on a permanent basis troublesome problems which have arisen under the nonprofit coverage provisions." The American Nurses' Association questions the adequacy of that permanent solution.

The proposed amendment allows the nonprofit employer to predate a waiver certificate but does not require it. The nonprofit employer may, if he chooses, claim a tax refund instead.

Neither the current law nor the proposed amendment eliminate the provision for termination of waiver in section 1321(k)(1)(d). The nonprofit employer who elects coverage may still terminate that coverage at the end of 10 years. Nor is the nonprofit employer required to inform his employees that a request for termination has been filed or granted.

These problems arise because coverage is voluntary, not compulsory for nonprofit organizations, an anachronism in modern American society. In 1961, President Kennedy proposed extension of unemployment compensation to employees of nonprofit organizations, the administration stating "the traditional exemption of nonprofit organizations from revenue-raising taxes should not be carried over to programs designed for the protection of their workers." The Advisory Council to the social security program recommends universal coverage. The American Nurses' Association agrees, and is convinced that coverage of all nonprofit organizations should be compulsory.

Nonprofit voluntary hospitals have by and large elected coverage under the voluntary provisions of the present law. We do not have exact information on the proportion of hospitals and hospital employees with coverage, but the figure is reliably reported to be in excess of 90 percent. However, the pockets of noncoverage are significant. One State nurses' association estimates that over 50 percent of the nonprofit hospitals in that State do not provide coverage.

The rationale for voluntary coverage, if indeed it ever had any validity, has been destroyed by the wide acceptance of the social security program. We urge the removal of the nonprofit exemption at this time. In fact, we recommend that this committee initiate an immediate study of the present coverage by nonprofit employers and the feasibility of compulsory coverage in 1966 for this significant group of employees in our Nation's work force.

Thank you for the privilege of presenting the statement to the committee.

Senator HARTKE. Thank you, ma'am. Senator Curtis, do you have any questions?

Senator CURTIS. Relating to your comment with reference to radiologists, pathologists, and these other specialist services, is it your intention to imply that, if the House bill remains as it is, patients will not receive the services of these four specialists?

Miss THOMPSON. We believe the bill as prepared by the House Ways and Means Committee would exclude those specialists.

Senator CURTIS. Are you aware they are carried under the supplemental health provisions of the bill?

Miss THOMPSON. In the voluntary coverage plan?

Senator CURTIS. Yes.

Miss THOMPSON. Yes, but they are not in the basic plan.

Senator CURTIS. They are physicians, are they not?

Miss THOMPSON. Yes.

Senator CURTIS. And all other physicians' services are carried in the part of the bill for the supplementary health benefits rather than the hospital portion, is that correct?

Miss THOMPSON. Yes. But it is quite possible that all persons would not make available the supplementary program for themselves. They would not subscribe to it.

Senator CURTIS. The Secretary has estimated that 90, 95 percent of the people will.

There are other specialists besides the four that you have mentioned that use the hospital facilities, isn't that right?

Miss THOMPSON. But they are not ordinarily employees or have a fee for service program worked out with the hospital.

Senator CURTIS. Well, these doctors are not employees of the hospital either.

Miss THOMPSON. In many instances they are.

Senator CURTIS. Salaried people?

Miss THOMPSON. Salaried persons. I think that the American Hospital Association, who is on the agenda this morning, will have more information on this subject and they are more able to speak to it than I am.

Senator CURTIS. What I mean is do the nurses have any objection as to which portion of the bill these specialists are in?

Miss THOMPSON. Yes, because if a person does not take advantage of the supplementary plan then the services will not be available and they should be available to all.

Senator CURTIS. Of course, I believe the Secretary's estimate is correct.

Here you have a greatly increased insurance operation run by the Government with physicians' and surgeons' services for $6 a month and the Federal Treasury pays half of it. It doesn't seem there would be any concern that any great number of people needing it would not qualify.

But so far as the nurses' work in the hospital and their operation under this bill, are they themselves affected one way or the other as to how these doctors are carried in this legislation.

Miss THOMPSON. No, we are concerned for the individuals who will be receiving the care.

Senator CURTIS. You think that they will get better care if these doctors have the status of employees of the hospital rather than if they operate in the status of all other doctors that are practicing in the hospital?

Miss THOMPSON. I don't think that I could answer that question as to whether they would get better care. It would be available if it was needed for the persons who were in the institutions. If not, they might not be able to afford having services which must be paid for in addition to the benefits provided for in the bill.

Senator CURTIS. Well, I think that the payment benefits of the supplemental health provisions section of the bill are probably more liberal than the hospital portion, and I am a little bit at a loss at witnesses being interested in this when it is not a question of whether or not the services will be provided.

The doctors do not prefer to be employees of the hospital, and I think that they have advanced quite a logical argument in that area.

You wouldn't object to the bill, though, if it wasn't in it? It isn't of great enough significance that the bill should be defeated, in your opinion?

Miss THOMPSON. I don't think the bill should be defeated but I do think it is significant, because this pattern could develop as far as other health insurance programs are concerned for persons other than the aged as services are negotiated under other health insurance programs.

Senator CURTIS. Well, now, isn't it true that these services are billed by the hospital and handled that way for accounting in many instances where they are not at all employees of the hospital, isn't that correct?

Miss THOMPSON. Yes, the charges are billed through the hospital.

Senator CURTIS. Yes. And that could still be done in either event. That is all, Mr. Chairman.

Senator HARTKE. Miss Thompson, as I understand, what you are trying to state here is that it is your belief that the method of billing is going to have an effect upon these individuals placing themselves in a position to become recipients of this treatment; isn't that what you are saying?

Miss THOMPSON. That is right.

Senator HARTKE. Basically, and let's go back to your history on this legislation, you have been as an association actively in support of the so-called medicare or hospitalization care for many years; isn't that true?

Miss THOMPSON. We have been supporting the principle of using the social security mechanism for the provision of health care services.

Senator HARTKE. That has been for a number of years. You are not just a recent convert, are you?

Miss THOMPSON. No.

Senator HARTKE. All right.

I would like to ask you one question which bothers me, and I think bothers maybe a lot of us. Are there enough nurses really to take care of the people now? Will there be a tremendous additional burden as a result of passage of this legislation?

Miss THOMPSON. I would say that we do not have as many nurses now as we should have to perform the services that are required. There are movements, however, to correct the situation. Congress passed legislation last year which would provide funds for construction of nurses' facilities which would increase the capacity of the schools so that more students could be enrolled. We participate in a recruitment program, and we are hoping that we will be able to extend the present supply of nurses sufficiently to take care of the persons that will be requiring services. I am sure there are going to be additional burdens placed on all facilities and personnel in the health occupations until we can furnish more personnel. We do have a large reservoir of nurses who are unemployed and many of these nurses are unemployed because they do not feel they can afford to work because the salaries are not sufficient to provide for care of families or households when they do return to work.

Senator HARTKE. When I was dedicating the Children's Variety Hospital in Miami this summer, I was informed by the hospital administrator that one new wing of the hospital was not being used

because of the unavailability of nurses to staff it. Is this a common occurrence?

Miss THOMPSON. It does occur periodically.

One of the reasons for this is that buildings are erected without consideration for availability of personnel or plans made for personnel along with the building. Perhaps these plans could be made concomitantly rather than waiting until a facility is completed and then begin seeking personnel.

If there are persons available in communities that could be called upon to come back to work, if they had some refresher courses this would help to provide personnel for the facility.

Senator HARTKE. In the long run do you visualize this legislation as putting a greater drain on the utilization of nurses and creating an even shorter supply or do you feel that this will make it possible for additional people to pay for the nurses' services? Which is your view? There is a difference.

Miss THOMPSON. I don't understand the last part of your question.

Senator HARTKE. In other words, will the so-called supply of nurses be drastically curtailed even for additional services or do you feel that the fact that there is going to be a method of paying some of these bills that this, in turn, will encourage a greater influx of nurses into the field and possibly some of them coming back who have temporarily dropped out of the active nursing field?

Miss THOMPSON. I can only speculate, but I would assume that with more hospital bills paid that the hospital revenue would be increased and it would be possible to pay the nurses more and, therefore, attract more back into the field.

Senator HARTKE. Maybe I can have the American Hospital Association give a commitment for you.

In this question of additional nurses, do you feel that the passage of this legislation possibly will result in additional requests for additional Federal participation in providing further financial aid for buildings and for nurses training or do you think the present legislation is sufficient?

Miss THOMPSON. We didn't think that the present legislation was sufficient when it was passed. However, it was a beginning. It will need to continue for some time to assist in creating an adequate supply; and there will be need for amendments to the present legislation.

Senator HARTKE. In other words, you are thankful for small favors, is that what you are saying?

Miss THOMPSON. Yes.

Senator HARTKE. Let me ask you this: are you fearful if there is an extension of this program that the Federal controls will be of such a nature that it will socialize the nursing profession?

Miss THOMPSON. We believe there are sufficient controls written into the legislation to prevent this from happening.

Senator HARTKE. I have no further questions.

I want to thank you for coming and I want to say that the nurses association has always been one of the finest witnesses that I have ever had in front of me in any committee.

Miss THOMPSON. Thank you.

Senator HARTKE. The next witness is Mr. Joseph Terenzio, from the American Hospital Association.

Mr. TERENZIO. Good morning, sir.

Senator HARTKE. We are delighted to have you with us this morning. I do notice you have a rather lengthy statement. I do not want to preclude you from presenting any testimony that you feel should be presented but we are operating under somewhat of a restricted level and hopefully that you will do the best you can to summarize those portions which you can and still present your case in the manner in which you think it should be done.

Mr. TERENZIO. Yes, sir.

Mr. Chairman, we don't plan to read the entire statement. We would like to have it recorded in the record, however.

Senator HARTKE. The part you skip in your oral presentation will appear as if you actually read it so as to preserve the continuity of your statement.

STATEMENT OF JOSEPH V. TERENZIO, EXECUTIVE DIRECTOR, THE BROOKLYN HOSPITAL; ACCOMPANIED BY DR. DAVID B. WILSON, DIRECTOR OF UNIVERSITY HOSPITAL, JACKSON, MISS.; AND KENNETH WILLIAMSON, ASSOCIATE DIRECTOR OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. TERENZIO. Mr. Chairman and gentleman, I am Joseph Terenzio, the executive director of the Brooklyn Hospital, a division of the Brooklyn-Cumberland Medical Center, Brooklyn, N.Y., and a member of the American Hospital Association's Council on Administration. With me are Dr. David B. Wilson, director of the University Hospital, Jackson, Miss., and chairman of the association's council on government relations, and Kenneth Williamson, associate director of the American Hospital Association.

The American Hospital Association is a voluntary, nonprofit membership organization including within its membership the great majority of all types of hospitals, among which are 90 percent of the Nation's general hospital beds. These hospitals in 1963 admitted more than 27.5 million patients. Our primary interest—and the reason for the organization of the association—is to promote the public welfare through the development of better hospital care for all the people.

Much of our testimony today is in support of the provisions of H.R. 6675 which are of special interest to hospitals and in which we are in agreement. There are, however, a few provisions in the bill on which we are not in agreement, and it is to these points that we should like to direct your attention first.

TITLE I. HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

PART A. EXCLUSION OF MEDICAL SPECIALISTS' SERVICES

Page 64, paragraph 4:

A provision in H.R. 6675 which gives hospitals great concern is the exclusion of those almost universally accepted services of radiologists, pathologists, anesthesiologists, and physiatrists as an integral part of hospital services. This exclusion we are sure would be very damaging to the program for a number of reasons which we shall try to point out.

In the first place, it seems most inconsistent that these services be excluded in the hospital insurance part of the bill and included in the public assistance medical care part of the bill. Also, the exclusion is contrary to the provisions of S. 1 and to the provisions incorporated in S. 2782, the Social Security Amendments Act of 1964, passed by the Senate on September 25, 1964.

Over the years the services of these specialists departments have been developed in hospitals as an integral part of hospital services. This was essential in order to make readily available such services which were generally needed by all patients and which are absolutely essential to maintaining high levels of medical practice in hospitals. Except in only a few instances, all of the facilities required for the rendering of these services are provided by hospitals and are a part of the hospital facilities which communities themselves have furnished. There is no question involved as to the full recognition of these physicians as fully qualified physician specialists, and there is full recognition as to the professional nature of the interpretative, diagnostic, and therapeutic services rendered by these physicians.

It is most essential that there be a clear understanding as to the distinction between the professional nature of these services and the economic factors involved. To all intents and purposes, these physician specialists have maximum control of their services in hospitals. There is limited physician-patient relationship. Their services are requesed by other physicians; not by patients.

As these services have developed, a variety of patterns of relationship have also developed as between the hospitals and the physician specialists involved. It is believed that upward of 60 percent of the pathologists are employed as salaried physician specialists receiving their compensation directly from the hospital. Approximately 25 percent of radiologists are in a similar salaried relationship. The great majority of the remaining pathologists and radiologists work through contractual relationships by which they receive an agreed percentage of either the gross or the net proceeds from their department.

Of particular significance is the fact that the arrangements in every instance are worked out locally between the individual physician specialists involved and the individual hospital. We feel strongly that it is totally out of order for the Federal Government, through the present language in this bill, to dictate one nationwide pattern of relationships between hospitals and these physician specialists.

This provision, we wish to point out, is totally contrary to the statement assuring "noninterference" which appears in the bill.

The bill proposes to separate services of the physician specialists in radiology, pathology, anesthesiology, and physiatry from those services and costs involved in the provision of these services by hospitals.

The American Hospital Association has for a great many years clearly expressed its belief that the services of radiologists, pathologists, anesthesiologists, and physiatrists were hospital services and that the reimbursement to the physicians involved should be worked out locally. This policy became particularly important at the time the association joined with hospitals and others in the development of the nationwide Blue Cross plan movement and has played a most important part in shaping the benefit structures of Blue Cross plans.

S. 1 and H.R. 1 specifically provided that as long as services were billed through the hospital they would be considered hospital services and would be included as hospital benefits under the program. We accepted and supported this provision in S. 1 and H.R. 1.

I should now like to discuss a number of specific problems which we believe will result from the exclusion of these physician services as set forth in H.R. 6675. At the outset we wish to stress that in numerous ways both the aged beneficiaries of this program and the public generally will suffer, and it is upon these effects that we primarily direct your attention rather than to the difficulties which will be encountered by hospitals.

1. We have emphasized that the provision of these physician specialists' services is inseparably involved in the efforts of physicians and hospitals over the years to improve the quality of patient care. The removal of these physicians' services is a backward step, and one which may well jeopardize continued improvement in the quality of patient care in hospitals.

2. The quality of care in smaller hospitals has been markedly improved in the past by arrangements with these physician specialists visiting the hospitals at periodic intervals under a "circuit rider" arrangement. These arrangements, by which hospitals have guaranteed payment, have provided essential financial incentive and assurances to physician specialists which are necessary to their being willing and able to provide their services to smaller hospitals. If these hospitals are forced to withdraw their guarantees to such specialists and leave to the specialists the uncertainty of handling their own collections on a wide range of individual service items, it is believed the results may force such physicians to withdraw any assured provision of their services.

3. It is believed that the removal of the costs of these physician specialists' services as part of hospital services will tend to increase the overall cost of care to aged people. It will further set in motion a process that will increase the cost of care not only to the aged but to the entire population.

For the most part, the patient has little, if any, choice in the selection of these medical specialists nor can he bargain in any way on the charges to be rendered under existing practices. The hospital governing body exerts, through employment or through negotiations, a certain measure of control over the charges and is, of course, definitely concerned about the quality of practice. The governing board has the legal obligation to protect the patients' welfare. It would be a great disservice to the entire public for hospitals to be forced to lose these checks and balances which have worked so well for so many years.

4. The language in the bill interferes with existing relationships which have been established and will force a nationwide renegotiation of contracts between these physician specialists and hospitals. Particular problems will arise in respect to the large number of physician specialists who maintain a salaried relationship with the hospitals. In addition, widespread renegotiation between hospitals and Blue Cross plans seems inevitable. This, in turn, will require substantial changes in Blue Cross plan benefit programs with contract changes for millions of individual subscribers.

5. It is most unlikely that the aged beneficiaries of this program will understand the significance of the deletion of these physician specialists' services from their hospital benefits. It is when they are patients in hospitals that they will be informed that these services are no longer included in the cost to be borne by the Federal Government.

Senator CURTIS. May I interrupt right there, is that statement correct?

Mr. TERENZIO. Yes; it is.

From our past experience our feeling is that in most instaances, I think you could say generally speaking, even the general public is not sufficiently aware of even such things as their own Blue Cross coverage.

Senator CURTIS. No. That is not what I am talking about. You say they are going to find out it is not included in the cost to be borne by the Federal Government. That is not correct, is it? It is in the other part of the bill, isn't it?

Mr. TERENZIO. Yes; it is. But you see——

Senator CURTIS. That is borne by the Federal Government, isn't it?

Mr. TERENZIO. Senator Curtis, what we are trying to point out is the fact that in most instances because of past practices and the fact when aged go to hospitals now they do receive these services, most likely they will not question this, and despite the fact that I am sure a great deal of publicity will be given to the bill, our feeling is that in most instances when the aged person goes to the hospital, he is going to assume that he is entitled to the benefits he has been receiving right along and not receive a separate bill from the pathologist and the radiologist, and this is the point where we think there will be some difficulty.

Senator CURTIS. That isn't what you have said.

You have said they will get in the hospital and find out that it is not included in that part the Government pays, is that correct?

Mr. TERENZIO. Well, we would know it was correct if we knew that every patient was advised in advance before they came into the hospital that the physician services would not be covered.

Senator CURTIS. No, no. Aren't these four physicians covered like all other physicians in the supplementary health portion of the bill?

Mr. TERENZIO. Yes, that is true.

Senator CURTIS. Isn't that paid by the Federal Government?

Mr. TERENZIO. Yes, it is.

Senator CURTIS. Why do you tell us then when they are patients in the hospital they will be informed that these services are no longer included in the costs to be borne by the Federal Government?

That statement isn't correct, is it?

Mr. TERENZIO. Yes, the fact of the matter is that patients, will, in our opinion, the patients will realize when they are admitted to hospitals that the services that they have been traditionally receiving, that is the services of the radiologists and the pathologists, will not be available to them when they are hospitalized.

Now, I don't think we could say as a flat statement it is always true. Perhaps we might temper this a little bit by saying in most instances when the patient is hospitalized that will be the first time he will find that these services are not covered.

Senator CURTIS. But they are covered.

Mr. TERENZIO. Yes, sir, they are under the supplementary portion of the bill.

Senator CURTIS. Yes.

And you are telling the public and you are telling this committee that they are not included in the costs to be borne by the Federal Government.

Mr. TERENZIO. Well, my original—my statement at the beginning is, it is most unlikely that the aged beneficiaries of this program will understand the significance of the deletion of these physicians specialists' services in their hospital benefits. We stand on that statement, Senator. We are convinced this is so.

Senator CURTIS. I am talking about the next statement and I want to know if you are going to stand on that. That is when these patients are in the hospital they will be informed that these services are no longer included in the cost to be borne by the Federal Government.

Senator HARTKE. Will the Senator yield at that point?

I think that the statement is correct in the context in which it is given. It is only when there is an election to participate in the supplemental benefits that the statement could be wrong.

In other words, the truth of it is that under the coverage of this bill this statement is correct, and if you want to make the assumption that all people will take out the supplemental coverage, that is one thing.

But it is supplemental because it is supplemental, and that is all there is to it. Supplemental doesn't mean it is in the original. It means it is something in and above and that is the very reason why it is a voluntary supplemental coverage, and if they take it out, the only way that there could be any fault finding in my opinion with this statement is to say that you assume that all people are going to be covered by the voluntary supplemental program. I think that assumption may be one which the Senator might want to make but I do not think that that would place you in a position at odds with the statement made by the witness.

Senator CURTIS. Well, I won't take time to encumber the record but he hasn't said anything of the kind. He hasn't restricted this to the aged who do not select the supplemental health benefits.

Senator HARTKE. On the contrary he has not said——

Senator CURTIS. Yes.

Senator HARTKE. No.

Senator CURTIS. He said these patients will be informed that the services of these four medical specialists are not included in the costs to be borne by the Federal Government.

Senator HARTKE. If you want to take the statement out of context, I think it could be ruined that way. But I think the witness is proper in his statement.

Senator CURTIS. I am not taking it out of context at all.

Senator HARTKE. I see no reason to question his integrity.

Senator CURTIS. I am not questioning his integrity but I am questioning the accuracy. And I would leave it up to him whether he wants to leave it that way.

Mr. TERENZIO. I would like to leave it that way. We would like to. What we are pointing out here, as I referred to earlier, is the hospital coverage section of the bill and these patients will not be covered for physicians' services in anesthesiology physiatry, radiology, and pathology.

Senator CURTIS. You are aware that the other portion covers these four.

Mr. TERENZIO. Yes, I am aware.

Senator CURTIS. And it includes these four?

Mr. TERENZIO. Yes, I am aware.

Senator CURTIS. And you are aware it is something that comes from the Federal Government, right?

Mr. TERENZIO. Yes, I am aware of it.

Senator CURTIS. That is all.

Senator HARTKE. I do think this, we might point out, that really it is not going to be borne by the Federal Government either. It is going to be borne by the payroll tax out of the employees' tax and not borne by the employer; isn't that correct? I think we understand what you are talking about. I think most people do.

Senator CURTIS. There is no payroll tax on the way it is provided now for physicians' services. It is 50-percent subsidy out of the general fund.

Go ahead.

Mr. TERENZIO. May I proceed?

They may then receive multiple bills from each of the physician specialists which may be involved in their care. We believe this constitutes a substantial reduction in anticipated benefits. The hospital will be placed in the near impossible position of explaining the deletion and the substantial increase in costs which patients will be required to bear. Certainly it will constitute a major change in practices to which many of the aged and the younger members of their families have become accustomed. The administrative difficulties inherent in this change will be formidable. The administrative problems within hospitals will be greatly increased, which in itself will undoubtedly be reflected in increased costs. The administration of the overall program will also be more costly.

6. We strongly believe that if the deletion of specialists' services for aged beneficiaries remains in this legislation, it will certainly lead to the extension of the practice to all other patients. In various ways the needs of the public and the efforts to provide the best possible patient care at the lowest possible cost is tending toward the increased concentration of a wide variety of highly skilled and trained specialists working full time in hospital centers. The separation of physician specialists as proposed in this legislation is totally contrary to the whole direction of health care practice in our Nation.

RECOMMENDATION

We, therefore, urgently recommend that H.R. 6675 be amended on page 64 by adding at the end of the paragraph on line 21 the following: "or to services provided in the field of pathology, radiology, physiatry, or anesthesiology."

I might mention, Senator Hartke, that is the Douglas amendment exactly.

Senator HARTKE. I understand that.

Mr. TERENZIO. Page 13, section 1813—Deductibles:

We have always opposed deductibles because we do not believe they accomplish their intended purpose of controlling hospital usage.

Deductibles in this program fall hardest upon those aged individuals who most need help. This situation is relieved somewhat by the requirement under the public assistance amendments in the bill which make it mandatory for a State providing benefits under the public assistance title to pay the deductible required under this section where the individual's circumstances indicate the necessity.

Also, deductibles constitute difficult "public relations" problems for hospitals, especially with aged persons, as the hospital is faced with the necessity of being the collection agent for the deductible imposed by the Federal Government. We recommend, therefore, that the requirement for money deductibles as they relate to both inpatient care and outpatient care be deleted from the bill.

Page 19, section 1814(b)—Reasonable cost of services:

This section provides that hospitals would be reimbursed for the reasonable cost of their services. The word "reasonable" can be interpreted quite subjectively. We believe, however, it is the intent of the Government to reimburse hospitals fully for the cost of the services they render. We have continually expressed our belief, therefore, that it would be preferable if the word "full" were used rather than the word "reasonable" as it now appears in the bill.

Even though we attach particular significance to the report of the Ways and Means Committee in respect to the intent of this section of the bill, we find that hospitals generally would much prefer the use of the words "full cost."

Senator HARTKE. I think generally the patients would prefer "reasonable." I cannot see the hospital association coming in and asking that they be in favor of unreasonable costs.

Mr. TERENZIO. Well, they would not, sir, I assure you.

Senator HARTKE. You would have to say if you took out the word "reasonable" if you wanted to put in "full reasonable costs," I think that is one thing. But I certainly think it would be the better part of public relations to not place the hospital association in a position of implying that they were not in favor of reasonable hospital costs, and I think this is a fair interpretation, although I understand that you do not mean it as such.

Mr. TERENZIO. Yes, sir.

Senator HARTKE. There is no question that the word "reasonable" has acquired a degree of flexibility but in the law we have found that it is a wonderful instrument and that if you use the word "reasonable" that you are using what people consider to be a good reason.

Mr. TERENZIO. Senator Hartke——

Senator HARTKE. It is a legal term——

Mr. TERENZIO. Senator Hartke, I am sure we would have no objection to correcting our statement to including "reasonable full costs."

Senator CURTIS. At that point may I ask a question?

Mr. TERENZIO. Yes.

Senator CURTIS. What term do you use in reference to these four specialists we are talking about a bit ago?

Mr. TERENZIO. What term, sir?

Senator CURTIS. In fixing their charges. Is the language of the bill "reasonable costs" or "customary charges"?

Mr. TERENZIO. Fixing the compensation for these four specialists?

Senator CURTIS. Yes.

Mr. TERENZIO. We think they are entitled to reasonable compensation, sir.

Senator CURTIS. Not customary charges?

Mr. TERENZIO. Not customary charges—well, we haven't commented on that section of the bill.

Senator CURTIS. I know you haven't commented on it. For the physician under the other section it is customary charges.

Mr. TERENZIO. Yes. We believe it should be customary charges, well, actually the position of the American Hospital Association is that these specialists should be included in the hospital portion of the bill, and the compensation would then——

Senator CURTIS. That switches them from customary charges to reasonable costs.

Mr. TERENZIO. Yes, sir.

Senator HARTKE. I think the provision on the physicians, also, and doctors, also, says "reasonable charges" there and I think the only use of the words "customary charges" are in the report.

Mr. TERENZIO. Yes.

Senator HARTKE. I would think that in good conscience that we ought to agree that doctors and lawyers—that puts me in the category—and hospitals ought not ever charge anything which is unreasonable.

Mr. TERENZIO. I think we agree, Senator. [Laughter.]

May I proceed?

Senator HARTKE. Yes, sir.

Mr. TERENZIO. Page 22, section 1816(a)—Use of public agencies or private organizations to facilitate payment to providers of services:

The bill leaves the selection of an administrative intermediary to the option of the Secretary. We have consistently urged that there be provision in the legislation for the selection of such an intermediary which would function in behalf of the providers of services.

We have always felt specifically that hospitals will choose the Blue Cross Association to function in this capacity. We believe the Blue Cross Association could serve the Government, the beneficiaries, and the providers of services in a fully advantageous manner and in a broadly administrative role considerably beyond the service which might be rendered as a purely fiscal agent used to reimburse providers of services. Of all the patients admitted to hospitals in 1963, nearly 8½ million were Blue Cross subscribers.

We have continually recommended that the Secretary, as the chief administrative officer of the program, should be required to use an administrative intermediary designated by the providers of services unless he can demonstrate that such organization is not experienced and compentent to function in this capacity.

We have also stressed the primary urgency on the part of the providers of services for the required use by the Secretary of the principles of reimbursement which the hospital field developed through the American Hospital Association and which is the widely used instrument for reimbursement for hospital care.

Further, we have urged that the Secretary be required to consult with the American Hospital Association as representative of the hospital field in the development of the regulations pertaining to reim-

bursement for services and in the development of the nationwide formula which will be used as a basis of reimbursement.

In reference to these two provisions, it is our understanding from the bill and from the report of the House Ways and Means Committee that its intention is that the American Hospital Association, in behalf of its members, could request the Secretary to use the organization designated by the American Hospital Association to functions as an administrative intermediary. The Secretary may accept such a designated organization if he wishes to. He may use such an intermediary to handle the reimbursement to providers of services and to administer the formula of reimbursement which has been agreed upon by the Secretary following discussions with representatives of the American Hospital Association. He may also assign a much broader administrative role to such a designated intermediary.

The language of the bill itself is not as explicit in these two matters as hospitals would wish. We strongly urge, therefore, that the report of the committee on this bill express the intent of the committee that the program be administered as we have outlined above. Such an expression of intent on the part of this committee together with the statement appearing in the report of the House committee would be very reassuring to the entire hospital field.

Page 90, section 1864(a)—Use of State agencies to determine compliance by providers of services with conditions of participation:

It would appear that this section is intended to provide for the use of State public health or other appropriate State agencies to assist in qualifying institutions as to their eligibility and to provide consultative services to these institutions or agencies so as to help them to qualify for the purposes of this title. We find the wording of this section to be unclear as to specifically what is intended. It appears to duplicate functions which the Secretary could authorize private organizations to render as provided in the bill. The language appears to involve the State in certifying the fiscal records of the institutions providing care and in providing information with respect to payments due for such care.

We very much hope that the Secretary will use private organizations, as provided in the bill, as administrative agencies with a primary role in making payments for care and in establishing information a to fiscal records. We specifically hope that State agencies will no be involved in such a role.

Page 97, section 1867—Health Insurance Benefits Advisory Council

We fully support the provision in the bill for the establishment o such a council. We believe, however, the qualifications for membership should be clarified. The word "related" appearing on line 2 is subject to different interpretations. We recommend that this sectio be amended as follows:

Delete the sentence beginning on line 21 and substitute the follow ing:

> The members shall include persons who are outstanding in the field of hospita administration, medical care, and other health activities, and at least one perso who is representative of the general public.

Page 99, section 1868(a)—National Medical Review Committee

This provision did not appear in earlier legislative proposals. W see no necessity for the creation of such a committee since it appear

o largely duplicate the responsibilities which would be assigned to the Health Insurance Benefits Advisory Council.

Further, we believe it is a cardinal principle in appointing members to Federal advisory groups that the individuals be selected on the basis of their individual competence and not as representatives of particular organizations and associations.

We further believe that the composition of the committee, as suggested, provides no assurance of competence or experience in the administrative aspects of health care programs.

RECOMMENDATION

We would urge that the bill be amended so as to entirely delete section 1868. If necessary, further authority might be given to the Health Insurance Benefits Advisory Council to appoint any essential technical advisory groups.

Page 9, section 1802—Free choice by patient guaranteed:

We understand a participant would have free choice of any provider of facilities or services which has agreed to participate. We believe that the existing wording would offer free choice provided adequate standards are established to protect the participant and the Government.

Page 10, section 1812—Scope of benefits:

We believe that it is desirable to be restrained in the benefits offered at the outset until adequate working experience has been gained. The present language of the bill and the benefits offered in this section are generally in keeping with this approach.

Page 13, section 1813 (3):

We believe that whole blood is generally supplied by uncompensated donors and, therefore, only the costs of processing and administering the blood should be covered. Therefore, we feel that whole blood should not be provided.

We recognize, however, that the bill requires the beneficiary to pay for the first 3 pints of whole blood used, which would cover the vast majority of users of whole blood; and that the bill is attempting to protect those few aged patients who may require very substantial amounts of blood. Therefore, we have no strong objection to this provision.

Page 19, section 1814(c)—No payments to Federal providers of services:

We fully support this section and believe the provision that payments cannot be made to Federal providers of service is desirable. Basically, we feel that it is not desirable that the hospitals operated by the Federal Government be encouraged to provide services to the general civilian population. In fact, we believe that the intent of this legislation should be to discourage any expansion of direct Federal health services and should rather be in the direction of encouraging the fullest possible use of the health services available in the voluntary health system of the country.

Page 20, section 1814(d)—Payment for emergency hospital services:

We believe it is proper that true emergency services may be provided in nonparticipating hospitals. However, we fully agree with the intent of this section that in such cases a nonparticipating hospital may

not be paid differently than a participating hospital would be paid for similar services.

Page 20, section 1814(e)—Payment for in-patient hospital services prior to notification of noneligibility:

We are very pleased that this section is in the bill. We believe it will facilitate care to aged persons and gives a necessary assurance to providers of services that they will be compensated for the costs of care when they act in good faith.

Page 21, section 1815—Payment to providers of services:

We believe the provision in this section that hospitals must be reimbursed no less often than monthly is most essential. Many hospitals will have very substantial accounts receivable representing services rendered to aged beneficiaries. Any less frequent reimbursement might well work a considerable hardship on hospitals.

Page 26, section 1817(a)—Federal hospital insurance trust fund:

We strongly support the provision in this section providing for the establishment of a special trust fund. Such a provision gives important assurances in respect to the solvency of the basic social security trust fund. The provision also has further strength in its implication that the program of health benefits is to be structured so as to live within its income.

In order to provide continuity to our discussion of this title, we have omitted any comment at this point in respect to part B, the supplementary health insurance benefits for the aged, and have arranged our remarks to continue starting on page 62, part C, "Miscellaneous provisions."

Page 63, part C, section 1861(b)—In-patient hospital services:

The definition of in-patient hospital services includes many of the traditional services furnished by hospitals. This includes bed and board; nursing skills and other related services; use of hospital facilities and all such services as are ordinarily furnished by hospitals for the care and treatment of patients; drugs, biologicals, supplies, appliances, and equipment used in the hospital; and all such items are provided as are ordinarily furnished by the hospital for the care and treatment of its inpatients.

Diagnostic and therapeutic services that are furnished by the hospital or by others under arrangement with hospitals are also provided.

The inclusion of the services of interns and residents in training under approved teaching programs is of special importance.

Page 65, section 1861(e)—Hospital:

We approve of the definition of the term "hospital" as it appears in the bill, and we believe it is essential to have such expressed standards as they appear in the bill. We also believe it is particularly important that the reference to the Joint Commission on Accreditation of Hospitals which appears on page 66 be retained in the bill as it provides that the Secretary cannot establish standards whose requirements are in excess of those which the health field itself prescribes.

Page 70, section 1861(h)—Extended care services:

We believe it is essential that there be an adequate definition of such services as set forth in this section.

Page 71, section 1861(i)—Posthospital extended care services:

It is stipulated that an individual may receive services in extended care facilities after transfer from a hospital in which he was an in-

patient. It can be argued that this may tend to increase admissions to hospitals in order to obtain eligibility for extended care.

However, on the other hand, such a requirement may be definitely seen as serving to control the admission of patients to extended care facilities and to provide essential medical evaluation and treatment services in a hospital as they are needed and for the continuation of treatment in an extended care facility rather than utilizing hospital beds for this purpose. This should provide definite economic and health values. It is our belief that the requirement is well worth adopting and following carefully to determine whether it, in fact, serves the intended purpose.

The eligibility provision permitting an aged person to be admitted to an extended care facility within a 14-day period following discharge from a hospital is, we believe, a desirable change in the legislation. This should avoid unnecessary readmissions to hospitals in order to meet eligibility requirements for admission to an extended care facility.

Page 72, section 1861(j)—Extended care facility:

We believe the requirement in this section that the extended care facility have in effect a formal agreement with one or more hospitals for transfer of patients is desirable. In fact, one of the requirements of the American Hospital Association for the inclusion of an extended care facility in its approval program is that there be such a formal arrangement with a short-term general hospital.

Such formal relationships between extended care facilities and hospitals can serve importantly to expedite the transfer of patients from one type of facility to another. They can facilitate the operation of utilization review mechanisms, and can result not only in improved patient care, but in more economical operation. Such formal arrangement will also contribute to training programs for interns, residents, and other personnel who train in hospitals. The result will be higher standards of care for aged persons.

Further, we believe that it is most essential that the bill prescribe standards as set forth for extended care facilities.

Page 74, section 1861(k)—Utilization review:

The provision for utilization review is in keeping with the trend taking place in the hospital field. Prepayment voluntary health insurance organizations are increasingly under pressure from government, labor, management, and subscribers to require utilization mechanisms in hospitals. We believe that under the program contemplated by this bill, it is well to provide for such utilization review.

As the bill is structured it permits most hospitals to use review committees set up within their own medical staffs. In the very small hospitals where the medical staffs are not of sufficient size or are not formally organized, the bill provides for the local medical society along with the hospitals in the area to establish a utilization review committee. The provisions are desirable as they tend to keep the utilization review within existing voluntary channels.

Page 77, section 1861(m)—Home health services:

We approve of the provisions in the bill in respect to home health services and the agencies to provide such services. The effect of these provisions will be to encourage alternate means of providing essential health services. This will serve to facilitate early discharge of

patients from hospitals and extended care facilities and will provide needed health services without requiring the use of most costly facilities.

Page 81, section 1861(p)—Outpatient hospital diagnostic services:

We are pleased that outpatient diagnostic services are included in the bill. The availability of such out-patient services is now widespread. By including the provisions in this bill, it will lend further encouragement to this essential development. It should serve further to obviate the necessity of hospital admission in certain cases. It should be clear, however, that the limitation of outpatient services to purely "diagnostic services" leaves a large area of outpatient services provided in hospitals untouched. It will also necessitate some quite arbitrary decisions as to which services aged persons may be entitled.

Page 83, section 1861(t)—Drugs and biologicals:

This description pertaining to eligible drugs and biologicals in this section is good and we believe the reference to the authority of the appropriate committee of the hospital medical staff is most desirable.

The present language will make it possible for all drugs determined essential by the hospital medical staff to be made available. The development and continuation of hospital formularies by pharmacy and drug therapeutic committees of hospitals will be encouraged. We urge that the present language in the bill not be amended so as to weaken the authority of the hospital medical staff committee.

Page 33, part B, supplementary health insurance benefits for the aged:

It has been a longstanding policy of this association that we not take any position in respect to the inclusion of physicians' services generally in such Federal legislation other than those physician specialists' services which are an integral part of hospital services. Therefore, the question as to whether physicians' services generally should be incorporated in this legislation is not a matter upon which we will comment.

INPATIENT PSYCHIATRIC SERVICE

Inpatient psychiatric services are provided under this section. Although acute psychiatric services can be provided in general hospitals under part A of the bill, such short-term acute psychiatric services cannot be provided in psychiatric hospitals under that part of the bill. This provision would enable beneficiaries to receive benefits in psychiatric hospitals for relatively short-term duration similar to those which can be provided in general hospitals under part A of this bill.

HOME HEALTH SERVICES

Home health services are to be provided up to 100 visits during a calendar year. This apparently is intended to supplement the 100 home health visits which may be provided to an individual under part A of the bill. It is noted that the home health visits provided under part A have an element of control in that they can only follow a period of institutional care. The home visits provided under part B, however, are not controlled and may be provided without any relationship to a previous period of institutional care and the medical evaluation which is an element of control. This different basis of utilization

of the service, therefore, may well tend to weaken the control aspects provided under part A and may result in an unnecessary drain on the financing of the program.

MEDICAL AND OTHER HEALTH SERVICES

The definition of these services which appears on page 82 of the bill seems to us to raise questions of conflict with the definition of the term physicians' services. In a number of instances, the services which are listed to be provided under "medical and other health services" are likely to be physicians' services. This separation may well provide increased problems in the administration of the program. We believe the structure of this section of the bill may be intended to exclude various items of service.

However, in so doing, the bill is, we believe, quite unclear and vague as to its intent and as to the administrative means of carrying out the program.

For example, part A of the bill, in respect to outpatient diagnostic services, faces the individual patient with a $20 deductible, and in applying part B of the program to these services they are also faced with a $50 deductible and a 20-percent coinsurance feature. The application of these various deductibles and coinsurance features to several physicians and to multicharges received from physicians does, we believe, provide some very difficult administrative problems. More importantly, we feel it is practically impossible for the aged individual to realize just what benefits he is entitled to and what costs he must pay in order to receive the benefits.

Page 124, Title XIX; Grants to States for Medical Assistance Programs:

This section of the bill recognizes the need to correct various deficiencies which exist in present legislation as well as the need to extend and improve a variety of services. We are in strong accord with the broad intent of this title which gives further recognition to health services along with other services needed by beneficiaries of the program. The extension of the basic philosophy embodied in the existing Kerr-Mills program to other groups is good.

It is well, also, at this time to relate the health services to be provided to indigent and medically indigent aged persons to the program and benefits for which they will be eligible under part A of this bill.

The broadening of the services which the Federal Government will require from participating States is very desirable. This should tend to remove the present inequities existing among the States and will give them much-needed impetus for the provisions of a broad spectrum of health services.

Inasmuch as the Federal Government will, under part A of the bill, be relieving the States of very substantial costs now involved in the provision of institutional health services, it seems to us reasonable for the Federal Government to make specific requirements of the States in relationship to the provision of substantial matching funds from the Federal Government.

As we see this section of the bill as it pertains to aged persons, it should be possible to assure continuity of benefits for indigent and medically indigent aged persons who have exhausted the benefits to

be provided under part A of the bill. It should also be possible to provide various services needed by indigent and medically indigent persons which are not provided under part A of the bill.

We would hope that it may be possible to provide a system of predetermination of eligibility for indigent and medically indigent aged persons under this section of the bill so that, when they are hospitalized under part A of this bill, payment for their physicians' services might be assured without delays and excessive social service evaluation and, also, so that, when indigent and medically indigent aged persons may have exhausted their benefits under part A of the program and are certified by physicians to need continued care, such care could be provided under this section of the bill, again without any lapses or undue delays.

Page 129, section 1902(13):

We wish to express very strong support for this provision and the requirement that the States will be required to pay hospitals for the reasonable cost of care rendered. As previously mentioned, we hope "reasonable cost" will be full cost. This provision should do much to remove one of the worst problems now existing in the Kerr-Mills program. The States may, and frequently do, pay hospitals less than the cost of care rendered to indigent and medically indigent aged persons and thus force hospitals to recover these losses from other paying patients. The principle embodied here of Government accepting full responsibility for care rendered and determining that Government programs will not be carried out at the expense of hospitals and their patients is most commendable.

CONCLUSION

At the present time Blue Cross plans serve as fiscal agents and in other ways participate in the administration of the Kerr-Mills program in a number of States. We believe it would be well to insure that there be a continuation of such arrangements.

Also, inasmuch as we anticipate that Blue Cross will be participating in the administration of part A of this bill, there would be considerable merit in assuring continuity of administration by using Blue Cross plans for the administration of the hospital aspects of the part of the bill under title XIX. This would avoid the necessity of the purveyors of service having to deal with different and separate administrative agencies within the same State. We would urge, therefore, that this section of the bill encourage the States in every way possible to utilize the administrative intermediary selected by the purveyors of service under part A of this bill to administer the benefit program set forth under this title.

We appreciate very much the opportunity of appearing before this committee to express the views of our association on the technical aspects of the legislation. We have in previous testimony reviewed extensively the policy position of this association on financing health care for the aged as it was adopted by our house of delegates in January 1962. Our policy on entitlement differs from the bill now under consideration as provided on page 6, section 226(a).

We hope that our discussion here will prove helpful to the committee in its difficult task of developing this most significant legislation.

We thank you very much for giving us this opportunity to present this and we will be very happy to answer any questions that you may have.

Senator HARTKE. Senator Curtis?

Senator CURTIS. You recommend the deletion of the deductible?

Mr. TERENZIO. Yes, sir; we do.

Senator CURTIS. Do you recommend this program for all citizens over 65 regardless of their property or income?

Mr. TERENZIO. The American Hospital Association in 1962 went on record as indicating that they were completely in accord with the purposes of the bill, and differed only in one respect, and that was with respect to the question of eligibility, and we feel, however, that since 1962 the hospital field generally is now very much in sympathy with this bill, and we would support it and do everything we possibly can to make it a good bill and to implement it and have it work as well as could be expected.

Senator CURTIS. You are aware that the way the bill is written if someone is 65, they need not retire, could have unlimited capital assets and the highest income of their lives, and they would still be eligible for free hospitalization and free medicine under this.

Mr. TERENZIO. Yes, sir; we are aware of that.

Senator HARTKE. I might point out they would also be eligible for social security benefits.

Senator CURTIS. No, not unless they retire. Under this they do not have to retire.

Senator HARTKE. That is right.

Senator CURTIS. They don't have to retire at all.

Now, coming back, and I do not want to belabor the point, we are short of time, but the pathologists and radiologists and so on, would you agree with the statement that 76 percent of all laboratory services rendered patients are performed outside of hospitals in physicians' private offices?

Mr. TERENZIO. I have no information on that, Senator. I don't—of my own knowledge I don't know whether that is a correct percent or not.

Senator CURTIS. These four specialists are not the only doctors that are provided facilities in the hospital, are they?

Mr. TERENZIO. No, sir; they are not.

Senator CURTIS. Because you provide operating rooms, expensive operating equipment, delivery rooms, nurseries and so on.

Mr. TERENZIO. Yes, sir

Senator CURTIS. But these four are picked out to be classified as hospital employees while all other doctors are independent practitioners, isn't that true?

Mr. TERENZIO. No, sir; I don't think that is the position that the American Hospital Association takes. There is a variety of arrangements between pathologists, radiologists, and so forth, through the United States. Some of them work on a straight salary arrangement, some of them work on a percentage arrangement with the hospital. There are a number of ways that these pathologists and radiologists have of varied contractual relationships with hospitals, and our feeling is that in H.R. 6675, the way the bill is worded, it would require us to alter that present pattern of medical care, present pattern of

established relationships between ourselves and the pathologists and radiologists and require that they send bills, individual bills, to the patients that they have cared for who are eligible under H.R. 6675.

Our feeling is that under H.R. 1, the way the provision was written, it indicated that the services of pathologists and radiologists would be covered under the bill; if the pathologists and radiologists were on a straight salary, their salary would be paid for under the hospital portion of the bill.

If they were on a percentage arrangement this could be taken care of under the hospital portion of the bill and would not disrupt what we consider to be the well-established existing relationships between the specialists and the hospitals.

That is the position of the American Hospital Association.

Senator CURTIS. Where a hospital is employing on a salary these four specialists, everyone who enters the hospital would bear a part of that cost, wouldn't he?

Mr. TERENZIO. Yes, sir; that is true.

Senator CURTIS. Even though the patient comes in there and wouldn't use the services at all; isn't that right?

Dr. WILSON. Senator, may I speak?

Senator CURTIS. It is true. It is prorated on all hospital beds.

Dr. WILSON. It depends on how the billing is arranged. If the hospital is billing charges you don't allocate that except as the charge are made.

Senator CURTIS. Why is it, rural hospitals that do not have these, the cost per bed is much, much lower. Isn't it true that where the hospital carries this, it is added onto the cost of bed indirectly, not as a separate item, but it is carried as an overall cost of the hospital and in deciding how much they must charge for a bed it does increase the price.

Dr. WILSON. It depends upon what the practice of the individual institution is. You mentioned, of course, some of the smaller rural hospitals, the medical staff in many cases desires the services of radiologists and pathologists for their consultation services in connection with checking what they have done.

In a small hospital in a rural community the radiologist won't be there every day so that the practicing general practitioner will have to read his own films, but in order to be absolutely sure that he is correct he needs the consultation services of this radiologist.

Now, some of that cost could be included in the total operating cost. But this is for the provision of the overall quality of care.

Senator CURTIS. Well, the cost of these services are absorbed as part of the overall costs of running the hospital, and are reflected in the per bed charge, the charge per bed to patients, even though they do not use those specific services.

Dr. WILSON. I am sure that Mr. Terenzio wants to comment. I will make just one short comment to say there may be confusion because we are using per diem costs and at times there are charges and I think when you use the per diem costs you have to assume that all costs are included in that per diem cost.

But where you are using charges you are basing your charges on the individual allocations.

Mr. Terenzio might wish to comment.

Senator CURTIS. I will rephrase my question.

Isn't it true that the cost of maintaining these laboratories when carried as a part of the hospital operation are included in the per diem costs to all patients?

Dr. WILSON. I would answer that by saying, sir, that all of the hospitals, to the best of my knowledge, are making an effort, let's put it that way, to cost account these areas and get all of their departments in line according to the expenses of those individual departments.

Senator CURTIS. That doesn't answer my question.

Mr. TERENZIO. Senator Curtis, may I answer?

Senator CURTIS. The facts remains you operate those things and they are added in the cost of the operation of the hospital, and it increases the cost of beds.

Dr. WILSON. I don't think so.

Senator CURTIS. I think that is the practice.

Mr. TERENZIO. Senator Curtis, may I say the total costs of operating the hospital are all lumped together in determining what the per diem cost to keep a patient in a particular bed is.

Senator CURTIS. That is right.

Mr. TERENZIO. I would like to, however, point out that with respect to rural hospitals and in suburban areas, to the best of my knowledge almost 100 percent of the services of radiologists and pathologists in these hospitals is on a percentage basis where one finds the salary arrangement is usually in a large urban teaching hospital.

And in the suburban hospital the compensation that the radiologist and the pathologist receives is a percentage of the income of the particular department, but, of course, it is all lumped in, the total costs, per diem costs, because the services are all lumped together when one calculates the per diem costs of hospital care.

Senator CURTIS. Per diem cost is what the patient pays.

Mr. TERENZIO. Yes.

Senator CURTIS. So he pays his portion of that whether he uses those services or not. You said it is all lumped in.

Mr. TERENZIO. No, sir, he doesn't necessarily, Senator Curtis, pay the per diem cost. The Blue Cross reimburses on the basis of per diem costs in some areas in the country. But the patient is—ordinarily the charge or rather the salary or the compensation that is paid to the radiologists and pathologists, comes out of and is calculated on the basis of the volume of work that is done in his own department.

Dr. WILSON. Senator, could we just ask one question?

Senator CURTIS. Yes.

Dr. WILSON. Would it not be possible for the committee to take into consideration that the arrangements that have been worked out on a local basis on a voluntary basis could be provided for so that in each individual institution and in each individual locality the bill would then permit this voluntary decison on the part of the physician specialist and the institution instead of making it compulsory that they can't do that.

Senator CURTIS. I think the decision that Congress is faced with is whether or not to put all the physicians in the same category. I think that physicians prefer that they be treated as independent practitioners, and there are admittedly many physicians who use hospital facilities, operating rooms, X-ray equipment, and everything

else, and I believe that their contention is that they all be treated in the same section of the bill.

Dr. WILSON. Could I ask one more question?

Senator CURTIS. Yes.

Dr. WILSON. Wouldn't the voluntary approach permit this and at the same time would not deprive the area of making a decision?

Senator CURTIS. I would think that maybe something like that should be explored. I just am not prepared to give an answer whether or not you could work out language on that, but it should be explored.

Dr. WILSON. We would like very much to work with you on that.

Senator CURTIS. That is all.

Senator HARTKE. In line with the same question, this is going to, evidently going to, be one of the major issues in this medical provision of the social security changes this year.

Let me ask this: Is it true that really we are talking about costs, or are we really talking about how the costs are going to be paid?

Mr. TERENZIO. Senator Hartke, we are really talking about how the costs are to be paid.

Senator HARTKE. That is right.

There is nothing in this bill or any provision of it that is going to provide a reduction really in the costs of medical or hospital services. All we are dealing with basically in this whole program is how to pay those bills.

Mr. TERENZIO. Yes, sir. In fact, our position in this matter is that if the physicians' services are placed in the supplementary portion of the bill this will increase the costs to the beneficiary as we stated in the first portion of our statement.

Senator HARTKE. Those are all the questions I have.

We have a distinguished gentleman who has just arrived and I am anxious to hear his testimony, the senior Senator from Massachusetts, Hon. Leverett Saltonstall.

I would think you would want to listen to more of these witnesses here.

Senator SALTONSTALL. Thank you, Mr. Chairman.

Senator HARTKE. You may proceed, sir.

STATEMENT OF HON. LEVERETT SALTONSTALL, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator SALTONSTALL. Mr. Chairman, I appreciate the opportunity to appear before the committee in connection with H.R. 6675. It is a most comprehensive bill which seeks to correct many of the outmoded provisions of current law relating to the needs of our older people. While I shall direct my remarks primarily to the health care features of the measure, I first should like to comment briefly on other important aspects of the bill. I personally would have preferred to have had it divided into two bills, one dealing with health care and the other with the increase in social security benefits and the various welfare programs.

We all recognize that social security benefits have not kept pace with the rise in the cost of living and that it has become increasingly difficult for our older citizens who depend primarily on these benefits to live satisfactorily. I think, therefore, that we all applaud the

7-percent increase in benefits which will mean so much to so many people.

I personally have introduced bills to increase the earnings limitation for social security recipients, to reduce the waiting period required before disability payments begin, and to enable children to receive benefits to age 22 when enrolled fulltime in school. I am glad that each of these subjects is covered in this bill; nearly 300,000 children will benefit under the latter provision alone. Among other improvements included in H.R. 6675 are actuarially reduced benefits for widows at age 60 rather than requiring them to wait until they reach 62—a provision which is expected to affect 185,000 widows—and for the first time, assistance for some 355,000 people age 72 and over who have lacked sufficient quarters under social security to qualify for cash benefits. The bill also demonstrates the concern of Congress in improving the daily lives, not only of our older citizens, but also of the physically handicapped, the mentally retarded, and families with dependent children. In these and other ways, then, the bill is most helpful.

I turn now to the health care provisions of the bill. Here, again, the Congress is responding to a need that we know exists.

Today about 18 million Americans have reached the age of 65. By 1970 the figure is expected to be more than 20 million. As the age span of the American people has been extended, the special problems which confront older citizens have received increasing attention. Rising medical costs, reduced incomes, and the increased medical services which older people require, combine to create a situation in which many of our aged citizens cannot afford to pay for the health care they need. According to the Public Health Service, the yearly amount the average American spends on medical bills has increased more than six times since 1939. Hospital costs, for example, have increased 100 percent in 10 years. The American Hospital Association tells us that the typical cost per patient for a day in the hospital has increased 400 percent in the past 20 years, and that in 1967 the average daily charge will be $47. We know that Governor Rockefeller's Committee on Hospital Costs has reported that if recent hospital trends continue, the daily cost of hospitalization in New York will be nearly $100 by 1973, with $1,066 being the total bill for an average stay of 10 days. Recently the expense of hospital care has been increasing four times as fast as the cost of living. Even though the percentage of persons 65 and older who have some form of health insurance has more than doubled in the past 13 years—rising from 26 to 60 percent—and is increasing four times as fast as that for all other age groups combined, the fact remains that some people who need coverage can't afford it, and others who have it can't afford as much as they need.

The question is not whether additional help is needed, but how it should be provided. In 1960 I introduced a health care bill designed to meet this problem, and on three occasions since that time—in each succeeding Congress—I have introduced bills on the same subject. They have been revised and improved some, but the basic principle of these proposals has remained the same. S. 395, which I and Senators Aiken, Cotton, Morton, Prouty, and Scott have sponsored this year, is a voluntary, State-administered health insurance program for persons 65 years of age and older, with low- or moderate-incomes. It offers

eligible participants a choice of three options, depending on which best meets their needs. There is a short-term program, a deductible major illness program, and a private insurance policy program under which payment is made toward defraying the cost of a qualified private health insurance policy. These private health policies must be guaranteed renewable for life. I am pleased to say that the proposals which I have introduced in the various Congresses have consistently provided somewhat more comprehensive coverage than the proposals introduced by the administration. For example, they have covered surgery, physicians' services, and prescribed drugs outside the hospital or nursing home. They would enable a person to enter directly into a nursing home without having to be transferred there from a hospital. In some respects, S. 395 remains more comprehensive than H.R. 6675 despite the helpful additions which have been made to that proposal.

S. 395 would be financed by a Federal-State matching program under which the Federal Government would cover 50 percent of State administrative costs, and from 60 to 80 percent of other costs depending on a State's per capita income, up to a maximum Federal contribution of $150 per enrollee per year. Individual participants would pay an enrollment fee, which would vary according to their income from $10 a month to $10 a year, with the average enrollment fee estimated at $26. The bill is designed to avoid the undesirable features of a means test; yet, by establishing an income limitation on eligibility—$3,000 for a single person over 65 and $6,000 for a couple—it would exclude individuals able to meet their own medical costs. Federally-approved State plans would be administered by a single State agency.

My colleagues and I think our bill offers a better approach to the problem of health care than does the administration bill.

Let me turn now to the health care provisions of H.R. 6675. Certainly improvements have been made in the administration's proposal since it was introduced at the beginning of the session. A section improving and extending the Kerr-Mills Act has been added. A voluntary supplementary plan, which makes the package far more meaningful, has been included.

In 1960 Congress recognized the need which existed to help the medically indigent and passed the Kerr-Mills Act in an effort to meet the problem. The act represented a major step forward, and it passed Congress by an overwhelming margin. I was glad to support it. Today, Kerr-Mills has been implemented in 40 States and 4 jurisdictions, and has been authorized in 3 other States. In December of last year, nearly 280,000 elder citizens received help from it. I am happy to say that Massachusetts was one of the first States to implement Kerr-Mills, and that I believe it is considered to have one of the best plans in the Nation. Although Kerr-Mills has provided help, there have been criticisms that the act, as it has been implemented in some States, imposes burdensome means test requirements and does not reach all aged people who need assistance with their medical costs. In my opinion some of these criticisms are justified.

I believe it is time to expand Kerr-Mills and to remove some of the flaws which experience has revealed exist in the way the act actually operates. I believe this bill will be helpful in this respect. By establishing a single medical care program to replace the varying

provisions for the needy which currently are found in five different titles of the Social Security Act, the House bill extends the provisions of the Kerr-Mills program to other needy people, such as those on the dependent children, blind, and permanently and totally disabled programs. By setting forth certain minimum benefits requirements which participating States must provide by July 1, 1967, the bill extends benefits to many people who need them. It also removes the financial responsibility of children of the aged for meeting their parents' medical expenses before Kerr-Mills can become operative, provides a more flexible means test, and increases somewhat the Federal share of expenses under the program.

The voluntary supplementary feature, which has been added to the administration's bill, provides medical services, including physicians' and surgical services, which are essential to any meaningful program. It is satisfying to me that a number of the features which have been part of my own proposals have found their way into this section of the administration bill, because I believe that our older citizens, who lack funds to meet their medical expenses, need help with their doctors' and surgical bills. I still believe that it is wrong to require that nursing home care must be preceded by a stay in the hospital, and I think that some provision should be made for prescribed drugs outside the hospital. Such drugs comprise about 26 percent of an aged person's annual medical expenses and, therefore, constitute an important segment of medical costs. I also believe that the amount a hospitalized person should have to pay himself should depend on his income.

I think that my bill is more helpful with respect to catastrophic illness cases, but I believe both bills could be strengthened in this regard. Cancer, heart, and other prolonged and costly illnesses represent special situations and should receive special consideration. Certainly we do not want a catastrophic illness of that kind to wipe out all of the resources a family has worked diligently for a lifetime to build up.

Even though the health care section of H.R. 6675 represents a great improvement over earlier administration proposals, I remain fundamentally opposed to certain of its features. I do not believe that health care should be placed under a social security or payroll tax as H.R. 6675 provides. I say this for several reasons. The cost assumptions which underlie the health care program differ significantly from those underlying the cash benefit program, and, therefore, it is important to separate them with different trust funds and boards of trustees. I am glad they have been separated, but I think their separation cannot hide the fact that for the first time we are changing the purpose for which the payroll tax has been used. This may have unfortunate results in the future.

Just as today we recognize that some adjustments in social security benefits is in order to keep pace with rising living costs, so, inevitably the day will come when the Congress will decide that a further adjustment upward is called for. If H.R. 6675 is enacted, for the first time we will be linking to the social security system a service benefit as opposed to a cash benefit. That is, we will be providing payment for a service such as hospitalization, regardless of what that service may cost; that is something quite different from providing for the payment of a specified amount of dollars at some future date. We must

recognize that this will place a strain on the system. A future Congress may not be able to provide increased cash benefits under the social security program because so much revenue from the payroll tax will be going into medical care. There has been general agreement that there is a limit to the payroll tax. We know that Wilbur Mills, chairman of the House Ways and Means Committee, is supporting this bill. I am impressed, however, with a statement he made last September on this very point. Chairman Mills said:

> I have always maintained that at some point there is a limit to the amount of a worker's wages, or the earnings of a self-employed person, that can reasonably be expected to finance the social security system. Not only is this a gross income tax, but it adds to the cost of American goods and services and thus affects our competitive position. I do not believe that the American people will support unlimited taxation in the area of social security.

In December of last year, Chairman Mills raised other important questions which relate specifically to the problem at hand and are worth recalling. He said:

> * * * we must remember that the primary needs of our senior citizens are for adequate cash benefits. The amount must be sufficient to produce a dignified standard of living when added to other spendable assets characteristic of the aged. Further, the amount must be raised periodically to keep in step with decreasing purchasing power of the dollar. A payroll tax to pay for health benefits, as I have stated before, should not be added to or harnessed with one to pay for cash benefits. Health expenses are less predictable and they are rising considerably faster. Within a tight coupling, the cash benefit would, in all probability, be compromised and the danger increased of stressing health care at the expense of the root factors of food, shelter, and clothing.

There are still other objections to the use of a payroll tax to finance health care costs. Undeniably, a payroll tax is a regressive tax which falls hardest on those least able to pay. Under H.R. 6675, a person earning $5,600 would have to contribute as much as a person earning $56,000. The general revenue financing provided for in my bill, on the other hand, calls on people to contribute according to their income level. This seems to me to be the proper way to proceed—under the graduate income tax system, rather than on the regressive payroll tax. We must remember, too, that approximately 40 percent of our income source would be excluded under the payroll tax procedure. General revenue financing would provide assistance through use of taxes involving all types of income.

Although the method of financing a health care program seems basic to me, I have also reservations about several other aspects of H.R. 6675. I favor more emphasis on State administration than is provided for in the bill before the committee. I believe, too, that Federal health care programs for the aged should provide assistance to those who need help, rather than to all individuals. S. 395 establishes reasonable income standards which cover an estimated 90 percent of single aged persons and more than two-thirds of aged couples. Persons outside those limitations generally would be able to afford their own private insurance without Government assistance. Here again, catastrophic illness represents a special situation which may require special consideration.

I also favor a voluntary rather than a compulsory plan of health care. I recognize, of course, that H.R. 6675 now has a voluntary supplementary feature, but the basic plan is a compulsory one. I am reluctant to impose this additional compulsory payroll tax on young

people who would have to pay it for the rest of their working years.

In summary, Mr. Chairman, I should like to make clear that I approve of the improvements which have been made in the bill you are considering, but I think the general approach of S. 395 remains superior. Financing health care through general revenues as our bill provides has the advantage of reaching all sources of income in accord with capacity to pay, and at the same time is less likely to jeopardize a future increase in cash benefit under our social security system should such an increase appear in order.

S. 395 stresses State administration and voluntary participation whereas the basic plan of the House-passed bill is compulsory and administration would be primarily federally rather than State directed. Further, our bill provides reasonable income standards covering 90 percent of single persons and two-thirds of married couples, with people fully able to meet their medical expenses through the purchase of private health insurance doing so. Our bill offers more comprehensive protection in the event of catastrophic illness, and is superior in making provision for prescribed drugs outside the hospital, since statistics reveal this represents 26 percent of the annual medical expenses of the elderly. Our nursing home care provision is also generally superior since no prior hospitalization is required.

I know that the committee will give careful consideraiton to this most important problem that confronts our older citizens. I believe that the better method of assisting them is the method set forth in S. 395, and I hope that the principles on which it rests will provide the basis for the action taken by the committee with respect to the health care section of H.R. 6675.

I appreciate the opportunity to present my views.

(An analysis of S. 395, follows:)

BRIEF ANALYSIS OF SALTONSTALL HEALTH INSURANCE FOR THE AGED BILL (S. 395, 89TH CONG.)

Introduced by Senator Saltonstall and Senators Aiken, Cotton, Morton, Prouty, and Scott (January 12, 1965)

I. GENERAL DESCRIPTION

A voluntary State-administered health insurance program for persons 65 years of age or older with low or moderate incomes. Eligible participants may choose one of three options—a first-dollar short-term program; a deductible and co-insurance long-term program; or payments toward a qualified private insurance policy.

Program to be financed under Federal-State grant-in-aid matching mechanism and by enrollment fees related to income of participants. Program available only to States with MAA program in effect.

II. BENEFITS

State plan must offer choice among three actuarially equivalent programs:

(a) *Preventive, diagnostic, and short-term illness benefits*

Under this option the plan must provide participants during any enrollment year[1] with at least the following minimum benefit:

(1) Inpatient hospital services up to 21 days.

(2) Skilled nursing home care, up to 63 days (number of hospital days to be reduced 1 day for each 3 days of skilled nursing home care).

(3) Surgical services provided in a hospital.

[1] Enrollment year is a period of 12 consecutive months so designated by the State agency in accordance with regulations prescribed by Secretary of Health, Education, and Welfare.

(4) Physicians' services for 12 days outside a hospital.

(5) Ambulatory diagnostic laboratory and X-ray services rendered outside a hospital or nursing home, up to $100.

Additional health benefits could be provided.

(b) Long-term illness benefits

Under this option, the plan, after a $50 annual deductible, would pay not less than 80 precent nor more than 90 percent of the following benefits:

(1) Inpatient hospital service, up to 120 days.
(2) Skilled nursing home care.
(3) Prescribed drugs.
(4) Diagnostic laboratory services, including X-ray, up to $200.
(5) Outpatient hospital services.
(6) Physicians' services, including surgery.

Additional health benefits could be provided.

(c) Private insurance policy program

Under this option, payment is made to insurance company or policyholder toward defraying cost of qualified private health insurance policy. Payment in an enrollment year may not exceed actuarial value (average per capita cost including administrative costs) of short-term or long-term program minus enrollment fee individual would have paid had he chosen one of the other two programs.

Benefits under private policy must have actuarial value at least equal to that of benefits provided by either the short-term or long-term programs.

Private health policy must be guaranteed renewable for life. Changes in rates must apply to all members of plan or a broad class of persons thereunder.

III. ELIGIBILITY

Persons who—

(a) Are age 65 or over and reside in the State; and

(b) Are not recipients of any other Federal public assistance program (MAA excluded from this limitation); and

(c) Have an annual income of $3,000 or less if unmarried or a combined income of $6,000 or less if married and living with spouse. Income defined as adjusted gross income plus benefits from social security, railroad retirement, and veterans' pension.

Or, at option of State—

(d) If they do not meet income requirements:

(1) Were enrolled in preceding enrollment year; and

(2) Meet conditions of eligibility for persons not meeting income requirements (including payment of increased enrollment fee).

States: Must have medical assistance for the aged program in effect to participate in insurance program.

IV. FINANCING

Individuals: For short- and long-term plans individuals pay an annual enrollment fee that varies with income as follows:

Annual income of individual:	*Amount of enrollment fee*
1. $1,000 or under	$10.
2. More than $1,000, not more than $1,500.	$10 plus 2½ percent of income in excess of $1,000.
3. More than $1,500, not more than $2,000.	$22.50 plus 3½ percent of income in excess of $1,500.
4. More than $2,000, not more than $2,500.	$40 plus 7 percent of income in excess of $2,000.
5. More than $2,500, not more than $3,000.	$75 plus 9 percent of income in excess of $2,500.

For purpose of applying this schedule to a married individual, his income is considered to be half of the couple's combined income. (A spouse who is under age 65 does not qualify but income would be considered in determining aged individuals enrollment fee.)

The enrollment fee for a person with an income in excess of $3,000 who still is qualified to participate (see section on eligibility) is $120 plus any additional amount the Secretary of Health, Education, and Welfare may prescribe.

State and Federal: Depending upon its per capita income, a State would receive receive from the Federal Government from 60 to 80 percent of the nonadministrative cost of the program in excess of the amount covered by enrollment fees up to a maximum of $150 per enrollee. Administrative costs would be shared equally between the Federal and State Governments. Federal portion financed from general revenues.

V. ADMINISTRATION

Federally approved State plan to be administered by a single State agency. State may utilize services of voluntary private organizations in administration of plan except for collection of enrollment fees.

Senator HARTKE. I want to thank you for your statement.

Any questions?

Senator Curtis?

Senator CURTIS. No questions. I do want to say you have made a distinct contribution to our studies here, and what the distinguished Senator says about social security taxes are very true. Within a matter of 4 or 5 years there will be some people paying nearly $500 in social security taxes per year, $498, and also I want to commend you for the point that you made about that portion of our population that can clearly afford to pay their own bill or provide their own private insurance should do so, and I agree with the Senator on that.

Senator SALTONSTALL. I thank the Senator from Nebraska for his comments, and I appreciate them.

And I appreciate the courtesy of the chairman in permitting me to come on at this time.

Senator HARTKE. All right, thank you, Senator Saltonstall.

The next witness we will have will be Dr. W. Montague Cobb, of the National Medical Association, Inc.

I welcome you to the committee, and we will be delighted to have you proceed.

STATEMENT OF W. MONTAGUE COBB, M.D., PRESIDENT OF THE NATIONAL MEDICAL ASSOCIATION; ACCOMPANIED BY DR. KENNETH W. CLEMENT

Dr. COBB. Thank you, Senator.

Mr. Chairman, I am Dr. W. Montague Cobb, president of the National Medical Association and professor and chairman of the department of anatomy in the Howard University College of Medicine. With me is Dr. Kenneth W. Clement, a surgeon of Cleveland, Ohio, and the immediate past president of the National Medical Association, and a member of the last advisory council on disability to the Social Security Administration. May I express on behalf of the National Medical Association our appreciation of this opportunity to convey to you our views in support of H.R. 6675 which we consider one of the most vital bills now before the Congress.

We of the NMA are most keenly mindful of the heavy responsibilities imposed by the high status which public opinion has accorded the medical profession in the United States of America. We realize that the esteem in which the profession is held can be maintained only through rendering the service which our Nation anticipates. The

mercurial speed of scientific advance and technological improvements in medicine in recent years has presented manifold problems in making properly available to all our citizens the benefits of this progress. In some areas we have made enormous strides. We now devote unprecedented sums to the prosecution of medical research. Chiefly with the aid of the Hospital Survey and Construction Act of 1946 and its subsequent amendments and extensions, we have practically rebuilt our hospital system, so that our facilities are without parallel in the history of the world. Court decisions and the Civil Rights Act of 1964 have guaranteed that our federally aided facilities must be equally available to all citizens without bias of any kind.

In the provision of adequate personnel for the healing professions, knotty problems remain, because population increases constantly and geometrically, while physicians, dentists, nurses, pharmacists, and the various specialized technical associates are graduated in limited numbers but once or twice a year. Nevertheless, large plans now being implemented are significantly increasing our educational facilities in the health fields, and, we are coming to sense the importance of prevention, as against the cure, of illness by our espousal of public health programs of ever broader scope and intensity.

Our greatest problem now lies in finding ways to pay the costs of the medical care that modern knowledge has made possible. The principle that in our society every citizens, rich or poor, should be able to obtain the medical care he needs is not debated. The problem of financing has been accentuated by the fact that costs of medical care have risen astronomically in recent times and may continue to do so. Hospital stays, diagnostic procedures and many drugs have zoomed upward in expense, and the application of future discoveries and advances is likely to raise costs even further. Moreover, because we have in large measure been able to conquer or control the diseases and conditions which produced mortality in early life, a major portion of our armamentarium for restoring and maintaining health must today be directed at the latter years of the lifespan and for the benefit of the elderly members of our population, a segment which steadily increases in numbers and in population percentage.

For the past two decades legislation considered by the Congress has reflected a recognition of a deep concern for this problem of the costs of medical care. The many volumes which record the testimony of experts and interested persons on the subject reveal that every possible aspect has been at some time examined. There has also accumulated a certain experience with some types of plans and legislation. Most of all, unflagging public interest in the problem is at peak.

The National Medical Association firmly believes that more than 20 years of study, observation and experience are enough, and that the time has come for broad definitive action.

We are of the opinion that from the long period of attention given the problem has emerged the recognition that our senior citizens, those aged 65 years and over, are in most need of financial assistance for medical care, and that the most effective and logical way to provide this assistance would be through the social security system.

Those of us who can remember the depths of the great depression which began in 1929, know that the social security system, which arose as one of the preventatives of future privation, has proved a bulwark

to the Nation's economy and the welfare and inner sense of dignity of our citizens. No one would think of abolishing social security. Rather our efforts have been toward extending its coverage so that no one would have to want in old age or suffer the indignity of sublimated "pauper's oaths."

The National Medical Association strongly endorses H.R. 6675, the Social Security Amendments of 1965 as passed by the House of Representatives.

We have not come hastily to this position. Our 5,000-member organization, formed in Atlanta in 1895 because of exclusion practices against Negro physicians, has gained in its 70 years a pervasive and national knowledge of the health needs and problems of those in poor economic circumstances.

In April 1946, through our late president at that time, Dr. Emory I. Robinson of Los Angeles, the National Medical Association endorsed S. 1606, a bill for a national health program, familiarly known as the Wagner-Murray-Dingell bill, before the Committee on Education and Labor of the U.S. Senate.[1]

In 1949 at our Detroit convention our house of delegates tabled a motion to rescind this endorsement. In 1961 at our New York convention our house of delegates unanimously adopted a resolution to support the extension of social security coverage to self-employed physicians. We here endorse the provisions for this purpose in H.R. 6675.

In 1962 our house of delegates at our Chicago convention formally endorsed the principle of providing medical care for the elderly under the social security system. This action was reaffirmed by the house at our Los Angeles convention in 1963 and our Washington convention in 1964, and further through action of our board of trustees in interim session in Cincinnati in February 1965. Our immediate past president, Dr. Kenneth W. Clement of Cleveland, who sits on my left, testified on behalf of the NMA in favor of H.R. 3920 before the Committee on Ways and Means of the U.S. House of Representatives on January 22, 1964.[2]

This statement of Dr. Clement's is of considerable length and detail and renders such elaboration unnecessary at this time.

Briefly, the National Medical Association considers that H.R. 6675 would provide medical assistance to the elderly on the most rational and equitable basis possible. As a prepayment plan it would permit our citizens to provide medically for their later years during their productive work period. The nationwide and uniform coverage afforded would protect against the exhaustion of meager life savings, liens on previously unmortgaged real estate and the indignities of means tests.

Because of the greater incidence of illness, the longer hospital stays and lowered income of the elderly, these citizens are an understandably high risk group to private insurance companies and they cannot afford the high premium rates of private insurance policies which are often found canceled when most needed.

Public assistance programs in the past have proved limited in scope, varying in coverage among the several States, and largely available only after aged individuals have expended their financial resources.

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[1] Hearings on national health program, S. 1606, before the Committee on Education and Labor, U.S. Senate, pt. 2, pp. 787–794, 1946.

[2] National Medical Association testimony, H.R. 3920, JNMA, vol. 56, pp. 218–221, 1964.

H.R. 6675 significantly improves the health care for the aged over past bills which our association supported; by the addition of supplementary voluntary health insurance which would include payment for physicians and other related services, at a cost which the aged would be able to pay.

This addition is recognized by the association as desirable and necessary. It is in keeping with present methods of providing for payment of physicians' services; it is modest in cost; it is significantly broad in coverage; and it satisfies a recognized unmet need in the basic social security program for meeting the cost of institutional health and other related services.

The National Medical Association finds no peril or threat in these programs to the private medical practitioner, or to the free enterprise hospital system in this country. Adequate safeguards are written into the bill, including prohibitions against unwarranted interference by the Government and allowing for the desirable participation of consumers and providers of health care through the advisory councils, etc.

As H.R. 6675 presently stands, no physicians' service would be paid for through the social security hospital insurance trust fund and provisions for private insurance company participation in this and the supplemental voluntary health insurance program is afforded.

The assertion that this is socialized medicine is, therefore, pure nonsense.

Payments to pathologists, physiatrists, radiologists, and anesthesiologists are removed in the present bill as reimbursable hospital cost items. However, we are for restoring them. Their inclusion would make the above criticism no more valid, for the precedent for including them is far more established in practice than excluding them.

Senator HARTKE. Let me ask you a question, you say radiologists should be covered but we have been told that anesthesiologists are in a different category.

Do you have any comment on that?

Dr. COBB. Yes, sir, pathologists and radiologists have no natural contact with the patient. They examine specimens or take a picture at some other point.

The physiatrist provides a service of physical therapy of some kind but it is at the request and direction of another physician. In that sense it is in a hospital service. The anesthesiologist has an even more intimate contact with the patient because he is responsible both preoperatively and postoperatively for some degree of care of the patient.

But it is, there is, a gradation in the degree, and you might say to a certain degree that matter is moot, but you can't dispense with it, and it is our feeling that it might be lumped in the inescapable services of the hospital costs.

Senator HARTKE. Thank you, sir

Dr. COBB. Moreover, the services provided in general by this group of physicians calls for a specified contractu[illegible] relationship with the hospital, and, the patients they "treat" are largely captive in nature and unrelated to any real free elective choice. Certainly the free choice exercised by patients of physicians located outside of, but practicing in, the hospitals is denied those using the service of this group.

In past testimony in favor of the enactment of H.R. 3920, the National Medical Association recognized a continued need for public assistance programs and their improvement in the area of health care.

This the association reaffirms and finds worthy those provisions in H.R. 6675, which improve these programs; namely, the consolidation of five titles of the Social Security Act into a new title, title XIX, which would set minimum benefit requirements, in in-patient hospital services, outpatient hospital services, other lab and X-ray services; and the provisions for the needs of funds to meet the deductibles that are imposed by the new basic program of hospital insurance.

The recently passed House bill provides for deductibles and coinsurance. This is an understandable inclusion, with the intent to dissuade abuse and overuse of the these plans. Initially the funds from which benefits are paid deserve such protection.

It is the hope of the National Medical Association, that these deductibles will remain under close scrutiny and should future experience dictate, lowered and ultimately removed.

H.R. 3920, in the amendment section dealing with public assistance and medical assistance for the aged, sets forth new eligibility requirements which could have the effect of making more deserving of medical care in the aged group eligible for same, by removing the deterrents inherent in means tests, real estate liens, and residency requirements.

The residency requirements in the several States have never taken adequately into consideration the necessary increasing mobility of the American people, including the aged.

The National Medical Association supports these amendments and other improvements in the Kerr-Mills law contained in H.R. 3920.

The principle is now firmly established in law that health care supported in whole or in part by public funds must be administered without discrimination as to race, creed, color, or national origin. We strongly urge that due antidiscrimination provisions be clearly written into H.R. 6675 so that possible litigation may be avoided.

Since the last general increase in cash benefits for social security beneficiaries, significant general price increases have occurred affecting clothing, food and shelter, merely reducing the purchasing power of the benefits.

The provisions of H.R. 6675 which increase the general cash benefits by approximately 7 percent are welcome. The National Medical Association supports this increase for it will contribute to the physical, mental, and social well-being of the aged.

The elderly, like the young, need a sense of affection and security. They have a yearning so beautifully expressed by Charles Matheson in his well-known hymn:

> O love that will not let me go,
> I hide my helpless self in Thee,
> I give Thee back the life I owe,
> That in thine ocean depths its flow,
> May richer, fuller be.

Like this love, the benefits of H.R. 6675 cannot be taken away. The sense of security thus imparted will help to sustain our elderly in their waning years. Can we deny this small assurance to those on whose shoulders we stand?

Thank you, Mr. Chairman.

Senator HARTKE. All right, thank you, sir.

I have no further questions.

The last witness this morning is Dr. Perry Volpitto of the American Society of Anesthesiologists, Inc.

We are delighted to have you with us this morning, and you may proceed in any fashion you may see fit.

STATEMENT OF PERRY P. VOLPITTO, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.; ACCOMPANIED BY JOHN LANSDALE, COUNSEL

Dr. VOLPITTO. Mr. Chairman, my name is Perry P. Volpitto, M.D., professor and chairman of the department of anesthesiology at the Medical College of Georgia and director of anesthesiology of the Eugene Talmadge Memorial Hospital of Augusta, Ga.

I am appearing on behalf of and as president of the American Society of Anesthesiologists, Inc. I have with me, Mr. John Lansdale, for many years counsel for our society.

I am here to oppose the exclusion of anesthesiology from the definition of "physicians' services" in H.R. 6675. The legislation as it passed the House would define anesthesiology as a physicians' service and include it in the portion of the bill covering physicians' services. You are being requested to exclude anesthesiology along with radiology, pathology, and physiatry from the definition of "physicians' services" and cover it as a hospital service, at least where the hospital bills for the service. Mr. Chairman, the reasons given for this request do not apply to anesthesiology. No reason to do this, applicable to anesthesiology, exists or has been claimed so far as I am advised, and I believe it would be harmful to my specialty.

An anesthesiologist is a physician who specializes not only in anesthesia as related to surgery and obstetrics, but also in resuscitation, whether repiratory or cardiorespiratory in nature, management of coma from drug overdosage, inhalation therapy as applied to acute and chronic pulmonary conditions, management of the patient in shock, whether it be a medical or surgical problem, and the diagnosis and management of acute or chronic pain occurring other than during surgical procedures. This medical specialty is known as anesthesiology

The physician who specializes in anesthesiology is to be distinguished from the technician or nurse anesthetist who may perform the physical act of administering anesthesia under the direction of and upon the responsibility of a physician.

As the legislation passed the House, the only services by physicians to be provided as part of hospital care are the services of interns or residents receiving training under an approved teaching program; i.e., the house staff. Services in any field of medicine, including, of course, anesthesiology by resident physician in training in that specialty, will be included. This recognizes existing facts. Services by the house staff are normally a part of hospital service. The amendment to section 1861(b)(5) (line 5, p. 64), introduced by Senator Douglas, would have the effect of adding to hospital service the professional services of physicians specializing in pathology, radiology,

physiatry, and anesthesiology, in addition to professional services provided by interns and residents in these and other specialties, where the hospital bills and collects for such services. We think there are valid reasons why none of these professional services should be offered as hospital service. However, I submit to you only the special considerations which, we believe, merit your attention and which indicate that, in any event, the word "anesthesiology" should be dropped from the amendment.

We understand that the intent of the amendment is to include in the hospital portion of the bill those services which are in fact normally supplied as hospital services throughout the country. The normal situation is that the professional services of radiologists, in diagnosis, pathologists, and physiatrists are offered as hospital services and their services billed for and collected by the hospital. One of the principal reasons for this arises out of the fact that substantial facilities are provided by the hospital solely for the provision of services by physicians in these specialties, the outlay for which must be recouped by the hospital. Thus some special financial relationship or arrangement has been thought to be required with respect to these specialties. This is not necessarily so; but it has been according to my observation the usual practice.

Anesthesiology, however, is in a substantially different position. Normally the anesthesiologist practices in the same manner as other physicians who have direct contact with patients in a hospital. They bill and collect for their own services. There are no circumstances requiring or suggesting any financial relationship with the hospital and in recent years there has not normally been any. Therefore, in health insurance programs, coverage for anesthesiology is normally found among the provisions for physicians' services and not in the provisions relating to hospital services. The latter, however, normally provides for nurse anesthetists who are usually, like surgical nurses, hospital employees.

We realize that the intent of the amendment is to provide for the services referred to only when they are billed for by the hospital. This means that, so far as anesthesiology is concerned, the coverage intended to be provided is largely illusory. Beneficiaries of this legislation would be led to believe that they would receive the services of physicians specializing in anesthesia, whereas they would seldom do so in fact. Hospitals do not bill for anesthesia rendered by physicians in 85 to 90 percent of the cases, thus it would not in fact be included in hospital service. It would not be furnished under the provisions of the medical side of the bill either because "physicians' services" are defined in subsection (a), pages 81–82, of section 1861 to exclude the professional services named in the last sentence of subsection (b), which is where the amendment would be made. Thus most of the anesthesia rendered by physicians in this country would not be covered at all by any of the provisions of this bill under the terms of the proposed amendment.

I used a moment ago the figures 85 to 90 percent as being the proportion of the cases in which anesthesiologists do their own billing and assume the risks of collection. I used these percentages in order to avoid any possibility of claiming too much. I believe the percentage to be greater. A survey conducted by the American Medical Associa-

tion in 1963 indicated that the percentage of physicians in various specialties who receive salaries from hospitals, ranged from 1.5 percent in ophthalmology to 40.5 percent in pathology. Certain of these figures are as follows:

	Percent
General surgery	8.4
Anesthesiology	8.8
Cardiovascular disease	10.2
Thoracic surgery	10.5
Neurology	15.5
Radiology	22.5
Therapeutic radiology	23.1
Psychiatry	23.3
Physiatry	29.1
Pulmonary diseases	35.0
Diagnostic roentgenology	40.0
Pathology	40.5

There are some infirmities in these figures. The salaried physicians include teachers, as well as physicians employed in city and State hospitals and other charitable institutions. On the other hand, they may exclude situations which do not include a salary strictly speaking but in which the hospital does the billing. Undoubtedly, there are instances of this in anesthesiology. It is quite frequent in radiology and pathology where, as mentioned above, it is often thought necessary to divide the fee for total service between hospital and physician. This is a matter which has deeply concerned my specialty for many years, and I can assure the committee that, overwhelmingly, anesthesiology is practiced like other specialties involving direct patient contact and, overwhelmingly, anesthesiologists bill and collect for their own services.

Secretary of Health, Education, and Welfare, Mr. Celebrezze, referring collectively to radiology, pathology, physical medicine, and anesthesiology, stated that his primary concern is that "medical services furnished to hospital patients in these fields be covered * * * in accord with the practices that hospitals and the health profession have developed over the years."

Mr. Chairman, in regard to anesthesiology, that is my concern, too. For this reason we ask that you leave "anesthesiology" out of the hospital side of this bill.

The Secretary suggests that the kind of objection we make is taken care of by the definition of "arrangements" which has the effect of including the coverage only if the hospital bills for the service.

The trouble with this, Mr. Chairman, so far as anesthesiology is concerned, is that it is written around the situation as it exists for the other specialties involved, other than anesthesiology. There is no question that, with respect to other specialties, the hospital bills for the services in most cases. We have no doubt that if these services go back into the hospital portion of the legislation the number of instances in which the billing is done by physicians will further diminish.

So far as anesthesiology is concerned, the problems suggested by Secretary Celebreeze simply do not exist. For example, we do not have the problem of separating the billing for the "nonphysician components of the affected hospital department" which, in his judgment, presents difficulty in the fields of pathology and radiology.

For example, the American Nurses Association this morning asked that specialist services, including anesthetists, be added to the hospital plan. The reasons given, however, are not applicable to anesthesiologists. Miss Thompson based this on salary arrangements. Only 8.8 percent of anesthesiologists are on salary, and this includes teachers and employees of State and city hospitals. Without material exception, the detailed argument presented on this subject by Mr. Terenzio on behalf of the American Hospital Association does not apply at all to anesthesiology. There seems to be a desire to include us simply by repetitious association with other specialties, sort of a guilt by association. No facts have been presented to justify inclusion of anesthesiology in this bill.

The necessary effects of classifying anesthesiology as a hospital service will be to subject physicians specializing in anesthesiology to tremendous pressure to become employees of hospitals so as to permit hospitals to bill and collect for their services, in order for the beneficiaries of the legislation to receive the benefits seemingly intended. This seems unfair and we are sure that it is unwise. The anesthesiologists have spent the last 20 years getting out of this very position. Anesthesiology is the newest of the medical specialties. It has made enormous strides during recent years. Somewhat belatedly physicians have recognized anesthesiology as a vital aspect of the practice of medicine and the number of anesthesiologists has increased at a rapid rate.

Your own State of Indiana is an example of this. It is now clear that continued advances in the art of anesthesia and increases in the number of physicians devoted to it are of prime importance to the continued advance of surgery, the care of elderly and "poor risk" patients, as well. The stature of anesthesia as an independent medical specialty, practiced like other medical specialties which involve intimate contact with the patient, and nothing is more intimate than life and death; it is very crucial, for example, that they continue to attract these individual physicians to the specialty. For this reason, the specialty has over the past 15 years made an enormous effort to bring the mode of practice of anesthesiology into line with the standards which exist for the other clinical specialties. This it has now succeeded in accomplishing to a substantial degree.

Over the past 2 years the society conducted, with professional assistance, an intensive survey of the specialty with particular attention to how it could attract still larger numbers of able young physicians and improve the coverage and care provided for patients. This survey demonstrates beyond peradventure that it is vital to the future of the specialty that the anesthesiologist practice as other independent physicians and not as a hospital service. The inclusion of anesthesiology in the hospital portion of this legislation and the exclusion of it from physicians' services covered in the medical side of the legislation would, we sincerely believe, have a very serious adverse impact upon the practice of medicine.

Mr. Chairman, on behalf of the American Society of Anesthesiologists, I wish to thank you for allowing me the privilege of appearing before you this morning.

Senator HARTKE. Thank you, sir.

I might say that this concludes the list of witnesses to be heard this morning. I do think in view of the statement just made, however, that it would be appropriate if the American Hospital Association felt that they would want to submit some information concerning this statement. I know that personally I am vitally concerned with this matter, and if there is some clarification or amplification upon this subject, I am certain it is going to be of help to all members of the committee because I am sure the committee is interested in trying to do the best job we can. We are not interested in hurting anybody or doing what is wrong; we are trying to write a good bill.

Thank you, sir.

Dr. VOLPITTO. Thank you.

(The following letter was subsequently submitted by the American Hospital Association:)

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., May 5, 1965.

Hon. HARRY FLOOD BYRD,
Chairman, Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BYRD: Following the presentation made before the Senate Finance Committee yesterday by the president of the American Society of Anesthesiologists, Senator Hartke who was presiding expressed a hope that the American Hospital Association would comment on the statement made by the anesthesiologists in respect to their being included along with radiologists, pathologists, and physiatrists in the definition of hospital services under H.R. 6675.

We have read the statement of the anesthesiologists very carefully and believe it expresses well various considerations which we have previously taken into account. The language of the recommendation we made for amending H.R. 6675 would leave it up to each of the individual medical specialists involved to work out his own financial arrangements with the particular hospital in which he desired to work. We believe this principle and the individual option involved should apply equally to each of the specialist groups and that there is no compelling reason to treat the anesthesiologists in a different manner. We note that the language which now appears in S. 1 was specifically written at the request of the anesthesiologists, and it was fully assumed, therefore, to meet their particular desires.

Any amendment adopted we feel should clearly make possible the payment of anesthesiologists under part B of H.R. 6675.

We would urge, therefore, that H.R. 6675 be amended as we have recommended so as to include the services of radiologists, pathologists, anesthesiologists, and physiatrists in the definition of hospital services. This, thereby, will prevent the Federal Government from dictating any particular pattern for handling these services and for the payment of these services as between hospitals and the individual physician involved. This freedom of medical practice and freedom of hospital operation, we believe, is in keeping with the stated purpose of the legislation.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director.

Senator HARTKE. The committee will now stand adjourned, and reconvene tomorrow morning at 10 o'clock.

(Whereupon, at 12:15 p.m., the committee recessed, to reconvene at 10 a.m., Wednesday, May 5, 1965.)

SOCIAL SECURITY

WEDNESDAY, MAY 5, 1965

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

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

Present: Senators Byrd (chairman), Long, Anderson, Ribicoff, Williams, Carlson, Bennett, and Curtis.

Also present: Elizabeth B. Springer, chief clerk.

The CHAIRMAN. The meeting will come to order. The first witness is Mr. J. McNerney of the Blue Cross Association.

Mr. McNERNEY. Thank you, Senator Byrd.

The CHAIRMAN. You have been allotted 15 minutes.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION; ACCOMPANIED BY BERT TOLLEFSON, JR., WASHINGTON REPRESENTATIVE OF THE BLUE CROSS ASSOCIATION

Mr. McNERNEY. I have on my right, Mr. Chairman, Mr. Bert Tollefson, who is the Washington representative of Blue Cross.

My name is Walter J. McNerney, president of the Blue Cross Association, which is the national organization of Blue Cross hospital service plans. I appear here today as a representative of these plans which collectively paid to hospitals and other institutions more than $2.6 billion for the care of the 10 million of our 60 million members who received care in 1964. More than 5.6 million of our members are age 65 or over, a third of whom are still employed regularly.

Blue Cross appreciates this opportunity to comment on H.R. 6675. The extended consideration given by the Congress to the subject of health care for the elderly in recent years clearly indicates the scope and importance of the problem. We have welcomed earlier opportunities to participate in this discussion, and do so again.

Earlier we have testified that some aged persons, and others with low incomes, lack enough purchasing power to avail themselves of broad health benefits. Comprehensive prepayment benefits are available, but many aged persons cannot afford to buy them. Blue Cross, as we have said here before, cannot solve that problem entirely through its traditional community service organization. The redistribution of medical costs to all in a local area can no longer be borne solely by philanthropy, hospital-pricing structures, or Blue Cross community rating. Assistance has been needed from and has been provided by Government. It is important to note that the problem we are dis-

cussing is the lack of purchasing power of senior citizens, not the capacities, interests, or programs of voluntary prepayment.

H.R. 6675 proposes to strengthen Government assistance by three programs of differing design, operating characteristics, and objectives. First, a basic plan in title XVIII, part A, providing benefits for care that is primarily institutional, mainly in the hospital, financed by a payroll tax, and covering practically everyone aged 65 or over. Second, a voluntary plan in title XVIII, part B, providing mainly physicians' services, paid for half by the Federal Government and half by the individual who elects to buy it. Third, in title XIX, an expanded program of assistance to the needy, combining all categories into one matching formula.

A major matter of public policy to be decided by the action on this bill is, "How should Government spend money for services to private individuals rendered by private institutions and practitioners?" There are two major alternatives. The Government can work through the privately financed health care system, of which Blue Cross is a part, or around it. The bill as presently written declares it to be the policy of Congress to distribute purchasing power through the system.

Under discussion now is the equally important matter of how the financing system is to be used. It is important that decisions regarding this be reached soon. The bill in its present form is quite complicated from a prepayment and administrative point of view and it must be translated into a program in a little over 1 year. The Department of HEW is aware of this and is now evaluating carefully what steps to take. Private agencies also have given a great deal of thought to the administrative problems involved.

Gradually emerging is the realization that if the private prepayment agencies are to play a full role, one, two or three patterns must emerge. The Government must contract out with one private agency system to perform an intermediary function for the entire given program; or, it must authorize different carriers to develop somewhat different but actuarially equivalent approaches to do the basic job Government wants done, and let the individually aged person decide which pattern and carrier he prefers; such as, under the Federal employee program; or, the Government must designate one carrier as a master carrier under the given program to administer the basic records to which all other approved carriers can have access.

If the bill formulates one benefit program only, such as we see in parts A and B, and many carriers are involved on a regional basis, then, with the amount of out-of-area travel now experienced by the aged, there will be need for a central record. This working record, often called the history record, would determine how many hospital days, for example, were left under the contract. It would be the determining factor in applying deductibles and co-pay or indemnity provisions. Importantly, it would be the source document in the process of utilization review by administrative and medical controls. In other words, it underpins many substantive carrier functions, including some of particular sensitivity to doctors and hospitals. If the administration of this record is not assigned to a private carrier under a given program of benefits, or, in the alternative if individual aged citizens are not allowed to select from equivalent Government-wide programs a given carrier and a given program (so that they

could be followed wherever they travel or become ill), there will be concern among doctors and hospitals that the record will be administered directly by the Government and that many control functions will bypass the carrier and be performed directly by Government.

The language in H.R. 6675 relies on hospital selection to produce one carrier system under part A, and although setting up a strong challenge to the medical profession to provide full service in part B, goes on in the report to urge "area assignments" so that evaluations of carrier effectiveness can be made.

If it is the intent of Congress to encourage the Secretary of HEW to use the capacities and experience of the private financing sector, the language of H.R. 6675 should be evaluated in light of the above discussion. Of primary concern is a viable program that is comprehensible to the aged citizen; workable in the minds of the providers of care; effectively administered and ready to go by July 1, 1966. In examining these issues the Congress might consider a few key matters born of Blue Cross experience administering benefit programs for 60 million citizens.

Administration of health care benefits is complex. Beyond the visible functions of receiving and paying money lies a great deal of important detail and know-how in many areas. These include credit verification to the provider of care that benefits are due under the contract, and to what extent; negotiation and implementation of reimbusement formulas; audit of provider financial records; review of final claims in terms of the contract provisions and in terms of appropriateness of care; studies of cost and use, followed by reports to buyers of prepayment; education of subscribers and information to providers, among many other things. The effectiveness of many of the tasks involved rests on sound relations with providers of care. The work requires personnel who understand not only the techniques of prepayment but, equally important, the health system and who are on the local scene to work within it. Health service is not provided in the same way all over the country and never will be. It is, as all of us know, a personal service which reflects local preferences, varying patterns of financing, varying medical traditions, and differing configurations of institutions.

The various tasks involved need to be well coordinated; they are part of one overall service. To the extent that Government retains some tasks (such as determination of unused benefits and recertifying need for care), and delegates others, there will arise a problem of coordination even within levels such as part A and part B. Relative roles must be developed with this thought in mind.

Coordination among levels is another key matter, particularly if the present benefit pattern of H.R. 6675 is retained. It has been described as a "three-layer cake." In reality, it is three layers from three different cakes. Most senior citizens will be involved in two of the layers and some in all three. A major task lies ahead in coordinating the benefits when an episode of illness cuts across two or three different designs and even philosophies of operation.

A sick man or woman who begins to use care after enactment of this legislation would need detailed instructions in many instances to find his way through the pattern. He would have to understand that he would have responsibility for the first $40 of expense for inpatient hos-

pital care in a "spell of illness," and what the term means; that if he had outpatient diagnostic services his expense would be only $20 each 20 days (a period different from the "spell of illness"), but that if he subsequently entered the same hospital within another 20 days after those tests his normal $40 obligation would become only another $20, unless he was already in the middle of a "spell of illness," in which case he might have no more obligation for either the $20 or the $40—unless while a bed patient in the hospital he used the services of a pathologist, etc. At the same time, he would have to remember that he was obligated for the first $50 of part B physicians' expense in a calendar year (including, here, the services of that pathologist)—unless he had paid part of last year's $50 deductible in the fourth quarter of the year, in which event less than $50 is now required, or unless he is a recipient of old-age assistance in a State which is going to pay that $50 (or less) for him. In considering what to tell his doctor he has already paid as an obligation this year, he will have to distinguish between the $50 deductible portion from last year and the 20 percent copay portion from last year.

Both the elderly beneficiary, and the hospital or nursing home or visiting nurse agency or individual physician he uses would find it impossible to straighten out such complications as these unaided. The elderly beneficiary is easily confused by far simpler benefit programs. Physicians and health institutions lacking a record of all prior use, equally are unable to clarify rights and applicability of contract provisions. Institutions feel peculiarly vulnerable, without certain knowledge, to incurring expense which can easily result in bad debts and uncollectible accounts.

To find the way through such a multilayer program, a coordinated administrative system is needed to function at the local level, closely involved with hospitals and physicians as well as with the elderly persons themselves. Further reference to the complications involved and the need for coordination can be seen in appendix A.

In this appendix we describe a patient who goes through an episode of illness, how the deductible, copay provisions, and others apply, and what the administrative problems attendant to these are.

Keeping track of the record requires that it be kept by the carrier intermediary. Of course, full information of the results of use should be made available to any designated Government agency. But the basic system of recordkeeping needs to be fitted into the process of claims evaluation, reimbursement, and review rather than primarily into the fiscal records of government. The latter can be done with some leisure. The former requires the fast timing of health-benefit delivery, rather than recordkeeping as such. For example, the hospital must know while the patient is in the house, what benefits apply. Under Blue Cross, for example, hospitals know this in a matter of hours or a day or two at most.

In addition to keeping track of use and paying for it, the intermediary must have quick ability to advise the elderly person and his physician. Choices have to be made. Should the patient use more nursing-home days instead of inpatient hospital days? How many of each are available? What is his future need likely to be? Shall the physician devise a plan of home care for his patient and when should it start? The benefits under part A and part B for home care are not now coordinated.

Senator LONG. Mr. Chairman, I would like to make a point of order. We are trying to limit each witness and all succeeding witnesses to 10 minutes this morning and this witness to 15 minutes. I don't mind taking these statements home and reading them either before the witness arrives or read them at night. I don't mind doing homework on this bill because this is an important statement and I certainly would want to study every word of it before we vote on these matters. I will study all of this, but I can read this myself when I am sitting in my own office three times as fast as you can read it verbally. If the witness is not going to summarize this statement, I don't think we can hear this 45-minute statement here.

Mr. McNERNEY. Senator Long, I would be glad to paraphrase the rest. I had intended to stop on page 9 and not read the total statement.

Senator LONG. All right.

Well, suppose you go ahead and read through to page 9.

Frankly, I want to study everything you have got in your statement because you know something about this business, but if we let you run over by 30 minutes——

Mr. McNERNEY. I appreciate that.

Senator LONG. Then the other fellow will feel he is being discriminated against. That is a bad word up here on the Hill these days. [Laughter.]

Mr. McNERNEY. Well, I wouldn't want to be any party to that so I can either paraphrase between now and 9 or stop promptly at page 9.

Senator LONG. Suit yourself.

Senator RIBICOFF. Mr. Chairman, may I parenthetically ask, wouldn't it be wiser having these statements in advance? If we were allowed to take a few minutes to ask those questions that bother us rather than exhausting the whole time hearing a prepared statement, we would all gain by it.

Mr. McNERNEY. Another problem of coordination should be mentioned. There will be many four layers on this cake. Insurance companies, Blue Cross and Blue Shield Plans, and comprehensive plans will certainly be providing supplementary benefits beyond those of parts A and B. Under title XIX, for instance, many State welfare programs will require this. So will union-management negotiations that have already surpassed H.R. 6675 in scope and limits. Both forms of benefit will have to be coordinated to eliminate double coverage and profiteering. Private carriers have worked out principles through which overlap of their benefits can be minimized.

Blue Cross has stated before that it would work with Federal and State Governments in implementing health benefit programs for citizens assisted by Government. Blue Cross is involved, in fact, under the Federal employee program with approximately 3.8 million enrolled; under the dependents of servicemen program in 35 States; and in such welfare programs as MAA, OAA, ADC, AB, and ATPD in 8 States. We feel that the partnership with Government has worked well. The carrier intermediary provides a channel through which the Government can negotiate with hospitals and other providers without direct interference with provision of care and through which hospitals collectively can express their points of view when, for example, matters of quality and quantity seem in conflict. There is room

for appeal by the provider directly to Government over the carrier and room for the Government to express its concern through the carrier rather than directly to the provider. These are highly useful checks and balances given the nature of medical care and its lack of response to direct confrontations.

We will assist in the implementation of H.R. 6675, if requested. Blue Cross plans, like many hospitals, were started by thousands of public servants, many of whom were not professionally involved in health. They were labor leaders, businessmen, educators, legislators who saw a vital need to help their fellow citizens have access to health care. They organized hospitals. They wrote, sponsored, and passed enabling legislation authorizing Blue Cross plans. These laws declared public policy to include the functioning of these plans as a public pool, using some of the principles of insurance, but dedicated to obtaining total community membership.

Blue Cross has the capacity to do a major job for the aged of this Nation. The system, which involves a confederation of 77 Blue Cross nonprofit corporations, can be accommodated easily to serve the aged further. No new program design needs to be invented. The system is on hand and it is working well.

Over 20,000 skilled and experienced personnel are in contact with hospitals and doctors in every corner of the country, tied together by a private wire communication system and many joint operating agreements. These personnel have vast experience in administering the benefits contemplated. There exists a farflung system of local offices ideally suited to effective claim and policy administration.

Subject to direct examination and general surveillance by Government, this system could be charged with responsibility for effective administration of the intent of Congress. It would fit Government into the health care enterprise of the Nation rather than vice versa. It would enable the fine staff of the Department of HEW to discharge its responsibilities through an effective set of working relationships.

Even a limited role to Blue Cross, such as only to pay bills after use of services, audit providers of care, or pass Government directives on to provides, would tend to force the health care enterprise into a role as an adjunct of Government, rather than assisting Government to participate in health care programs.

The Blue Cross record is clear. A large number of highly respected members of the community are associated with it as Board members and a large number of distinguished industries and associations are enrolled. It serves almost every segment of American society and has moved more comprehensively into the areas of utilization, cost, and capital controls than any other major carrier.

It has long been a policy of the Federal Government to employ private services, including those in the health field. Employing qualified services, the Government avoids needless duplication of effort and, importantly, strengthens the services it uses, thus benefiting a much broader population—in this case the under 65 population as well as the elderly.

Blue Cross now serves several million aged well. It integrates them with dignity into the community of which they are a part. And it can expand existing capabilities as needed.

To simplify the essential tasks of coordination, Blue Cross believes that the provisions of H.R. 6675 should be reviewed to facilitate the

meshing of the three layers as much as possible, with regard to benefit periods, deductibles and other underwriting features. Attention should be given to the possibility of leaving certain details, involving neither public policy nor important controls, to the Secretary to be translated into regulation. Health care is changing rapidly and it ought to be possible for the health care agencies to assist the Secretary in timely revisions to fit new facts on how health care is rendered.

In addition, we feel that the bill should clearly specify that the Secretary can contract for the services of an intermediary carrier system, if it be the intent of Congress to use such a system, without regard to geography or other matters that would compromise a full carrier intermediary role. The Secretary's interest should be to obtain, with reasonable dispatch, publicly accountable efficient service susceptible to regulation.

We would like to submit for the record some specific comments regarding points which time has not permitted me to make directly. They follow in the text.

(The balance of Mr. McNerneys' statement which he did not read follows:)

First among these points, is the exclusion of services of hospital-based medical specialists from part A. We feel unequivocally that this exclusion is inherently unsound and highly disruptive of many carefully negotiated local arrangements. We urge strongly that these services be paid for as part of hospital care if billed that way, under part A. Other points covered include: costs of H.R. 6675, deductibles, selected benefit areas, reimbursement and uncovered items of health care.

It has been an honor to have this opportunity to testify before this committee. We are at the disposal of the comimttee for any additional information it may desire.

FURTHER POINTS

The hospital based medical specialists

We have recommended strongly that these services be financed the way they are actually rendered in the hospital and local community: under part A if the hospital actually provides and bills for the services of radiologists, pathologists, anesthesiologists and physiatrists, and under part B if these specialists function independently in private practice and bill for their services directly. There are several substantive reasons for this recommendation.

First, there is the important matter of hospital organization. A major contribution of medicine in the 20th century is the modern hospital. Here, through a structure of discipline, patient care improves and medical science is advanced through research and education. The hospital based specialist is a pivot point of care, research, education, and administration.

The large number of salary and billing arrangements worked out through the hospital is an indication of the need for these specialists to be given institutional rather than concessionaire status, and enough independence to perform their essential scientific and evaluative functions without prejudice.

Second, the patient simply will not understand a different arrangement in an area which traditionally arranges its practice in this

manner. Consider the case of a man aged 66 and wife aged 64. He goes to the hospital under H.R. 6675 and is asked to pay as part of his initial $50 yearly deductible the sum of $40 for the services of a pathologist while his wife under private coverage learns that such work is part of hosptial service and is paid for by Blue Cross in the normal course of events. The financial impact of this man's few days of inpatient care may be that he is asked to pay $40 as a deductible to the hospital, $50 as a deductible for the pathologist whose bill is the first one he receives, and 20 percent of the charges from the radiologist and internist. A total of $90-plus. How will this look to the thousands of elderly citizens who have held on to their Blue Cross and Blue Shield benefits at some sacrifice after retirement because they wanted no part of "welfare" and were proud to be "well covered?"

Third, arrangements between full-time specialists and hospitals vary considerably. They vary by specialty and within specialty by hospital size and geographic area. An exclusion under H.R. 6675 which would omit the costs of specialists now included within hospital cost would clearly be disruptive of the contracts in force although it would not require their revision entirely. To cost out the services which apply to aged persons and not those applying to others is clearly an artificial requirement, however. On the basis of Blue Cross experience, particularly pathology and radiology are often considered to be "hospital services" in the United States and are customarily billed for and paid for that way. Why should H.R. 6675 become a device by which special interests seek an objective which they haven't been able to reach in the private market, with the Federal Government an unwitting accomplice?

Whether removal of these services from being part of hospital care results in an increased total cost for the services as part of health care, there will assuredly be greater cost to aged persons under H.R. 6675 as enacted by the House of Representatives. Certainly the administrative costs of paying individual charges for these services will be substantially greater than if they were considered to be hospital cost under part A when this is the local standard practice.

The cost of the specialist services has been estimated by the Government's actuary to be approximately 4 percent of per diem hospital costs. It can be reinstated in part A without serious effect on the present financing base.

Costs of H.R. 6675

The Blue Cross Association has testified on previous occasions that in our judgment the estimated costs of various proposals for health care of the aged were too low. We believe that the present bill approaches much more nearly an adequate tax and a realistic expense balance. If anything, our experience still indicates that the cost estimates are near or below the minimum we would expect to occur. Primarily, our difference with the actuary in this area now rests on our estimate of the rate of usage of care, which is higher than his.

Deductibles and copay provisions

We have opposed consistently the use of deductibles applied to hospitalization in health care legislation, and do so again. We concur with the insistence in title XIX that welfare programs include provisions for meeting the cost of deductibles that may remain from other

portions of the bill as a liability of the indigent person. There is no substantial evidence that a $40 deductible in each spell of illness will deter admission to in-patient hospital facilities by aged persons, nor that a $20 deductible in a 20-day period for hospital out-patient diagnostic services will retard use of those services. Any limiting effect from such provisions would probably occur in the out-patient diagnostic services, and this seems precisely contrary to the intent of the bill's structure.

Use of a 20-percent copay provision applied to services rendered in the hospital likewise serves to cut cost to the program but not certainly to discourage unneeded use. Because the hospital is the major cost center of an episode of use, copay provisions may place substantial burdens on elderly citizens. Although the truly indigent will have these amounts covered by local government, there may well develop an undesirable tendency among beneficiaries to feel only a minor obligation actually to make the payments intended to be paid by them under this program. Providers also may seek to absorb such bad debts within the pricing and cost structure of the institutions. Encouragement to pay these amounts is in the interest of the whole health care field, and of Government. Since the deductible and copay provisions really fill only the function of a cost-reducing device, we would strongly urge the Secretary to devote early attention to the improvement of the system by eliminating deductibles that apply to institutional aspects of care whether billed for under part A by the institutions or under part B by physicians. If it should be desired to eliminate these deductibles now, as we recommend, without increasing the anticipated cost of part A to be met by payroll tax funds, coverage of in-patient care under part A might be reduced to 30 days per spell of illness and additional in-patient days be added to the voluntary benefits in part B to avoid reducing the total scope of service now proposed to be provided. (Of course, doing so would require an increase in the estimated present cost of the optional program.) Other adjustments in benefits could be explored easily.

Tuberculosis institutions

In 1963, there were approximately 110 TB hospitals (not TB units in general hospitals) which could qualify for reimbursement under part A. The vast majority of these are State institutions which render sound patient care and public health services. As a matter of priority, it might be wise to review whether such assistance to States under part A is really appropriate since the prime focus of that part is to assist individuals to meet their costs rather than to change Federal-State cost patterns in public health.

Rehabilitation centers

We have suggested previously, and wish to state again, that we believe it insufficient to define rehabilitation centers as hospitals or extended care facilities rather than as diagnostic and therapeutic services. We urge a separate definition of these facilities designed particularly to be effective for care of aged persons. Rehabilitation centers serve a vital role in modern comprehensive medical care. This bill should include carefully drawn standards which fit the special characteristics of rehabilitation centers, not simply define them as hospitals which do rehabilitation.

Outpatient hospital services

We are concerned that a grandmother, who goes to a hospital outpatient department for some diagnostic examination of a wart on her elbow, may well be entitled to some benefit for the hospital's services under part A of this bill, but if she breaks her elbow and is treated in the same hospital outpatient department she would not be entitled to full hospital services under part A. The diminution of the value of hospital outpatient diagnostic services by the House-proposed exclusion of diagnostic physicians' services will, hopefully, be corrected; the present proposal is of little value. Use of such facilities during the course of home care has been wisely incorporated into the present version. But there is still no provision for coverage in part A of the emergency accident services provided by the hospital unless they be diagnostic, and coverage under part B is incomplete. The private market values this service highly, in preference to diagnostic services as such. With the accidents to which the elderly are prone, admission from the bill of full hospital outpatient department services for accidental injury is an undersirable oversight. The benefit is not costly, but its absence will cause great misunderstanding and unhappiness.

Reimbursement

To pay for care in extended care facilities or home programs on the basis of audited cost is to undertake something that has been tried rarely as yet in any market. It will be a major task. To do the same thing on a universal basis among hospitals is also ambitious in 1966.

Public interest is twofold: good care and low cost. The providers' concern is also twofold: good care and adequate reimbursement. One of the assets which Blue Cross can bring to the prime administration of H.R. 6675 is its special capacity for serving the dual needs of both parties, striking a professional balance at the myriad points where legitimate interests bump up against each other. The proper demands of the provider must be balanced with the proper demands of the public. The threat to the public interest is not high cost, it is waste. The threat to the providers of health service is not planning or discipline, it is domination. The threat to the public interest is not strong controls, it is poor quality of care. The threat to the providers is not cost reimbursement, it is economic starvation.

The basic concepts of reimbursement to providers on the basis of their cost and of payment to physicians on the basis of reasonable fees or local service contracts are sound. What causes concern at the moment is the question of whether the specifics of the bill are so precise as to require a rigid form determination of "cost," providing reimbursement under some formula such as "the relationship of charges to cost," and who will determine whether a particular institution's costs are "out of line," to use a term which is contained in the report of the House Committee on Ways and Means. There is need for recognition, within the report of action to be taken by the Senate on this bill, of a degree of tolerance to adapt to local differences.

Reimbursement on the basis of a cost-to-charges ratio, which attempts to isolate expense by various classifications of patient, is largely untried and its implications are far from clear. It would be unfortunate if Government settled on a new device which resulted promptly in increasing charges to all the rest of the population before more is

known about this new basis for reimbursement. It is possible that whereas the aged use less ancillary services than younger patients, they might use significantly more nursing time. What provision in the formula measures and then weighs this factor? As a matter of social policy, where would the heaviest burdens fall under class reimbursement—perhaps on young couples starting to raise a family.

Uncovered items of health care

We applaud the granting of an income tax deduction for the cost of health benefits purchased, as well as the cost of total benefits purchased for care of the dependents of aged persons in the private market. This will enable aged persons as well as others to purchase drugs prescribed for use outside institutional settings and encourage purchase of further protection against extended care facility services. This type of experience is needed with both forms of care to permit better evaluation of their insurability.

(Appendix A referred to follows:)

APPENDIX A

CASE EXAMPLE[1] OF BENEFITS AND ADMINISTRATION UNDER H.R. 6675

CASE EXAMPLE

John Q. is aged 74; widowed; lives alone in Chicago; is unemployed; and subsists on OASI pension of $100 monthly; has elected the part B coverage under H.R. 6675; has a married daughter living in Newark, N.J.; has a medical history which includes a longstanding diabetes mellitus, well controlled by daily injections of insulin; but his general physical condition is good.

CHRONOLOGY

Episode

1. July 1, 1966: Becomes eligible for part A and part B benefits under H.R. 6675.

2. July 14, 1966: Visits office of Dr. A, a general practitioner in Chicago, for a physical checkup, which shows no new maladies. Charge: $25, including $8 for a chest X-ray and $3.50 for routine laboratory tests.

3. July 25, 1966: Goes to local drugstore to refill his insulin prescription and buy a new needle and syringe set. Charges: $3.50 for syringe and needles, $14 for 10 vials of insulin, a 100-day supply.

4. August 17, 1966: Visits office of Dr. B, a general dentist, for a regular checkup and treatment of diseased gums. Charges: $18, including $8 for X-rays.

5. November 2, 1966: Suffers mild cerebrovascular accident (stroke) and is taken to hospital C, under the care of Dr. A. He remains hospitalized for 16 days, during which time he regains his ability to speak clearly, and is discharged, under medication, for further physical therapy at home, on November 18, 1966. Charges: $558 by the hospital, including $4 for medications taken home. Also $26 for radiologists' services, $15 for pathologists' services, $24 for physiatrists' services, and $72 for Dr. A's services, each billed separately.

6. November 20, 1966. Local drugstore delivers refill of his insulin prescription and a new needle and syringe set. Charges: $3.50 for syringe and needles, $14 for 10 vials of insulin, a 100-day supply.

7. November 22, 1966: Travels to Newark, N.J., to recuperate and spend holidays with his daughter and her family. Brings with him Dr. A's order for physical therapy and a prescription for additional medication. On arrival he feels ill, and is taken by his daughter to the emergency room of hospital D, where he is seen by an intern and referred to Dr. E, an internist, for an appointment on November 25, 1966. Charges: $7.50 for emergency room, including $1.50 for laboratory tests.

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[1] This case has been developed to illustrate some of the complexities of administering the present provisions of H.R. 6675, and the kind of coordination that could be provided through Blue Cross and Blue Shield to render an effective service to a beneficiary and the various physicians and providers of care with whom he dealt. It has no other purpose. While not at all an unusual history, it is obviously purely fictional.

8. November 25, 1966: Visits office of Dr. E, who telephones Dr. A in Chicago for a report, examines the patient and rewrites the physical therapy order. Charges: $10 for Dr. E's services, plus $2.50 for the telephone call to Dr. A.

9. November 28, 1966: Visits hospital D's physical medicine department. Sees Dr. F, a physiatrist, and begins 3 weeks of daily physical therapy through December 16, 1966: Charges: $10 for Dr. F, $75 for physical therapy by a hospital therapist.

10. December 19, 1966: Visits Dr. E, who writes a new prescription and tells the patient to call only if he feels ill. Goes to pharmacy and has prescription filled. Charges: $10 for Dr. E, and $12 for the medications.

11. January 10, 1967: Suffers another cerebrovascular accident, taken by ambulance to hospital D, treated by intern in emergency room, and admitted for a 15-day period. Charges: $15 for ambulance, $6 for emergency room, $600 for hospitalization, plus $40 for radiologists' services, $20 for pathologists' services, $35 for physiatrists' services, and $80 for Dr. E's services.

12. January 25, 1967: Discharged with partial paralysis and aphasia (loss of speech) to home-care program with 4-week "plan" by Dr. E calling for weekly laboratory tests at hospital D, visits three times weekly by visiting nurse, visits four times weekly by physical therapist, weekly visit with Dr. E, and weekly speech therapy and hydrotherapy at hospital D. Charges: $15 for initial home-care evaluation, $20 for laboratory tests, $60 for VNA visits, $144 for physical therapy visits, $40 for Dr. E's visits, $40 for speech therapy visits, and $30 for hydrotherapy visits.

13. February 22, 1967: Suffers sudden massive cerebrovascular accident. Is taken to hospital D's emergency room by ambulance, and dies shortly after arrival before being admitted—in spite of heroic efforts by Dr. G, who happened to be in the hospital at the time. Charges: $15 for ambulance, $6 for emergency room, $15 for Dr. G, and $4 for emergency medications.

What happens	Part A		Part B		Uncovered
	Deductibles	Covered	Deductibles and co-pay	Covered	
EPISODE					
1. John Q. receives HIB and SHIB cards from SSA.					
2. Dr. A submits claim to local BC-BS[1] office for $25. BC-BS has no history record on John Q. Eligibility query confirms part A and part B benefits. BC-BS informs patient to pay Dr. A $25			$25.00		
3. Outpatient drugs and medical supplies are not covered by the program					$17.50
4. Dental care is not covered by the program					18.00
5. Hospital reports admission to BC-BS, which approves admission for up to 60 days, to be reviewed after 20 days. Upon discharge, BC-BS informs John Q. that $40 is due to the hospital and $47.40 to the 4 physicians involved (including the $25 balance of the $50 deductible). The balance is covered by the program, except for the take-home drugs, for which the hospital is advised to bill the patient directly	$40.00	$514.00	47.40	$89.60	4.00
6. Outpatient drugs and medical supplies are not covered					17.50
7. There is no coverage for an emergency room charge. The hospital notifies the local BC-BS office of the outpatient laboratory charge. BC-BS has a history on John Q., so approves the claim, but since it falls under the $20 deductible on outpatient diagnostic services, BC-BS informs John Q. to pay the hospital the $1.50	1.50				6.00
8. Dr. E notifies BC-BS of the charges. BC-BS disallows the telephone charge, pays Dr. E $8, and informs John Q to pay Dr. E $4.50, including the telephone charge			2.00	8.00	2.50
9. Hospital outpatient physical therapy is not covered under the program. Dr. F notifies BC-BS, which pays him $8 and informs John Q to pay the $2			2.00	8.00	75.00

[1] Blue Cross-Blue Shield.

What happens	Part A		Part B		Uncovered
	Deductibles	Covered	Deductibles and co-pay	Covered	
EPISODE—continued					
10. There is no coverage for outpatient drugs. Dr. E notifies BC-BS of his charge. BC-BS pays him $8 and informs John Q to pay him $2	....	....	$2.00	$8.00	$12.00
11. The emergency room is not covered. The hospital notifies BC-BS of the admission, and is informed that John Q has 44 days of hospital coverage remaining. This is now 1967, with a new part B $50 deductible due, but the $25 paid toward the 1966 deductible on Nov. 2, 1966, counts again in 1967. Therefore, BC-BS pays the doctors and the ambulance service a total of $132, and informs John Q that $58 is still due	....	$600.00	58.00	132.00	6.00
12. The home health agency is operated by Hospital D. BC-BS approves up to 100 "visits." Dr. E's plan calls for 18 visits in 4 weeks. Dr. E notifies BC-BS of his charges. BC-BS pays him $32 and informs John Q of the $8 balance due. More than 20 days have elapsed since the last outpatient diagnostic service was received by John Q at Hospital D, so BC-BS informs him of the $20 owing for the outpatient laboratory tests	$20.00	280.00	8.00	32.00	....
13. The hospital informs BC-BS of the incident. BC-BS approves the ambulance charge, but disallows the emergency room charge and the medications. Dr. G is paid $12, and BC-BS notifies John Q's daughter of the balance of $3 due each to Dr. G and the ambulance service	....	....	6.00	24.00	10.00
Total	61.50	1,403.00	150.40	301.60	168.50

COMMENTS

Episode

1. This case study assumes that John Q is continuously covered by both parts A and B. In fact, a great many people will be moving into and, to a lesser extent, out of a covered status each month, especially with regard to part B. It will be BC-BS's job to account for "spells of illness," calendar years, and the other benefit periods in determining remaining amounts of coverage. This study omits the possibility of title XIX assistance coming into play.

2. Had John Q seen Dr. A in a hospital outpatient department, part A benefits would have come into play for the $11.50 worth of diagnostic tests.

3. If John Q were on a "home health services" plan at this point, as he is later, the syringe and needles would be furnished by the home health agency as a covered item. If he were an inpatient, as he is later, the insulin as well would be furnished by the hospital or extended care facility.

4. X-ray diagnostic tests are covered in the bill, but it is assumed here that routine dental X-rays would not be covered unless they were ordered, taken, or interpreted under the responsibility of a pyhsician.

5. The part B benefits may be determined in part by the fact of an earlier deductible charged to the patient. A way must be devised to allocate the uncovered portion of the part B incurred expenses among multiple providers and physicians (the doctors' bills total $187, while the benefits are only $89.60. Which physicians get how much of this?)

7. The bill excludes hospital emergency room services as such, although certain components would be included under parts A and/or B if they could be billed separately, such as out-patient diagnostic services, services by an intern or resident, and medical supplies. The medications, administrative overhead, and nursing services are clearly uncovered. While hospital outpatient diagnostic service expenses before an admission count toward the deductible, identical expenses after an admission start a new deductible. The amounts to be accounted for can be very small indeed, $1.50 in this case.

8. The telephone call would be covered as a part of "reasonable cost" if it were made by a contracting provider.

9. If John Q had been on a "home health services" program, the physical therapy would be covered.

10. The assumption is made throughout this case that the physicians have agreed to the fee requirements of the program. If Dr. F were not a participating physician, and if he charged, for example, $15 instead of the agreed-upon $10, John Q would have to pay the whole $15 and get $8 back from BC-BS on the strength of a receipted bill. If this were involved in the $50 deductible, only $10 of the $15 which John Q paid would come into play. All of this underscores the point that the co-pay amounts can be controlled only by having the recipient await notification by BC-BS before making any payment.

12. The assumption has been made throughout that the hospitals have all been participating providers, that the services have not violated the standards of the hospitals' utilization committees, and that the BC-BS claims processing turned up neither bookkeeping errors, improper utilization, nor any other reason to reject all or part of a claim.

13. If John Q had died an hour later, after being admitted, the medications would have been covered under part A.

NOTE.—No comments for 6 and 11 which are self-explanatory.

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

I would like to say I have a very high respect for the Blue Cross Association.

Are there any questions?

Senator RIBICOFF. What are the present administrative costs to run Blue Cross?

Mr. McNERNEY. On a nationwide basis, which includes group and nongroup contracts both, we are slightly under 5 percent.

Senator RIBICOFF. Under 5 percent?

Mr. McNERNEY. Right.

Senator RIBICOFF. What do you think the administrative costs would be to run this program as an intermediary?

Mr. McNERNEY. Senator Ribicoff, this would depend upon what functions were assigned the intermediary as opposed to giving it to the Federal Government or the States.

In Colorado where the plan is an intermediary in regard to some welfare programs the overhead is of the order of 1 or 2 percent. In Texas where we are also the intermediary in regard to a welfare progam, old-age assistance, to be specific, it is 3 pecent. I would say that it is a function of the number of tasks we are given by Government—but it could vary anywhere from 1 to 2 percent up to about 3 or 4 percent.

Senator RIBICOFF. How many carriers are there presently in the United States who are capable of being intermediaries, excluding yourself or including yourself?

Mr. McNERNEY. Well, within Blue Cross, we have 77 plans throughout the country which are the products of permissive legislation at the State level. All are nonprofit corporations. All are accustomed to paying reimbursements or most are accustomed to paying reimbursement costs or charges related to costs.

The number of carriers that are in the commercial field is somewhere between, I should judge, 800 and a thousand. Their qualifications in terms of their pervasiveness and their experience varies considerably, as you know. Some have had no experience in all the States. None has had experience with reimbursement costs. I would find it difficult without the criteria to be established to say how many would be so-called qualified.

Senator RIBICOFF. Thank you, Mr. Chairman.

Senator ANDERSON. I would like to ask a question.

In your statement you have got a statement:

We have opposed consistently the use of deductibles applied to hospitalization in health care legislation, and do so again.

Do I understand you are opposed to the $40 deductible?

Mr. McNERNEY. Yes, Senator Anderson.

Senator ANDERSON. What do you propose in lieu of it in financing?

Mr. McNERNEY. If the $40 deductible were removed from the hospital under part A, then I think our recommendation would be to lower the number of days.

Senator ANDERSON. To what, 30 days, for example?

Mr. McNERNEY. Thirty or forty days, whatever the actuarial equivalent would be.

Senator ANDERSON. Does your experience show that is better for the average poor family?

Mr. McNERNEY. Our experience has shown that a $40 deductible when it is in harness——

Senator ANDERSON. When it is in what?

Mr. McNERNEY. With a $50 deductible under the medical side and a 20-percent co-pay—when you go to the hospital you not only have to pay the hospital but you at the same time incur doctor's expenses—that the harnessing of both of these might add up to a bill of, say, $90 or $100, and that is quite an appreciable hurdle for many aged families.

Senator ANDERSON. Well, just a second now. I don't have my figures with me at the moment, but is it your testimony that you think when a man goes to a hospital at age past 65 his average bill is $90?

Mr. McNERNEY. No. I am saying that under part A——

Senator ANDERSON. What is it, do you think?

Mr. McNERNEY. His average bill, as an aged person might be of the order of $300 or $400.

Senator ANDERSON. It is at least $230 a year according to the figures of the Department of Health, Education, and Welfare for a single person who has medical costs and doesn't go to a hospital. But if he goes to a hospital the average costs are over a thousand dollars.

What are we talking about when we say $90?

Mr. McNERNEY. I am saying under part A, a deductible of $40 would have to be paid.

Senator ANDERSON. Yes.

Mr. McNERNEY. Since he would also have a doctor under part B, he would, say, pay a deductible of $50. The sum of those two would be $90. In addition to that there would be 20 percent of the costs of the physician under part B, so it would be $90 or more that he would have to take out of his pocket when he was hospitalized under many conditions in this bill, and we feel that that is quite an amount of money for several aged individuals or families to pay.

And I agree with you wholeheartedly that it is the hospital that is the occasion of major illness. That is to say when hospitalization is involved, ordinarily the expenses are very, very high for aged families, and it is that part that I think the aged citizen and his family need the most help in.

If there is any one episode that requires the focus of the Government, it is that which involves hospitalization.

Senator ANDERSON. I am only trying to find out whether you believe we should worry about these hospital bills or the doctor bills, and some people think that hospital bills are larger than the average doctor bills.

Mr. McNERNEY. There is no question they are.

Senator ANDERSON. Some people think when people go to a hospital when they are past 65, the average costs of a person is about a thousand dollars or more. If they don't go to the hospital it is about $200 and it is that very large jump we are trying to take care of, and is your organization opposed to that?

Mr. McNERNEY. No. We are very much for full payment of the hospital bill.

Senator ANDERSON. What does that do to the program from the cost standpoint?

Mr. McNERNEY. If the deductible were removed from part A, it would mean you would have to lower the number of days or lower some other benefits. What would happen is that a larger number of citizens would benefit from this and our feeling would be that the few that were above the 30 days, if you brought it down to 30 days or 40 days, if they were really destitute would benefit from title 19.

Senator ANDERSON. As you know, this was a matter of great discussion in the past 2 or 3 years.

Mr. McNERNEY. Yes.

Senator ANDERSON. And there were three plans, one to have no deductible at all and 45 days, one to have a reasonable deductible and 90 days, and one to have 180 days and a slightly larger deductible. Now people who are very skilled in this business, and have had long experience in it favor the provisions in now for deductible. The Bureau of the Budget strongly favors it. I just wonder what your experience has been that qualified you to say it is the wrong approach?

Mr. McNERNEY. I think that our service to approximately 60 million people in this country makes Blue Cross one of the largest and most experienced carriers, and some 89 percent of our contracts are free of deductibles or copay provisions in the hospital, and I think the fact that the American public in such large numbers has brought these contracts and put such emphasis on covering the hospital fully is a significant event in the sense of the first dollar coverage.

This is a matter of benefit design which is a complicated situation. We are not trying to reduce benefits to the aged. We are trying to simplify them, make them more understandable, easier to put together.

One of the merits of not having deductibles in the hospital is that it removes another administrative application that has to be made in determining the aged persons eligibility.

Now the outpatient deductible is a particularly complicated arrangement. There it is a $20 deductible every 20 days, which if it happens within 20 days of admission to the hospital reduces the hospital deductible. You have three administrative steps to take, none of which will reduce utilization, all of which are primarily rate factors, that is to keep the rate down. I think we would feel better to pay those first dollars, to reduce the administrative complication, to make it clearer to the patient what his rights are, and then if someone, after 30 days, finds himself in a very difficult position, and this will be relatively few aged, he will then have recourse to title 19 for which he can become eligible by virtue of medical expenses.

Senator ANDERSON. Isn't it true that a great many of your plans, three-fifths of them or more, have dollar limits and coinsurance?

Mr. MCNERNEY. Three-fifths of our plans use these devices in one or more contracts, but they are very low volume contracts.

For example—in other words, the fact that a plan uses a deductible or copay means not that they use it all the time, but that they use it some of the time. The most significant figure is that almost 90 percent of our total contracts are without these provisions, and we have found that the public finds this a more attractive and more comprehensible type contract.

Senator ANDERSON. Does the national Blue Cross Association have public representation on its board of directors or does it merely represent the Blue Cross plans?

Mr. MCNERNEY. The Blue Cross plans across the country have approximately 58 percent of their members, what I would call public representatives. These are men who are not employed by hospitals, and these are not doctors.

Senator ANDERSON. The question is does the national Blue Cross Association have public members on its board?

Mr. MCNERNEY. Excuse me, the association has a board comprised of men who operate the plans.

Senator ANDERSON. But no public representatives?

Mr. MCNERNY. No public representation.

Senator ANDERSON. Has New York State been considering legislation to give the general public stronger representation on the board of directors?

Mr. MCNERNEY. The State of New York is now considering some legislation to increase the amount of public representation on the Blue Cross board. I might say this, Senator, that over the past 10 and 20 years there has been a marked shift around the country with or without legislation, toward greater public representation on the Blue Cross board, and you can see that shift. More public, fewer hospital employees or doctors.

Senator ANDERSON. I was particularly attracted by your testimony here when you say how awful a puzzle it is to understand the language of the bill.

Have you language to replace that?

Mr. MCNERNEY. I would be prepared, if you would like it, Senator, to write you or to the chairman of the committee regarding some suggestions that we think would be helpful in this regard.

Senator ANDERSON. I wish you would write the chairman, but it sounds to me as if you are trying to say "This is so complicated let Blue Cross have it. We will administer it."

(In lieu of the information requested the following letter was submitted on May 17:)

BLUE CROSS ASSOCIATION,
Chicago, Ill., May 17, 1965.

MRS. ELIZABETH B. SPRINGER,
Chief Clerk, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MRS. SPRINGER: On behalf of the Blue Cross Association, I want to express appreciation for your having extended the time within which the association could submit additional information for incorporation in the record of the hearings on H.R. 6675. Due to unavoidable complications, it has not been possible to get the information together up to this time. In view of your already

generous indulgence, we do not ask or expect you to hold the record open any longer.

Yours very truly,

BARRON K. GRIER, *Blue Cross Association.*

Mr. McNERNEY. I am trying to say this: that our experience in programs in the private sector where there is a basic coverage of, say, the hospital and the doctor, and then a supplemental program such as under Federal employees, and perhaps a complementary program beyond that that the individual person takes out, that this is an administrative situation with which the person needs help. It is very difficult for the individual citizen to understand or appreciate his rights without that help.

I am not being critical of what the Government is trying to do here. I am simply underscoring the fact that if the Government wants to serve the aged citizen well and minimize his misunderstanding and maximize the cooperation of the providers of care who have to render the care, a strong intermediary mechanism is needed.

If you fragment that job in the middle ground too much, there will not only be a falling apart of help to the individual citizen, but there will be a large coordination job between, let's say, the Government, the intermediary, and the provided, and it is in that helpful vein that I make these remarks.

Senator ANDERSON. Did you take that same position toward the King-Anderson bill as originally introduced?

Mr. McNERNEY. From the beginning in testifying before the Ways and Means Committee and the Senate Finance Committee Blue Cross has taken two or three fundamental positions.

One, the aged need help.

Two, that we are interested in talking about playing an intermediary role. I think the main conflict we had with H.R. 1, Senator, was that we, first of all, felt there was insufficient money to pay for the benefits. That being the case, we recommended that payment be made with reference to scaled income rather than all getting the same amount.

But the House has seen fit under one of these programs, namely the part A, to make it on the basis of entitlement. That was about the main point on which there was a difference.

Senator ANDERSON. I find this language and this is all I am worried about—

to find a way through such a multilayer program a coordinated administrative system is needed to function at the local level closely involved with hospitals and physicians as well as with the elderly patients themselves.

That is a recommendation for Blue Cross.

Mr. McNERNEY. I think Blue Cross can serve a very useful purpose.

Senator ANDERSON. They recommend themselves in the situation. I can understand that. But I don't think they need to tear the bill to pieces to recommend themselves.

Mr. McNERNEY. I would recommend no changes in this bill, Senator, that didn't make it a better bill for the aged citizen or for the providers of care.

Senator ANDERSON. The AMA takes that same position, doesn't it?

Mr. McNERNEY. The AMA's position has been very difficult for me to identify, but I think not.

Senator ANDERSON. All right.

The CHAIRMAN. Any further questions?

Senator BENNETT. Mr. Chairman, may I ask just one.

Senator Anderson raised a question of the average cost of hospital care for the aged, and you have told us how many million of aged patients your program has served.

Can you give this committee a figure which would show the average cost of care for the aged under the program that you have been operating? Is your statistical information in such form that you can tell us how many of the 2½ million aged that you claim to have served, have actually represented a certain number of days in the hospital and a certain number of dollars cost per service?

Mr. McNERNEY. I can't give you off the top of my head, Senator, the exact——

Senator BENNETT. I didn't expect that.

Mr. McNERNEY. Let me just say this and it might be helpful. We have 5.6 million aged persons enrolled.

Senator BENNETT. That is right.

But how many have——

Mr. McNERNEY. Their admission rate to the hospital is about 14 to 17 percent higher than the under 65. Their length of stay is apt to be almost twice as much and the product of the two means that they get about two and a half to three times as much care as the under 65.

Senator BENNETT. But you are evading the specific point I want to get at.

Senator ANDERSON. Can he comment on a figure I will put in the record? The Department of Health, Education, and Welfare in 1963 made a survey of what happened in 1962 and they said that aged couples who didn't receive free care provided by Government or other agencies without charge had average medical costs of $442.

Couples in which one or both were hospitalized the average cost was $1,220. If one or both were not hospitalized, $233. It is the hospital that causes the trouble.

Mr. McNERNEY. Precisely. I agree with you.

Senator BENNETT. I raised the question to find out whether your experience verifies the estimate of HEW or whether your experience in serving more than a million of these aged people would turn up a different set of figures? I don't know of any agency that should have access to more accurate experience.

Mr. McNERNEY. All right. I think I understand your question. Our experience would substantiate those data, and we have looked hard at the cost estimates of the Government under this program, and the utilization estimates, and find that we are substantially in agreement with the estimates now under this bill of both costs and utilization.

There are some minor differences, but they are ones that I don't think are worthy of discussion. I mean they are close.

Senator BENNETT. Thank you.

Senator ANDERSON. Mr. Chairman, that is exactly why I think Blue Cross has done a good job in this field. Because when a man goes to pay a doctor bill he is able to pay that himself. When he gets involved in a hospital, and all the charges that come along, then he does lack the services of an extra agency and I think that is where Blue Cross has done a fine job.

Mr. McNERNEY. Thank you. We are very proud of it.

The CHAIRMAN. Thank you, Mr. McNerney.

The next witness is Mr. Blue Carstenson, of the National Farmers Union. Take a seat.

STATEMENT OF BLUE CARSTENSON, DIRECTOR, SENIOR MEMBER COUNCIL, NATIONAL FARMERS UNION

Mr. Carstenson. My name is Blue Carstenson, director of the Senior Member Council of the National Farmers Union.

Mr. Chairman and members of the committee, I would like to submit the entire text of my staement for the record, and just comment on a few major items in the testimony.

The Chairman. Without objection it will be inserted.

Mr. Carstenson. We are happy, incidentally, to find ourselves in so much agreement with the former witness on so many of the things, even though a few matters are things we do disagree on, but for the moment, for the most part we are in agreement with the statement of Blue Cross.

We have had a very large health insurance plan; we have insured many older people. We know that it is a losing proposition. We have been paying something like $2.13 for every single dollar premium brought in by these older members of the Farmers Union who participate in our health insurance program.

Senator Bennett. I notice you base that figure on people over 70.

Mr. Carstenson. Yes.

Senator Bennett. Well, this is a program for people over 65. What is your figure?

Mr. Carstenson. I can get that for you. We didn't have it at the time.

I called our actuaries to pull the breakdown on it. If you would like I will submit it for the record. We do have the figure that on the whole group over 65 that we were losing, last year, $75,000 on the premiums.

Now, we didn't increase the premiums because they become older. We keep the same premium rate, and so this gives you an idea, we don't cut down the policy. It just simply means it costs a lot more to service these older policyholders.

I agree with the Blue Cross witness that this is a major problem of income for the older person and I would like to spend just a moment or two on that because nearly one-fourth of the people who are still working over age 65 are farmers, and nearly—one-fifth, and they constitute a sizable proportion of those people who still must work, and we are convinced that the main reason is income.

We feel that just as when the original social security bill was passed, which helped many people in the cities to retire, and similarly when social security was broadened to encompass the farmer, many farmers began to retire early, we think that the medicare bill, the Mills medicare bill, will also increase the number of farmers who are able to retire.

However, even with the medicare bill there are still a large number of farmers and farm families, who will not be able to retire, who would like to retire, if their income was adequate.

I think we have come to the point where we really can no longer afford large numbers of the aged to be in the competitive labor force

or in farming. Goodness knows we are having a problem now of overproduction in the farm field and perhaps a major increase in social security cash benefits along with medicare would do much to help many farmers retire and hence alleviate some of the problem.

After all, the average age of the farmer is 57, and we have many, many farmers in their 70's and late 80's, who are still continuing to farm primarily because they simply don't have the money or the insurance necessary to retire.

Senator BENNETT. Do you think, if the farmers retire, the land also will be retired or will a younger farmer take it up and continue the overproduction?

Mr. CARSTENSON. Well, part of this will be true. We do have to have other programs that will help to take care of this situation.

I thing also that it has been proved over the last few years that there is a public mandate. This issue has been discussed more than probably any other issue in depth in terms of the White House Conference on Aging; in terms of the public debate; and in terms of the political arena, and I think a recent poll would show that two-thirds of the public were still in favor of medicare despite the millions that have been spent to prove, to the contrary, that the American public still very strongly want the medicare bill.

I indicate in here a number of facts and statistics that I think you may find interesting and useful concerning the economic conditions of older people, and the health-care conditions. It reminds me a little bit of the statistician who couldn't swim and he found himself one day on the edge of a swimming pool with an average depth of 3 feet. He went in and thought he was safe and they found him drowned at the 10-foot level. The average was 3 feet. I think this is what is happening to a lot of older people.

We talk about averages; we talk about the means; we talk about the level, but we have to remember that there are many people below that average who are in a sense drowning and we have many cases which have been submitted in the House testimony about older people who are in serious difficulty because of inability to cope with the medical expenses.

Skipping on over, there is, I think, some pertinent information concerning farmers and why they need medicare even more than city people—less medical attention; smaller private insurance; less cash incomes; less cash savings; and so forth. I think that information is fairly clear.

The resources are also shown as being really inadequate to cope with the medical care problems.

We have very specific recommendations on health care. I would like to join in the feeling about the deductible. We think that it should be as low, or eliminated, as possible. We do support in general the Mills medicare bill. We see it as an improvement, and we would like to say at this point that, speaking for our own insurance company and we have been in contact with several other companies, who have been pro-medicare, that we would be interested in helping and trying to work out on the voluntary portion of the program.

We do feel that the home health services will be particularly valuable in rural communities. Most rural communities today simply don't have them and the reason they don't have them is the inability to cope with the problem of the older person in rural areas.

I know, I set one up in Stockton, Calif., and we couldn't go out into the rural areas, simply because there were no means available to finance the home health services. We feel that the deductible under the diagnostic services is very important and we urge that it be kept, and we think they are a very important thing. We think that perhaps a little bit of flexibility might be put into that deductible or into the deductible concerning diagnostic services because we feel that it might be possible to actually save the Government money by having more frequent annual checkups and we would like to see the Secretary given the authority to do some experimenting in this area.

We do feel very strongly that the drugs should be left out of the program. This is the out-of-hospital drugs. There is just too much room for excess profits, too little control over out-of-the-hospital drugs, and we did spend quite a bit of time with members of the House committee in explaining why this portion should be dropped and we are very happy that they did drop out the drugs because even though it is needed, unless the committee is willing to put in the safeguards and the controls to insure that there is no excess profits, we think it would be a very dangerous waste of the Public Treasury to finance something where you don't have any control over the profits.

Incidentally, we do have the language in case you are interested in putting the drug program in, the language which would safeguard the Treasury and would help curtail the excess profits.

We do feel very strongly in the long haul we are going to have to go after basic social security. We have seen the incomes of older people are completely inadequate. By anybody's measure they are below the poverty line, the average, and this means more than half, probably two-thirds are living below or on a marginal budget, and we think that we, being a very wealthy country, should be able to do a little bit better than we are today in coping with this problem.

It surprised me a little bit to see that we are doing just about the same on social security as the country of Panama and that 22 countries are doing much better than we, a number of countries doing twice as much in the area of social security.

Finally, I want to take this opportunity to congratulate a number of people, including the Senator from New Mexico, and Congressman Mills, for their long fight on behalf of older people, and I tell you that they are deeply appreciative of the efforts you have made in developing the medicare and the bill that has come out of the House of Representatives.

(The prepared statement of Mr. Carstenson follows:)

STATEMENT OF THE NATIONAL FARMERS UNION BY BLUE CARSTENSON, DIRECTOR, SENIOR MEMBER COUNCIL, NATIONAL FARMERS UNION

HEALTH CARE AND SOCIAL SECURITY LEGISLATION

NFU's concern

The National Farmers Union represents nearly three-fourth million farm people. The age of our average farmer is 57. The Farmers Union is and has been deeply concerned about health care of the aged for many years. Our records show that the Farmers Union held its first leadership conference on health care for older people back in 1946. Long before this, however, the Farmers Union has been concerned about health. In the 1930's the Farmers Union set up community cooperative hospitals and health clinics. Today the

Farmers Union has its own health insurance plan through NFU Property & Casualty Co., licensed in 22 States with $11.7 million a year in premiums.

NFU has a good health insurance plan for our members. We know what good hospital insurance costs for older people. We know that good hospital insurance for older people is not a paying operation. On our older policyholders of 70 years of age we pay out $2.13 for each $1 premium collected. On this basis we cannot afford to take on any new policyholders after age 65. Last year NFU insurances had a loss of approximately $75,000 on our senior policyholders. Unless we were willing to give these people an inferior policy or more than double the rates, private health insurance for older people is and will increasingly be a losing business.

Overproduction of farm products and early retirement

One-fifth of the active farmers are over age 65. Over one-fourth of all people over age 65 who continued to work are still farmers. Yet farmers only constitute 6 percent of the labor force. It would seem that the average farmer still is working long after his city cousin has retired. Of course, the stronger protestant ethic of work is an important factor in keeping people at work in later years. This is compensated for by the generally poor health of the older farmer. We feel that in most cases the decisive factor is the lack of retirement income.

It used to be that farmers used to literally work until they dropped in their tracks. Then came social security for farmers. We were the first farm organization to advocate that farmers be included under social security. Large numbers stopped farming as they became eligible and retired. When the medicare bill passes, we anticipate many older farmers will retire. If social security really began to furnish a decent retirement, there would be plenty of room for the younger generations on the farms, and at least a part of the problems of American agriculture would be solved. Today with neither medicare nor an adequate social security, the older farmers generally do not retire. They get along on their farms even though at a loss in net worth of the farm. Often the younger farmers do not have adequate farmland to farm effectively. An important consideration in solving the problem of overproduction or underconsumption of food and agricultural products is the rate of retirement.

Just as social security was originally used to spur retirement of the factory worker during the depression, so social security should be used as a governmental effort to spur retirement of farmers. If we can get older farmers to want to retire, we can cut the number of farmers without forcing millions of farmers into bankruptcy as has been suggested.

A major program aimed at early and adequate retirement of farmers might well be the key to solving the overproduction problems in agriculture as well as the underconsumption of food of older people in rural America.

During World War II nobody retired except for reasons of extreme ill health. People already retired came back into the labor force in mass. Today if the able-bodied elderly came back into the labor force, it would be a national disaster because of the wide-scale unemployment it would create. We can no longer afford for the aged to be in the competitive labor force or in farming save for national emergency.

A public mandate for medicare

Few times in the course of national politics has an issue been more thoroughly discussed and debated. It was debated officially in every State, in Governors' conferences and in most communities preceding the 1960 White House Conference. The experts have collected data since 1957 on the aged and health and finances. The technical problems hammered out, the congressional testimony now stretches 4 feet on my bookshelf.

It has been tested in the political arena. In the House on 487 separate occasions Congressmen have returned to their districts waving the medicare flag asking to be returned. Only once out of the 487 times has a strong promedicare Congressman been defeated. On the other hand, nearly 100 Congressmen who ran for reelection with the blessing of the doctor politicians are no longer in Congress.

Even after the AMA has wasted an estimated another $7 million during the past 4 months, two-thirds of the public stand resolute in favor of medicare, according to the most recent national poll by Lubell. This is despite the fact that there has been no countereducational propaganda effort in favor of medicare during the same period.

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While nobody relishes it, the senior citizens, labor, and the farmers—and other groups supporting medicare—will, if necessary, take this issue to the ballot box again. We hope that at last the American public can have a good medicare program which they have so clearly indicated to the Congress through conferences, opinion polls, and the ballot box, despite the millions spent by the medical fraternity.

Financial conditions of senior citizens

The U.S. Census Bureau reports income for older people has improved slightly during the past decade, but incomes of this group have not improved as rapidly as for the general population. For the year 1961, in cases of single individuals 65 and over, 45 percent had $1,000 or less per year income, two-thirds had less than $1,500 income per year, three-fourths had less than $2,000 and 1.2 percent had $10,000 or more income per year.

For the year 1961, in cases where families were headed by persons over 65, one-third had less than $900 a year income per person, 40 percent had less than $1,000 a year income per person, two-thirds had $1,750 or less and 1.2 percent had $4,800 or more per year. While the median family, where the head of household was 65 or over, had an income of $3,074 per year, the average income per person was $1,220 per year.

Any way you look at it, two-thirds of the people over 65 are living on a marginal or submarginal budget.

Rising hospital costs

The average length of stay for persons of all ages has decreased but the average cost per day has increased, as well as the average cost per hospital stay.

In 1946 the average length of stay was 9 days, average cost per day $8, and the cost per stay was $85. In 1960 the length of stay was 7½ days, cost per day, $35, cost per stay, $245. Dr. Howard Rusk reported that by August 1963 the cost per stay had risen to $279.

The average cost per patient per day in the American hospital has more than doubled in the last 10 years. In 1945 it was about $10 per day; 1950 it was roughly $15 per day; 1960 about $32 and has actually gone up to $50 per day in certain areas and is moving up to the $60 a day mark in other places.

Hospital costs have increased at a rate faster than any other item in the cost of living, except hospital insurance. While overall medical care prices increased by 17 percent from 1958 to 1963, hospital daily service charges increased nearly 40 percent.

Health care of older people

The National Health Survey and the American Hospital Association agree that people 65 and over are hospitalized nearly twice as often as younger people. The population under the age 65 has an average of 75 admissions per thousand persons per year (excluding maternity cases). Persons age 65 and over had 121 admissions per thousand persons per year.

The aged stay nearly three times as many days in the hospital as do younger people. Persons under 65 years of age average 833 days of hospital care per thousand persons per year—those over 65 average 2,333 days per thousand persons per year.

During 1959, 12 percent of the aged were hospitalized as compared with only 7½ percent in the younger groups.

When they go to the hospital, the National Health Survey shows older people stay about twice as long. Most of the hospitalized aged (82 percent) stay less than 1 month, 6 percent stay more than 2 months, and only 2½ percent stay more than 3 months.

The average duration of hospitalization per aged person is 21.2 days.

Older people are twice as likely to have chronic conditions as younger people. The average aged persons is incapacitated for 5 weeks a year and must spend 2 of these weeks in bed because of these conditions.

Percentage of aging with one or more chronic conditions: Two-fifths of the people under age 65, four-fifths of the people over age 65, 84 percent of the people over age 75.

The proportion of the aged with one or more chronic conditions that limits activities, one-fifth of the people under age 65, one-half of the people over age 65.

Older people have five times as much chronic illness as younger people.

One-third of the persons in mental hospitals are over 65. One-fourth of all first admissions in mental hospitals are persons over age 65.

Many of these elderly people who are in mental hospitals should not be there at all, but are sent to these institutions as the only places they can get free care.

One out of every four persons over age 65 has an accident every year. Twice as many as younger people.

Persons over 65 had 6.8 physician's visits per year as compared with 4.8 visits for younger people.

Nine out of ten people over 65 can expect to be hospitalized once during their retirement, two out of three aged persons at least twice, and one-third at least three or more times.

Cost of health care

When an older person goes to the hospital he must expect to spend at least $700.

For the 300,000 aged who must be in the hospital more than 30 days each year, the average individual bill runs well over $1,000.

The aged spend $42 a year for drugs compared to $18 for younger people. These figures from the National Health Survey are conservative and would be increased by at least one-fourth if the survey had included the aged who died during the year.

Twenty percent of all expenditures made for personal health services in 1961 were for the care of the aged, who constitute 9 percent of the population in the United States. Twenty-eight percent of the $5.4 billion spent on the care of the aged came from public sources. Only 20 percent of the money for the care of people under age 65 came from public sources.

Under our present system, one-third of the people who are forced to accept old-age assistance do so because of inability to otherwise handle medical care costs. Nine out of ten of these people never leave welfare.

Several checks of bankruptcies of individuals indicate unpaid hospital bills as a major factor.

While over 90 percent of the aged on social security who went to the hospital paid some portion of their hospital bill out of their own resources, only 60 percent of the couples and 40 percent of the single people indicated that they paid all of their hospital bills from their own resources, including income, savings, and hospital insurance.

One-fifth of the aged couples with one member hospitalized and 12 percent of single persons hospitalized each year have a long-term debt resulting from their hospitalization.

Eighteen percent of the couples and 35 percent of the single persons hospitalized had been aided with their hospital bills by relatives. The amount of the bills average $230, with 9 percent of the cases amounting to over $1,000.

Since the aged have less income they are likely to have more untreated symptoms. A Michigan study shows that 45 percent of the persons of all ages with less than $1,000 income had untreated symptoms, while only 10 percent of the people with over $5,000 income had untreated symptoms. In Boston among people 65 and over there were twice as many untreated symptoms in the lower economic groups as the upper economic group.

The National Health Survey and the social security studies show that 14 percent of the persons on social security who had hospital insurance were hospitalized, while only between 8 and 9 percent on social security without hospital insurance were hospitalized.

There are at least 10 reasons why farm families need medicare even more than their urban cousins

1. Older people living on farms or in small rural towns have more disabling chronic ailments and longer lasting illnesses than do elderly town folk. Yet they receive less medical attention. They see doctors less frequently and get less hospital care than the people over 65 who live in cities.

2. Older farmers and their families have even less private health insurance than the aged living in urban areas. And the hospital insurance a farmer has is poorer in quality, more expensive, and pays even less of the hospital bill than the insurance available to older city dwellers.

3. Older farm families have even smaller cash incomes than do older city families. For every $4 received by an aged nonfarm family, the farm family has

only $3. People 65 and over living in farm areas had a median income of $740 a year in 1960.

4. Older farm families have special difficulty in building up cash savings to meet hospital bills. And on retirement, most of their assets are likely to be tied up in the farm. A serious illness can wipe out an older farmer's cash resources even quicker than those of his city brother. Many hospitals want payment before you leave the hospital.

5. Medical expenses take an even bigger chunk out of the low incomes of older farm families than of older city families, leaving less money to buy other necessities. Younger farm families have only about half the income of younger city families and are therefore at a serious disadvantage in paying for health care of the older relatives.

6. The average age of farmers is 57. In rural America, the proportion of residents who are over age 65—and who would therefore automatically be eligible for medicare—is higher than in big cities. In many small towns, one person out of every five is past 65.

7. Because older people in rural areas don't have as much money to pay for the hospital care they need, many rural hospitals run into serious financial difficulties. Medicare would assure older people of the hospital care they need and hospitals of continuing financial support. Sixty-seven farm counties do not even have a doctor of any description. A primo reason: no hospital facilities available.

8. The Kerr-Mills program of medical assistance for the aged has not been put into effect in many States—States with especially high proportions of their elderly living in rural areas. In most predominantly rural States, Kerr-Mills is nonexistent or is simply a token program. This means that farm people pay Federal taxes for this program even though their older residents can't hope to benefit.

9. And wherever Kerr-Mills operates, it requires proof that the old person is medically indigent—investigation of his resources and usually of his relatives, too. Such a program is especially distasteful to the retired farmer and his children. Many will go without the medical care they need before taking a "pauper's oath" at the welfare department.

10. The Kerr-Mills medical welfare program adds to the already crushing burden of property and sales taxes at the State and local levels. These taxes are disproportionately hard on the retired farmer, all retired people, and the small family farmer.

Resources of retired farmer inadequate

Average per capita incomes in rural areas are less than half those of urban areas. Cash assets are relatively low, and rural homes of the aged are mostly substandard, as measured by safety, convenience, and protection aaginst hazards to health.

The accumulation of substantial cash reserves is not a characteristic of the average farmer. As a rule, his net worth consists largely of investments (or equity) in his farm, livestock, and equipment. He relies on his property rather than on life insurance to provide an income to his widow.

Many surveys in the United States, however, indicate that the average farmer owns too little property to provide self-support in old age for himself and his wife or his widow.

Recommendations on health care

We support the Mills medicare bill. It is not perfect but a great improvement over the King-Anderson bill.

We would like to see the number of days of hospital and nursing home care extended as under the King-Anderson bill.

We think it might be somewhat better and easier and somewhat more beneficial to the people if the raidologists' and other doctors' fees which were shifted to the physicians' insurance plan were to be shifted back to the hospital plan.

We feel that home health services are one of the most essential features of the entire bill. Most rural communities cannot now afford such services, simply because they are in no position to give the free services or the charity services to the older people who cannot afford them.

We feel that any older person, except for religious reasons, who elects to take cash and does not elect the medical insurance option probably is in need of psychiatric services. We urge that the House version be changed so that the individual must elect to take cash rather than elect to take the insurance.

We feel that the diagnostic service will save the program money and we would urge that the deductible for outpatient diagnostic services not be fixed except as a maximum and that the Secretary be allowed to experiment to see if more easily obtained checkups will actually save the overall program money. A study in San Jose, Calif., by the public health and welfare programs showed that they could save vast sums of money in hospital bills by good annual checkups.

We ask that the committee in its report urge the Department of Health, Education, and Welfare to begin work now with the smaller health insurance companies (and also the large companies) to assist them now to develop a pool so as to be able to participate in the out-of-hospital optional insurance plan.

Our recommendations on drugs

The 18 million senior citizens in this country spend nearly a billion dollars a year for drugs and medicines.

While we have long known that older people have roughly 2½ times as much medical costs as younger people, the drug industry and the public laws have a notion that the young family purchases the greatest portion of the drugs. The facts from several recent studies show the exact reverse. Despite their limited incomes, older people spend considerably more for drugs than younger people.

The average individual over 65 spends 3½ times as much on drugs as is spent on the average child.

Twenty-four cents out of every health care dollars for persons over 65 goes for drugs and medicines, compared with 21 cents for persons under 65.

The average person over 65 in the United States spent $42 on drugs and medicines in 1958. The average person under age 65 spent $19 a year. An individual over 65 spends $33 on prescribed drugs, $9 on nonprescribed drugs per year, according to the Health Information Foundation Survey.

The National Health Survey reported that for 1962 roughly one-sixteenth of the people over age 65 spent more than $100 per year on medicines.

One-third, or about 6 million people over age 65, spent more than $50 for medicines, and one-fourth did not spend anything on medicines.

According to a study of retirees in the Detroit-Windsor area—by the University of Michigan—the average older person buys 7½ prescriptions per year with an average cost of about $4 per prescription.

We believe action is needed on drug prices and the Farmers Union has undertaken a private nongovernmental approach to bring prices down by from 20 to 50 percent.

We have studied the problem in great detail. We found that in State after State too many welfare departments are more intent on pleasing the druggists association than in helping the poor. They pay outrageous prices for drugs. Action by this committee is needed to stop the hijacking of the welfare funds.

We can only support the inclusion of out-of-hospital prescription drugs in the medicare program if there are provisions to assure a reasonable cost for the drugs. If there is no way to prohibit exhorbitant profits in drugs, we reject inclusion of out-of-hospital drugs and the drug stamp plan. Unless someone can tell the druggist that he is charging too much, there is too much room in such a program for corruption, graft, kickbacks, percentage rakeoffs, and exhorbitant profits. Proof of this is documented in Senator Phil Hart's subcommittee hearings of last year. We can supply language which will prevent such cheating if the Congress desires it.

Fortunately, drug prices at most hospitals run at a reasonable profit level.

The level of profit sold to hospitals allows for a decent profit and at least a 30-percent increase in research if the drug industry really wanted to show what private research can do. But the profits of drugs sold over the counter are unconscionable profits made in large measure from the poor of this country, particularly the elderly poor.

We, the National Farmers Union, have opened a fight to combat drug prices. Attached is a list of retail drug prices of the more commonly used

geriatric drugs and also the prices which we are currently charging to supply these drugs.

We feel that there are better places to spend our limited public moneys than to spend them in order to provide excessive profits to the giant drug companies.

Recommendations on social security and public welfare cash benefits

While much has been said on hospital and medical care, little has been said about the other amendments which HEW has come up with. I feel that some are good—darned good, especially those relating to social security. We endorse them. The medical assistance amendments are fine. The public welfare amendments fall short. It is time that we radically alter the old-age assistance program.

Let it be said here and now that the cash increases in the Mills bill are little more than the amount necessary to cover the medical insurance cost.

We must still face the fact that the average older person by everybody's standard is far below the poverty level. Until we increase the money going into social security cash benefits by one-third to one-half, we cannot possibly win the war against poverty among the one-third of the poor who are aged. This increase cannot occur through increased social security but, as in the case of the most advanced nations, the increase should come from general reserves. As a nation, we can afford it.

Twenty-two countries already provide more social security benefits than the United States. Eight countries provide twice as much social security benefits as the United States. Even Scotland and Ireland provide better social security than the United States. We are at about the same level as Panama.

We flatly endorse the concept of a "market basket" social security. Social security should provide a minimum standards of living above which people can add their pension programs and savings in order to reach a decent standard of living. As the social security surveys show, most people retired on social security have little or nothing in addition to their social security check upon which to live. Unless we want to assign older people to poverty for all time, we must do something to increase their incomes.

Medicare is the most essential part as it is the problem which worries older people the most and the economic problem for which they can least plan or protect themselves against. The House-passed version will give them an insurance policy worth an estimated $300 to $350 in the private health insurance field, it will help.

However, since few have that kind of insurance, the passage of medicare doesn't mean that each individual will get to keep $300 or $350 because they don't have to buy health insurance or pay all the hospital or medical costs. It should just about bring the average older person to within a couple of hundred dollars of the survival level or, as the Department of Labor puts it, the "economy level."

Our nursing homes financed by public welfare payments reek the smell of poverty of our "old-age assistance recipients." Much of our delapidated housing is supported by the welfare check. Too much of the grief, despondency, and despair in old age is created not by illness but by fear of being forced onto welfare, the level of living provided once they are eligible for public welfare.

In Chicago last year, not far from the offices of the great cattle-buying syndicates, proud old men were found to be living on dog food as they couldn't afford hamburger or bologna. We are glad that Mayor Daley and Governor Kerner have moved to adopt the food stamp program to help 100,000 in Chicago get needed food. We would urge that the food stamp program be mandatory in all communities as a part of the public welfare program.

We urge that a national welfare floor be established for public welfare of about $1,400 for the older single person and at least $1,600 for retired couples, which is roughly the economy level of living set by the Department of Labor minus the benefits provided under medicare.

We support a "market basket" social security and a floor under the public welfare old-age assistance program would be a firm start.

The Farmers Union's Senior Member Council in cooperation with Greenbelt Consumers Co-op announces the opening of **THE SENIOR CITIZEN DIRECT DRUG SERVICE.**

Below are prices on some of the most commonly prescribed geriatric drugs.

The Officially "Established Name" of Drug. Its Strength, Number of Tablets	The Various Brand Names For the Drug	The Company holding this trademark	Price when Doctor Prescribes by Brand Name		Price when Doctor Prescribes by Official Name and filled by Direct Service
			You are Probably Paying	Direct Drug Service Price	
DEXTRO AMPHETAMINE SULFATE (5mg.) # 200	Dexedrine	Smith-Kline-French	$ 7.95	$ 6.90	$1.20
PREDNISONE (5mg.) # 100	Meticorten	Schering	$26.70	$21.95	$2.40
DIGITOXIN (1mg.) # 200	Crystodigin	Lilly	$ 2.70	$ 2.20	$1.20
MEPROBAMATE (400mg.) # 100	Miltown Equanil	Wallace Wyeth	$ 9.90 9.90	$ 7.50 7.50	$5.90
RESERPINE (.25mg.) # 100	Serpasil	Ciba	$ 6.75	$ 5.15	$ .75
PENTAERYTHRITOL TETRANITRATE (10mg.) # 200	Peritrate	Warner-Chilcott	$ 8.30	$ 6.50	$1.40
SECOBARBITAL (1½gr.) # 100	Seconal	Lilly	$ 3.25	$ 2.80	$1.70
OFFICIALLY ESTABLISHED (OR GENERIC) NAME	BRAND NAME	COMPANY	YOU ARE PROBABLY PAYING	DIRECT DRUG SERVICE PRICE FOR BRAND NAME PRODUCT	OUR PRICE FOR THE SAME PRODUCT BUT USING THE GENERIC OR OFFICIAL NAME

ALL PRESCRIPTIONS USING THE OFFICIAL NAMES OF THE DRUGS OR MEDICATIONS WOULD BE FILLED WITH THE HIGHEST QUALITY LEAST EXPENSIVE DRUGS AVAILABLE UNDER THE SPECIFICATIONS ESTABLISHED UNDER THE KEFAUVER-HARRIS LAW.

Any member of National Farmers Union in good standing may use this service by sending their prescriptions to:

DIRECT DRUG SERVICE, 823 UPSHER STREET, N.W., WASHINGTON, D.C.

The drugs and bill will be sent to you in approximately one week.

The CHAIRMAN. Thank you very much.

Any questions?

Senator BENNETT. Mr. Chairman, I am puzzled by one statement in here which the witness skipped in the interest of time.

> **We feel that any older person except for religious reasons who elects to take cash and does not elect the medical insurance option probably is in the need of psychiatric services. We urge that the House version be changed so that the individual must elect to take cash rather than insurance.**

It seems to me that is a complete contradiction in those two sentences.

Mr. CARSTENSON. Well, what we are saying here is, in fact, that I don't see that anyone who really understood the difference between cash and what they could buy in the way of doctor's services and what is offered by the plan would rationally choose to take the cash. The benefits in the Mills medicare bill are so good in the voluntary program that we think that the weight really is on that side. This is the one that makes the most sense economically to older people, and in the Mills bill it says that the person must elect to take the voluntary insurance.

We would rather see it on the other side or at least that they must make the decision. The way it is now if he doesn't do anything he will get the cash. If he forgets or forgets to mail back his card or do anything that is late, he is stuck with the cash rather than the program. We thing the program is so good that we hate to have someone miss out because he mislaid the letter or in some way he wasn't able really to exercise his judgment.

Senator BENNETT. I understand all that.

But that isn't what it says. Your statement says:

We urge the House version be changed so that the individual must elect to take cash——

Mr. CARSTENSON. That is right, yes, right now it is the other way around. They must elect to take the insurance otherwise they get the cash.

Senator ANDERSON. I think about all he means is of the two choices, he would prefer to have the choice, if they didn't announce they would take the cash they automatically would get the insurance.

As it states now if they don't elect they automatically get the cash.

Mr. CARSTENSON. Yes. At least they would have to make a choice one way or the other. That would be a satisfactory arrangement with us that they would have to be forced to check one or the other so that they would be——

Senator BENNETT. But your statement would be much clearer if it said that the bill be changed so that the automatic election is for the insurance.

Mr. CARSTENSON. Thank you.

Senator BENNETT. But as you read this, it sounds as though you are saying first that the individual who takes cash is crazy but he must elect to take cash.

Mr. CARSTENSON. All right.

Senator BENNETT. OK.

The CHAIRMAN. Thank you very much.

Senator ANDERSON. I think that is of useful help to your statement because otherwise it could be interpreted and be turned around the way Senator Bennett has said. He has helped you.

The CHAIRMAN. Thank you.

The next witness is Mr. Mahlon Z. Eubank of the Commerce & Industry Association of New York.

Take a seat, sir, and proceed.

STATEMENT OF MAHLON Z. EUBANK, DIRECTOR, SOCIAL INSURANCE DEPARTMENT, COMMERCE & INDUSTRY ASSOCIATION OF NEW YORK, INC.

Mr. EUBANK. My name is Mahlon Z. Eubank, director of the Social Insurance Department of Commerce & Industry Association of New York, Inc.

Mr. Chairman, due to the lack of time I would like to summarize my statement and put it in the record.

The CHAIRMAN. I would appreciate it if you would.

Mr. EUBANK. On the first point in the bill, the hospital insurance benefits for the aged, part A, the basic plan.

In the past before this committee we have opposed the medical part of the bill. These reasons are still valid.

At this time, recognizing the political realities, these are our comments on this part of the bill:

1. The medical care program under part A of the bill should be amended to cover all individuals 65 and over and not just social security beneficiaries. The payroll tax should provide the funds to pay all such individuals.

2. We call to the attention of the committee that it must be realized that additional tax rates and/or an increase in the tax base could well be necessary in the future to finance this program without any further liberalization.

Commenting particularly on the voluntary supplementary insurance plan covered by part B of the statement, we oppose this part of the bill and it should be eliminated because setting up a voluntary but Government-subsidized private insurance program to cover medical and similar costs for the aged side by side with a compulsory Government medicare program to finance hospital and nursing home care under the Social Security Administration would create complications when both get involved with every patient who runs up hospital and medical bills.

President Johnson in his 1965 health message to Congress urged that private insurance carriers play a major role in providing supplementary benefits over and above the basic plan provided in part A. The supplementary plan provided in part B is contrary to this recommendation.

The supplementary plan puts the Government in the insurance business. This is contrary to the present policy of the Johnson administration, as we understand it, to get the Government out of business.

You might also check and see what the Bureau of the Budget Bulletin No. 60.2 says on this subject.

We fear that enactment of the supplementary plan would be merely a prelude to the Government takeover of health insurance for people under 65. Within the near future individuals under 65 who will be subject to increased payroll and income taxes could demand the same right to buy this insurance on an optional basis and socialized medicine might well result.

Commenting on the change in definition of the term "disability" in the Social Security Disability Act program, section 303 of H.R. 6675, which includes temporary total disability of 6 months' duration as well as permanent total disability now in the law, its purpose, according to the House committee report (p. 88) is to pay benefits to individuals totally disabled for an extended period who can be expected eventually to recover in order to provide them financial independence and not be dependent on public assistance. A worker contracting tuberculosis was given as an example. The new definition of total disability also covers psychiatric cases, confirmed alcoholism, and all other types of illness and injuries of 6 months' duration. There is no limitation.

Section 303 is not an innocuous administrative change. If enacted into law, it will have these undesirable effects:

1. Benefits would duplicate those of other established programs.

First, under this, salary continuation plans financed by the employer.

Many employers finance salary continuation plans for employees who are temporarily totally disabled by non-industry-connected injuries or diseases. Duplication of these benefits with those provided by section 303 of the bill would cause employers difficulty in getting employees back to work when the combined amount received by the employee is near or more than the take-home pay. Existing collective bargaining agreements that provide salary continuation plans would be disrupted and any change in new or renegotiated agreements would seriously interfere with labor-management agreements when employers insist on an offset for social security benefits provided by section 303 of H.R. 6675.

Second, dual benefits of workmen's compensation and those provided by section 303 would generally exceed the take-home pay the disabled worker received as an able-bodied workingman on the job.

To illustrate: The average annual wage for manufacturing workers in New York is around $5,000. Using this figure, the taxable deductions from that wage, with standard deductions, illustrate net wages for a married man with two children, and for a married man with no children. Net pay after taxes would be $4,488 for a married man with two children, and this man getting workmen's compensation and social security disability benefits, and I might say I am very conservative on that figure, would receive total tax-free benefits of $6,201.60 a year.

A married man with no children would have net pay after taxes of $4,238. He would be able under this duplication to receive $4,545.60 a year.

In both instances they would be receiving either more than gross wages or take-home pay. There would be no incentive to return to work as the end of the 6-month waiting period approached, or for medical rehabilitation to eliminate or reduce the disability to the greatest degree possible. When this is done, the individual can return to work or be retrained through vocational rehabilitation within the limits of his disability or to the hilt of his capability. There is no incentive if the individual knows his earnings after he returns to work or is rehabilitated will be less than if he were to remain disabled.

I understand that there has been prior testimony that this duplication is only 2 percent. We have some doubts on this figure, and if you are interested on why we have some doubts, I will be happy to explain it.

Senator ANDERSON. We would be very glad to have you explain your doubts.

Mr. EUBANK. Now or later?

Senator ANDERSON. Now, as far as I am concerned, because the figures are one way, and, if you have something else, where did you get your figures?

Mr. EUBANK. I am reading now from the social security bulletin of April 1965, an article on overlap of benefits under OASDI and other programs by Ida C. Merriam, who is Director of the Division of Research and Statistics, and on page 23, this is what she said:

The area of overlap that has been attracting the most interest recently is actually the smallest in extent, that is the concurrent payment of workmen's compensation cash payments and disability benefits under OASDI. Probably—

and I want to emphasize the word "probably"—

fewer than 3 percent of those getting disability benefits under OASDI also receive workmen's compensation payments.

We have the 3-percent figure.

Senator ANDERSON. No, no; I am sorry. It says less than 3 percent, 2 percent is less.

Mr. EUBANK. Now, this 3 percent figure appears to be based upon this, Senator, "limited"—and I want to emphasize the word "limited"—"information from a 1960 disability survey made by the administration."

In other words, this 2- or 3-percent figure and the reason why we have doubts, is that it was based upon limited information from a 1960 survey, and she goes on further and says:

Clearly, however, it would be desirable to have more information on how many and what kind of individuals and families are affected by this particular overlap. The Social Security Administration has plans for several types of studies bearing on this question.

We don't feel that you are going to know what percentage, we have some doubts, maybe less than 3 percent but when you base it on limited information we feel a real honest-to-goodness survey must be made before you can get an adequate figure.

We base this on another fact that in the testimony you have been given before you, the Secretary said the disability benefits go chiefly to victims of TB, cancer, stroke, and heart ailments and only 2 percent to individuals who are disabled by work-connected injury.

Now in New York, we find out that in TB and in these particular cases the most numerous cases that we have are an aggravation of a preexisting injury as well as those who have an exposure of heat and cold. We have many cases. We have cases on cancer which are compensable under workmen's compensation. We have cases where there has been a stroke of apoplexy, and we have many cases on heart disease. Most of these cases are based on an injury aggravating a preexisting injury.

New York is very liberal on heart cases. A heart injury such as a coronary occlusion when brought on by overexertion or strain in the course of daily work is compensable in New York and we feel if you are going to count all of these people, they are undoubtedly eliminated from their figure of 2 percent. If you have a real honest-to-goodness survey on this you are going to get an accurate figure. I don't believe anybody knows what the overlap is on it at this time.

Going back—do you have any further questions?

Senator ANDERSON. Well, I do have.

If you are going to contradict one man's figure you ought to have something besides the word "probably." I quite agree with you this is a very serious question. It happens I am probably on the same side you are on but I don't try to use some figures that you can't substantiate.

The figure they have used was that one-fourth of all these accidents are very temporary in their nature that of the remaining three-fourths not more than 2 percent are of this general nature and you have a figure of 3 percent.

Mr. EUBANK. That is a 1-percent difference.

Senator ANDERSON. I don't know where you get your arithmetic.

Mr. EUBANK. Yes.

Senator ANDERSON. Two percent of three-fourths is not 1-percent difference, less than 3 percent, because 2 percent is less than 3 percent; isn't it?

Mr. EUBANK. Yes. I agree with you on that. I won't argue with you but I do feel that this 2-percent figure was based upon this very limited study in 1960, and I said I had some doubts as to it. I am not questioning their figure but I certainly have some doubts as to its accuracy.

Senator ANDERSON. Well, the point is there is supposed to be a review of this that is supposed to come in by December 31, 1966. Many of us think it ought to come in much earlier than that and probably could. There are some of us who think it might be well to wait until that survey comes in.

Of course, a decision has to be reached on this very important point.

Mr. EUBANK. I agree it would and I am going to mention that later in my own statement, Senator.

Senator ANDERSON. All right.

Mr. EUBANK. We fear that if this section is enacted, State workmen's compensation programs could be destroyed in the future. An indication of where enactment of these benefits under the social security program might lead is contained in the statement of Dr. Eveline Mabel Burns, a member of the Federal Advisory Council on Employment Security, published in the Journal of the American Public Welfare Association of January 1962, concerning our State system of workmen's compensation which has been successfully developed during the past 50 years.

Here is what she said:

> I would like to see us write off this antiquated fossil among social security programs. Let us instead work for a universal disability insurance program which would cover not merely permanent disability as now, but short-period disability as well.

Now if the present pattern of liberalization of the Social Security Act is continued and Dr. Burns' suggestions are followed, it is almost certain that the 6-month waiting period will be further reduced in the future to a point where a disabled individual now covered under the workmen's compensation law would receive both State workmen's compensation benefits and disability benefits under the social security law.

We feel that this would develop undesirable results. The most important which I will mention here is that the incentive to the safety program could vanish.

We feel there will be harmful effects of duplication and they require study before enactment of section 303.

The Advisory Council on Social Security has suggested a study and the House report has also suggested a similar study. The time to make this study is before enactment and before harm is done to other established programs. It is inconceivable that if section 303 is enacted, Congress would later repeal it. The history of the various amendments to the social security program shows conclusively that the results invariably are the liberalization rather than taking away the

rights of the claimants. I have set out the suggested study from the House report and on that we suggest that the lost earnings referred to in the contemplated study be defined as the amount the beneficiary receives after the deduction of Federal, State, and local income taxes and social security contributions.

The Advisory Council on Social Security should advise the Department and review the study as to its completeness and feasibility. The study should be complete and not made on a small sample as in the 1960 act.

We urge this section 303 be eliminated from the bill until such study.

Another reason for delaying action on changing the definition of the term "disability" is that the additional cost of this disability change was never considered in the financing for disability benefits because it was included in the bill just a few days before it was reported out of the House Ways and Means Committee.

This change with its millions of dollars cost makes the figure for financing OASDI questionable.

It also indicates more tax money might be required to finance disability benefits.

Further study is also necessary to see if the tax formula must be altered to provide additional funds for this proposed change in the definition, and to ascertain if more tax money should be allocated to the disability insurance trust fund.

I thank you for permitting me to be here.

(The prepared statement of Mr. Eubank follows:)

STATEMENT OF THE COMMERCE & INDUSTRY ASSOCIATION OF NEW YORK, INC., PRESENTED BY MAHLON Z. EUBANK, DIRECTOR OF THE SOCIAL INSURANCE DEPARTMENT

Commerce & Industry Association of New York, Inc., the largest service chamber of commerce in the East, represents approximately 3,500 employers, large and small, in all branches of industrial and commercial activity, including many corporations headquartered in New York but engaged in multistate operations. Through its committees on health insurance and on social security, comprised of executives specializing in these fields from leading national business organizations, and its social insurance department, the association studies and actively presents management thinking on the Federal social security program and significant medical issues at both National and State levels.

Commerce & Industry Association appreciates this opportunity to testify before your committee concerning H.R. 6675. Our views on the various subject areas covered by this bill follow.

HOSPITAL INSURANCE BENEFITS FOR THE AGED (PT. A—THE BASIC PLAN)

Part A of H.R. 6675 primarily provides for medical care for those 65 and over under the social security system. Over the last several years, we have opposed similar bills on this subject before this committee, our most recent testimony having been presented on August 14, 1964 (Senate Finance Committee hearings on H.R. 11865, p. 649). The reasons given for our opposition on that date and on prior occasions are still valid. However, the Senate for the first time last year included this type of legislation in amending H.R. 11865 and this year the House for the first time included it in H.R. 6675. At this time, recognizing the political realities, these are our comments on this part of the bill:

1. The medical care program under part A of the bill should be amended to cover all individuals 65 and over and not just social security beneficiaries. The payroll tax should provide the funds to pay all such individuals.

This bill would provide hospital and related benefits under part A to individuals not having the requisite social security coverage who are now 65 or become 65 before 1968. During this period the benefits provided would be financed out of general revenues and not out of the payroll tax.

Not one penny of contributions has been paid for medical care provided in part A by aged people whether or not they are eligible for social security benefits. Need for these benefits exists for those not receiving social security in as great or greater degree as for those receiving old age payments. In fact the apparent intent is to allow such benefits to those in the high income brackets who are social security beneficiaries and deny it after 1967 to those who need it the most.

Those who are not social security beneficiaries are entitled to benefits under part B of this bill if they pay the $3 premium. After 1967 those that do pay the premium would have to pay $50 (deductible) for posthospital home health care services and 20 percent of the cost thereafter. Those receiving social security benefits, however, would pay nothing additional unless there was no prior hospitalization. This again creates an inequity.

Payment of hospital and related benefits under part A out of general revenues for those not covered under social security implies that such individuals are receiving charity, while social security beneficiaries receive such benefits as a matter of right. Since neither has paid a red cent for the benefits to be provided, both groups should have a common test for their entitlement to benefits with the financing by a common method, the payroll tax.

2. The Department of Health, Education, and Welfare during the last few years has underestimated anticipated cost in all bills which provide hospital care under the social security system, including an upward revision for this bill greater than for H.R. 1. This does not reflect on the ability of representatives of the Department of Health, Education, and Welfare but it does point to the uncertainty of predicting such cost, as was noted in our testimony of last August 14. Accordingly, it must be realized that additional tax rates and/or an increase in the tax base could well be necessary in the future to finance this program without any further liberalization.

VOLUNTARY SUPPLEMENTARY INSURANCE PLAN (PT. B)

A complete surprise in H.R. 6675 is the proposed package of benefits supplementing those provided under the basic plan which would be offered to all persons 65 and over on a voluntary basis. It would cover physicians' services, home health services, hospital services in psychiatric institutions, and other medical and health services in and out of institutions. Payment for drugs by those 65 and over, one of the largest expense items, is not included.

Individuals who enroll initially would pay a premium of $3 per month (deducted where possible from social security or railroad retirement benefits). The Government would match this premium with $3 from general revenues. An enrollee under this supplementary plan would receive the benefits provided only after an annual deduction of $50 and the payment by him of 20 percent of the cost of the services. There would be special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment in any calendar year would be limited in effect to $250 or 50 percent of the expenses, whichever is smaller.

The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively, and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service) the cost is reasonable. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services) the carrier must see that such charge is reasonable and not higher than the charge applicable for a comparable service and under comparable circumstances to the other policyholders

and subscribers of the carrier. Payment by the carrier for physicians' services is to be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Adding a supplementary plan (pt. B) on top of the basic plan (pt. A) creates a hydra-headed monster which could become a nightmare. Setting up a voluntary but Government-subsidized private insurance program to cover medical and similar costs for the aged side by side with a compulsory Government medicare program to finance hospital and nursing home care under the Social Security Administration would create complications when both get involved with every patient who runs up hospital and medical bills. A beneficiary covered by both part A and part B could be confused as to his coverage when services of radiologists, anesthesiologists, pathologists, and physiatrists are provided for in the supplementary plan and such services have been paid for them in the past by their private insurance coverage.

Administration of the supplementary plan (pt. B) by the carriers would be most difficult under the terms of this bill. What is reasonable and necessary may be difficult to determine. Is cost, for example, the primary factor or is quality of care to be considered? Does the Department expect the carrier to take up alleged high charges for physicians' services with review and grievance committees of the medical societies without a provision for reimbursable cost? Under the supplementary plan, if the physician charges the beneficiary an amount in excess of the reimbursable charge in the carrier's policy is it the carrier's responsibility to see that the physician does not receive the additional amount? These are just a few of the questions which could arise. The result could be higher premiums for workers under group or individual plans if the Department takes an unrealistic view of what is necessary and a reimbursable amount for administrative costs is too low.

As we read this bill, the supplementary plan covers all workers 65 and over (if they pay the $3 premium) regardless of whether they are still working or covered under the Social Security Act. We are unable to understand the purpose of such wide coverage when under part A, the basic plan, only those entitled to monthly benefits under the social security program and those not covered through 1967 are entitled to the benefits provided.

President Johnson in his 1965 health message to Congress urged that private insurance carriers play a major role in providing supplementary benefits over and above the basic plan provided in part A. The supplementary plan provided in part B is contrary to this recommendation. If the supplementary plan is adopted, there will be little, if any, room left for private health insurance for all those over 65. If such plans are eliminated, beneficiaries could be hurt because private nursing, etc., are provided.

Adoption of the supplementary program in part B could have serious implications for the future of the private voluntary insurance business because the Government for the first time would be offering coverage to a segment of the general public (all those 65 and over) on an optional basis along lines characteristic of the private insurance program to be additionally subsidized from general revenues. The outright invasion of an area of private enterprise and the establishment of a new line of Government business is contrary to the present policy of the Johnson administration of getting Government out of business.

We fear that enactment of the supplementary plan would be merely a prelude to Government takeover of health insurance for people under 65. Within the near future individuals under 65 who will be subject to increased payroll and income taxes could demand the same right to buy this insurance on an optional basis and socialized medicine might well result.

Not enough recognition has been given to the rapid growth and present scope of voluntary insurance for older people. The mass enrollment of individuals in the "65" plans has been phenomenal. These plans have been created by State legislatures to permit insurance companies to operate jointly on a nonprofit basis. Since the existing plans have won such wide public acceptance, the supplementary plan proposed here might lead to adverse consequences. Before the Government moves into this area, the potential economic and social effects should be thoroughly studied and weighed. Alternative measures also might be considered before final conclusions are reached.

Payment for a large part of the program under an optional plan out of general revenues violates the social security principle of receiving a benefit as a matter

of right, financed by payroll taxes. The general revenues approach provided as part of the financing under the supplementary plan makes it much easier to make up underestimates of cost and to provide in the future for costly liberalization.

We urge that the supplementary plan (pt. B) be eliminated from the bill.

CHANGE IN DEFINITION OF THE TERM "DISABILITY" IN THE SOCIAL SECURITY DISABILITY ACT PROGRAM (SEC. 303 OF H.R. 6675)

This bill, reported by the House Ways and Means Committee and passed by the House without public notice and public hearings, changes the definition of the term "disability" in the social security disability act program. Under present law disability insurance benefits are payable only if the workman's disability is expected to result in death or to be of long-continued and indefinite duration. Section 303 would broaden the disability insurance protection afforded by the social security program by providing disability insurance benefits for an insured worker who has been totally disabled for at least 6 calendar months (temporary total cases under workmen's compensation laws) even though it is expected that he will recover in the foreseeable future. The first payment would begin at the end of the sixth month of continuous disability (for that month).

This change was made in the last several days of the meetings of the House Ways and Means Committee before the bill was reported (see Congressional Record, vol. 111, No. 62, Apr. 7, 1965, p. 6977). Its purpose, according to the House committee report (p. 88), is to pay benefits to individuals totally disabled for an extended period who can be expected eventually to recover in order to provide them financial independence and not be dependent on public assistance. A worker contracting tuberculosis was given as an example. The new definition of total disability also covers psychiatric cases, confirmed alcoholism, and all other types of illness and injuries of 6 months' duration. There is no limitation.

Section 303 is not an innocuous administrative change. If enacted into law, it will have these undesirable effects:

1. Benefits would duplicate those of other established programs

(*a*) Salary continuation plans financed by the employer.

Many employers finance salary continuation plans for employees who are temporarily totally disabled by non-industry-connected injuries or diseases. Duplication of these benefits with those provided by section 303 of the bill would cause employers difficulty in getting employees back to work when the combined amount received by the employee is near or more than the take-home pay. Existing collective bargaining agreements that provide salary continuation plans would be disrupted and any change in new or renegotiated agreements would seriously interfere with labor-management agreements when employers insist on an offset for social security benefits provided by section 303 of H.R. 6675.

(*b*) Dual benefits of workmen's compensation and those provided by section 303 would generally exceed the take-home pay the disabled worker received as an able-bodied workingman on the job. To illustrate:

The average annual wage for manufacturing workers in New York is around $5,000. Using this figure, the taxable deductions from that wage, with standard deductions for a married man with two children and for a married man with no children, would be—

	Married man, 2 children	Married man, no children
Gross wage	$5,000	$5,000
Federal income tax	286	497
New York income tax	52	91
Social security tax	174	174
Total	512	762
Net pay after taxes	4,488	4,238

If these individuals, each with wages of $5,000, were to be permanently disabled as under the existing law, or temporarily totally disabled under the proposal in H.R. 6675, these are the amounts each would receive a year:

	Married man—2 children	Married man—no children
State workmen's compensation, $60 a week [1]	$3,120.00	$3,120.00
Social security disability benefits	[2] 3,081.60	[3] 1,425.60
Total tax free benefits	6,201.60	4,545.60

[1] Assume Governor's recommendation to increase maximum benefits for workmen's compensation from $55 to $60 is enacted into law by July 1, 1965 (proposal of Democratic majority is $65): $60×52 weeks=$3,120 a year.
[2] Assume average monthly wage (taxable) of $325—maximum family benefit is $256.80 (see p. 164 of H.R. 6675): 12×$256.80=$3,081.60 a year.
[3] Assume average monthly wage (taxable) of $325—primary benefit is $118.80 (see p. 164 of H.R. 6675) 12×$118.80=$1,425.60 a year.

In both instances they would be receiving either more than gross wages or take-home pay. There would be no incentive to return to work as the end of the 6-month waiting period approached, or for medical rehabilitation to eliminate or reduce the disability to the greatest degree possible. When this is done, the individual can return to work or be retrained through vocational rehabilitation within the limits of his disability or to the hilt of his capability. There is no incentive if the individual knows his earnings after he returns to work or is rehabilitated will be less than if he were to remain disabled.

(c) In the medicare portion of H.R. 6675 (p. 87 of the bill, concerning exclusions from coverage) no payments may be made under either the basic or the voluntary plan where the individual furnished such items or services has no legal obligation to pay or where such item or service is covered under a workmen's compensation law. If the principle of nonduplication of benefits is sound under the medical portion of the bill, it is equally sound in providing disability benefits under the social security system.

2. State workmen's compensation programs could be destroyed

If the amendments in section 303 of H.R. 6675 are enacted into law, individuals of any age now receiving workmen's compensation benefits for temporary total disabilities of 6 months' duration or more would receive disability benefits under the social security program. An indication of where such an enactment might lead is contained in the statement of Dr. Eveline Mabel Burns, a member of the Federal Advisory Council on Employment Security, published in the Journal of the American Public Welfare Association (January 1962 issue), concerning our State system of workmen's compensation which has been successfully developed during the past 50 years:

"I would like to see us write off this antiquated fossil among social security programs. Let us instead work for a universal disability insurance program which would cover not merely permanent disability as now, but short-period disability as well."

If the present pattern of liberalization of the Social Security Act is continued and Dr. Burns' suggestions are followed, it is almost certain that the 6-month waiting period will be further reduced in the future to a point where a disabled individual now covered under the workmen's compensation law would receive both State workmen's compensation benefits and disability benefits under the social security law. As the social security program expands into the area of disability benefits, a Federal program could develop with these results:

(a) Pressure would bring about dropping the present 50-50 basis of cost between employers and employees, with employers assuming the major part or all of the burden. One illustration is the Italian program in which 50 percent of payroll goes for social benefits, with the employer paying 42 percent and the employee 8 percent.

(b) In some countries, notably England, where the workmen's compensation program has been nationalized, the right of the employee to bring suit against the employer at common law has been made available again. Under the State compensation programs the employee gives up his common law rights to sue the employer for any injury received on the job in exchange for a definite amount

of compensation. Should the State programs in this country be superseded by the Federal program, there is every reason to believe that we will return to the chaos, confusion, and suffering that existed under the common law operation.

(*c*) States might be inclined to reduce benefits or repeal their workmen's compensation laws. Such repeal would cause workers to lose their present medical benefits which, by further amendments, Congress could include in medical care provisions as part of their social security disability benefits, all of which adds up to much higher costs.

(*d*) Each employer now pays the cost for industrial accidents and disabilities according to his experience. The cost, if this bill were enacted, would begin with, and eventually fall on, the social security program. Employers without safety programs and those whose employment is hazardous would pay no more than employers who have put in safety programs or have less hazardous employment. This would result because there would be no direct relationship between accidents, cost and premiums. The incentive for safety programs could vanish and the miraculous downswing in losses over the last three decades would be halted if not reversed.

(*e*) Harmful effects of duplication require study before enactment of section 303 of H.R. 6675.

The Advisory Council on Social Security in its report last year made a recommendation for a study by the Department of Health, Education, and Welfare of the significance of overlapping benefits presently under the workmen's compensation laws and the social security disability program (permanent total disabilities). No study has been made but this problem of overlapping has been compounded by including under section 303 individuals who have temporary total disabilities of 6 months' duration. Nevertheless, the report of the House Committee on Ways and Means (p. 90) calls for a similar study to be made by the Department of Health, Education, and Welfare, to be reported back no later than December 31, 1966.

The time to make the study is before enactment and before harm is done to other established programs. It is inconceivable that once section 303 is enacted, Congress later will repeal it. The history of the various amendments to the social security program shows conclusively that the results invariably are the liberalization rather than the taking away of rights of the claimant.

The suggested study would cover these areas:

(1) The number and proportion of beneficiaries under each program who are receiving cash disability benefits under the other program.

(2) The characteristics of persons who receive dual benefits as compared with those who do not.

(3) The extent to which combined payments under the two programs are effective in replacing lost earnings, both currently and for the future.

We suggest that the lost earnings referred to in the contemplated study be defined as the amount the beneficiary receives after the deduction of Federal, State, and local income taxes and social security contributions. The Advisory Council on Social Security should advise the Department and review the study as to its completeness and feasibility.

We urge that that part of section 303 relating to the change of definition of disability be eliminated from H.R. 6675 and that any legislation in this area await the finding of such a survey.

Another reason for delaying action on changing the definition of the term "disability" is that the additional cost of this disability change was never considered in the financing for disability benefits because it was included in the bill just a few days before it was reported out of the House Ways and Means Committee (see Congressional Record, vol. 111, No. 62, Apr. 7, 1965, p. 6977). This change, with its millions of dollars cost, makes the figures for the cost of financing OASDI questionable. It also indicates that more tax money might be required to finance disability benefits. Further study is necessary to see if the tax formula must be altered to provide additional funds for this proposed change in definition and to ascertain if more tax money should be allocated to the disability insurance trust fund.

STRENGTHENING THE KERR-MILLS ACT

On August 14, 1964, this association's representative testified before the Senate Finance Committee and suggested these possible amendments to the Kerr-Mills Act:

1. Eliminate State family responsibility laws, except for the spouse (applicable in 12 States), provided that provisions for recoupment from the estate of the aged individual (after death of the surviving spouse) are strictly enforced.

2. Provide that any statement of a claimant for medical assistance for the aged, if made under oath or affirmation and on such form as may be prescribed by the State agency, shall, insofar as such statement relates to the financial status of such claimant, be presumed to be factually correct for purposes of determining his immediate eligibility for such assistance. Penalties would be provided for any false statements revealed by subsequent audits.

3. Provide the same matching grant for administration cost as now is provided for the cost of medical care.

4. Provide for a single matching formula for medical care for individuals 65 and over, regardless of whether the individual is eligible under the Old-Age Assistance (OAA) or Kerr-Mills Acts (MAA). The present matching formula for public assistance would still be applicable to pay medical expenses for individuals under 65 and to pay day-to-day living expenses for all.

Our suggestions 1, 3, and 4 to amend the Kerr-Mills Act are generally covered by section 121 (title XIX: Grants to States for medical assistance programs) of H.R. 6675.

One of the major criticisms of the MAA program has been the delay in providing benefits, due to cumbersome investigation procedures. This deficiency, as we read the bill, is not covered and should be corrected by proper legislation, at least for those 65 and over. Our recommendation No. 2 stated heretofore, would be one way that could be accomplished.

The CHAIRMAN. Thank you very much.

Thank you.

The next witness is Dr. John J. McGraw, Jr., Bucks County Medical Society.

Take a seat, sir, and proceed.

STATEMENT OF DR. JOHN J. McGRAW, JR., BUCKS COUNTY MEDICAL SOCIETY, BUCKS COUNTY, PA.

Dr. McGRAW. Mr. Chairman, and members of the committee, I am Dr. John J. McGraw from the Bucks County Medical Society in Bucks County, Pa.

Before starting, I would like to clarify one thing.

On some of the lists I am listed as representing the Bucks County Medical Society, and the Bucks County AFL–CIO. This is not quite accurate. It is true that the Bucks County Medical Society and the AFL–CIO council did work out a compromise plan to suggest to you gentlemen regarding financing medical care for the aged. I have some copies of this plan here if you would care to see them.

OUTLINE OF A PLAN FOR PREPAID FINANCING OF MEDICAL CARE FOR THE AGED

I. SOURCE OF FUNDS

A. Increase the social security tax on employers, employees, and self-employed persons by an amount sufficient to pay for the benefits desired.

II. MANAGEMENT OF THE FUNDS

A. Sequester the funds for medical care for the aged and nothing else.
B. Permit excess funds to be invested in interest-bearing Government bonds.

III. DISBURSEMENT OF THE FUNDS

A. The funds shall be disbursed by purchase of approved service type insurance policies issued by private insurance companies such as Blue Cross and Blue Shield.

B. The fund may alternatively purchase other approved policies which may better fit the needs of any eligible person. The choice shall be solely that of the eligible person.

C. The policies shall have a modest copay feature.

IV. ELIGIBILITY FOR BENEFITS

A. Everyone who has reached the age of 65 or who has been retired for disability shall be elegible for the insurance policy of his choice without a means test. The policy shall cover the dependent spouse. Payment for the policies shall be as outlined below.

1. Those who have paid into the fund for 10 years or more shall receive the policy of their choice without obligation to anyone. Full payment for the policy will be made from the fund.

2. Those who have not paid into the fund for 10 years shall receive the policy of their choice without a means test. Full payment for the policy shall be made from the fund but the recipients shall become indebted to the Federal Government for 10 percent of the cost of their policy for each year less than 10 that they have paid taxes to the fund. They may elect to pay the difference at the time they receive the policy or, on their own initiative, they may elect to delay payments until death of husband and wife. The estate, after death of husband and wife, shall be liable for payment of the cost of insurance policies. If there are surviving dependent children, this fact shall be taken into consideration before the estate shall be liable. If the estate is not adequate to cover the cost of the policies, the surviving relatives shall not be held liable. If the estate cannot repay the cost of the policies, the fund shall be reimbursed by the Federal Government from general tax funds.

V. COVERAGE

A. Hospitalization, medical and surgical care, nursing home care, drugs and essential appliances. The amount of coverage shall be dependent upon the amount by which the social security tax is increased. Coverage should be, at least, as extensive as that outlined in the King-Anderson bill and include medical and surgical fees.

However, I really can't presume to testify for the AFL-CIO so I am really representing just the medical society.

Our medical society has been interested in financing medical care for the aged for several years. We reached the conclusion that the best way to finance medical care for the aged is to provide everyone with an opportunity to earn a decent living so that he could save enough money to care for himself.

We realized, however, that this ideal solution wasn't going to be achieved, at least in our time. We then studied the Kerr-Mills law and we concluded that it is a pretty good law, and that actually all of the real needs of the people could be met this way. However, even 3 years ago, we realized that sooner or later and probably sooner, something along the line of the various King-Anderson plans would be enacted into law.

We believe that H.R. 6675 will be enacted into law and we are ready to accept it and work within its framework to give the best possible care for our patients.

We accept the social security tax or a similar payroll tax as a method for financing medical care for the aged and we urge you to approve of this method. In fact, we feel that the social security tax, with its uniform percentage and its limited ceiling, is far more fair and equitable than the other most likely alternative which is the graduated income tax.

However, we feel that it is important to call to your attention what we consider to be at least three major flaws in H.R. 6675.

No. 1: H.R. 6675 permits the Federal Government to intrude itself into local affairs more than is necessary.

No. 2: H.R. 6675 provides more help than is needed for small hospital bills, and not enough for catastrophic illnesses which require more than 60 days of hospitalization.

No. 3: H.R. 6675 is unfair to the workingman of today when it taxes him to pay for the health care of the aged who have not paid into the health fund and who do not need financial assistance.

At this point I want to reemphasize we do not ask you to reject H.R. 6675. We expect that you will pass it but we would like for you to consider three proposals which we feel would eliminate the three objectionable features that I mentioned above.

No. 1: We ask that you consider dispersing of benefits by providing the aged with approved private insurance policies such as Blue Cross and Blue Shield. This is only a modest diversion from H.R. 6675. We realize that the proposed bill permits the Department of Health, Education, and Welfare to deal through intermediate carriers but we ask that you direct that this work be done. We believe that this would help to keep the Federal Government out of local affairs to some extent.

Senator ANDERSON. Can I ask you this, Would you confine it to Blue Cross and Blue Shield?

Dr. McGRAW. No, sir; Blue Cross or Blue Shield or any approved insurance policy.

Senator ANDERSON. The Kaiser plan or HIP or any of those?

Dr. McGRAW. Any approved insurance policy that gives a fair return to the patient. I am sure there are some insurance companies that profit 50 cents on the dollar, I wouldn't expect that you would approve of those plans.

Senator ANDERSON. Thank you very much.

Dr. McGRAW. We believe you should provide insurance such as Blue Shield to cover doctors' services. Your constituents expect this, and you may as well provide it now as face the wrath later on.

The services of all physicians including pathologists, radiologists, and anesthesiologists, we believe, should be covered by Blue Shield-type policies.

Senator ANDERSON. Doctor, you don't really believe anybody is going to be worried about this wrath, do you?

Don't you think we have stood about all the wrath we can stand now?

Dr. McGRAW. Blue Cross and Blue Shield and many insurance companies have demonstrated they can do an excellent job at a very fair price. The reason the aged don't have adequate insurance now is not the failure of these companies. It is the failure, we feel, of the people to save their money to pay for the premiums.

When H.R. 6675 taxes the people it compels them to save the money for the premiums. We feel that that is as far as Government should go. You have solved the problem. We already have the mechanism for distributing the benefits. We don't think that Government should displace private enterprise where private enterprise has demonstrated that it can do the job.

Secondly, we request that you consider a larger copay or deductible feature and provide extended coverage beyond the 60 days of hospitalization.

The present provisions of H.R. 6675 which provide 60 days of hospitalization and require the patient to pay approximately $40 will have certain undesirable results, first, large amounts of money will be spent by the health fund unnecessarily. A certain number of hospital bills are only $100 or $200. Now, we think that it is wasting the Government's money for them to pay $60 of a hundred dollar hospital bill. It would be far better to take that money and put it toward premiums that will give extended coverage for disastrous illness.

In addition, the pressure to admit patients to hosptials unnecessarily is going to be enormous. This is a very, very serious problem now, and when H.R. 6675 is activated, it is going to be much, much more of a problem. It is a terribly difficult problem now.

Senator ANDERSON. Doctor, how will these patients get into the hospital; on certification of a regular physician, will they not?

Dr. MCGRAW. Yes, Senator, and the physicians, all of these physicians, are human beings and are subject to all the pressures that all human beings are subject to and when you have people screaming and hollering to get into the hospitals and threatening to call their Congressman and their Senator, some of us are going to weaken, and we need your help with a larger deductible to back us up.

Senator ANDERSON. Doctor, I think that is a very fine, honest statement. Many of us feel that way, many of the temptations, are things which doctors will resist.

Dr. MCGRAW. We try to resist but what happens, as you and I well know, is that a patient will go from one doctor to another, and the one who hollers and screams the most gets the better service which is unfortunately true, but it is so.

So, we recommend that the patient be required to pay the first $50 and then $15 a day for the first 10 days. We feel that even if the patient is required to pay as much as $200 (you may want to cut this down) in the first 10 days, that this will make very few people destitute. If they can't afford the $200, then they need help all the way. Such people need help from the very first dollar and you have provisions to take care of that.

Senator LONG. In the event they can't pay the $200 if a State has a good Kerr-Mills plan, that would take care of the $200 anyhow, wouldn't it?

Dr. MCGRAW. That is correct. If they can't pay the $200 these people are not going to be left out in the cold, but it will be a deterrent for people who do have the money to pay. It will tend to keep them out of the hospital a little bit if hospitalization is not really necessary.

As I say, we feel it is far more appropriate for the Government to provide coverage for relatively fewer people but who have large problems than it is to provide for a lot of people with little problems. To cover the first dollar of care is ridiculous.

As a matter of fact, it costs you $5 in administrative expenses to cover the first $5 of medical care.

Senator ANDERSON. Doctor, how many patients stay more than 30 days?

Dr. MCGRAW. I don't know, sir.

Senator ANDERSON. Well, less than 10 percent. And 60 days?

Dr. MCGRAW. I don't know, but I know in general you should cover the big problems. I don't want you to keep these people out of the

hospital completely. But let's provide less coverage on the little problems and more coverage on the big problems.

Senator ANDERSON. But is catastrophic illness the big problem?

Dr. McGRAW. For the patient who has the catastrophic illness it is a terrible problem.

Senator ANDERSON. Yes. It is hardly the answer.

Dr. McGRAW. He is the one who needs your help, the one who has a $100 hospital bill doesn't need for the Government to pay $60 toward his bill.

But the man who has a $5,000 hospital bill, and who is in more than 60 days needs help. He may have worked all his life, as my father did, and saved $25,000 and yet he may have to spend that $20,000 or $30,000 before he gets Kerr-Mills help. That is what my father did. He had to spend it all.

On the other hand, the fellow who doesn't save his money, who went bowling and played golf, and so forth, gets Kerr-Mills right off the bat. You see that is the fallacy of that part of your program.

Senator LONG. If I might say it, my mother-in-law had a very long terminal illness, and it took practically all of her resources. Now the bill we have before us would have helped her some, but all of her resources would still have been taken.

Dr. McGRAW. We want the bill to be extended beyond the 60 days, less in the first few days, more after 60 days.

Senator LONG. I agree with your logic. If you are going to give people insurance, you ought to insure them against those things which they can't afford, if you can't insure them against everything.

Dr. McGRAW. That is right; don't insure them against the little things.

Senator LONG. You would do better to insure them against the risks they can't afford to take rather than insure them against the risks they can afford to take. It is the same thing as insuring your automobile—if you can't insure it against everything, you would do better to insure it against the risk you can't afford to take.

You would be better off, for example, to have a $1,000 deductible for the damage you might do somebody and to be insured for $200,000 than to have no deductible and then to find that you had an accident and somebody collected in judgment against you everything you owned.

Dr. McGRAW. That is what I tried to say here but I think you said it better than I did. Thank you.

Senator LONG. Right.

Senator ANDERSON. As somebody who has written a little insurance of various kinds, I think you take care of the great majority of the cases even though once in a while a man does get stuck with $200,000 or $300,000. If you take care of the individual, who can't afford to take these day-by-day losses, you have said: Disburse it through the Blue Shield or Blue Cross.

Now, you are talking about no deductibles at all, and they have no deductibles at all.

Dr. McGRAW. The gentleman who testified about Blue Cross didn't come from Philadelphia, I guess. My own Blue Cross policy has a $5-a-day deductible for the first 15 days up to $75 in any one year for myself and my whole family. This is a real good policy, and almost everybody in Philadelphia has that kind. That is the better kind.

Also the other kind, the other alternative in Philadelphia, he says has no deductible. It pays from the first day. However, it only allows $25 part pay for laboratory and $35 for X-ray work. Everything above that the patient has to pay, so that is kind of a deductible in that sense.

Senator ANDERSON. I wondered, Mr. Chairman, if I could put these figures back on the record again, I know you heard them a while ago but the reason some of us have talked about hospitalization there has only been one study that I know of that touches this very carefully and that was the 1963 study of Health, Education, and Welfare, and they found that a married couple who didn't have hospitalization to take care of them—that their average medical costs were $442.

Now, if either one of the married couples went to the hospital, their average costs came up to $1,220. If they didn't, it stayed down to $233. It is that jump from $233 up to $1,000, to $1,220, that is the real problem in this situation because that happens.

Dr. McGRAW. That is right, sir; we want you to pay for, everything over $200.

Senator ANDERSON. That happens to be about 95 percent of the patients, and catastrophic illness cuts it below that. These patients are out in less than 60 days. If you go onto 90 days, they are almost all gone and there is only 1 percent left. And you are worried about 1 percent of catastrophic illness, the great problem is with the 95 or 96 percent.

Dr. McGRAW. I don't think paying a hundred dollars is a big problem.

Senator ANDERSON. It isn't to you but to a person who has an annual income of a thousand dollars it is quite a problem.

Dr. McGRAW. He is covered by Kerr-Mills.

Senator ANDERSON. He is if he is willing to go in and say, "I am medically indigent," and he might not be. He might have a little self-respect. He wants to take care of himself. I don't want to go in and say he is an indigent patient. I think Kerr-Mills has done a fine job and I am not quarreling with that at all. But you say you can wipe out all of these hospital benefits. The average man can't pay a hundred. You may be able to but the average man can't. He has a problem.

Dr. McGRAW. All right. I have one final suggestion, I am sort of lost in my continuity.

Senator ANDERSON. I apologize.

Dr. McGRAW. We felt it was unfair to tax today's population to take care of the present aged who haven't paid into the fund. We are aware of the fact that H.R. 6675 is social insurance and that social insurance usually covers those who were not in the program when they were working because it didn't exist.

However, we believe that this is unfair to the people who are now working and, furthermore, this starts the fund off with an enormous deficit, maybe of $30 billion. This is a figure that I took out of the air, but it probably is not too far off.

Senator ANDERSON. It is also taken out of the hearings of a few years ago.

Dr. McGRAW. Well, I took it out of the air—the same air.

Senator ANDERSON. We should have you in the Treasury Department. [Laughter.]

Dr. McGRAW. We believe that our proposal would cover everyone in a dignified manner and at the same time it would be fair and equitable to all concerned. We propose that you provide insurance coverage to everyone over 65 or retired for disability with health insurance without a means test of any type but that the present aged and some of the future aged would assume some responsibility as follows:

(*a*) Those people who have never paid into the fund would still receive the insurance policies without a means test, but our plan would permit the fund to recover the cost of the premiums from their estates after the death of the husband and the wife, and any dependents. You won't be mean to these people. They will be dead.

However, if there is no estate, then the fund should be reimbursed from general tax funds, because these people were, in effect, indigents and they should not be provided for by the social security tax. Their care should be paid from the income tax. In this way the people who can afford more will be providing more toward the care of the indigent.

Those people who had paid into the fund for 10 years would have their policies free and clear. Those who had paid into the fund for less than 10 years would have a pro rated obligation. Some of you may feel that this is an impossible administrative task. I have been informed, however, that the Commonwealth of Pennsylvania has always collected from the estates of people who have been on public assistance and collections run as high as $5 million in 1 year. In return for adding this somewhat obnoxious, I admit, but eminently fair feature to H.R. 6675 you would be able to give greater coverage than you now plan.

If this feature of our plan were adopted you would have an additional source of income. This would ease the burden for a period in which you are going to gain experience and when you really don't know the cost of this program. You would have a little extra money coming in.

In summary, we ask that you amend H.R. 6675 to provide the following:

(1) Benefits shall be dispersed by providing the aged with one of a variety of approved health insurance policies purchased from private companies; such as, Blue Cross and Blue Shield. Physicians' bills should be covered as well as hospitalization.

(2) The policies should have a larger deductible or co-pay feature but should provide more coverage for a long term and exceptionally costly illnesses.

(3) The fund shall be empowered to regain the cost of premiums from the estates of those who received coverage but did not pay into the fund for at least 10 years.

In conclusion, I would like to say that the doctors of Bucks County agree with the purposes and goals of H.R. 6675 and we feel the changes we suggest would achieve the same goal but a little bit better and quicker and more certainly.

Thank you.

(The prepared statement of Dr. McGraw follows:)

TESTIMONY PRESENTED BY DR. JOHN J. MCGRAW, JR., FOR THE BUCKS COUNTY MEDICAL SOCIETY, BUCKS COUNTY, PA.

The Bucks County Medical Society respectfully requests that you consider our views on the subject of financing medical care for the aged.

We have been actively interested in this subject for several years. As a result of our studies we have reached certain conclusions.

First we have concluded that the ideal way to finance medical care for the aged is to provide every person with an opportunity to earn a decent wage and for every person to save sufficient money to purchase their own health care either directly or through prepaid insurance plans of their own choice.

However, we never suffered from the delusion that this ideal solution would be realized in our time. We know that many people are unable and that some are unwilling to plan for their future needs in this manner.

We also studied the Kerr-Mills law and we concluded that this is a reasonably good law. We urged that it be fully implemented in our State. We believe that full implementation of the Kerr-Mills law could solve all of the real problems with regard to financing medical care for the aged.

However, even 3 years ago, we realized that the Kerr-Mills law would not be widely and adequately implemented. We felt certain that additional legislation along the lines of the various King-Anderson plans would eventually be enacted into law.

We believe that H.R. 6675 will be enacted into law, and we are ready to accept it and to work within its framework to provide the best possible care for our patients.

We accept the use of the social security tax or a similar payroll tax to finance medical care for the aged. We urge you to approve of this method of financing.

We feel that the social security tax, with its uniform percentage and limited ceiling, is far more fair and equitable than the other alternative, the graduated income tax.

However, we feel that it is important to call to your attention at least three major flaws in H.R. 6675. The flaws are these:

1. H.R. 6675 permits the Federal Government to intrude into local affairs more than is necessary.

2. H.R. 6675 provides more help than is needed for small hospital bills and not enough for catastrophic illnesses which require more than 60 days of hospitalization.

3. H.R. 6675 is unfair to the working men and women of today when it taxes them to pay for the health care of the aged who have not paid into the health fund and who do not need financial assistance.

At this point I want to reemphasize that we do not ask you to reject H.R. 6675. We expect that you will pass it but we ask that you consider three proposals which we feel would minimize the three objectionable features listed above.

The three proposals we offer are these:

1. Disburse the benefits by providing the aged with approved private insurance policies such as Blue Cross and Blue Shield.

This is only a modest diversion from H.R. 6675. We realize the proposed bill permits the use of insurance companies as disbursing agents. We request that you go a step or two further and direct the issuance of approved private insurance policies to the aged.

We believe that this would help to keep the Federal Government out of local affairs a bit more than the present provisions of the bill.

We believe that you should provide insurance such as Blue Shield to cover doctors' services. Your constituents expect this and you may as well provide it now as to face their wrath later on. The services of all physicians, including pathologists, radiologists, and anesthesiologists should be covered by Blue Shield type policies.

Blue Cross and Blue Shield and many other insurance companies have demonstrated that they can do an excellent job at a very fair price. Government should never replace private enterprise where private enterprise has proven that it can meet the needs of the people.

2. Require a larger co-pay or deductible feature and provide extended coverage beyond 60 days of hospitalization.

The present provisions of H.R. 6675 which provide 60 days of hospitalization and require the patient to pay only approximately $40 will have the following undesirable results:

(*a*) Large amounts of money will be spent by the health fund unnecessarily.

(*b*) Less money will be available to extend coverage beyond 60 days or to provide other benefits.

(*c*) The pressure to admit patients to hospitals unnecessarily will be enormous. This will be a very serious problem as soon as H.R. 6675 is activated.

We recommend that the patient be required to pay the first $50 and then $15 per day for the first 10 days. Even if the patient is required to pay up to $200 in any 1 year, very few people will be made destitute. If they are that close to bankruptcy a single hospital bill of $200 would not make the difference. The saving to the health fund would be enormous; the pressure on hospital beds would be relieved and more money would be available to extend coverage beyond 60 days.

It is more appropriate for the Federal Government to provide coverage for a relatively few large problems which people cannot handle than it is for the Government to meddle in many small problems where their help is not needed.

If local governments wish to reduce the co-pay feature they still have King-Anderson funds to do so.

3. Recover the cost of insurance from the estates of those who have not paid into the health fund.

H.R. 6675 proposes to cover everyone over 65, rich or poor, whether they have ever paid into the health fund or not. This is not fair to the people who are now working.

We are aware of the fact that H.R. 6675 is "social insurance" and that social insurance usually covers those who did not have the opportunity to contribute to the plan because it did not exist when they were working. This sentiment is very nice but it is still not fair. Furthermore, by covering the present aged, the fund starts out with a deficit of approximately $30 billion.

We believe that our proposal will cover everyone in a dignified manner and, at the same time, be fair and equitable to all concerned. We propose that H.R. 6675 provide insurance coverage for everyone over 65, or retired for disability, with health insurance without a means test of any type but that the present aged and some of the future aged would assume some responsibility as follows:

(*a*) Those people who had never paid into the fund would still receive the insurance policies without a means test but our plan would permit the fund to recover the cost of the premiums from their estates after death of the husband and wife and if there were no surviving dependents. If there is no estate the health fund would be reimbursed from general tax funds.

(*b*) Those people who had paid into the fund for 10 years would have their policies free and clear.

(*c*) Those who paid into the fund for less than 10 years would have a prorated obligation.

Some of you may feel that it is an impossible administrative task to collect from the estates. I have been informed that the Commonwealth of Pennsylvania has always collected from the estates of people who had been on public assistance and that the collections have run as high as $5 million in 1 year.

In return for adding this somewhat obnoxious but eminently fair feature to H.R. 6675 you would be able to give greater coverage than is now planned.

If this feature of our plan were adopted the health fund would have an additional source of income for at least 10 years. This would ease the burden for a period in which much needed experience will be gained regarding the true cost of the program. Present estimates are really not much more than educated guesses.

This feature of the plan would be almost completely eliminated in 10 years since almost every one would then have paid into the fund by that time.

In summary, we ask that you amend H.R. 6675 to provide the following:

(1) Benefits shall be disbursed by providing the aged with one of a variety of approved health insurance policies purchased from private insurance companies such as Blue Cross and Blue Shield. Physicians bills should be covered as well as hospitalization.

(2) The policies shall have a larger deductible or co-pay feature but shall provide more coverage for long-term or exceptionally costly illnesses.

(3) The fund shall be empowered by regain the cost of premiums from the estates of those who received coverage but who did not pay into the fund for at least 10 years.

In conclusion, I wish to say that the doctors in Bucks County agree with the goal which H.R. 6675 attempts to achieve. We feel that the changes that we suggest would achieve the same goal with greater certainty and with less involvement of the Federal Government in the affairs of the patients, hospitals, and doctors alike.

Senator LONG. That lien proposal that you suggest——

Dr. MCGRAW. Pardon?

Senator LONG. We usually refer to that as a lien proposal.

Dr. MCGRAW. Lien on your estate.

Senator LONG. When you collect something from the estate after the person passes away, that lien proposal that you recommend is opposed by quite a number of people in the various welfare agencies. There are quite a few of them that oppose it but in some cases it does seem fair. I can recall the case of an old person who lived all by himself, nobody ever came to see him, it looked like, but by golly when he passed away at the homestead there were around 50 cars around of all the relatives seeing what they could get.

Dr. MCGRAW. I don't see why the workingman today should pay for this person and then the son who didn't take care of him inherit what little he has. As you say, you are not being mean to this man, he is dead. I won't take it from him. I wouldn't take his house from him or his car or television set or anything away from him as long as he is alive. But as soon as he dies, if he has been cared for by the workingmen and women of today, they should have the burden relieved.

A lot of people say, we don't worry about taking care of one millionaire. But a lot of my relatives, they don't like that sort of thing. They don't want to be paying money to take care of him. They don't want to provide anything for the care of that millionaire but that is what you are going to be doing.

Senator LONG. I don't know about your State but in Louisiana, if a doctor treats a patient and the patient passes away after the doctor has administered to him and the hospital cares for him, that expense of last illness is an obligation of his estate and it must be paid to the hospital or to the doctors, if they render a bill, before it can be divided among the heirs.

In my State if you say the State pays the doctor or the Government pays the doctor then you would put them in the same position as the doctor would have been in in seeking to collect his bill.

Dr. MCGRAW. That is right.

The Government would regain the cost of the premiums. If he lives to be 67 you get 2 year's premiums back.

Senator LONG. Thank you.

The CHAIRMAN. Thank you very much, Doctor.

Dr. MCGRAW. Thank you.

Senator ANDERSON. It is a good statement.

The CHAIRMAN. The next witness is Mr. Don B. Goodloe, of the Local 6 of the American Federation of Teachers.

Take a seat, Mr. Goodloe.

STATEMENT OF DON B. GOODLOE, LEGISLATIVE REPRESENTATIVE OF THE WASHINGTON, D.C., TEACHERS' UNION, LOCAL 6 OF THE AMERICAN FEDERATION OF TEACHERS

Mr. GOODLOE. Mr. Chairman, my name is Don B. Goodloe. I am legislative representative of the Washington, D.C., Teachers' Union, American Federation of Teachers, which is also affiliated with the national AFL-CIO.

In so doing, I am supporting the position of the AFL-CIO which testimony has already been presented by Mr. Nelson Cruikshank.

I realize the time of the committee is precious, and inasmuch as what I am supporting has already been given by Mr. Cruikshank, I accordingly, in the interests of time am appearing and requesting that my statement be placed in the record.

The CHAIRMAN. Thank you very much, sir.

Mr. GOODLOE. Thank you.

(The prepared statement of Mr. Goodloe follows:)

TESTIMONY BY DON B. GOODLOE

Mr. Chairman and members of the committee, my name is Don B. Goodloe. I am the legislative representative of the Washington, D.C., Teachers' Union, Local No. 6 of the American Federation of Teachers. I am appearing today in support of H.R. 6675, commonly known as the medicare bill. In so doing, I am supporting the position of the AFL–CIO, which testimony has already been presented by Mr. Nelson Cruikshank. Accordingly, in the interests of time I am appearing and requesting that my statement be placed in the record.

As the representative of the Washington, D.C. Teachers' Union I have the honor of submitting the following testimony in regard to H.R. 6675, recently passed by the House of Representatives to provide a hospital insurance program for the aged under the Social Security Act, increase benefits under the old-age, survivors, and disability insurance system, as well as for other purposes designed for the public good.

Our local union consists of actively employed, as well as retired teachers from the public school system of the District of Columbia. We are, moreover, affiliated with the metropolitan organization of the Washington area known as the Central Labor Council of the National AFL–CIO.

We wish to make it clear that our members would not benefit directly from the provision of this act. Public school teachers of the District of Columbia were covered by Public Law 382—the Health Insurance Act enacted by the 86th Congress—and those who had retired too early to get coverage under the act of September 28, 1959, were subsequently included under Public Law 724, enacted by the 86th Congress approved September 8, 1960.

As teachers, however, and as citizens of the United States, we are interested in providing adequate medical care and hospitalization for millions of our senior citizens, some of whom are very inadequately prepared for the expenses contingent on a protracted illness, or may be covered by no system of hospitalization whatever.

We are a great and progressive nation—the wealthiest in the world. Our citizens, on the whole enjoy the highest standard of living in the world. We, furthermore, are in the forefront of the advance of civilization on many fronts. In short, there are some respects in which we lead the world. That, nevertheless, cannot be said when we speak of providing medical care for our elderly people, who are becoming an increasingly large percentage of the total American population.

At least this is true at the present time. If, however, this bill is enacted into law, the situation will be entirely different. The system set up under the provisions of H.R. 6675 would give our elderly citizens substantially as good protection against protracted and castastrophic illness as is provided in some European countries cited as good examples in this field of nationally supported group health insurance.

Thees facts have been known to the American people for quite some time and much has been said about our backwardness in providing adequate medical care for aged American citizens without the financial resources to secure it for themselves, if they remain seriously ill for any considerable time. Perhaps one of the most powerful forces to awaken our Nation to its negligence in this matter and spur us to remedial action was the speech made by President Kennedy to the Second Annual Convention of the National Council of Senior Citizens in the spring of 1963.

In this remarkable address, President Kennedy clearly and forcefully explained how the lack of an adequate national plan to care for the medical needs of elderly people affected different groups of individuals. It was comparatively easy to understand the hardships of men and women without any hospitalization coverage or financial resources.

Indigent persons, nevertheless, are not the only victims of prolonged and catastrophic illness. The President showed how people who had accumulated moderate savings could find themselves destitute, if they suffered from a long period of sickness. Again he demonstrated the fact that high cost of hospitalization, surgery and other phases of prolonged illness affects not only the man or woman directly concerned but involves other individuals.

In other ways, he showed how the problem of caring for afflicted and incapacitated senior citizens cannot be regarded as strictly an individual matter. Families, including human beings in all age groups, have a stake in a financially sound medicare program for our elderly citizens.

It is not necessary to comment on everything contained in this presentation to the National Council of Senior Citizens made by the head of our Government at that time, but in the paraphrase or summary we are including in this testimony, one point stood out beyond all. This was the importance of considering the dignity of the older segment of our population.

Like other self-respecting individuals, elderly Americans do not wish to be regarded as objects of charity. They have never desired to be treated as beneficiaries of a welfare program in their declining years. They want to pay for what they get. When they receive the benefits of a program, they are glad to feel that they have earned what they are getting.

President Kennedy did the Nation a great service in stressing the fact that a prepaid medical and hospitalization plan under the social security system was the way to solve this problem. Under the system worked out in this bill, any gainfully employed worker or self-employed individual can be insured against the possibility of expensive hospitalization or outpatient care by the deductions from his earnings while actively employed. This means that if and when such a misfortune occurs, he is receiving the benefits of a program toward which he has personally contributed.

As far as we have studied this bill, the provisions contained in it are financially sound. Deductions under the social security system will be gradually increased so as to meet added expenses as they are likely to increase in future years. Insofar as population trends and the increase in the number of individuals who will come under the program can be forecasted, we think it has been done in drawing up this piece of legislation.

There are some things in the bill which we would prefer to have amended. For instance, as the bill now reads, there will be a general increase of 7 percent in social security benefits with a minimum increase, however, amounting to $4 per month. We would prefer to have an across-the-board increase for all recipients of benefits under the system. Of course, we realize that the matter of cost must be taken into account in implementing any such program as this.

We wish to have a financially sound system set up or, in the long run, almost everyone will eventually be harmed. If, however, a flat increase of $7 were granted to all concerned, the cost would probably amount to about the same as that involved in the legislation, as it now stands. It would be about $1,400 million. This, however, does not mean that we would oppose the bill on that account. There is always differences of opinion on such matters; and such a matter does not count as much as the overall benefits contained in H.R. 6675.

Likewise, we would like to see the deletion of the deductible $40 for inpatient care and the $20 for outpatient care. Still, we would not consider that sufficient cause for opposing this bill as it now stands.

On the other hand, what we like most about the bill is the three-layer system of health benefits. Although our main interest is in the basic hospital insurance program, it seems to us that the other two parts of the program may be of benefit to a great number of individuals. In other words, an effort has been made to minister to the needs of as many people as possible. That is one of the requisites of sound legislation.

Finally, aside from the strictly financial advantages to be acquired by our fellow Americans, if this bill is enacted into law, there are moral and psychological factors to be considered. Initiation of this program might well mark a turning point in our history.

This is what I mean: During the last two decades, there has been a growing tendency to downgrade men and women in this country because of advancing age. I think it is no exaggeration to say that elderly Americans are being

relegated to a status of second-class citizenship. To be sure, the difficulty of securing gainful employment is perhaps the most obvious disadvantage from which people suffer in this Nation, as they advance in age. Still, that is not all. There are other difficulties with which the committee has not the time to be concerned, during the 10 minutes allotted for this testimony.

There can be inferior types of citizenship based on race, religion, class, national origin, or almost anything else. In America, we have had a second-class citizenship based on race or color. That, however, is being slowly but steadily eliminated. That is all to the good.

Still, we do not wish to retrogress in one direction, while we are making progress in another. Inferior status in society based on age is as repugnant to American ideals as is any other form of unjust discrimination. Giving senior citizens of this Nation a chance to safeguard themselves against the hardships and vicissitudes of life through financial contributions made during their active, productive years will give them more self-respect and, in turn, will increase their prestige among their fellow citizens. The enactment of this legislation may, consequently, reverse a pernicious trend toward the disparagement of age, which has become a serious defect in our national attitude.

For these reasons, we, as members of the American Federation of Teachers, strongly support the passage of H.R. 6675 by the Senate and hope this committee will report it favorably.

The CHAIRMAN. Next witness is Mr. David Pile, Nashville, Ark.

(No response.)

The CHAIRMAN. The next witness is Dr. Edward Young of Physicians Forum. Take a seat, Doctor. Proceed, sir.

STATEMENT OF DR. EDWARD L. YOUNG, CHAIRMAN OF THE PHYSICIANS FORUM, INC.

Dr. YOUNG. Mr. Chairman, I am Dr. Edward L. Young, speaking for the Physicians Forum, which is a national organization of physicians, including doctors of all ranks, practicing physicians, specialists, professors, hospital administrators.

I am an honorary surgeon at the Massachusetts General Hospital; I am a member of the State medical society, American College of Surgeons, and certified by two specialty boards.

I want to express the appreciation of the forum for the opportunity to come here and say that we back this bill and hope for its passage at an early date, but we feel that there are certain things which weaken the bill and which, if not changed, will lead to trouble in the implementation.

First, I want to compliment Senator Douglas for having an amendment to restore words to the original Anderson bill that have to do with the pathologists and anesthesiologists, and so forth, in the hospital. We feel that that is an essential change which is necessary because of two reasons: One, it means too much interference with the Government in medicine; and second, it would cost the patient a great deal more because the expenses in this line are very great.

Second, I think that the bill is weakened very much in regard to the nursing home care transfer. You must remember that the nursing homes throughout the country up to today by and large have been a national disgrace and, unless there is some way in this bill to put the pressure on them, that will continue and the Government will be in the position of paying for substandard nursing home care.

Of course, they have increased their work during the last few years because the shadow of this bill was on them and they have improved.

But there are still the majority of nursing homes which might just as well put over their door, "Abandon hope, all of you who enter here."

I wish some of you could go into some of these nursing homes where, on a transfer from a hospital, we are forced to put patients. I am also on the advisory committee of the Massachusetts General Hospital, and as such, know something about the nursing home situation. So I believe there should be restored to this bill the obligation for a nursing home in order to receive these patients and compensation should be affiliated with or under the direct control of a hospital.

Third, I would like to eliminate all deductibles for this reason: That I believe in the long run it costs you more—it costs the Government more—because conditions which when seen early are often curable; if delayed, may require either an immediate fatality or a long-term expensive care.

I can think of a patient I saw 3 years ago who refrained from reporting, as she told me, because of expense, and the result has been that, for 3 years, large sums of money have had to be paid for supervoltation treatment, hormonal treatment, special drugs, and in the long run it cost a great deal more to take care of that patient. She would have had a 90-percent change of complete cure within a relatively short time if she had reported earlier.

Then the second part: There is no care of the standards of the doctors involved, and I think that is of the very greatest importance because, particularly in the surgical field, there are too many men not qualified to do surgery who because of the greater compensation will attempt to do it; because of p or surgery, there may be fatalities.

We will never know in this country how many people are 6 feet underground because of a poor surgeon or how many people have suffered prolonged disability because of inadequate surgery.

So, that I think there should be standards put into that second part.

Then in the nursing homes the expensive drugs and biologicals are not paid for. The reason I would like to have that restored is, I believe, that it will send a certain number of patients back to the hospital when they can get in the hospital those drugs which are necessary for conditions such as arthritis, diabetes, cancer therapy, and so forth, which they can't get in either home care or most nursing homes.

So, that I believe that should be restored.

The third, Kerr-Mills, the elaboration of that we do approve, but I wish it could be put under the department of health rather than welfare. In Massachusetts it is under the department of welfare and there are 271 subheadings in the State and each chief of a subheading feels that he or she can say what can be done. Although Massachusetts has implemented the Kerr-Mills bill as you know, one of the States, one of the strongest States in the country, nevertheless, it is in a good deal of confusion because many doctors when told you can't do this, you can't do this, they feel it is not right, do not have the time or do not have the knowledge to appeal to the State director who could and generally would correct it.

I think that you have my full statement and I would like to emphasize these few things and thank you for the privilege of expressing myself on these few statements.

(The prepared statement of Dr. Young follows:)

STATEMENT BY THE PHYSICIANS FORUM

The Physicians Forum supports the principle of social security financing of medical care for the aged, which is the basis of H.R. 6675. It urges passage of the bill, with appropriate amendments, as a significant step forward in improving the availability of health services to the public. Some features of H.R. 6675 represent compromises with its opponents, which greatly weaken the proposed program. Unless changed by the Senate, this bill will establish certain retrogressive patterns of benefits and administration which will plague health services in the United States for a long time to come.

Mandatory health insurance benefits

H.R. 6675 specifically excludes the services of radiologists, pathologists, anesthesiologists, and physiatrists—all of which are basic hospital services—from the mandatory insurance coverage for hospital and outpatient diagnostic care. This provision represents Federal dictation of a new, regressive national pattern which serves the financial interests of the specialty groups concerned at the expense of the health interests of the aged. It sharply increases the noncovered costs of hospital care. To the $40 deductible for hospitalization, and the $20 deductible for outpatient diagnostic services, it imposes additional charges which may amount to hundreds of dollars in individual cases. This provision should be deleted from the bill.

H.R. 6675 further weakens the provisions for safeguarding the aged from substandard nursing home care. H.R. 1 was grossly deficient in this respect; it permitted nursing homes which have merely a transfer agreement with a hospital to qualify for payment under the program. H.R. 6675 removes even this inadequate protection; any nursing home which makes an unsuccessful attempt to have such a transfer agreement and is needed to provide care to beneficiaries can qualify. This provision in effect endorses the present outrageous situation in which substandard nursing homes are permitted to dominate the field because of the shortage of decent facilities. If allowed to stand, it will inevitably result in the further massive proliferation of poor quality nursing homes. The bill should be amended to limit eligible nursing homes to those operated by or affiliated with a hospital, in order to promote the rapid nationwide development of good nursing home facilities.

H.R. 6675, in contrast to H.R. 1, permits profitmaking home health agencies to qualify for payment under the program. This provision opens the door to exploitation of the aged by organizations which are willing to sacrifice service and quality to financial gain. The original provision limiting payment for home health services to nonprofit agencies should be restored.

Voluntary health insurance benefits

H.R. 6675 remedies the failure of H.R. 1 to include physicians' services among the health insurance benefits for the aged. The methods proposed for such inclusion, however, are seriously deficient in these respects:

1. Coverage for physicians' services is on a voluntary basis. This penalizes the poorest of the aged, whose minimal social security benefits will not allow the payment of additional funds for voluntary coverage.
2. The $50 deductible and 20 percent coinsurance provisions will place a heavy financial load on the aged.
3. There is insufficient provision for standards to safeguard the quality of services provided.
4. Experience with the proposed "reasonable charges" for physicians' services has made it abundantly clear that the program will be subject to unnecessary and rapidly rising costs.
5. The bill turns over the administration of physicians' service benefits entirely to the insurance carriers, thereby effectively abdicating the principle of Government responsibility for the expenditure of Government funds.

The only satisfactory alternative to these provisions is the revision of H.R. 6675 to include physicians' services, along with hospital, nursing home, home health, and outpatient diagnostic care, among the benefits provided by the mandatory insurance program for the aged.

Medical assistance programs

H.R. 6675 takes important steps forward in liberalizing and expanding the Kerr-Mills and other medical assistance programs. These are long overdue and

deserve full support. The maintenance and improvement of standards of care will best be served if the bill is amended to place administrative responsibility for this program in health departments rather than, as the bill now provides, in welfare agencies.

Maternal and child health services

H.R. 6675 increases Federal funds for maternal and child health and crippled children's services, provides funds for training professional personnel for the care of crippled children, adds a new program of special project grants for the comprehensive health care of children in low-income areas, and provides assistance to the States in implementing plans to combat mental retardation. These provisions of the bill deserve support.

The CHAIRMAN. Thank you very much, sir.

The committee will recess until 10 o'clock tomorrow morning.

(Whereupon, at 11:55 a.m., the committee recessed, to reconvene at 10 a.m., Thursday, May 6, 1965.)

SOCIAL SECURITY

THURSDAY, MAY 6, 1965

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

The committee met, pursuant to recess, at 10 a.m. in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Long, Anderson, Gore, Talmadge, McCarthy, Ribicoff, Williams, and Carlson.

Also present: Elizabeth B. Springer, chief clerk.

Senator TALMADGE. The committee will please come to order.

The chairman has requested that I place in the record a statement and resolution by the American Legion in support of section 306, providing for the payment of a child's insurance benefits after attainment of age 18 in case of child attending school. The American Legion has submitted this written statement in lieu of testifying so as to conserve the time of the committee. We appreciate this courtesy.

(The statement and resolution follow:)

STATEMENT OF THE AMERICAN LEGION

The American Legion Resolution 100 asks that the Congress of the United States amend title II of the Social Security Act in a manner which would authorize the continuance of payments to students after they reach age 18 enrolled in an approved school but not beyond age 22. Approximately 285,000 young people would benefit immediately from this change.

The American Legion has a long, sustained interest in providing opportunities for youth of our Nation, including the opportunities obtained through education. The active support of the American Legion provided in the passage of the GI bill of rights for veterans after World War II and after Korea is well known to the people of this Nation. The initiation and support of legislation which resulted in the passage of the junior GI bill that now provides funds to assist children where the parent lost his life in or as the result of service is a matter of record. The many activities, particularly of the American Legion's Americanism Commission relating to education and youth programs, are further testimony on this point. In recent years a compilation of career and scholarship opportunities for all youth bearing the title "Need a Lift?" has reached a distribution of nearly a million copies. The American Legion "Official Policy on Education," which has been reprinted in the pages of the Congressional Record, provides further evidence of the American Legion's position with reference to educational opportunity.

The support of the American Legion for the amendment of title II of the Social Security Act is therefore consistent with the historic and active position of this organization.

Studies reveal as of June 30, 1964, there were 2,591,000 young people under the age of 18 receiving social security benefits because their wage earner parent was either decreased (1,776,000), totally and permanently disabled (472,000), or over 62 years of age and no longer employed (343,000).

Under the present reading of the social security law the payments terminate on the month each beneficiary reaches 18 years of age. In many instances this has and will eliminate the possibility of continuing education beyond high school

and frequently is the cause of school dropouts before graduation from high school. The opportunities afforded this group gains in importance when we project our thinking throughout the 1960's and relate them to all young people and find there will be approximately 26 million who will enter the labor market and of the total about 7½ million will have dropped out of school before they complete their high school training.

Further studies show approximately 40 percent of all students who drop out of school before graduation from high school do so with financial need in the home as the major cause. Among the group that dropped out during the past few years we are finding our highest unemployment ration and that the incidence of juvenile delinquency is 10 times higher when compared with those finishing high school.

Other research we have conducted reveals there are nearly 700,000 students attending high school who are over 18 years of age. This is frequently due to illness and regulations which do not permit children to start school until age 6.

The present limitation of benefits to age 18 therefore affects people still in high school. More particularly it affects the opportunities of this group to get additional technical or college preparation.

As America educates its youth this represents a type of economic upgrading which is ultimately returned to the taxpayer as a benefit. The GI bill cost the American taxpayer some $15 billion according to Veterans' Administration estimates. These same statisticians calculate that in less than 6 years from now—by 1970 the almost 10½ million veterans who look training under the law will have paid off the full cost of the program because through this education the veterans were enabled to attain an income level at which they are paying over an extra billion dollars a year in Federal income taxes. The most recent studies available from the U.S. Census and the Office of Education cite average lifetime incomes for males who graduated from college in 1958 to be $435,242 which is over $177,000 more than the average with a high school education.

If the above figures are used as an example we can see what this might mean in economic terms in the case of an individual. The lifting of the age ceiling for dependents as proposed in the amendment to title II would, under estimates made by the Bureau of Old-Age and Survivors Insurance Division of Program Analysis, Actuarial Branch, October 5, 1964, affect 285,000 children during the month of September 1965. Under the 4-year proposed extension of benefits the average student who remained in school would draw approximately $2,500. It is the belief of the American Legion that the average beneficiary after graduating from college would over his lifetime pay in additional taxes an amount that would be sixfold as compared to the funds provided him through the adoption of this proposed amendment.

Those estimates do not take into account, of course, the incalculable human and social values, hard to measure in dollars, for both the individual and society through enhanced productivity and potential contributions.

From an economic standpoint the American Legion supports the amendment to title II because it believes it is feasible to finance.

Furthermore, this approach to assist students to further their education would eliminate the objections held by some individuals and States where it is believed a source of Federal funds would have an influence on our educational system, because payment is made directly to the beneficiary with the privilege of selecting the school of his choice.

Finally, the American Legion supports this amendment for a humanitarian reason in that it is in keeping with the great American tradition of providing opportunity for those who have become disadvantaged because of the economic uncertainty imposed upon them by the loss of income from the wage earner in the family group.

RESOLUTION NO. 100

SOCIAL SECURITY PAYMENT TO MINORS FOR THEIR EDUCATION

Whereas one of the major objectives of the American Legion's education and scholarship program is to help make it possible for children who have the ability and desire to receive an education beyond high school; and

Whereas present provisions of the Social Security Act, title II, terminate benefits to children of deceased wage earners when they attain the age of 18; and

Whereas it is at this age when the continuation of social security benefits would in many instances be the determining factor as to whether or not children

would be financially able to continue their education beyond high school: Now, therefore, be it

Resolved by the American Legion in national convention assembled in Dallas, Tex., September 22–24, 1964, That it reiterates its stand taken at Miami Beach in October 1960 to actively support legislation which would amend title II of the Social Security Act in a manner which would authorize the continuance of payments to children after they reach age 18 while enrolled in an approved school, but not beyond age 22.

Senator TALMADGE. Because of the large number of witnesses that have requested to be heard, the Chair regrets that it is necessary to impose a time limitation on the witnesses.

The first witness will be Dr. Russell B. Carson. The time allotted to Dr. Carson is 15 minutes.

Dr. Carson, you may proceed.

STATEMENT OF DR. RUSSELL B. CARSON, CHAIRMAN, BOARD OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, ACCOMPANIED BY JOHN W. CASTELLUCCI, EXECUTIVE VICE PRESIDENT OF THE ASSOCIATION, AND DR. DONALD STUBBS, CHAIRMAN, GOVERNMENT RELATIONS COMMITTEE

Dr. CARSON. Good morning, Mr. Chairman.

I am Dr. Russell B. Carson, a practicing physician in Fort Lauderdale, Fla., and chairman of the board of the National Association of Blue Shield Plans.

With me on my right is Mr. John Castellucci, executive vice president of the association, and on my left, Dr. Donald Stubbs, a practicing physician in the District of Columbia, who is also a member of our national board and chairman of our Government relations committee. In addition, we have with us several members of our association staff who will be available for any technical assistance.

The National Association of Blue Shield Plans is the coordinating organization of 85 Blue Shield plans in the United States, Puerto Rico, Canada, and Jamaica. There are now over 56 million people who enjoy prepaid medical and surgical security under these plans. The Blue Shield name is an internationally recognized service mark and a highly respected symbol.

You have before you the testimony, together with several exhibits.

Our comments and recommendations will relate principally to the voluntary supplemental health benefits program, so designated in part B of title 18 of H.R. 6675.

I. We are here to testify that the best interests of the aged population will be served by granting a choice of programs, one of which should be the traditional Blue Shield pattern.

II. To testify that the aged citizen should be offered the opportunity to continue the pattern of prepayment to which he as accustomed.

III. To testify that Blue Shield can make its maximum contribution to this program in a full carrier role.

IV. To testify that our services can be most effectively used on a nationwide, rather than a regional or other geographic basis.

V. Finally, to testify that under these conditions Blue Shield can contribute in a major capacity in carrying out the purposes of this legislation.

We respectfully commend the Ways and Means Committee and the House of Representatives for their forthright statement of policy in the opening section of H.R. 6675 that—

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

We further commend the Ways and Means Committee for its recognition of the importance of a willing and informed participation on the part of the physicians and of the prepayment organizations in the operation of this program.

We also commend the framers of this bill for their keen understanding of the role which voluntary health insurance organizations can and should perform in the implementation of this program.

I. THE BEST INTERESTS OF THE AGED POPULATION WILL BE SERVED BY GRANTING A CHOICE OF PROGRAMS, ONE OF WHICH SHOULD BE THE TRADITIONAL BLUE SHIELD PATTERN

The National Association of Blue Shield Plans believes that the Senate has an opportunity greatly to improve the impending Social Security Amendments of 1965, specifically by amending part B of the new title XVIII, relating to the proposed voluntary supplemental health insurance plan, in such a way as to afford the beneficiary a free choice among the patterns under which the entire voluntary health insurance movement has grown in the United States.

We submit that it would be consistent with repeated congressional declarations against the establishment of "socialized medicine" in the United States, for the Government not only to purchase medical prepayment from the major private carriers, but to offer the voluntary beneficiaries a reasonable degree of choice among the major patterns of prepaid care already available to the people.

The Federal employee health benefit program, enacted by Congress in 1959, took cognizance of the major forms of voluntary health insurance which have grown competitively in the United States, and whose competition has produced the most phenomenal insurance development in our history.

As presently proposed in H.R. 6675, the supplemental program offers a single pattern of medical and health benefits, all subject to an annual calendar year deductible of $50 and thereafter to a coinsurance factor of 20 percent.

The single pattern of benefits provided in part B of H.R. 6675 is virtually identical to the Government-wide indemnity program, one of the two alternative Government-wide plans offered under the Federal employee health benefits program—the other principal alternative being the Government-wide service benefit program, offered through Blue Shield and Blue Cross.

At present, 56.2 percent of all enrolled Federal employees have chosen the Blue Shield program, and 20.5 percent are enrolled in one or another of the 36 qualified local plans, many of which, like Blue Shield, are "service benefit" plans. The remaining 23.3 percent have

chosen the "Government-wide indemnity program" which is essentially the same as the program now specified in part B. Thus, a substantial majority of the Federal employees have chosen a pattern of benefits other than the only one offered the aged under H.R. 6675 (exhibit A).

Should the Federal Government now choose for its aged citizens a program that is preferred by less than one-fourth of the Government's own employees?

This is a voluntary program, and it would seem only reasonable that that its beneficiaries should be able to choose among the major patterns that are available to other citizens. The aged citizens should have the same privilege of choice, which they have exercised in their earlier years and which is still available to their younger fellow citizens.

II. THE AGED CITIZEN SHOULD BE OFFERED THE OPPORTUNITY TO CONTINUE THE PATTERN OF PREPAYMENT TO WHICH HE IS ACCUSTOMED

People with substantial cash resources sometimes prefer cash indemnity coverage with deductible charges and coinsurance—as now prescribed by H.R. 6675. But people with limited cash resources (and this, we suggest, applies to many of the aged), generally prefer a first-dollar, basic coverage program.

The need for alternative program or programs for this latter group within the supplemental provisions of this act is further underscored by the fact that the single program now incorporated in H.R. 6675 would raise several significant difficulties for many of the aged subscribers:

1. Approximately 5 million persons over 65 now covered by Blue Shield would be confronted with a difficult choice. These persons would have to choose between retaining a relatively uncomplicated program on the one hand (a program offering first-dollar coverage for basic medical care on a service benefit basis) or be forced to abandon this program in order to avail themselves of the plan prescribed by H.R. 6675.

2. The pattern prescribed in H.R. 6675 could require the aged patient to make large out-of-pocket payments before benefits could be obtained.

3. The procedures for obtaining benefits in a program where deductible and coinsurance apply throughout the entire range of covered services will offer some real difficulties to the aged patient. It will be difficult for him to know what his rights are and how to claim them; he will be required to keep records of expenditures, to fill out various claim forms, submit proofs of expenditures, etc.

Some of the administrative problems which will confront the patient, the physician, or both, under the single pattern prescribed by H.R. 6675 are suggested by these questions:

1. How does one apply deductible charges when several physicians and institutions are accruing charges simultaneously?

(The average aged person admitted to the hospital may be attended simultaneously by several physicians, for example, a surgeon, an anesthesiologist, a physician caring for a concurrent medical condition, the family physician, a consultant, a pathologist, a radiologist.)

2. How does one know at any given time how much of an annual deductible payment has already been satisfied?

(The $50 calendar year deductible would apply to the casual visit to the physician's office or call to the patient's home, apart from and in addition to any hospitalized medical care required.)

3. In satisfying the deductible, how does the patient know what payments to make, when to make them, and to whom?

In contrast we should emphasize the simplicity of Blue Shield's service to the patient. Avoiding deductibles and insurance factors on basic medical services (such as surgery, in-hospital medical care, radiotherapy, anesthesia, et cetera.), we obviate much recordkeeping on the part of patient and plan. By paying physicians directly we also obviate the necessity of the patient advancing cash payments against expenses for which he is, at most, entitled to partial reimbursement.

Blue Shield's membership includes the active working forces and the retirees of many of America's greatest industries, including motors, steel, communications, and the Federal Government itself. None of the medical prepayment programs of any of these groups conforms to the exclusive pattern of benefits prescribed in H.R. 6675.

Most of these are service programs with first-dollar coverage which have been evolved by labor-management study and renegotiation. Retiring employees of many industries are now carrying services benefit coverage into retirement, and they should be permitted to apply the available public subsidy to the kind of program to which they have become accustomed (exhibit B).

Elderly people are known to cling to the ways of life which have brought them satisfaction over the years. They like the familiar, the understandable, and the dependable institutions of society. Blue Shield is, for some 5 million of these citizens, such an institution. It has served them well, and it asks, for them, only a continuing opportunity to serve them in the future.

III. BLUE SHIELD CAN MAKE ITS MAXIMUM CONTRIBUTION TO THIS PROGRAM IN A FULL CARRIER ROLE

Section 1842 of title XVIII of H.R. 6675 provides that, in arranging for the administration of benefits under part B the Secretary of HEW "shall to the extent possible enter into contracts with carriers which will undertake to perform * * *" certain functions including determination of the reasonableness of charges of physicians and others, handling and accounting for funds, promoting proper utilization, serving as a channel of information, et cetera.

We would emphasize the desire of Blue Shield nationwide, to make its maximum contribution to the fulfillment of the purposes of this legislation. As evidence of this intent, the Member Plans of the National Association of Blue Shield Plans, on April 4, 1965, unanimously authorized their constituted officers to propose the services of Blue Shield in connection with this impending legislation,

> In the public interest, in a manner that will maintain a good quality of medical care, freedom of choices of physician, and without interference in the patient-physician relationship.

Blue Shield would bring to this program a wealth of experience and expertise in the administration of prepaid medical care. Moreover,

because of Blue Shield's close relationships with participating physicians and local professional societies, our plans have established effective patterns for determining prevailing charges, for assuring patients of predictable benefits, and for controlling utilization practices.

For more than a quarter of a century, Blue Shield plans have served the needs of all segments of the population for prepaid medical care. The predominating Blue Shield pattern of medical prepayment has provided a constantly broadening and improving scope of protection to a constantly growing number of people.

Today, Blue Shield provides vital service to more than 51 million pepole in the United States and an additional 5 million beyond our borders. Its pattern of service has been shaped to the demonstrated needs of the patient, with the guidance and support of the medical profession (exhibits C and D).

Blue Shield plans are nonprofit, community-oriented programs. They are designed for the purpose of enabling people to prepay the costs of medical care. Blue Shield plans enjoy a close relationship with the practicing physicians. Indeed, Blue Shield is the only nationwide prepayment mechanism which provides its benefits for the most part on a paid-in-full basis. Through formal agreements between local service plans and participating physicians, Blue Shield is able to assure its member subscribers whose incomes are within locally determined limits that these participating physicians will accept plan payments as full compensation for the basic services covered by the subscriber's contract.

Blue Shield also enjoys a close relationship with its subscribers. Blue Shield specializes solely in the prepayment of medical services and has evolved into the most expert, efficient, and personal subscriber service organization in its field.

In deed, each Blue Shield plan is well staffed with highly trained persons from the community for this purpose, many of whom have had decades of such experience.

In addition, orientation sessions are customary among Blue Shield plans for the purpose of explaining our administrative techniques and contract provisions to physicians and their office personnel. Thus, the physician and his patient are able to discuss the financial aspects of an illness with complete understanding and confidence.

In formulating payment schedules, Blue Shield plans customarily request information from local physicians as to prevailing charges in the community. The plans also utilize mediation committees and other evaluating groups organized by local medical societies, in resolving fee problems and in controlling utilization of medical services. Accordingly, because of its relationship with local physicians and their professional societies, Blue Shield enjoys unique advantages in terms of built-in controls of utilization and of fee levels (exhibit E).

Blue Shield plans were organized locally to meet local needs. Nevertheless, over the course of years, our plans have learned to work together to meet national challenges, both in the public and the private sectors. As indicated previously, Blue Shield serves many industries and labor groups on a national basis.

IV. BLUE SHIELD SERVICES CAN BE MOST EFFECTIVELY USED ON A NATIONWIDE, RATHER THAN A REGIONAL OR OTHER GEOGRAPHIC BASIS

If Blue Shield is to participate in this program, it would expect to do so on a nationwide scale. This would enable all member plans to participate and composite their rates and costs, while still allowing for regional variations in charges and costs.

We, therefore, take respectful exception to the report of the Ways and Means Committee in which (p. 46) it is stated to be—

> the committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance.

(We wish to call to the attention of this committee the fact that the intent to so select the carriers is neither stated nor implied in the text of H.R. 6675.)

We submit that a valid comparative analysis of performance of a single program would be impossible to obtain on such a basis, because of wide variations in the characteristics of the various regions of this country.

One carrier might be assigned an area where the availability of medical facilties and a high economic level would influence utilization. Another carrier might be assigned a region where opposite characteristics dominate. Valid comparison and evaluation of carrier performance under such diverse circumstances would be impossible.

Also, we believe the aged patient has a right to prompt settlement of claims and consistent interpretation of his benefits. Confining carriers to regional areas increases the possibility that, as individuals move from place to place, responsibility for claims adjudication and interpretation will be divided between carrier organizations. Subscriber service under such conditions may degenerate into subscriber frustration as the coordination between the carriers becomes bogged down in redtape.

As illustrated by the Federal employee program, Blue Shield has demonstrated that it can provide coverage, nationwide, on a uniform basis, with coordinated subscriber service and transferability of coverage from area to area. This is the program we are proposing.

V. BLUE SHIELD CAN CONTRIBUTE IN A MAJOR CAPACITY IN CARRYING OUT THE PURPOSE OF THIS LEGISLATION

It can be readily understood that if H.R. 6675 were to be finally enacted in its present form, insofar as the supplemental health insurance program is concerned, Blue Shield plans would be confronted with great difficulties in their effort to participate as carriers of this program.

Our plans would have to consider the effects of this pattern of benefits upon our contractual agreements with participating physicians, upon the attitudes of our present subscribers, upon the cost of administering our total business, and particularly we would have to consider the interests and needs of our present members in the over 65 group.

Therefore, we would urge the Senate to amend H.R. 6675 in a manner to make possible the provision of a program patterned after the best

features of the highly successful Federal employees health benefits plan. Specifically, we would urge that the Secretary be authorized and required to contract for and approve the following health benefit plans:

1. *Service benefit plan.*—A nationwide plan under which payment is made by a carrier under contracts with physicians, or other providers of health services for benefits of the types described in section 1832(a) rendered to persons enrolled under the supplemental health insurance program for the aged.

2. *Indemnity benefit plan.*—A nationwide plan under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described in section 1832(a).

3. *Comprehensive medical plans.*—

(A) Group practice prepayment plans;
(B) Individual practice prepayment plans.

Blue Shield would propose to offer its services as a carrier on an underwriting basis as the nationwide carrier under the service benefit plan option. It would propose to offer the benefits of H.R. 6675 on the following basis:

(1) Basic surgical-medical benefits—First-dollar coverage (no deductible):

(*a*) Surgical care (including care for reduction of fractures and dislocations);
(*b*) Emergency first aid;
(*c*) In-hospital medical care;
(*d*) Anesthesia;
(*e*) Radiation therapy service;
(*f*) In-hospital diagnostic X-ray service;
(*g*) In-hospital laboratory and pathological services; and
(*h*) In-hospital physiatry (physical therapy).

(2) Extended and other medical health services—subject to annual deductible of $100 and 20 percent co-payment:

(*a*) Diagnostic X-ray and laboratory (out of hospital);
(*b*) Home and office calls;
(*c*) Home health services;
(*d*) Consultation;
(*e*) Rental of durable medical equipment such as iron lungs;
(*f*) Prosthetic devices;
(*g*) Braces and artificial legs, arms, and eyes;
(*h*) Ambulance services;
(*i*) Inpatient psychiatric hospital services (60 days); and
(*j*) Outpatient psychiatric care (maximum $312.50 per year).

In our considered judgment, Blue Shield can deliver the above outlined program on a nationwide basis within the financing specified in H.R. 6675 for the voluntary supplementary program.

We would urge the Senate to give careful consideration to the pattern of prepaid medical service which has been evolved by Blue Shield over the years. This pattern has met with impressive public acceptance, and our experience shows that it would offer the Government the opportunity to develop a considerable degree of predictable liability in its projected program.

We would also urge Congress, in devising the final form of this legislation, to enable and encourage Blue Shield plans to play the fullest possible role in the administration of these programs, in order to bring all their resources and experience to bear on the effective and economical implementation of these services. By so doing, Congress would take full advantage of the most competent instrument available to carry out the purpose of this legislation and would, at the same time, help enhance the value of Blue Shield both to the 5 million elderly citizens now served by these plans and to the 47 million younger citizens who also are members of Blue Shield plans throughout the United States.

We thank you, Mr. Chairman and the members of your committee for the privilege of appearing here today. We shall continue to be available to you for information or for any further assistance we may be able to render.

Senator LONG (presiding). Thank you very much, Dr. Carson. Any questions?

Senator ANDERSON. I am sorry, I didn't get a chance to hear your paper, but did I just hear you saying something about $100 deductible?

Dr. CARSON. Yes, sir.

Senator ANDERSON. What percentage of the cases would that cover?

Dr. CARSON. Senator Anderson, I should say that $100 deductible would apply only to the small proportion of patients who would require the extended services listed in our testimony—beyond the basic medical services, which would not be subject to any deductible or coinsurance.

Senator ANDERSON. What percentage of the cases would be ruled out by a $100 deductible?

Dr. CARSON. A sufficent saving would be made on the less essential extended services so that it would not increase the overall rate or cost of the program. The $100 deductible would apply only, as we have stated, to extended benefits, not to basic medical or surgical care in hospital.

Senator ANDERSON. You are proposing that Blue Shield should have something to say about those benefits, aren't you, the scale of them?

Dr. CARSON. We are listing the benefits as they appear in our presentation there. They are essentially those now listed in the bill.

Senator ANDERSON. Senator Long, I wonder if we might have a chance later on to question Mr. Carson a little bit. I wonder if perhaps we could question you later if I might. We all get caught in long-distance telephone conversations and I can't get loose from them this morning.

Dr. CARSON. We will make ourselves available at any time you want to talk to us.

(Senator Anderson subsequently submitted 14 written questions to Dr. Carson. The questions by Senator Anderson and the replies by Dr. Carson appear on p. 528.)

Senator TALMADGE. Mr. Chairman, and Dr. Carson, your present policies provide for no deduction whatever at the present; isn't that correct?

Dr. CARSON. Are you referring to the Federal employees program?

Senator TALMADGE. I am talking about the Blue Shield policy generally that you sell.

Dr. CARSON. In general——

Senator TALMADGE. As I understand, it provides for certain coverage with limitations but without deductions; isn't that correct?

Dr. CARSON. That is correct.

Senator TALMADGE. Do you propose now to provide for a $100 deduction for medical services only, or would this apply to hospital costs as well?

Dr. CARSON. No. The $100 deductible would apply only to certain services and treatment materials that may be required beyond the basic medical care for which there is no deductible or coinsurance.

This is our customary way of doing business.

In those cases where these extended services are needed, then the deductible applies.

Senator TALMADGE. I am not sure I understand. Does the patient pay the first $100 or does Blue Shield?

Dr. CARSON. The patient pays the first $100 after receiving the basic program, for which there is no deductible charge under our program.

Senator TALMADGE. That is provided in the supplemental provisions of the bill?

Dr. CARSON. Yes, sir.

Senator TALMADGE. Now, as I understand it the supplemental provisions would be financed $3 contribution from the insured, which could be deducted from his social security, matched with $3 from the Federal Treasury. That is correct, isn't it?

Dr. CARSON. Right.

Senator TALMADGE. Making a total of $6 per month for your proposed supplemental insurance plan. You propose to assume the same rate, I take it, without any change in rates?

Dr. CARSON. Yes, sir; the same rate.

Senator TALMADGE. Is your $100 deduction predicated upon the idea that you will assume greater responsibility under the bill than you are now assuming under your coverage?

Dr. CARSON. Predicated on the fact that we would be able, with the $100 deductible, if applied in the limited manner and to the limited extent proposed in our testimony to keep the rate under the $6.

Senator TALMADGE. Is your proposal then basically that you change the proposition of a $50 deductible to a $100 deductible?

Dr. CARSON. No. Our proposition is that we eliminate the $50 deductible and coinsurance on the basic portion of the coverage, and that on the extended facilities that are so listed in our presentation where it states—

> extended and other medical health services subject to the annual deductible of $100 and 20 percent coinsurance—

your program as a result of the $100 deduction?

Senator TALMADGE. Do you propose to give more benefits under your program as a result of the $100 deduction?

Dr. CARSON. We feel that more people would benefit by more medical coverage.

Senator TALMADGE. Have you prepared amendments to effectuate your recommendations?

Dr. CARSON. Yes, sir.

Senator TALMADGE. Will you turn them over to the staff for their consideration at the appropriate time?

Dr. CARSON. Yes, sir.

Senator TALMADGE. I suggest you turn them over to the staff in order that we may have an opportunity to look at them when we get to executive markup.

Thank you, I have no further questions.

Senator LONG. Thank you very much, sir.

Dr. CARSON. Thank you very much.

Senator LONG. Our next witness——

Dr. CARSON. May I ask what Senator Anderson would like to ask me?

Senator ANDERSON. I don't know. Questions come up. May I ask you just a second, you talk about the simplicity of Blue Shield services, you say "avoiding deductibles to obviate much recordkeeping on the part of the people in the plan."

The forms you give Federal people, isn't that recordkeeping? Don't you ask them to do it now?

Dr. CARSON. I am sorry.

Senator ANDERSON. Is it your packet? You recognize it, don't you?

Dr. CARSON. Yes, sir.

Senator ANDERSON. When you say you have to keep records on the other programs we now have, don't you have to keep records now?

Dr. CARSON. Yes. On the extended benefit.

Senator Anderson. What is the difference then?

Dr. CARSON. On the extended benefit portion of it.

Senator ANDERSON. What is the difference?

Dr. CARSON. On the basic portion of it which would cover, we feel a great deal of the needs of the patients, there would not be this recordkeeping.

Senator ANDERSON. What would he keep? Wouldn't he have to keep a record of his expenditures? It is $100 deductible. Wouldn't he have to keep records of it?

Dr. CARSON. There would be no deductible to keep records on as far as the basic medical care is concerned.

Senator ANDERSON. Don't all people have to keep records if they have your program in effect now?

Wouldn't they all have to keep records under this program?

Dr. STUBBS. Only after they get into extended benefits. All the basic hospitalization, everything that the ordinary illness includes, would be without any of this recordkeeping on that brochure.

Senator ANDERSON. I want to read here:

> It would be difficult for him to know what his rights are, how to plan them. He would be required to keep records of his expenditures, make out claim forms.

All these great administrative problems that you suggest the Government would have him do, here is your kit, don't you now make him fill out all these forms?

Dr. CARSON. This applies to the extended benefits, Senator Anderson. The recordkeeping of the basic program is done by the plan.

Senator ANDERSON. Let me go on down, if I may just a second. We have three layers in the cake in H.R. 6675. Will you require him to keep any records under the so-called King-Anderson section of it?

Dr. CARSON. No.

Senator ANDERSON. Not at all.

What about the supplemental coverage; no records at all?

Dr. CARSON. The B portion of it.

Senator ANDERSON. Yes.

Dr. CARSON. If our plan were accepted, the basic portion of our plan would not require the patient to keep a record of his medical illness. When it came to the use of the second portion that we present there with the deductible, then records would be needed.

As you suggested, may we visit with you and go into more detail on this?

Senator ANDERSON. Yes.

Dr. CARSON. Is that the chairman's wish?

Thank you, sir, very much.

Senator LONG. Very well.

(The exhibits A through E referred to follow:)

EXHIBIT A

Federal employee health benefits program enrollment statistics

	Distribution of employees and annuitants enrolled		
	Government-wide service benefit plan (Blue Shield)	Government-wide indemnity benefit plan	Other plans
At July 1, 1960	937,648	465,385	328,321
At June 30, 1961	998,169	481,994	340,606
At June 30, 1962	1,074,510	487,895	395,645
At June 30, 1963	1,132,720	503,905	405,725
At June 30, 1964	1,206,520	500,115	439,130
	Percentage distribution of employees and annuitants enrolled		
At July 1, 1960	54.1	26.9	19.0
At June 30, 1961	54.8	26.5	18.7
At June 30, 1962	54.9	24.9	20.2
At June 30, 1963	55.4	24.7	19.9
At June 30, 1964	56.2	23.3	20.5

EXHIBIT B

SAMPLES OF INDUSTRY- AND GOVERNMENT-NEGOTIATED RETIREE PROGRAMS

A recent study of corporate retirement practices showed that over 60 percent of the program studied include provisions for continuation of health insurance at retirement. In 1955, only 40 percent of these firms extended such benefits to retirees. Further, two of three companies studied, currently pay all or part of the costs of health insurance for retired workers. Most of these firms have followed the same policy as the Federal Government adopted for its employees by allowing retired workers to maintain the same scope and level of protection that is afforded to active workers.

Blue Shield has been chosen as the underwriter for numerous negotiated retiree programs. Among the firms which are included in this manner are the General Motors Corp., United States Steel, American Telephone & Telegraph, Johnson & Johnson, and Liggett & Myers, to name but a few. Unions involved include the United Auto Workers, the Communications Workers of America, the United Steelworkers of America, the Textile Workers of America, and the Tobacco Workers International, among others. Nearly one-half million of the approximately 5 million persons age 65 or older now enrolled by Blue Shield are members of retiree programs. All of these have basic coverage without dollar deductibles or coinsurance provisions.

A summary of the General Motors and A.T. & T. retiree programs and the retiree program for civil service employees is attached for your information.

Illustrative Blue Shield retiree programs

	General Motors	A.T. & T.	Federal employees
Type of service:			
Surgery	Basic	Basic	Basic.
Anesthesia	do	do	Do.
In-hospital medical care	Basic, 365 days	Basic, 120 days	Basic, 365 days.
In-hospital intensive care	Basic	Basic	Basic, 10 days.
Radiation therapy	do	do	Basic.
Diagnostic X-ray and lab while hospitalized.	do	do	Do.
Outpatient X-ray and lab	Basic, co-payed	Basic, dollar maximum.	Supplemental.
Consultation	Basic	Supplemental	Do.
Assistance at surgery	do	do	Do.
Other medical services	Supplemental or extended benefits.	do	Do.
Income limits (single/family) or benefit objective.	$7,500/$7,500	$4,000/$6,000 or 80 percent average area costs.	$5,000/$7,500 or service benefits for 75 percent of employees.
Number of retirees	46,000	44,000	88,000.
Employer contribution	Full	Partial basic; full supplemental.	Partial.

NOTE.—Basic refers to 1st-dollar coverage without coinsurance and deductibles. Supplemental benefit are provided subject to coinsurance and deductibles. Extended benefits refer to additional coverage, some of which is provided by allowance schedules, and the remainder on the basis of co-payment of reasonable charges.

EXHIBIT C

NATIONAL BLUE SHIELD ENROLLMENT

United States (Only)

1948-1964

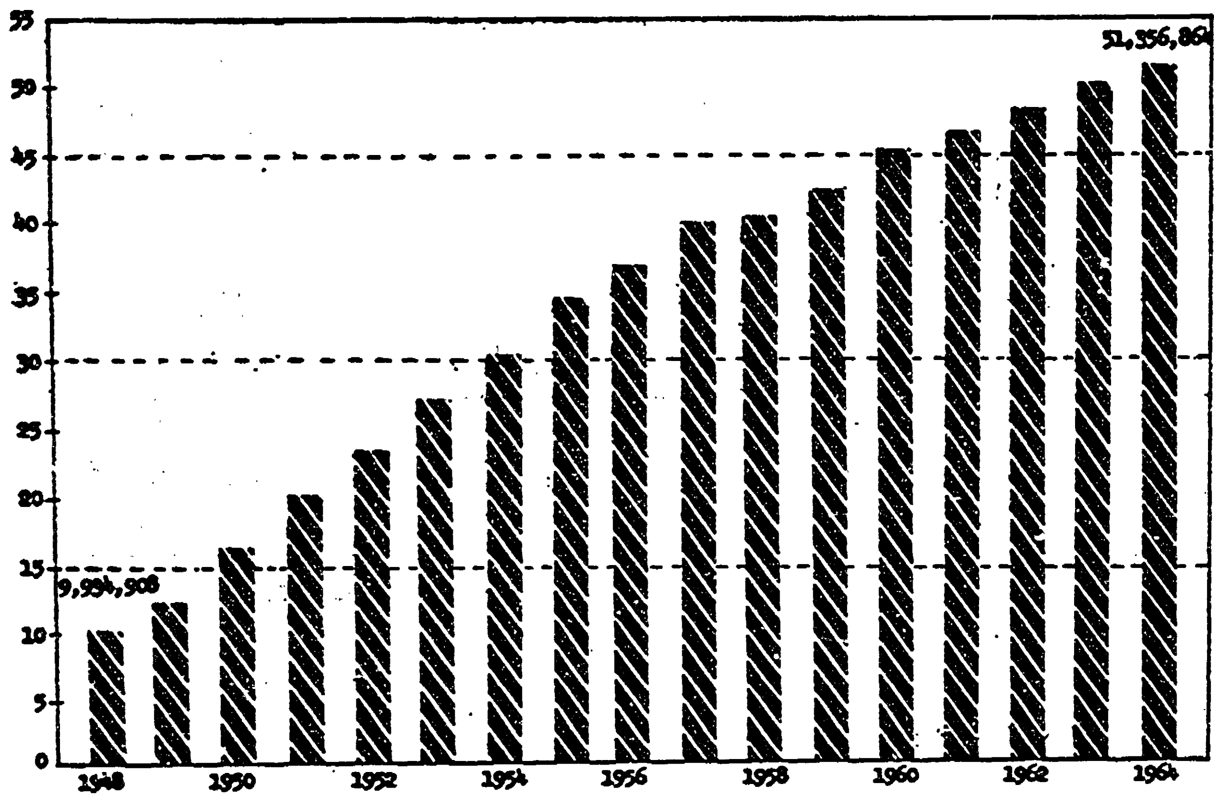

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EXHIBIT D

Blue Shield financial data, 1948–64, United States (only)

Year	Total assets	Total liabilities	Reserves	Earned subscription income	Total income	Claims expense	Operating expense	Net income	Percent of earned subscription income: Claims expense	Percent of earned subscription income: Operating expense
1964	$614,023,607	$296,495,701	$317,527,906	$1,209,394,139	$1,227,557,076	$1,095,713,474	$108,690,625	$23,152,977	90.6	9.0
1963	551,573,866	262,133,492	289,440,374	1,086,355,622	1,101,745,323	977,147,095	99,662,490	24,935,738	89.9	9.2
1962	500,136,459	233,600,101	266,536,358	974,085,675	985,373,393	868,816,031	91,136,349	25,421,013	89.2	9.4
1961	442,722,576	206,622,059	236,100,517	837,772,845	848,991,607	752,695,184	82,740,697	13,555,726	89.8	9.9
1960	407,292,984	178,658,496	226,634,488	741,164,152	751,528,883	670,776,220	76,244,736	4,507,927	90.5	10.3
1959	376,865,241	155,626,281	221,238,960	678,332,693	687,730,187	610,342,407	69,034,939	8,352,841	90.0	10.2
1958	354,539,883	141,907,642	212,632,241	592,272,390	600,447,396	528,588,758	61,362,226	10,496,412	89.2	10.4
1957	327,616,336	125,599,820	202,016,516	540,700,166	547,393,838	473,490,046	57,201,529	16,702,253	87.6	10.6
1956	289,057,594	103,644,560	185,413,034	470,582,658	476,009,070	407,350,023	50,702,153	17,956,894	86.6	10.8
1955	250,833,836	86,129,017	164,704,819	399,781,293	404,294,345	331,067,785	43,610,345	29,616,215	82.8	10.9
1954	205,540,336	71,490,558	134,049,778	344,653,131	347,963,030	279,386,975	39,341,958	29,234,097	81.1	11.4
1953	164,827,999	61,573,084	103,254,915	295,000,697	297,448,716	237,157,194	34,014,603	26,276,919	80.4	11.5
1952	126,197,220	51,074,655	75,122,565	246,361,718	247,997,928	195,645,997	29,984,648	22,367,283	79.4	12.2
1951	94,212,615	41,591,049	52,621,566	195,662,728	196,730,111	155,973,458	24,686,886	16,069,767	79.7	12.6
1950	67,591,102	32,637,090	34,954,012	140,816,896	141,594,207	111,038,711	18,653,307	11,902,189	78.8	13.2
1949	44,907,778	21,915,453	22,992,325	95,[illegible]42,633	96,289,166	76,033,579	13,560,899	6,694,688	79.5	14.2
1948	36,062,102	17,932,381	18,129,721	78,741,422	79,229,257	61,293,561	11,053,429	6,882,267	77.8	14.0

EXHIBIT E

THE ADEQUACY OF BLUE SHIELD SERVICE

In order to establish the degree to which Blue Shield plans meet the needs of those whom they serve, the National Association of Blue Shield Plans recently conducted an analytical nationwide research study.

The special study, known as the test of performance, was conducted on a nationwide basis during the months of May and June 1964. The basic purpose of the project was to study payments to determine both the adequacy of these payments against the costs incurred for the services and to measure predictability; i.e., what percentage its payments were meeting the full cost of service.

The project involved 54 Blue Shield plans from coast to coast as well as some 125,000 practicing physicians. Each plan selected, at random, a significant number of claims as the basis for surveying the attending physician about his charges, the acceptability of the Blue Shield payment, his customary charge for the same service, as well as several other questions for statistical analysis. Physicians cooperated beyond our expectations by returning more than 80 percent of the questionnaires, thereby providing greater reliability to our results and making our project an outstanding success.

Much of the statistical analysis and many of the detailed studies contemplated remain to be done. Overall results and measurements pertaining to adequacy and predictability have been accomplished however, and are presented on the following pages.

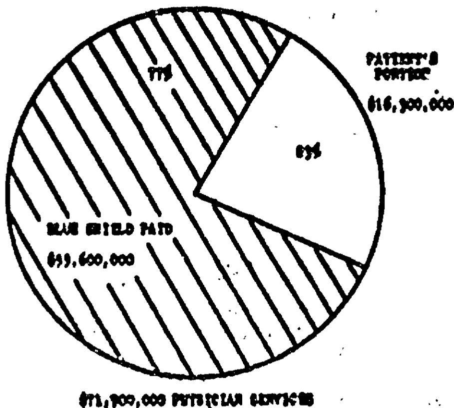
I. SURVEY RESULTS

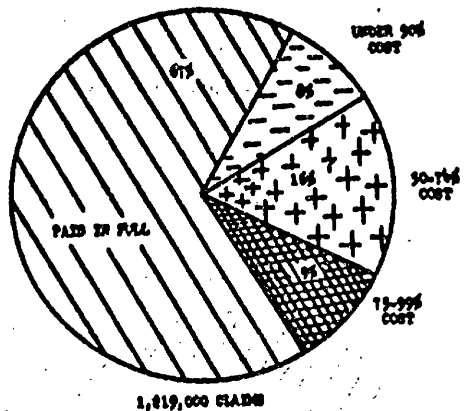
The national results reflect the composite of all plans participating in the study, regardless of their size or geographic location.

OVERALL PERFORMANCE OF BLUE SHIELD

All Certificates and Types of Service Combined

Percent of Patient's Cost Covered by Blue Shield

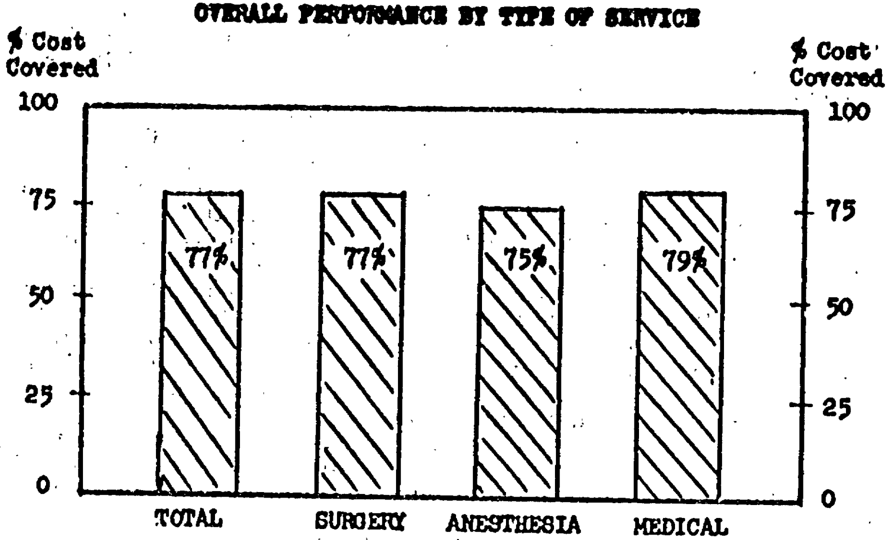




The left-hand chart above indicates that the Blue Shield plans participating in the study paid a total of $55.6 million in benefits during the 6-week study period, against total costs of physicians services of $71.9 million. For every dollar of studied cost, Blue Shield plans on the average paid 77 cents.

The right-hand chart above indicates that of the 1,219,000 claims involved, regardless of their dollar value, Blue Shield paid 67 percent of them in full. For another 9 percent, benefits met from 75 to 99 percent of reported patient costs. For 16 percent, Blue Shield payments covered more than half, but less than three-fourths of costs. The remaining 8 percent of the claims had less than half of reported costs met by the Blue Shield benefit.

If Blue Shield's total performance is analyzed by the type of service rendered, the result is as shown below.



NOTE.—The studied services were surgery, wherever rendered, professional anesthesia services, wherever rendered and physicians' in-hospital medical visits. Data was also collected on maternity delivery services, but these services are not included in this report because of the widespread practice of indemnifying the patient in these instances. Other physicians' services, such as radiation therapy, diagnostic examinations, consultations, etc., were not a subject of this particular study, due to the wide variations in patterns of practice. These services will be similarly studied at a later date.

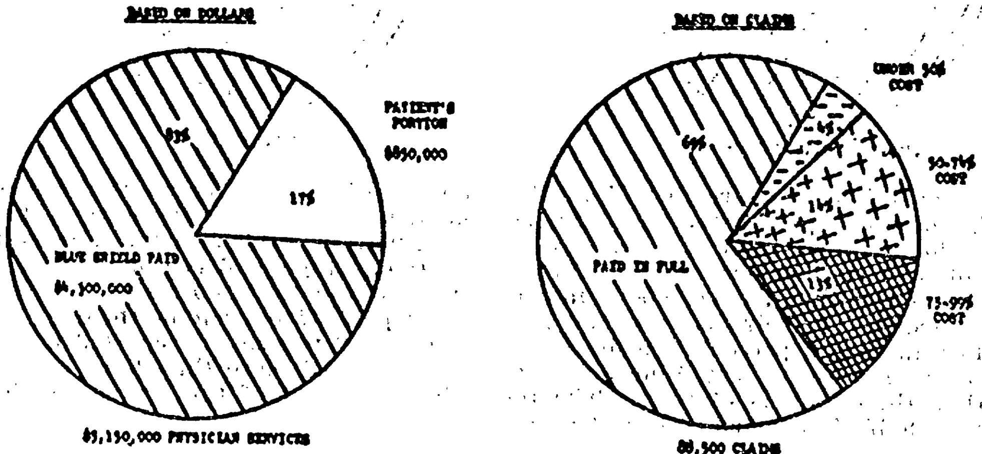
II. FEDERAL EMPLOYEE HIGH-OPTION CERTIFICATE

Of special national interest, is the performance for Blue Shield's largest single group. The high-option contract for Federal employees covers 8⅓ million employees and annuitants, and their dependents. The following charts show Blue Shield's overall performance under this program.

FEDERAL EMPLOYEE PROGRAM HI-OPTION CERTIFICATE

Surgery, Anesthesia, Medical Care Combined

Percent of Patient's Cost Covered by Blue Shield

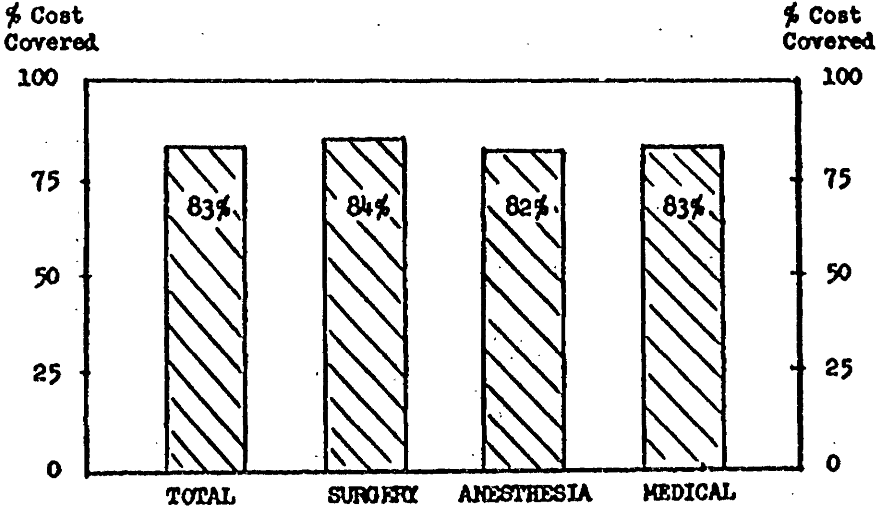


For 88,500 claims, total Blue Shield benefits of $4,300,000 were paid against total costs of $5,150,000, yielding an 83 percent average performance. Sixty-one

thousand claims, 69 percent, were paid in full. But only 4 percent had less than half the cost met.

When studied by type of service as shown below, a consistency in final percentages confirms that this is a well-balanced program.

FEDERAL EMPLOYEE PROGRAM HI-OPTION CERTIFICATE BY TYPE OF SERVICE



As the illustrations indicate, performance is higher under the Federal employee program high-option certificate than it is for comparable aspects of Blue Shield's overall project results. Since the survey period, 11 of the participating plans, with more than one-third of total Federal employee program enrollment, have increased service benefit ceilings from $6,000 family to $7,500 or higher, with accompanying adjustments in benefit allowances. These changes were made effective November 1, 1964. Thus, it is likely that the average performance under this program today is significantly higher than indicated by this 1964 survey.

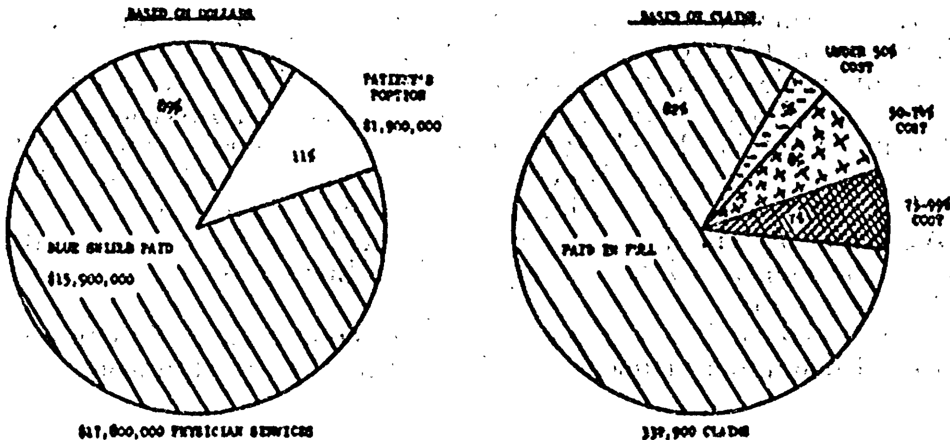
III. BEST AVAILABLE CONTRACTS

Of equal or, perhaps, more importance in evaluating the performance of Blue Shield is the results that were obtained when considering only the latest and best contract that each plan offers. During the study period, 832,000 claims were paid for individuals enrolled under these contracts. The total benefits paid were $15.9 million against total patient costs of $17.8 million, yielding an average performance ratio of 89 percent.

BEST CERTIFICATES ONLY

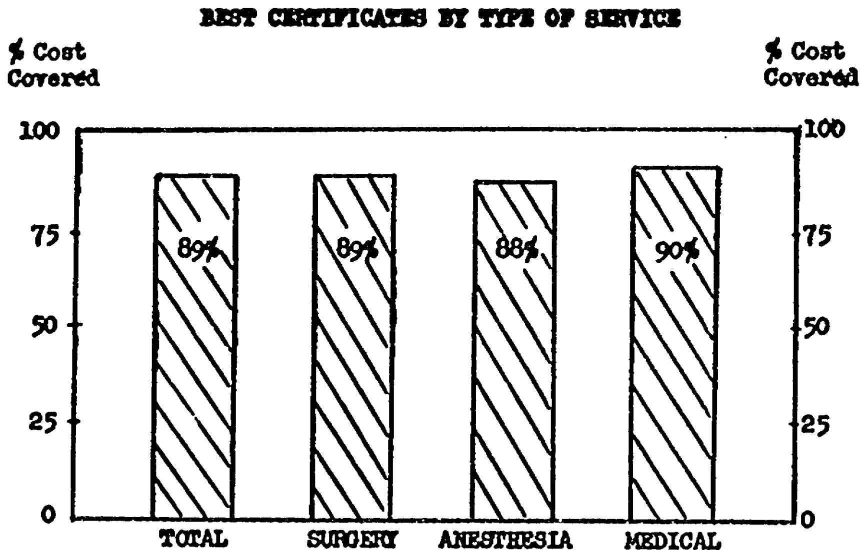
Surgery, Anesthesia, Medical Care Combined

Percent of Patient's Cost Covered by Blue Shield



Of the 332,900 claims studied, 82 percent of them were paid in full. In only 3 percent of the claims did the Blue Shield payment meet less than half the patient's reported cost.

The following chart analyzes Blue Shield's overall best group performance by the type of service which was rendered. Again, there is a notable consistency in the final percentages.



Senator LONG. Mr. Raymond E. King of the National Association of Life Underwriters.

We are glad to have you here, Mr. King. Will you proceed?

Mr. KING. Thank you, sir.

Senator LONG. We have allotted 10 minutes for each witness. All right. If you could make this statement in 10 minutes why you are welcome to do so but I think you will find it necessary to summarize it to stay within the time.

STATEMENT OF RAYMOND E. KING, JR., CHAIRMAN, COMMITTEE ON SOCIAL SECURITY OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS; ACCOMPANIED BY CARLYLE M. DUNAWAY, GENERAL COUNSEL, THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS; AND DAVID PATTISON, COUNSEL, THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. KING. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Raymond E. King, Jr., of Charlotte, N.C., and I am the chairman of the Committee on Social Security of the National Association of Life Underwriters and also a member of the association's board of trustees.

On my right is Mr. Carlyle M. Dunaway, general counsel of the National Association of Life Underwriters, and on my left, Mr. David Pattison, counsel of the National Association of Life Underwriters.

We have presented a prepared statement for your consideration but as you mentioned, we hope you will allow us to summarize some of the highlights.

My association is a trade organization composed of 50 State and 855 local life underwriter associations with an aggregate membership

of approximately 90,000 individuals, principally life insurance agents, general agents and managers. Most of these individual members sell health insurance as well as life insurance.

My purpose in appearing before your committee today is to make known to you my association's objections both to the basic and the supplementary health care programs as provided for in H.R. 6675 and to certain changes that would be made by this bill in the existing program of old-age, survivors and disability cash benefits.

I. BASIC AND SUPPLEMENTARY HEALTH CARE PROGRAMS

H.R. 6675 would establish two coordinated health care programs—a compulsory "basic" program and a voluntary "supplementary" program—for persons aged 65 and over. Both programs would be administered by or under the control of the Department of Health, Education, and Welfare.

At the outset I wish to make it absolutely clear that our association is in favor of Government-financed health care for those aged individuals who, for one reason or another, are unable to meet the costs of their own health care needs.

We have, for example, long supported the Kerr-Mills program. We sincerely believe that tax funds can be most effectively used in a program of this type which is directed to helping those aged people who are actually in need.

However, we are vigorously opposed to any system that would exact additional taxes from the younger working population—many of whom are more financially hard pressed than many individuals over 65—to provide health care benefits to all aged individuals irrespective of their ability to finance their own health costs.

In this connection, we wish to point out that among the aged people entitled to the health care benefits provided under the basic program would be literally hundreds of thousands with substantial incomes either from continued employment or from retirement programs or from a combination of these sources.

In short, H.R. 6575 would increase the already heavy social security taxes paid by the younger workers and their employers to provide health care benefits for an extremely large group of aged individuals who are completely capable of paying for their own health care costs.

Moreover, no one really knows just how heavy the tax burden might become to support even the proposed basic program because no one, in our opinion, has yet demonstrated any convincing ability to predict the eventual cost of the program with any reasonable degree of accuracy.

This statment find ample documentation in the continual and ever-rising changes that have appeared in the cost estimates made by the Department of Health, Education, and Welfare in the space of just a few short years.

In addition, the HEW's current cost estimates, like those made in the past, do not and, of course, cannot take into account the still further increased costs that would result from the expansion and liberalization of the basic program that would inevitably follow its initial enactment.

Incidentally, we respectfully suggest to you that you not overlook the fact that HEW apparently has not undertaken the making of any

similar relatively long-range estimates in the case of the supplementary program. Indeed, the bill expressly contemplates that the so-called premiums payable by enrollees in the supplementary program, and the matching Government contributions, would be subject to periodic adjustment every 2 years.

Finally, we wish also to single out for particular criticism certain aspects of the method of financing the benefits that would be provided under the basic program. Specifically, we have reference to the proposal that the new social security payroll tax be used to finance the benefits for those 17 million aged people who are entitled to cash social security or railroad retirement benefits but that general revenues be the source of financing benefits for the remaining 2 million who are not entitled to such cash benefits.

As your committee is well aware, the vast majority of those in the 17-million group, like those in the 2-million group, would not pay or have paid 1 red cent of the new social security tax provided to finance this basic program.

It would thus make no earthly sense to use the social security tax to pay for the basic health care benefits received by the 17 million and general revenues to take care of the other 2 million.

Furthermore, we are of the firm opinion that the introduction of general revenue financing, no matter how small in degree initially, or how smoothly rationalized, would represent an unwholesome and even dangerous departure from the heretofore long-accepted concept of payroll tax financing.

Next, let us consider briefly the supplementary program. Our association is, if anything, even more opposed to the supplementary program than to the basic program.

First of all, the supplementary program would virtually complete the elimination of the private health insurance business from any meaningful role in the provision of health insurance for the aged.

This result would seem plainly to be contrary to the administration's intent as announced in the President's health message to Congress earlier this year.

Further, this result would certainly mark a clear and undesirable departure from the principle upon which the social security system was founded and has heretofore operated; namely, that the system is designed to provide only a basic floor of protection.

Second, the Government's share of the financing would come from general revenues rather than from a payroll tax.

We strongly believe that any Government program that provides benefits as a matter of right, rather than on a basis of demonstrated needs, should be financed by appropriate payroll taxation.

Third, the supplementary program would be entirely voluntary.

Now, it has always been our understanding that one point on which practically everyone has long agreed is that a so-called social insurance program simply will not work unless it entails compulsory participation.

Accordingly, it is our belief that given a voluntary program of the type under discussion, there would be a distinct tendency for the financially better off individuals to enroll, and for most at the lower income levels to remain outside the program.

Thus, as we see it, the Federal Government would be in the position of heavily subsidizing a program for aged individuals best able to provide for themselves while doing nothing for many of the much less fortunate.

In brief, the Federal Government would have set up a health care program which served little or no necessary social purpose and which would be a direct, unwarranted, and completely unfair intrusion into private enterprise.

So far as the cost of the supplementary program is concerned, we submit that but for the large Government subsidy involved in the program, the costs to participants would be about the same as the cost of similar coverage purchased from private insurers, and this is supported on page 7 of the recent book entitled "Social Insurance and Allied Government Program" written by Robert J. Myers, Chief Actuary of the Social Security Administration of the Department of Health, Education, and Welfare. The passage referred to is quoted in full in my prepared statement.

Let me turn now briefly to some of the proposed amendments that H.R. 6675 would make in the existing old-age, survivors, and disability benefits system, and more particularly to the proposed increases in the taxable earnings base.

In the first place, the increases in the earnings base would place upon the higher paid employees and self-employed individuals a further disproportionate share of the burden of financing the social security system.

Second, the increases in the earnings base would result in substantially increased future cash benefits to the better paid employees and self-employed individuals and their families, and only to them, even though such individuals are in much less need of Government benefits and are much better able to provide for their own economic security than their lower paid fellow men.

In this connection, we again stress that the social security system properly is and should be designed to provide only a basic floor of economic protection to covered individuals and their families.

Accordingly, we urge that such additional financing as may be required to support any amendments to the social security system approved by your committee and the Congress be derived solely from appropriate increases in social security payroll tax rates.

Let me now deal briefly, please, with some of the proposed amendments to the disability benefits program.

H.R. 6675 would substantially liberalize the eligibility test for disability benefits by removing the present requirement that a covered individual's disability must be expected to result in death or to be of long-continued and indefinite duration.

This would mean that disability benefits would be paid to a covered individual who had been totally disabled for at least 6 months even though it was expected that he would recover at some definite future date.

Furthermore, the bill would make such benefit payments retroactive for the sixth month of disability.

Your committee has heard detailed objections to these proposed amendments submitted by witnesses who have already appeared before you. We have been advised that you will hear still further detailed

objections. Therefore, we do not intend to burden the record of these hearings with undue repetition due to limited time.

Suffice it to say, however, that we see in the proposed amendments an unnecessary, unwarranted, and unsound intrusion by the Federal Government into both the temporary and long-term disability income insurance field now being adequately and efficiently served by the private insurance business.

We are also greatly concerned that the amendments would result in duplicate benefits often being paid, and would in many cases thus create situations where disabled individuals actually received substantially more take-home or net income during their disabilities than they had received while working.

Obviously, this would act as a strong deterrent to the rehabilitation of such beneficiaries.

This, in turn, would tend to increase the incidence and the duration of claims, which would ultimately and inevitably cause increasingly higher costs both to insureds under private plans and to the social security taxpayers.

Accordingly, we urge your committee to reject these amendments pertaining to disability benefits.

In conclusion, I would like to express to your committee our association's appreciation for giving me this opportunity to express briefly our views on the foregoing provisions of this bill.

If you feel that we can be of any further assistance, or that our staff can be of assistance in any way, we hope that you will not hesitate to call on us and contact us at your convenience, Mr. Chairman.

Senator LONG. Thank you very much.

Senator Anderson?

Senator ANDERSON. I would just like to ask one or two questions here. You quote Robert Myers.

Do you do that because you believe Mr. Myers is an expert?

Mr. KING. Beg your pardon?

Senator ANDERSON. Do you do that because you believe Mr. Myers is an expert?

Mr. KING. I would think probably Mr. Myers would qualify as an expert in a number of fields; yes, sir.

Senator ANDERSON. I do, too.

You have quite a bit of material about the difference in the change in estimates.

Mr. Myers thought that the program in 1960 was solvent, thought the program in 1964 was solvent.

Why don't you think it was solvent?

Mr. KING. I am only following Mr. Myers in this particular case, and I am only taking Mr. Myers as an expert——

Senator ANDERSON. He is only an expert when he agrees with you?

Mr. KING. I beg your pardon?

Senator ANDERSON. He is only an expert when he agrees with you?

Mr. KING. No, I would not say that, Mr. Senator. Of course, that would fit my idea if I could adapt it; certainly, I would like to use him as an expert when he thought as I thought. [Laughter.]

But we can't quite do that sometimes. But I am using him here as an expert, yes, I agree with you that in many fields he is an expert.

But HEW made predictions of the cost of this basic health care program in 1961, in 1962, and 1964, and they continued to increase these predicted costs, Senator, as the record reveals. Their predictions today of the cost of this program are substantially higher than they were 4 years ago, and Mr. Myers will agree with that.

Senator LONG. Perhaps you might claim the rule of evidence that a self-serving statement is not admissible but an admission is, and proceed on the theory that Mr. Myers is for the program.

You might contend that anything he says that supports the program would not be entered into evidence because it would be a self-serving statement, but anything he says that does not support the program would be admitted into evidence as an admission.

Senator ANDERSON. I don't think Mr. Myers is so far off on these things. My understanding was, you may have better information, but the Ways and Means Committee openly said, they accepted Mr. Myers' figures but they raised them to be more conservative. In their own report the committee says:

The cost estimates are made under very conservative assumptions with respect to all foreseeable factors.

Now, the Ways and Means Committee has changed Mr. Myers' figures, not Mr. Myers.

Isn't that correct?

Mr. KING. That is correct, Senator, according to the information I have. The point I was attempting to make here, Senator, is this: This is the largest program of this type that has ever been established in the history of the world, and I don't think that any actuary has had adequate information on which to base reasonable cost predictions. I would assume that Mr. Myers' predictions are as competent as any predictions that could be made by any actuary in this country.

But the point I am making, Senator, is this: That in the 87th Congress, in 1961, HEW estimated that the King-Anderson bill, as it was called at that time, could be financed by increasing the combined employer-employee social security tax rate by one-half of 1 percent and by raising the taxable earnings base from $4,800 to $5,000. That was only 5 years ago, Senator. Now the HEW people have increased their cost predictions to the extent that the earnings base, for example, would go up to $6,600 instead of to $5,000.

Senator ANDERSON. Did Mr. Myers suggest that?

Mr. KING. HEW suggested it though I assume that it came out of the House Ways and Means Committee.

Senator ANDERSON. I think the Ways and Means Committee——

Mr. KING. Excuse me, Senator, are you talking about the final suggestion—the final recommendation as the bill came out of the House Ways and Means Committee—or are you asking whether Mr. Myers suggested the cost figures now in the bill?

Senator ANDERSON. I think some of the changes that were made were made by the Ways and Means Committee in an effort to be sure they were completely cautious in their approach.

Mr. KING. I agree with that.

Senator ANDERSON. Whether Mr. Mills was right or wrong, I know Mr. Myers stayed pretty well with his figures and if you will go back and check the figures of the Social Security Board and HEW which

they have had over a period of 25 years you may be surprised how accurate they are compared to some of the figures put out by life insurance companies, for example, with respect to this bill.

Mr. KING. Senator, you could well be right and certainly I would not disagree with that statement except to say that I apparently have not been able to make myself clear.

That is the problem some of us country boys have from down south have.

Senator ANDERSON. You are getting along all right. [Laughter.]

Mr. KING. But the point I am making, and to me it appears quite valid, Senator, is this: In 1961, in the 87th Congress, HEW estimated that the King-Anderson health program, which was quite similar to the basic program provided for in H.R. 6675, could be financed at that time by an increase of one-half of 1 percent in the combined employer-employee tax rate and by raising the taxable earnings base by only $200, from $4,800 to $5,000. That was in the 87th Congress in 1961.

We come along now in 1965 and find that, before the present bill has even been adopted and has become law, the cost estimate has been changed to this, Senator: That in order to pay for the basic program—whether Mr. Myers changed the estimate or whether the House Ways and Means Committee did it—the ultimate combined employer-employee tax rate would have to be increased by eight-tenths of 1 percent and the ultimate earnings base to $6,600.

Now, Senator, to me that indicates that there have been substantial changes in the projection of costs from 1961 to 1965 even before the plan has been adopted.

I am no actuary; I am just a country boy trying to make a living selling insurance. So, whether the projections were correct in 1961 or whether they are correct in 1965, I do not know. I think the actuaries will tell you that the estimated cost figures are nearer correct in 1965 than they were in 1961 but I doubt that there is available in this world the sufficient information on morbidity for any actuaries to make really capable cost projections of the basic program far into the future.

Senator LONG. Couldn't that relate to three factors, though. One, that you have more old people than you had then because your population is getting older; two, that you are perhaps providing somewhat greater benefits under this bill than you had in the bill at that time; and three, that the committee states in its report that they deliberately made their estimates more conservative than the administration bill that was sent down to them.

Mr. KING. Certainly, Senator, those factors could be important. What the ratio of old people to the working population is today compared to 4 years ago, I am not sure. I am not sure whether it has increased or not. The benefits provided under the basic program in H.R. 6675 may be somewhat greater than Senator Anderson proposed in his original bill.

Senator LONG. With every year that goes by, the percentage of aged people over 65 to those below 65 tend to become greater because people are living longer. That is one of the advantages provided now for medical research and health treatment.

Mr. KING. That is correct.

Senator WILLIAMS. However, that was a known factor in 1961; it is known in 1965; it will be known in 1970, and it should be taken into consideration in the estimates made at any of those points, should they not?

Mr. KING. Certainly. We will assume, of course, and we will agree that Mr. Myers and other actuaries have always taken that factor into consideration.

Senator LONG. Don't the projections here—I haven't studied it as closely as you have, but don't the projections here indicate that the cost of this thing will go up even to provide the continued benefits that are projected under this bill?

Mr. KING. The bill——

Senator LONG. As population—as the average age of the population advances?

Mr. KING. Senator, we are talking about two different benefit plans here. First, there is the basic plan that would be financed by increased social security payroll taxes derived both from increased tax rates and from two increases in the taxable earnings base up to a maximum of $6,600 in 1971.

Now, as far as the voluntary supplementary health care program is concerned, Senator, I would like to call your attention to the fact that I doubt seriously that HEW has given the same type of study to the cost of the supplementary program that they have given to the cost of the basic program. The reason I say that is simply this: The bill itself provides that the cost of the supplementary program, the monthly premium to be paid—$3 by each participating individual and $3 from general revenues—be reconsidered every 2 years. The reason, I think, why the bill provides for periodic reconsideration is because the HEW people are afraid that the initial premium is not going to be sufficient to support the claim costs and the cost of administration.

Senator ANDERSON. I want to say, Mr. Chairman, I have been in on discussions on every one of the changes made in the bill, and I feel a little bit like the Irishman who had four children with whooping cough and who went to church and heard the padre preach a sermon on the blessings of matrimony, and said, "I wish he would have mine."

Mr. Myers pointed out the change in the base rate would have to take place because of a steady rise in earnings that would have to take place in any system. It wasn't a mistake at all by the social security people.

Things do change in the world. I think he made a great estimate and if you want to do it you ought to do it carefully.

They have been remarkably accurate over the past 30 years.

Mr. KING. Senator, agree with you. As I said earlier, I consider Mr. Myers an expert and I don't imply that he was mistaken. However, assuming that he was exactly right, Senator, if I am making $400 a month and it is going to cost me $10 a month for payment for a health care program and in 4 years the same program is going to cost me $20 a month, it doesn't make any difference to me whether anybody made a mistake now or whether he was exactly right and had every reason to increase the monthly cost to $20. It is still going to cost me the same $20 out of my earnings.

The increase in cost is going to be the problem to us.

Senator ANDERSON. You point out what the King-Anderson bill had in 1961. Then you point out it was raised at a later date, and your assumption is that HEW revised its estimate because they were wrong in the earlier years.

Mr. Myers very carefully stated what happened.

It was a rise in wages; it wasn't a question of error. If you can stop the whole economic cycle of this country and keep all wages where they now are, you can have a pretty stable estimate, but if they go up about 3 percent a year you have a wholly different picture. He has tried to point that out. It is not they made the mistakes in it. They knew what they were doing, that is what caused their good estimates to be made; they know what they are doing.

Do you have any opinion?

Mr. DUNAWAY. Yes, sir, I agree with Mr. King. We are not questioning Mr. Myers' expertise.

You will note that we said that "no one" really knows what the cost of this program is going to be. That refers to any actuary, not just Mr. Myers.

Now, with respect to Mr. Myers' earlier estimates, we are certainly not questioning his arithmetic. I think that you will find over the years that these cost estimates have been upgraded largely because Mr. Myers from time to time has been given different assumptions, more conservative assumptions, to work with——

Senator ANDERSON. Sure.

Mr. DUNAWAY. By the Ways and Means Committee, for example, and the Senate Finance Committee as well. I think that Mr. Myers himself has admitted over the years, when he was questioned on his cost estimates, that if certain more conservative assumptions had been used in the first place, the projected cost of the type of basic program proposed in H.R. 6675 would of course have been necessarily greater than his estimates.

So, we are not——

Senator ANDERSON. Wouldn't you admit that?

Mr. DUNAWAY. Sir?

Senator ANDERSON. Wouldn't you admit that?

Mr. DUNAWAY. Of course. So, we are not questioning Mr. Myers' ability as an actuary. We do question the various changes in the underlying assumptions which have been made over the years. Why weren't the same conservative assumptions made back in 1961?

Senator ANDERSON. Because the wage rates weren't the same in 1961. If you will go back and look it up you will find that to be true.

Mr. DUNAWAY. Wages were then increasing at about the same rate as they have been subsequently. The point is that there have been a lot of different assumptions that have been changed over the years on the conservative side and that some of these more conservative assumptions probably should have been known and used back in the days of 1961.

Senator Williams, I think, made a good point in rejoinder to Senator Long's comment that there are more older people now and that every year we are getting still more older people. Well, of course, we are, but this sort of trend should have been know back in 1961.

Senator ANDERSON. Is it your feeling that in 1961 the people who were sponsoring the bill felt that the wage base could stay where it is forever?

Mr. DUNAWAY. Well, that was one of the assumptions that later was shown to be unrealistic.

Senator ANDERSON. Wait a minute.

One of the assumptions by whom?

Mr. DUNAWAY. Well, I recall that when Mr. Mills was questioning Mr. Myers in, I believe, late 1963, it was revealed that a lot of the earlier cost estimates made by the HEW with respect to the King-Anderson bill were based on the assumption—not provided for in the bill itself—that the wage base would continually be raised to keep pace with the earnings level.

Senator ANDERSON. And has it?

Mr. DUNAWAY. It has not. But this is one of the assumptions that was made originally. That the wage base——

Senator ANDERSON. You mean there isn't a change in the wage base in this bill?

Mr. DUNAWAY. In this bill there is.

Senator ANDERSON. Sure.

Mr. DUNAWAY. That is the reason it is in here—to provide in advance for more realistic financing.

Senator ANDERSON. Was there one in the 1964 bill?

Mr. DUNAWAY. I think that the Senate's version of the 1964 bill provided for an increase in the base to $5,600.

Senator ANDERSON. That is right.

Mr. DUNAWAY. But that was later found to be not too conservative an assumption, at least in the eyes of the Ways and Means Committee, because they have provided for a further increase now to $6,600.

Senator LONG. May I just try to explain part of the difference here and I think this is the main point of contention here.

The old bill assumed that the tax rate was going to have to go up, and that——

Senator ANDERSON. The tax base.

Senator LONG. Well, the cost of the program is going to have to go up. You either increase the tax base or the tax but you had to do one or the other. This bill assumes you are not going to do that so this is a much more conservative bill.

Mr. DUNAWAY. That is right.

Senator LONG. This bill assumes, in other words, yes, the costs are going to go up but we are making the tax higher so when the costs go up we won't have to raise the tax. That being the case you come in with a higher tax.

Senator ANDERSON. It doesn't prove the old estimate is wrong.

Senator LONG. No, it doesn't prove the old estimate is wrong at all. It is on a different assumption. One goes on the assumption when the costs go up the tax will have to be raised; the other when the costs go up we are going to have it covered because we will have enough of a tax to cover it to begin with.

So, it is just the difference in approach, that is all. One is a pay-as-you-go, and the other was a basis of saying when the cost goes up we will have had it covered.

Mr. DUNAWAY. The only point I was trying to make in that connection, Mr. Chairman——

Senator LONG. It is not the same proposal, that is the whole idea.

Mr. DUNAWAY. That is quite right.

My only point was that up until about a year or so ago, I certainly was not aware and I don't think that most members of the Ways and Means Committee were aware that underlying all of these earlier cost estimates was the largely unpublicized assumption that from time to time in the future Congress would be called upon to increase the taxable earnings base as the level of earnings and hospital costs increased.

Senator LONG. Well, the whole thing about it is——

Mr. DUNAWAY. And they have done it now.

Senator LONG. In the committee report itself here it says that the estimate is that they have very conservative estimates and they would cover the increased costs in the event the costs continue to rise and so this just seems to me it is like saying that oranges don't cost the same as apples, well, they never did.

You just have got a different bill in that respect.

Senator ANDERSON. I only want to remind him that not only has in our economy the wage rate been raised but it was pointed out if you got it equal to what it was in the early days of the social security system it would go up to $13,000. You have heard those estimates, therefore, you know we have been talking about an increase in wage rates. I have never been in a discussion of the base when it has not been proposed as the years go by that it will have to be raised if costs go up. There is nothing unusual about these figures here at all, the natural development of a program over a period of years and nothing else.

Senator LONG. Any further questions?

Thank you very much. A very good statement.

Mr. KING. Thank you, Mr. Chairman.

(Mr. King's prepared statement follows:)

STATEMENT PRESENTED BY RAYMOND E. KING, JR., THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

I am Raymond E. King, Jr., of Charlotte, N.C., and I am the chairman of the Committee on Social Security of the National Association of Life Underwriters and also a member of the association's board of trustees. My organization is a trade association composed of 50 State and 855 local life underwriter associations with an aggregate membership of approximately 90,000 individuals, principally life insurance agents, general agents, and managers. Most of these individual members sell health insurance as well as life insurance.

My purpose in appearing before your committee today is to make known to you my association's objections both to the basic and the supplementary health care programs provided for in H.R. 6675 and to certain changes that would be made by this bill in the existing program of old-age, survivors, and disability cash benefits.

I. BASIC AND SUPPLEMENTARY HEALTH CARE PROGRAMS

H.R. 6675 would establish two coordinated health care programs—a compulsory "basic" program and a voluntary "supplementary" program—for persons aged 65 and over. Both programs would be administered by or under the control of the Department of Health, Education, and Welfare.

A. Basic program

Subject to the conditions and limitations spelled out in the bill, the basic program would provide for payment of the costs of hospital care, posthospital extended care, out-patient hospital diagnostic services, and posthospital home health services.

This basic program would be financed principally through an additional and separate social security payroll tax and trust fund. The rate of this new tax—

which would be the same for employers, employees, and self-employed individuals—would start at 0.35 percent in 1966 and rise over the years to a maximum of 0.8 percent in 1987. It would be applied to a $5,600 earnings base commencing in 1966 and then to a $6,600 base commencing in 1971.

On August 14, 1964, Roy D. Simon, the former chairman of my association's committee on social security, appeared before your committee and testified in opposition to the then pending King-Anderson social security health care bill (H.R. 3920, S. 880, 88th Cong.). Since the basic program proposed in H.R. 6675 is essentially similar to that for which the King-Anderson bill provided, our opposition remains unaltered and our reasons therefor unchanged. Thus, you will understand why this part of my statement is much along the lines of Mr. Simon's testimony of last year.

At the outset, I wish to make it absolutely clear, as Mr. Simon did, that my association is, of course, in favor of Government-financed health care for those aged individuals who, for one reason or another, are unable to meet the costs of their own health needs. We have, for example, long supported the Kerr-Mills program and will continue to do so through our affiliated State and local associations. We sincerely believe that tax funds can be most equitably and effectively used in a program of this type, which is directed to helping those aged people who are actually in need.

However, we are vigorously opposed to any system such as that contemplated in the basic program provided for in H.R. 6675 that would exact additional taxes from the younger, working population—many of whom are more financially hard pressed than many individuals over 65—to provide health care benefits to all aged individuals irrespective of their ability to finance their own health care costs. In this connection, we wish to point out that among the aged people entitled to the health care benefits provided under the basic program would be literally hundreds of thousands with substantial incomes either from continued employment or from retirement programs (such as social security, private pension plans, annuities, etc.) or from a combination of the foregoing sources.

In short, H.R. 6675 would increase the already heavy social security taxes paid by the younger workers and their employers to provide health care benefits for an extremely large group of aged individuals who are completely capable of paying for their own health care costs.

Moreover, no one really knows just how heavy the tax burden might become to support even the proposed basic program, because no one, in our opinion, has yet demonstrated any convincing ability to predict the eventual cost of the program with any reasonable degree of accuracy. This statement finds ample documentation in the continual and ever-rising changes that have appeared in the cost estimates made by the Department of Health, Education, and Welfare in the space of just a few short years.

For example, when the King-Anderson bill was first introduced in the 87th Congress in 1961, HEW estimated that it could be financed by increasing the combined employer-employee social security tax rates by one-half of 1 percent and by raising the taxable earnings base from $4,800 to only $5,000.

Later, HEW revised its estimates to show that while the proposed tax rate increase of one-half of 1 percent would still be adequate, it would be necessary to raise the earnings base to $5,200.

Then during the hearings held by your committee last August, you were told by HEW representatives that sound financing of the King-Anderson program would require either that the employer-employee tax rate be increased by eight-tenths of 1 percent and the earnings base to $5,400 or that the tax rate be increased by four-tenths of 1 percent and the earnings base to $6,600.

The current cost estimates made by HEW with respect to the King-Anderson type of basic program provided for in H.R. 6675, call for an eventual employer-employee tax rate of eight-tenths of 1 percent and an ultimate wage base of $6,600. Furthermore, as pointed out on page 49 of the report of the House Ways and Means Committee on H.R. 6675, even these upgraded cost estimates are stated to be applicable only during the next 25 years, rather than for 75 years as in the case of the cost estimates relative to the cash benefits system. This is so, as the Ways and Means Committee concedes, "because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit."

In addition, the HEW's current cost estimates, like those made in the past, do not and, of course, cannot take into account the still further increased costs that would result from the expansion and liberalization of the basic program

that would inevitably follow its initial enactment. And we might add that no one familiar with the history of the continued expansion and liberalization of the present social security cash benefits system can honestly doubt that the same pattern would be followed in the case of the basic health care program provided under H.R. 6675.

Incidentally, we respectfully suggest to you that in evaluating the validity of HEW's cost estimates concerning the basic program, you not overlook the fact that the Department apparently has not undertaken the making of any similar relatively long-range estimates in the case of the supplementary program. Indeed, the bill expressly contemplates that the so-called premiums payable by enrollees in the supplementary program, and the matching Government contributions, would be subject to periodic adjustments every 2 years.

Finally, while we would be opposed to the basic health care program in any event, we wish also to single out for particular criticism certain aspects of the method of financing the benefits that would be provided for the approximately 19 million aged people who would become eligible for such benefits as soon as the program went into effect. Specifically, we have reference to the proposal that the new social security payroll tax be used to finance the benefits for those 17 million aged people who are entitled to cash social security or railroad retirements benefits but that general revenues be the source of financing benefits for the remaining 2 million who are not entitled to such cash benefits.

As your committee is well aware, the vast majority of those in the 17-million group, like those in the 2-million group, would not pay or have paid 1 cent of the new social security tax provided to finance this basic program. It would thus make no earthly sense to use the social security tax to pay for the basic health care benefits received by the 17 million and general revenues to take care of the other 2 million. Furthermore, we are of the firm opinion that the introduction of general revenue financing—no matter how small in degree initially or how smoothly rationalized—would represent an unwholesome and even dangerous departure from the heretofore long-accepted concept of payroll tax financing.

B. Supplementary program

Subject to an annual deductible of $50 the voluntary supplementary program provided under H.R. 6675 would pay 80 percent of each participant's bills for doctors' services, wherever rendered; limited mental hospital care; home health services (with no prior hospitalization requirement); and numerous additional medical and health services. The supplementary program would be financed by (*a*) monthly contributions (initially set at $3) from individuals electing to enroll, and (*b*) matching Federal Government contributions from general revenues.

My association is, if anything, even more opposed to the supplementary program than to the basic program.

First of all, the supplementary program would virtually complete the elimination of the private health insurance business from any meaningful role in the provision of health insurance for the aged. This result would seem plainly to be contrary to the administration's intent as announced in the President's health message to Congress earlier this year. Further, this result would certainly mark a clear and undesirable departure from the principle upon which the social security system was founded and has heretofore operated; namely, that the system is designed to provide only a basic floor of protection, with covered individuals being left with the responsibility of providing any additional needed or desired economic security through private programs of thrift and protection.

Second, the Government's share of the financing would come from general revenues rather than from a payroll tax. As I have indicated earlier in this statement, we strongly believe that any Government program that provides benefits as a "matter of right" rather than on the basis of demonstrated needs should be financed by appropriate payroll taxation.

Third, as I have noted earlier, the supplementary program would be entirely voluntary. Now, it has always been our understanding that one point on which practically everyone has long agreed is that a so-called social insurance program will simply not work unless it entails compulsory participation. Accordingly, it is our belief that given a voluntary program of the type under discussion, there would be a distinct tendency for the financially better off individuals to enroll and for most at the lower income levels to remain outside the program. Thus, as we see it, the Federal Government would be in the position of heavily subsidizing, at the expense of the general taxpayers, a program for aged individuals best able to provide for themselves in the first instance, while doing nothing for many much less fortunate people.

In brief, the Federal Government would have set up a health care program which served little or no necessary social purpose and which would be a direct, unwarranted, and completely unfair intrusion into private enterprise.

So far as the cost of the supplementary program is concerned, we submit that but for the large Government subsidy involved in the program, the cost to participants would be about the same as the cost of similar coverage purchased from private insurers. In support of this statement we wish to refer to the following passage on page 7 of the recent book entitled "Social Insurance and Allied Government Programs," written by Robert J. Myers, chief Actuary of the Social Security Administration of the Department of HEW:

"Actually, a social security system is not a magical machine. We cannot put $1 of contributions into one end and continuously get $10 of benefits out from the other end. It is basic logic that the cost of a system is determined solely by the benefits and the administrative expenses paid. Accordingly, if in the aggregate the relative benefit cost of a social security system is the same as that of a private individual insurance plan or a group insurance program, the only difference in total cost arises from any differences in administrative expenses. Generally, however, administrative expenses represent only a small fraction of benefit costs, so that costwise, any advantage that a social security system possesses because of its size arises primarily on this account."

Now it is clear that the benefit cost of the supplementary program would be the same whether it was underwritten by the Federal Government or by private carriers. And as for the matter of administrative expenses mentioned by Mr. Myers, we wish to point out that H.R. 6675 itself recognizes that private carriers can administer a supplementary program of this nature at least as inexpensively and efficiently as the Federal Government in that the bill expressly requires the Secretary of HEW to use such carriers in the administration of the program to the extent possible.

II. PROPOSED AMENDMENTS TO EXISTING OLD-AGE, SURVIVORS AND DISBILITY BENEFITS SYSTEM

A. Earnings base

As previously mentioned in this statement, H.R. 6675 would increase the annual earnings base for tax and benefit purposes from $4,800 to $5,600, commencing in 1966, and $6,600, commencing in 1971. These increases would be necessary as a principal means of financing both the proposed basic health care program and the numerous proposed liberalizations of the existing social security cash benefits system. We are opposed to these increases for two reasons.

In the first place, the increases would place upon the higher paid employees and self-employed individuals a further disproportionate share of the burden of financing the social security system. In a contributory system of this nature, we feel that this burden should be shared with reasonable equality by all covered individuals.

Second, the increases in the earnings base would result in substantially increased future cash benefits to the better-paid employees and self-employed individuals and their families—and only to them—even though such individuals are in much less need of Government benefits and are much better able to provide for their own economic security than their lower paid fellowmen. In this connection, we again stress that the social security system properly is and should be designed to provide only a basic floor of economic protection to covered individuals and their families and that such individuals properly are and should be left with the responsibility of supplementing this basic protection through resort to private thrift programs.

Accordingly, we urge that such additional financing as may be required to support any amendments to the social security system approved by your committee and the Congress be derived solely from appropriate increases in social security payroll tax rates.

B. Disability benefits

H.R. 6675 would substantially liberalize the eligibility test for disability benefits by removing the present requirement that a covered individual's disability must be expected to result in death or to be of long-continued and indefinite duration. This would mean that disability benefits would be paid to a covered individual who had been totally disabled for at least 6 months, even though it was expected that he would recover at some definite future date. Furthermore, the

bill would make such benefit payments retroactive for the sixth month of disability.

Your committee has heard detailed objections to these proposed amendments voiced by witnesses who have already appeared before you. We are advised that you will hear still further detailed objections from other witnesses who will testify later on. Therefore, we will not burden the record of these hearings with undue repetition on these points.

Suffice it to say that we see in the proposed amendments an unnecessary, unwarranted, and unsound intrusion by the Federal Government into both the temporary and long-term disability income insurance field now being adequately and efficiently served by the private insurance business.

We are also greatly concerned that the amendments would result in duplicate benefits often being paid and would in many cases thus create anomalous situations where disabled individuals actually received substantially more take-home income during their disabilities than they had received while working. Obviously this would act as a strong deterrent to the rehabilitation of such beneficiaries. This, in turn, would tend to increase the incidence and the duration of claims, which would ultimately and inevitably cause increasingly higher costs both to insureds under private plans and to the social security taxpayers.

Accordingly, we urge your committee to reject these amendments.

In conclusion, I would like to express to your committee my association's appreciation for giving me this opportunity to express our views on the foregoing provisions of this highly important bill. If you feel that we can be of any further assistance, we hope that you will feel free to contact us.

Senator LONG. The next witness is Mr. Edwin P. Jordan of the American Association of Medical Clinics.

Will you proceed, sir.

STATEMENT OF EDWIN P. JORDAN, M.D., EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF MEDICAL CLINICS

Dr. JORDAN. Mr. Chairman and members of the committee, my name is Edwin P. Jordan and I am a physician serving as executive director of the American Association of Medical Clinics with offices in Charlottesville, Va. This is a voluntary medical society composed of over 160 private medical clinics located in 38 States and the District of Columbia. About 18 percent of our members own or control their own hospitals. The physicians in these clinics care for approximately 8 million patients who make approximately 20 million visits to the doctors in these clinics annually. Hence, our members are concerned with many aspects of this bill, although my remarks will be confined to only a few of its provisions.

The services described under "Outpatient hospital diagnostic services" under section 1861(p) on page 81 and elsewhere are of paramount importance. We believe that the stated provisions are obscure as to coverage, unsound medically, discriminatory, and will cost more than necessary. It is poor medicine to try to separate diagnosis from treatment: a patient who breaks a leg needs to have it set as well as to know that it has been broken.

Many hospitals do not have outpatient facilities or services. In many instances those which are available are for emergency care only.

The pressure on hospitals which do not now operate such services to introduce them would bring about heavy new costs and duplication of facilities.

In many areas, indeed, such hospital outpatient services as are available are greatly overburdened already and the services intended are already adequately covered by private medical clinics, such as

the members of this association, or by other established an approved services in the community.

In view of the addition to this bill since the original introduction of S. 1 and H.R. 1 of part B of title XVIII, "Supplementary Health Insurance Benefits for the Aged," we would urge that the benefits included under outpatient hospital diagnostic services, now described in section 1861(p) be transferred to section 1832. This would place all medical services under the same portions of the bill and would correct a situation in which it is implied that diagnostic services can be provided without the participation of those who are qualified to perform such services—namely, licensed physicians. Furthermore, such transfer would solve the arbitrary and medically unsound division of medical care into diagnostic and therapeutic categories.

We are in complete accord with the deletion from the original S. 1 and H.R. 1 of the provision included there under "Hospital insurance benefits for the aged" of services rendered by physicians in the fields of anesthesiology, radiology, pathology, and physiatry. Some of the services rendered by these physicians are diagnostic, some are therapeutic—indeed most of the services of the anesthesiologist and physiatrist are therapeutic. The physicians practicing in these specialties are trained, qualified, and licensed as are other physicians and now payment for their services can be made under part B of the new bill in the same manner as payment for other physician services. Consequently, we would strongly urge that such services be not replaced in the part A section on "hospital insurance benefits."

Section 1861(q) as now written, "physician's services" would include those provided by an intern or resident (see lines 15–21, p. 64) many of whom are not licensed to practice medicine or are otherwise unqualified. Some change, we believe, should be made in this paragraph to remedy this situation.

We should like at this time to reiterate a position which we have taken previously regarding section 1861(i) on page 71—, namely, that there should be some provision in the bill for direct entry into an "extended care facility" (or care in the home) without the necessity of going to a hospital first. There are may instances in which hospitalization prior to care in an extended care facility or skilled nursing home would simply increase the cost without medical benefit to the patient.

Furthermore, there are occasions, such as may occur in certain stages of illness following a stroke, in which unnecessary moving of a patient from home to hospital to nursing home might result in actual harm to the patient. Whether a patient is best cared for in a hospital, "extended care facility," or in the home involves a professional medical judgment and should not, we believe, be determined by prior location of the patient.

We feel that further attention should be given to the definition of "spell of illness" (sec. 1861(a) on p. 63). As now written, we would interpret this to mean that an elderly person who suffered a fractured hip, and received the maximum care allowed under the bill in the hospital or an extended care facility, and 10 days after reaching home following such care fell ill with pneumonia, would not be eligible for any further benefits. Indeed in a situation such as this it is not clear (aside from the time element) whether a pneumonia following

a fractured hip was the same or a different "spell of illness," although they are not infrequently medically related.

Finally, we should like to express the opinion that this committee can make a most important contribution by clarifying the language in many portions of the bill in order to avoid ambiguity and confusion in administration.

For example, paragraph (f) of section 1812 on page 12 and paragraph (a)(1) of section 1813 on page 13 are virtually impossible to understand as now written.

I thought perhaps that this was because I was just a doctor, so I showed it to three lawyers, and they couldn't understand it either.

There are many other places in the bill where the language is obscure.

I wish to thank you very much.

Senator LONG. Thank you very much for your statement and I am going to ask that our staff take a look at these points to be sure that we try to clarify the language so that you will know one way or the other what this bill means.

Dr. JORDAN. Thank you.

Senator LONG. Any other questions?

Senator RIBICOFF. How many medical clinics are there in this country?

Dr. JORDAN. It depends on the definition.

Senator RIBICOFF. In your association.

Dr. JORDAN. A little more than 160.

Senator LONG. Any further questions?

Thank you so very much, Doctor.

Dr. JORDAN. Thank you.

Senator LONG. Dr. I. Lawrence Kerr, of the American Dental Association.

STATEMENT OF DR. I. LAWRENCE KERR, MEMBER, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION; ACCOMPANIED BY BERNARD J. CONWAY, CHIEF LEGAL OFFICER, AMERICAN DENTAL ASSOCIATION

Dr. KERR. Good morning, Mr. Chairman, and gentlemen of the committee.

Mr. Chairman and members of the committee, my name is Dr. I. Lawrence Kerr, of Endicott, N.Y. In addition to maintaining a private practice in that city, I am a member of the Council of Legislation of the American Dental Association.

With me here today is Mr. Bernard J. Conway, chief legal officer of the association. We are pleased to have this opportunity to appear before you. We have submitted a more detailed statement for the record, which I will attempt to summarize in the 10 minutes allotted for our presentation. Our comments, for the most part concern title I of H.R. 6675.

The American Dental Association has long been concerned with the health problems of the aged, recognizes that the problems are not yet entirely solved and agrees that the Federal Government has a proper role to play in solving them. The hospital and medical care plans being considered here, however, are not the answer. In our

opinion, they are unnecessary and imprudent and we are opposed to them.

Dentistry, we are aware, is not deeply involved in these plans. Nonetheless, were they to be enacted, it is only realistic to expect a broadening both of benefits and of coverage. The pattern for such extension can be seen in the history of the present OASDI law.

Our opposition to these plans is twofold: we believe the underlying assumptions to be mistaken and we believe the basic principle—extension of care without regard to need—to be wrong. Later in this statement we would also like to draw your attention to what is, in our professional judgment, an incompleteness in the plans themselves.

At the start, I should like to make it clear that our opposition to these plans does not stem from a negative view of Government's role. We fully support the legitimate and essential activities the Federal Government carries out in the health field. I refer here to such programs as hospital construction, research, aid to professional education, and support of local public health services and facilities. When President Johnson sent his health message to Congress in January, an association spokesman publicly praised many portions of it as being "prudent and realistic."

Indeed, we are deeply concerned that embarkation on such a massive treatment program as H.R. 6675 authorizes would deter Congress from giving adequate support to these other essential activities.

Our major objection to these plans, as I have said, is that they extend care without regard to need. Now, anyone who needs health care is entitled to it irrespective of his ability to pay. But we see nothing unreasonable in saying at the same time that those who can be self-sufficient, should be self-sufficient. Methods of determining need in a way that is neither demeaning nor humiliating are readily available.

This objection, of course, relates to both the hospital and medical plans. A second drawback in regard to the latter, is that it is so designed that those in greatest need of the benefits may well be the very ones least likely to join the plan.

It should also be noted that this medical care plan was not the subject of open hearings before being incorporated into H.R. 6675. This is true, as well, of part 2 of title I. This, we believe, is most unforunate.

Another questionable assumption underlying both plans is the mistaken belief that this problem is permanent rather than transitional.

A man who is 65 this year probably began his working career about 1920. This was a very different country then from what it is today. Today we have social security. Today we have widespread pension and retirement plans. Today, we have rapidly growing voluntary health insurance that can be carried into retirement years. We also have, it should be noted, a soundly established and swiftly growing system of prepaid dental insurance both on a nonprofit and commercial basis.

A great many of today's middle-aged, not to speak of future generations, could, under prevailing conditions, enter their retirement years with considerable proctection in terms of income and health insurance.

Finally, we believe the proponents of these plans fail to recognize the impact that Kerr-Mills has had and could continue to have.

Admittedly, Kerr-Mills is not free from defects. It needs perfecting amendments by Congress and fuller implementation by the

States. But it has demonstrated its soundness; it has shown it can do the job without earmarking our Nation on an unwarranted and irreversible course.

Another advantage of Kerr-Mills is that it reasons the community and the State as active partners with the Federal Government. These political bodies are the ones best able to judge the local needs and tailor a program to meet them.

We have, Mr. Chairman, the utmost respect for the sincerity and competence of those supporting these plans. The objections, nonetheless, are overwhelming and we believe both plans should be eliminated from the bill.

In addition to the conceptual objections just discussed, the association believes it has the obligation to point out a number of defects in H.R. 6675 which relate solely to its soundness from the professional viewpoint.

Perhaps its foremost defect from the standpoint of total health is the failure of the draftsmen of the bill to carry out the recommendation made by President Johnson in his January 7 health message to Congress with respect to dental care. The President asked Congress to—

> Permit specific Federal participation in paying costs of dental care for children in medically needy families.

However, that part of the bill, dealing with grants to States for medical assistance virtually ignores this Presidential request. In doing so, it ignores the fact that 60 percent of the children between the ages of 5 to 14 who are members of families whose income is below $2,000 have never received dental care. It ignores the fact that in this same age bracket, irrespective of economic considerations, 24 percent of urban children and 42 percent of rural farm children have never received dental care.

We believe the President's recommendation should be honored and that the bill should be amended to include dental care as one of the required benefits for dependent children under the expanded medical assistance program being proposed.

Oddly enough, one of the required benefits in this section of the bill is skilled nursing home care. We have been told that in a recent Children's Bureau study of 11,000 nursing home patients, it was found that only 8 of these patients were under the age of 15. We don't know why even these eight children were placed in old folk's homes, but we believe the example illustrates the folly of requiring nursing home benefits that would be of great help to most, if not all, needy children.

The association also has serious professional objections to provisions of part B of "Title I, Supplementary Health Benefits for the Aged," which discriminate unfairly among practitioners of the healing arts.

In this country, there are hundreds of dental practitioners who admit patients to hospitals for oral surgical procedures. Many dentists who have completed internships and residency programs in oral surgery regularly perform such procedures as excision of oral tumors and cysts, removal of stones from salivary ducts, reduction of fractures of the jaw or facial bones, and other operations that certainly are intended to be covered under part B of title I of the bill. Yet, as presently written, a beneficiary who selected a dentist rather than a physician to perform such procedures would arbitrarily be denied a covered benefit.

The drafters of the bill ignored the fact that no sound comprehensive health benefits plan can be written without the inclusion of some benefits that are within the scope of dental practice. They also ignored the fact that today practically all health insurance plans in the private sector recognize the right of dentists to perform oral surgical procedures and include a dentist within the definition of "doctor" or "physician" under such plans. All contracts under the Federal Employees Health Benefits Act, contain provisions permitting beneficiaries to select dentists to perform covered oral surgical services.

There would appear to be no valid reason why, in the supplementary benefits portion of H.R. 6675, the Government should depart from a pattern that is so well recognized and so firmly established in the private insurance field.

This defect in the bill should be corrected by appropriate amendments. It should be clear, Mr. Chairman, that such amendments would in no way increase or expand the present scope of benefits in the bill.

Finally, Mr. Chairman, the association wishes to record its objection to the reimposition of the 3 percent limitation on the deductibility of medical and dental expenses by taxpayers 65 years of age and older as proposed in section 106 of the bill.

The rationalization given for this by the House Ways and Means Committee is that with the basic and supplementary benefit plan provided in the bill, older persons will not have a need for this tax incentive. This argument has no validity with respect to dental expenses since dental care is not included as a benefit in title I.

Many aged people require dental treatment, much of it involving replacing natural teeth with dentures. Such treatment is necessary for nutritional reasons and to maintain good general health. People should continue to be encouraged to so provide for their dental health needs; but rather than encouraging them, enactment of this section of H.R. 6675 would, in effect, penalize them for taking steps to protect and maintain their good health.

In conclusion, we reiterate our unreserved opposition to the hospital care and supplementary care portions of H.R. 6675, but we also emphasize the necessity of including dental care, in any plan for providing health care to our aged population and needy groups.

Thank you for the opportunity to appear before this committee; Mr. Conway and I are prepared to answer any questions you might have.

(The full prepared statement of Dr. Kerr follows:)

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the committee, my name is Dr. I. Lawrence Kerr of Endicott, N.Y. In addition to maintaining a private practice in that city, I am a member of the council on legislation of the American Dental Association. With me here today is Mr. Bernard J. Conway, chief legal officer of the association. We are pleased to have this opportunity to appear before this committee to discuss the important questions raised by H.R. 6675. Most of our comments concern title I of the bill.

PART I

The American Dental Association is well aware of the fact that there is a serious problem regarding the health care of the aged, that the problem has not yet been entirely solved and that the Federal Government has a proper role to play in such a solution. The solution envisioned by part I, title I of H.R. 6675,

however, is one that the association considers to be unnecessary and imprudent and we consequently oppose passage of H.R. 6675 in its present form.

Our opposition is twofold: We first of all believe that many of the principles underlying the hospital and medical care plans are mistaken ones, especially the principle of extending care without any regard for need. And then, secondly, we believe that the plan as drawn is, from a professional point of view, incomplete. This latter objection we will deal with in the second section of this statement. At this time, I should like to briefly discuss the mistaken premises upon which these plans are based.

As prolog to our comment, I should like to make it absolutely clear that our opposition is not based on mere obstructionism or on an unduly negative attitude toward the Government's role in the health field. The dental profession has long recognized that the Federal Government has a legitimate and essential role in improving health standards for our people and over the years the association has supported many legislative proposals involving the participation of the Federal Government. The Federal Government, for example, has traditionally and properly assisted in such health activities as hospital construction, expansion of community health services and facilities, general health and specific disease research, aid to professional education and general public health programs. These are activities that benefit not just a few of our citizens, but all of them.

When President Johnson sent his health message to Congress this past January, Dr. Fritz A. Pierson, serving this year as president of the American Dental Association, issued a statement praising many aspects of the Presidential message for offering "a prudent and realistic approach" to meeting our Nation's health needs.

Our opposition to the hospital and medical care plans in H.R. 6675, then, doesn't spring from an unreasoning bias against governmental action. Indeed, we are deeply concerned that if Federal resources are concentrated on a new and massive treatment program, this would inevitably deter Congress from continuing to support adequately these other essential activities.

Such a consequence could well be one effect of the hospital and medical care plans of H.R. 6675.

Dentistry, we are aware, is involved only to an incidental degree in the pending proposals. It is only realistic to expect, however, that were these parts enacted it would mark the first step in an inevitable broadening both with respect to benefits and coverage. The pattern for such extension can be seen in the history of the present OASDI law.

Our major objection, as we have said, is that both plans extend care without regard to need. Now, any person in need of health care is entitled to receive it, irrespective of his ability to pay. But there is nothing unreasonable, in our judgment, in the proposition that those who have the resources to be self-sufficient should be expected to be self-sufficient. Whatever programs are enacted to provide health care should be designed to include a method of determining who is in need and who is not. Such a determination should not, and need not, be made in a way that demeans or humiliates anyone. Strictly from the standpoint of logic, if it is proper for the Government to provide health services for one segment of the general population without regard to need, then it would be proper to provide such services to any or all other segments. Certainly, there are persons in all age groups within our society who for one reason or another do not receive adequate health care.

For example, the dental profession has long concentrated much of its attention on the dental health of children. This is because it is with children that the dentist can most effectively establish sound oral health and thus prevent much serious disease from occurring during adulthood and old age. From direct experience, we know that there are children who do not receive adequate dental care because their families cannot afford it.

Certainly, such children are entitled to assistance. We agree here with President Johnson, who called for such assistance in his health message, and we regret that the Department of Health, Education, and Welfare has seen fit to ignore the President.

Nonetheless, it does not follow that a massive Federal health benefits program should be established which would also include the many millions of children whose families are self-sufficient.

Relative to the importance of children's needs, it is worth noting that since Britain began its national health program there has been a concentration on restorative care for adults and a consequent neglect of preventive care for children.

This objection, of course, relates to both the hospital and the medical plans in the bill. A second drawback with respect to the medical plan is that it is so designed that those in greatest need of it may well be the very ones least likely to join it.

Conversely, those in the best position to provide their own health care of the type covered will undoubtedly and understandably hasten to take advantage of this bargain package. It should also be noted that this medical care plan was not subject to full and open hearings before being incorporated into the bill. This is true, as well, of part 2 of title I. This, we believe, is most unfortunate.

Another questionable assumption underlying both plans is the apparent belief that this problem is a permanent one rather than being transitional.

A man who is 65 this year probably began his working career about 1920. This was a very different country then. There was no social security system; there was little in the way of pensions, retirement plans, or private annuity programs; health insurance was virtually unknown. Furthermore, today's elderly citizens lived out part of their middle years in the midst of a worldwide depression that undoubtedly limited their ability to provide for their retirement.

Today, obviously, all this has changed. We now have social security; we have widespread pension and retirement plans and rapidly growing voluntary health insurance that can be carried into the retirement years. In fact, a great many of today's middle aged, not to speak of future generations, could, under prevailing conditions, enter their retirement years with considerable protection in terms of income and health insurance. In passing, it might also be noted that we are witnessing for the first time a soundly established and swiftly growing system of prepaid dental insurance both on a nonprofit and commercial basis.

These plans, then, propose a permanent solution for a problem that very probably is temporary. They ask the Nation to transform the health care system that has served it so well at the very moment when it is demonstrating its ability to cope with this problem.

We finally believe that the proponents of these plans fail to recognize the impact the Kerr-Mills program has had and could continue to have. Admittedly, the Kerr-Mills program is not free from defects. It needs perfecting amendments by Congress and fuller and more imaginative implementation by the States. But it has demonstrated its soundness; it has shown its basic capability for doing the job without at the same time embarking our Nation on an unwarranted and irreversible course.

Another advantage of Kerr-Mills is that it retains the community and the States as active partners with the Federal Government in providing the care necessary. This is important since it is these political bodies that can best judge the needs that exist in their localities and most efficiently tailor a program that will meet fully those needs.

The hospital and medical care plans of H.R. 6675, then, are ill conceived. They unnecessarily single out a segment of the population even though many persons within that segment have no need for assistance. They propose a permanent solution to a transitional problem. They ignore the progress that has been made by the private sector and by such public programs as Kerr-Mills. Because they go beyond the provision of assistance to those who truly need it, these plans will prove a drain on those resources of the Federal Government that can prudently be allocated to the health field. We have, Mr. Chairman, the utmost respect for the sincerity and competence of those supporting these plans. The objections, nonetheless, are overwhelming and we believe both plans should be eliminated from the bill.

PART II

In addition to the conceptual objections just discussed, the association believes it has the obligation to point out a number of defects in H.R. 6675 which relate solely to its soundness from the professional viewpoint.

Perhaps its foremost defect from the standpoint of total health is the failure of the draftsmen of the bill to carry out the recommendation made by President Johnson in his January 7 health message to Congress with respect to dental care. The President noted the need for dental care for poor children and recommended a program to—

> Broaden the public assistance program to permit specific Federal participation in paying costs of medical and *dental care* for children in medically needy families, similar to the Kerr-Mills program for the aged. [Italic supplied.]

However, part 2 of title I of the bill, dealing with grants to States for medical assistance, virtually ignores the President's request insofar as dental care for needy children is concerned. It ignores the fact that 60 percent of the children between the ages of 5 and 14 who are members of families whose income is below $2,000 have never received dental care. It ignores the fact that in this same age bracket, irrespective of economic considerations, 24 percent of urban children and 42 percent of rural farm children have never received dental care. It ignores President Johnson's statement in his health message that at age 15, the average child has 10 decayed teeth.

We believe the President's recommendation in this respect should be honored and that the bill should be amended to include dental care as one of the required benefits for dependent children under the expanded medical assistance program proposed in the bill. Oddly enough, one of the required benefits in this section of the bill is skilled nursing home care. We have been told that in a recent Children's Bureau study of 11,000 nursing home patients, it was found that only 8 of these patients were under the age of 15. We don't know why these 8 children were placed in old folks' homes but we believe the example illustrates the folly of requiring nursing home benefits that would be virtually unused while not requiring dental care benefits that would be of great help to most, if not all, needy children. A simple amendment would remedy this defect in the bill.

The association also has serious professional objections to provisions of part B of title I, "Supplementary Health Benefits for the Aged," which discriminate unfairly among practitioners of the healing arts.

In this country, there are hundreds of dental practitioners who admit patients to hospitals for oral surgical procedures. About 40 percent of our hospitals have formalized dental services. Many dentists who have completed internships and residency programs in oral surgery regularly perform such procedures as excision of oral tumors and cysts, removal of stones from salivary ducts, reduction of fractures of the jaw or facial bones, and other operations that certainly are intended to be covered under part B of title I of the bill. Yet, as presently written, a beneficiary who selected a dentist rather than a physician (M.D. or D.O.) to perform such procedures would arbitrarily be denied a covered benefit.

The drafters of the bill ignored the fact that no sound comprehensive health benefits plan can be written without the inclusion of some benefits that are within the scope of dental practice. They also ignored the fact that today practically all health insurance plans in the private sector recognize the right of dentists to perform oral surgical procedures and include a dentist within the definition of "doctor" or "physician" under such plans. All contracts under the Federal Employees Health Benefits Act which is administered by the U.S. Civil Service Commission contain provisions permitting beneficiaries to select dentists to perform covered oral surgical services.

Virtually all hospitals permit dentists to admit patients for oral surgical services and standards regarding dentistry in hospitals have been adopted by the Joint Commission on Accreditation of Hospitals.

There would appear to be no valid reason why, in the supplementary benefits portion of H.R. 6675, the Government should depart from a pattern that is so well recognized and so firmly established in the private insurance field. To do so is unsound from the health standpoint and discriminatory against program beneficiaries and dental practitioners.

This defect in the bill should be corrected by appropriate amendments. It should be clear, Mr. Chairman, that such amendments would in no way increase or expand the present scope of benefits in the bill. The amendments would merely permit a patient to select a qualified doctor of dentistry as well as a doctor of medicine or osteopathy to perform covered oral surgical procedures.

Finally, Mr. Chairman, the association wishes to record its objection to the reimposition of the 3-percent limitation on the deductibility of medical and dental expenses by taxpayers 65 years of age and older as proposed in section 106 of the bill. The rationalization given for this by the House Ways and Means Committee is that with the basic and supplementary benefit plan provided in the bill, older persons will not have a need for this tax incentive. This argument may have some validity with respect to medical care but it has none with respect to dental expenses since dental care is not included as a benefit in title I of the bill. Many aged people require dental treatment, much of it involving replacement of natural teeth with dentures. In many cases it is

absolutely essential for nutritional reasons and for the maintenance of good general health in aged persons. Such people should continue to be encouraged to provide for their dental health needs. Rather than encouraging them, enactment of this sectior of H.R. 6675 would, in effect, penalize them for taking steps to protect and maintain their good health.

APPENDIX I

The board of trustees of the American Dental Association adopted the following resolution on April 1, 1965:

Resolved, That Congress be requested to improve and expand State medical assistance to the aged programs by amending the Kerr-Mills Act to include the following provisions:

1. Entitlement for health care benefits under the MAA portion of the Kerr-Mills Act should continue to be based upon need; but individual or family need should be determined by reference to income only. (Other factors such as assets and ability of children to contribute would not be considered in determinations of need.)

2. Those administering the State plan should be authorized to confirm the income statement submitted by an applicant for Kerr-Mills benefits by reference to his Federal income tax return.

3. States should be given strong encouragement to establish a basic plan of benefits for Kerr-Mills (MAA) recipients. As an incentive to the establishment of such uniform basic benefits, the Federal Government should increase the Federal share of Kerr-Mills (MAA) funds paid to a State by 10 percent if that State adopts a uniform basic benefit plan as outlined in the Kerr-Mills Act.

4. Dental care should be included in any uniform basic benefit plan described by the Kerr-Mills Act.

5. The uniform basic benefit plan should be available to those applicants for Kerr-Mills coverage whose income is below a minimum prescribed in the Federal Kerr-Mills Act.

6. States which do not elect adoption of the uniform basic benefit plan should be permitted to continue to determine the scope and types of care to be provided in their programs.

7. States which expand upon the uniform basic benefit plan should be free to determine the scope and types of care to be provided within the expanded portion of their programs.

8. States should be permitted to establish a sliding scale of income test. The range of income would be between a minimum, which would call for no financial contribution from an aged recipient (including recipients eligible under the uniform basic plan), through graduated brackets of income up to a maximum; in each bracket the recipient would contribute an increasingly larger share of an enrollment fee (the equivalent of a flat annual premium for the health care coverage specified in the State's program).

9. States should be left free to determine the amount of income beyond which there would be no health care entitlement.

10. States should place the responsibility for administering MAA plans within the State department of health or equivalent agency. States should be permitted to assign administration of their plans to nonprofit prepayment agencies or commercial carriers.

11. The Federal share of Kerr-Mills (MAA) State plans should continue to be financed from general revenue; and it further

Resolved, That the association urge Congress to reject any plan for aged health care which would offer benefits without regard to financial need

Senator ANDERSON. Senator Williams, do you have any questions?

Senator WILLIAMS. No questions.

Senator ANDERSON. Senator Gore?

Senator GORE. No questions.

Senator RIBICOFF. From your professional standpoint, do I understand that, since the bill already provides for oral surgical benefits to be paid, to exclude the dentists is unfair because many dentists perform oral surgery on people?

Dr. KERR. Senator, I would take myself, as an example, and then the rest of the profession with me, of course. It is within the scope of our license to practice these oral surgical services and they are everyday affairs. In my own case, even coming from a smaller community, each day I admit an aged person for oral surgical services.

Senator RIBICOFF. And you are allowed to do this in hospitals?

Dr. KERR. Oh, yes, sir; and we have a great many hospitals that have this service, and many hundreds of dentists who participate in this activity and I really feel we should not deny the patient the specialized services of these men who are capably trained for this work.

Senator RIBICOFF. In other words, you seek an amendment not to include overall dental care for people but only to provide that the fees already payable to doctors for performing oral surgery on a person over 65 should be able to be paid to dentists as well?

Dr. KERR. Yes, sir.

Senator RIBICOFF. On the children, you are not asking for dental care for all children, as I understand it, but just for the dependent children?

Dr. KERR. Yes, sir.

Senator RIBICOFF. Under the expansion of the Kerr-Mills section of this bill?

Dr. KERR. Yes, Senator; and it is a passion with me. Having dealt with needy children all my life I can tell you that this investment in the dental health of needy children will provide citizens who are today among our greatest natural resources, really, with better health and better able to serve this Nation.

Senator RIBICOFF. Thank you.

Senator CARLSON. Mr. Chairman.

Senator ANDERSON. Senator Carlson.

Senator CARLSON. Dr. Kerr, did I understand you to say all contracts assumed by the Civil Service Commission under the Federal Employees Health Act recognize the right of the dentists to do oral surgery?

Dr. KERR. Yes. The Federal employees' health benefits plans have this benefit in them and it is really a fine part of the services rendered under these contracts.

Senator CARLSON. Then, is this not a standard pattern in the private health insurance industry?

Dr. KERR. Yes, sir; in the overwhelming majority of plans these services are covered.

Senator CARLSON. I noticed the Senator from Connecticut, Mr. Ribicoff, got into the children's section.

Now, section 532 of the bill on page 150 authorized special project grants for needy—for medical and dental care for needy children. Among the institutions authorized to receive such grants are:

> Any school of medicine (with appropriate participation by a school of dentistry).

Now, can you tell us why this rather curious language was used with respect to dental schools?

Dr. KERR. I really cannot, Senator Carlson, and I just don't quite understand it. It seems to me that the bill should merely say any school of medicine and any school of dentistry, and these schools would be most capable of providing the service, sir.

Senator CARLSON. It seems to me, as we get into the executive session on that bill, we should at least get some further information on it or at least clarify that.

Dr. KERR. Yes, sir.

Senator CARLSON. That is all, Mr. Chairman.

Senator ANDERSON. I was glad to hear what you said about this 3-percent deduction for those past 65. I had a "little Taj Mahal built in my mouth one day" and I thought the bill was way too high. I was very stirred up about it and my wife said, "Isn't it deductible?" I realized he charged me a very little bit; that "Uncle Sam" paid the the rest of it.

Thank you very much for your testimony and I do think that you are a little overoptimistic about pension plans taking up too much of this. I think the maximum of people believe it might reach 25 or 30 percent but there still remains a large group that are not taken care of.

Dr. KERR. Thank you very much. We appreciate your courtesy, Mr. Chairman.

Senator ANDERSON. Dr. Standard. Will you identify yourself for the record, please?

STATEMENT OF SAMUEL STANDARD, M.D., ON BEHALF OF COMMUNITY COUNCIL OF GREATER NEW YORK, INC.

Dr. STANDARD. I am Dr. Samuel Standard, and this is Miss Minges, who is executive secretary of the Citizens Committee on Aging, and we are both representing the Community Council of Greater New York.

This is a central coordinating body for welfare and health services in New York City, and in discussing the council's position regarding health care benefits for the aging contained in H.R. 6675, I draw on my experiences as professor of clinical surgery, New York University Medical Center and director of department of surgery, Montefiore-Morrisania Affiliation.

Community Council of Greater New York endorses all three portions of this bill which would make health care benefits available to the aging, accepting the spirit and general content as a step forward in health care of our aged.

As I was listening to the testimony that came before, I was interested in seeing how a difference in discipline makes a difference in point of view.

As a surgeon, I must say, who has been taking care of people, I think this worry about whether people who have now attained the age of 65 have not paid 1 red penny in social security is not altogether a reasonable thing for which to exclude them. I think we now sit in the shade of trees that we never planted, and these people planted them, and I think this is one way we can repay them.

The other thing is about rising costs with the passage of time. I listened to the aspect of cost rising and there is one more aspect that I think must be understood and that is that medical care as it is increasing in time with the greater scientific knowledge we have will raise these costs far above what may be submitted in costs.

We have in the past been all to prolong life. Now, we are able to postpone death and the postponement of death is a very expensive pastime.

Right now we can bypass a patient that has kidneys that no longer function for him; that costs him $10,000 a year, and I think the problem that will be faced by legislators as well as by doctors will be not so much where the money comes from, it will have to come from somewhere, but rather the moral question of who shall be subjected to this. Shall it be the gangster who has earned a million dollars or racketeer in his lifetime or shall it be the teacher or artist or composer or the poet who cannot afford it.

This moral problem will become a serious one unless the cost of these various items are reduced significantly as time goes on.

However, this kind of legislation, I think, is the first step as we must always have the first step in a thousand-mile journey, and rather than looking at it as a finished product, I think all of us should look at it as a hope for the future, and I think it is not quite understood by people who are not in medical care that a man suffers when be becomes ill. Actually, when he becomes ill he does suffer both the pangs of illness and the cost it may be to him when he ceases being a wage earner and the cost of hospitalization and doctors and the rest. But more than that this man suffers from the anguish of the apprehension of illness throughout his life, so that where he is ill three or four times a lifetime may be serious, he actually worries about it the rest of his life.

This will take his anguish away from him; this will remove the specter of fear he has that hangs like a sword of Damocles over his head and he never knows when he will be struck and when he won't and this will remove his difficulty.

I think aside from being a money matter, President Johnson now speaks of an antipoverty program, I think this is the first step in an antihumanity program. This deals not around the care of the sick but the comfort of those who are not sick against a time when they will be sick.

So, we are for it completely.

Being for it we still feel that there are certain aspects of it that we wish were different, and I am here today to speak of some of those aspects.

One aspect of any training I will emphasize now because it deals with the—with my acquaintanceship with the quality of medical care. I have been a surveyor of 30-some surgical services for the Health Insurance Plan in New York.

I was a surveyor for the Hotel Trades Council survey before they set up their health organization in New York. I was the surveyor in both of the reports for the Teamsters, the one that came out years ago and the one that just came out here a scant month ago, and in this capacity, I have been measuring the quality of medical care and I should like to discuss some aspects of this bill in which it could be strengthened in that direction.

I will say that when I speak I speak as a physician, and, therefore, I think my closest association must be with that organization of physicians which objects to this entire bill and that is the American Medical Association.

I would like to say from the beginning that those aspects of the American Medical Association's activities that deal with elevation of

hospital accreditation standard; elevation of surgical training standards for surgeons is to be applauded. They have done a magnificent job and I might say that as a member of the accreditation committee which consists of the American Medical Association, the American Board of Surgery, as well as the American College of Surgeons, I am a member of all three, I have been chosen as one of the surveyors for this accreditation committee and have gone about looking at hospitals and measuring the quality of their facilities, their material, their equipment, and the caliber of their teachers on their intended staff to see whether it is safe to send a young surgeon there for training.

The American Medical Association has done a magnificent job in that direction, and just as I applaud this association for this, I must say that I find myself a little disappointed in its attitudes outside of patient care and education of the doctor.

I would say that the difficulties that I see we are getting into is, one, the assumption that the physicians of the country represented by the American Medical Association or most of them are—in some areas it does not represent me as I will prove this morning—that the American Medical Association speaks as though in its hands rests the health of the Nation.

This is not all together true.

I think the physician of the country contributes an important part in the health of the Nation, but only a part. I think the economist, the sociologist, the philosopher, perhaps the engineer, for all I know, also contribute a very important part to health care, and those aspects of health care that deal with the economics of sociology, and the philosophical side of it are either overlooked or neglected by the American Medical Association and I must say that whereas they are in the forefront of scientific advances in medicine, they are in the backfront, if I can coin a word, in the understanding of the sociological changes that make changes in medical practice inevitable and they cannot, like King Canute, stand up and hold these waters back.

So, one, I think they are only one spoke of this wheel and when their spoke reaches the ground it opposes the health of the Nation.

The other spokes that up hold the segments of this wheel must be taken into account and I think the simplest way that I can look at it is to show where the American Medical Association stands strongest and where it stands weakest in this opposition to this bill is this: that the scientific knowledge necessary for the care of men sick today, in this country, is excellent. It is said this country has the best medical care in the world. This may or may not be so but it doesn't matter, in my opinion, the question is does this country have the best medical care that this country can achieve with its wealth, with its scientific achievements, and so I say that the medical know-how, available use of scientific knowledge that stands up and we all look up at it with great respect as it glistens on some hillside and everybody ooh's and ah's about it, but it is there for a purpose. It is not there to be admired or adored or worshiped. It is there to produce the care that another hilltop here has, of the needs of the health of our people.

And the thing that I think the AMA has failed to realize is that we need a road leading from that hill to this hill, and it is the building of this road that the AMA has been incalcitrant about and intransient about. They refuse to see this road built and this road

must be built and it is this bill that is beginning to lay the first paving stones in this road.

If it were up to the AMA for the past 10 years they have tried to keep this road an old mud road that the hubs go hub deep into the mud in order to progress, and it is windy and it is narrow. It is a lane, whereas now what we need is a six-lane highway that transportation of this beautiful knowledge we have can be brought to the people who need it, and in this bill the objection of the AMA to this bill, I think, is actually driving spikes into this road in order to keep this medical care, medical knowledge, from coming to this medical care, and the spikes I mention, and these are the things I would like to see introduced or restored into this bill, if we can divide this bill into the King-Anderson components, just grossly speaking, and into the pure voluntary components, and into the Kerr-Mills components, I would say in the King-Anderson components which last year when we fought for this, contained what we deemed hospital care.

I think that here the AMA has torn out of it the X-ray, pathology and laboratory data and anesthesia data that brings hospital care down to hotel care. It gives us board and lodging and very little else, and this thing is a universal matter, it has been established in all decent voluntary hospitals, it exists in all municipal hospitals and there was no reason for tearing this out of the bill, except the need and the want to drive spikes into this road so that we can't travel on it.

I believe that the physicians of this country are poorly represented by the AMA that professes to represent them if they are thought to believe that these matters should be taken out of the bill. There is no reason in it, either medically or sociologically and certainly not economically.

Economically the cost of our laboratory data at Montefiore Hospital which we just went over 2 weeks ago, shows that every specimen taken from a urine specimen to blood chemistry to a specimen a pathologist examines under a microscope, if we take all together the average cost is 26 cents per specimen, done by competent people being paid full time salaries by the hospital, satisfied with their salaries, and costs very little.

The AMA's contention that this is interference with patient-doctor relationships is specious. I think it is more incitement than prophecy.

Senator LONG. Doctor, could I ask just one question at this point because this does confuse me about this subject.

These people who provide these services and want us to stay by the House bill in that respect indicate to me that they feel that when a patient is billed by the hospital the hospital renders them a bill that has the effect of charging more for these laboratory fees than, by very considerable amount than, the hospital pays for these services and in the last analysis it means these fees are being used to subsidize the hospital cost of nursing and the cost of bed and board.

What is your reaction to that?

Dr. STANDARD. I think what you say is true, I think that is true. Nevertheless these fees, even with that overcharge come down to this 26 cents a piece, whereas any specimen sent to any private doctor could not possibly be done under this. The cost would be many times what it is. But it is true what they charge they probably do make a

profit on, and do apply to other areas of the hospital. That is true.

Does that answer your question?

Senator LONG. Yes.

Dr. STANDARD. The question of the other point——

Senator LONG. Let me try to get this thing straight, too. They feel, they contend, of course, if this is the case, that if the House bill is pursued in this respect that this would cause the fees to be much less that the patient would pay in this hospital.

Now, I imagine they would also assume, though, that it would cause the costs to the bed and board to go up as well?

Dr. STANDARD. Well, the question, I suppose you are asking, is should a man who has laboratory work done for him also add to the bed and board part of it which may be unfair to him. But my point is that although it would be—it is higher than it need be for the tests themselves it is still so low compared to what it would be under the circumstances that it is not even comparable.

Senator LONG. In other words, you are satisfied that the charge, that the overall charge would be more for the patient in the event that these fees were put aside?

Dr. STANDARD. Infinitely more, infinitely more.

The other point that is important is this, let's talk about pathologists for the moment. The pathologist is really the conscience of the hospital. It is he who decides why the patient died when he died and must say so freely. If he becomes the employee of a surgeon, let us say, whose patient he must take care of, he is no longer a free agent, and he must be free. None of these people ever see a patient alive, and therefore, this patient-doctor relationship is purely a frivolous thing, and, therefore, I think this should be restored because from every point of view it has no reason to be taken out of it.

And I stress this point although I am sure this has been brought home to you before, not so much for the detail of itself which is important, but I stress it to show the small boy tantrum that the AMA goes into when it is crossed in its activities. It is really scuffling its feet and kicking a cat around. That is one point. That is the first point I would like to make.

Then the other several points, one deals with the quality of medical care that I think is an important matter in this bill. Once the Federal Government is going to subsidize this, then I think there should be standards set by which quality can be controlled and as something of an authority on the quality of care I would like to say that I would like to see built into this bill an addition to that committee which is going to look after the accreditation of hospitals where patients may go. I think they should go into some accreditation of doctors who may be permitted to do certain things. I know the AMA says this is interference with medical care. I say if it is interference then bless it, we need it, because I think it is wrong. We have seen this in the Teamsters Union study. We have seen it in the Hotel Trades Council, it is wrong to assume that a man who has graduated from school is by that token able to take out somebody's stomach the next day or take out his colon the next day although legally he is permitted to do this and, therefore, there should be some measures taken by which the standards of excellence of the people involved should be measured.

Senator ANDERSON. Would you agree that is a pretty touchy subject?

Dr. STANDARD. I think it is a touchy subject and it is high time that it was being touched, Senator Anderson. I say that a man who is practicing medicine in his own office for 40 years and taking care of you or me or anybody else, has done this for 40 years and nobody, I repeat, nobody, has ever looked over his shoulder to see what he is doing. Let me tell you of a survey I made in this thing for the Health Insurance Plan where the chart I looked at was a manilla envelope and in it were several little sheets of the patient care on the day he came, on prescription sheets, that he wrote out and he would say, well, headache, aspirin or diarrhea, paregoric, like that, and as I went through the chart I suddenly noticed that this patient whom I thought I was surveying had some difficulty with some endocrine matter and it turned out this was his wife, so she was in the same envelope with him, and this is the way he kept his charts and he made maybe 40 or 50 patients there, and then I saw this patient, I thought getting diphtheria toxoid, and as I looked he had the children in the same envelope.

My point is that no record of this kind can be of any value in the care of a patient and once we discovered it we looked over his shoulder and saw what he was doing, he was made to keep a record of the kind that we could follow, and this is what I am saying.

I think this is a touchy subject, Senator Anderson, I know it, and nobody has been willing to touch it and it is high time it was touched.

Any patient who is sent into a hospital is by that token being surveyed. If I send in a surgical problem my colleagues all see it, see what happens, the pathologist sees it. When I see someone in my office no one ever sees it and knows what I am doing and I think it should be brought out and it should be included.

May I say just one more word.

Senator ANDERSON. Yes.

Dr. STANDARD. I want to talk about the implementation of this plan, and I would like to say that it has been turned over to the welfare departments mainly of most States because the health departments are good in some States and poor in others, and I would say that in the Kerr-Mills part of it I am talking about, I think that the health departments is the one that is responsible for the health of the Nation and I think the welfare department is responsible for the charity of the Nation, and I think that health belongs to the Department of Health and I would suggest that either a group or another group be set up of physicians, laymen, Government people to survey the quality of care that goes into these methods and report every year, every 2 years in order to strengthen it or improve it or enlarge it.

Senator ANDERSON. Do you wish to have your statement put in the record, Doctor?

Dr. STANDARD. Yes. I have already—you already have a copy of my statement.

Senator ANDERSON. Yes, we will put it in the record.

Dr. STANDARD. Sir?

Senator ANDERSON. We will put the statement in full in the record with the addition of the comments you made.

We appreciate your being here.

Dr. STANDARD. Thank you.

(The prepared statement of Dr. Standard follows:)

STATEMENT BY SAMUEL STANDARD, M.D., IN BEHALF OF THE COMMUNITY COUNCIL OF GREATER NEW YORK, INC.

I am Samuel Standard, M.D., testifying on behalf of the Community Council of Greater New York, Inc., the central coordinating body for welfare and health services in New York City. In discussing the council's position regarding health care benefits for the aging contained in H.R. 6675, I draw on my experience as professor of clinical surgery, New York University Medical Center and director of Department of Surgery, Montefiore-Morrisania Affiliation.

Community Council of Greater New York endorses all three portions of this bill which would make health care benefits available to the aging, accepting the spirit and general content as a step forward in health care of our aged.

This kind of legislation belongs to no school of thinking but its very own. We speak of antipoverty movements. Let me label this bill as one to eliminate antihumanity. It deals with more than money. It deals with the elimination of that specter which haunts every aged person. That specter is always there, looking out of the eyes of men and women whom life and time have defrauded of joy. He thinks not of poverty, but of the demoralization of dependence. He thinks not of illness, but of the fear of illness that abides with him throughout his days of health, and hangs like a black dream over his day-to-day activities. It is this specter, this fear, this dependence that is eliminated by this bill. This is no more than kindness of man to man, of understanding between man and man, of insight into the bottom of my neighbor's grief. The AMA brands this "socialism." Gentlemen, if this be socialism, then let us all turn socialist, and thus come closer to the teachings of Christ and Gandhi.

We have the following recommendations to strengthen the implementation both quantitatively and qualitatively.

1. Provision of hospital and related benefits through the tested mechanism of social security is warmly supported by community council as in previous years. We are deeply distressed, however, by the exclusion of hospital specialists' services, and strongly urge that they be restored to this plan of benefits by the committee. The reinstatement (as it existed in the King-Anderson bill of last year) of pathology, X-ray, laboratory, and anesthesia into the understanding of the definition of "hospital care" is essential. Take out these elements and one is left with little more than bed and board. One is left with hotel care, not hospital care. The argument that these services are supplied by doctors is a thoroughly specious one. Except for the anesthetist, the pathologist, the X-ray man, and the laboratory man sees the patient only in the form of bottles containing specimens to be examined, or tissue to be stained for microscopy, or X-ray plates to be interpreted. There is no patient-doctor relationship with these people. And so the wail of the AMA that to include these will destroy patient-doctor relationships is frivolous. The Blue Cross contracts include all of these except the anesthetist in some instances. All of the voluntary and municipal hospitals include this as their hospital expenses. To tear this part out of the bill is the act of vindictive, mindless, heartless, organization. There is no justification for it in care or in quality. The only purpose it will serve will be to increase the doctor's income. At Montefiore Hospital the average cost of any examination done in the laboratories, both chemical and pathological, is 26 cents. This runs true for the total gamut from urines to blood chemistries to microscopic sections. Put on a piecemeal cost system, the rise in costs would be astronomical. The AMA like any good labor union, seeks to increase the benefits of its members. This bill is not formulated to increase physician's incomes. Its aim is the improvement of health care of the aged in our country. It ill becomes the medical profession to be so misrepresented by those who presume to represent them.

We regret the deductible provisions of this and the supplementary benefits plan, particularly in relation to diagnostic services. Years of experience with health insurance indicate that deductibles, rather than discouraging abuse, encourage delay in seeking early care and result in needlessly inflated costs of neglected illness as well as collusion in payment for existing illnesses. We therefore recommend removal of these barriers to early diagnosis and treatment.

2. We welcome the voluntary supplemental medical benefits plan as a practical means of providing physicians' and related services essential to health maintenance and restoration. However, for this and the hospital benefits portion, we

are uncertain if this bill does give the Secretary of Health, Education, and Welfare the authority he needs in order to develop the kind of standards and administrative relationships which will assure needed protections. For example, the archaic notion that a man who has graduated from medical school is equipped to engage in all the specialties of medicine must be recognized for its dangers. We note the inclusion of a National Medical Review Committee and suggest that this be extended to the State level, with added emphasis on quality of service. What is needed is a mechanism with authority to establish standards of professional competence as well as facilities, to insure the delivery of quality medical care that is commensurate with that available in our country.

3. We endorse the proposal for improvement and extension of the Kerr-Mills program to other groups, particularly children, for whom other health provisions do not exist. With regard to the aging, we have long advocated a vastly liberalized program of medical assistance and believe this proposal will ease the State-imposed restrictions to its utilization.

This program will be needed by very substantial numbers of elderly people below the poverty line who will, as previously mentioned, suffer severe hardship regarding the deductibles; some will be unable to afford even the modest premium for the voluntary plan. In addition, the need to provide for costs of catastrophic and long-term institutional care is obvious. We particularly applaud eliminating the requirement of financial contribution by adult children which in the past impoverished many of them or was made at the expense of their own children.

For this expanded program of medical assistance, we would prefer that the implementation be left with the State departments of health, trained in methods of health, rather than departments of welfare, trained in methods of charity. At the very least, we would hope for the fullest possible role of health departments in assuring quality of care in this program, and recommend that the section on cooperative arrangements be broadened to include the development of standards.

Senator ANDERSON. Mr. Hicks.

STATEMENT OF W. B. HICKS, JR., EXECUTIVE SECRETARY, LIBERTY LOBBY

Mr. HICKS. Mr. Chairman and members of the committee, I am W. B. Hicks, Jr., executive secretary of Liberty Lobby. Liberty Lobby represents over 130,000 Americans [1] including a significant percentage who are elderly people—people who must live on very low incomes in many cases—people on social security and others who are not covered by social security benefits.

It is our function to represent the interests of these patriotic Americans in preserving the Constitution and freedom of the United States. At the same time, we recognize that there is a problem of serious dimensions in the high cost of medical care for the aged who must live on fixed incomes.

The members of this committee are quite familiar with the reasons for this problem. Basically, it is a problem created by the very government that now seeks to solve it, because the Government has followed a policy of ever increasing the false expansion of the economy—otherwise known as inflation. Inflation is the real villain of the case. It is one threat against which the elderly are the most helpless.[2]

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[1] The figure, 130,000, represents the number of adult subscribers to the monthly legislative report, "Liberty Letter," published by Liberty Lobby. Surveys indicate that over 50 percent of the subscribers represent families rather than a single individual. In this light, the 130,000 Americans quoted may be considered a conservative account.

[2] "Inflation," as it is used herein, refers to an increase in the supply of money and credit that outruns the increase in the supply of goods to the point that the money and credit are reduced in value. This is the economic policy which causes anyone of working age to constantly require raises in their wages. It is precisely this policy which works an unfair burden on those who provided themselves with a retirement income which although set at a fixed amount was thought at the time to be adequate.

Liberty Lobby desires the best medical care, for the most people, at the lowest cost, just as much as any witness who has appeared before this committee. The question before us is: Does H.R. 6675 accomplish the purpose? We feel that it does not.[3] Further, we see in this bill a threat to the future of the Nation far more serious, even, than the problem it seeks to solve.

The major fault of this bill is that it is irrevocable. Does any member of this committee imagine for a moment that, once enacted into law, this bill can ever be repealed? Is it not true, that no matter what serious error it may contain; no matter what future development might demonstrate that the bill was not necessary; or that it went too far in promising too much to too many—is it not true that it can never be revoked?

This bill, we believe, is a proposal to sell insurance to the American people. In effect, it offers a contract that, once signed by the President will, for all time, bind the taxpayers of the Nationl to the principle of socialized medicine—a contract that, no matter how regrettable its consequences, cannot in good conscience be broken.

For, once this bill becomes law, I can assure you from my own correspondence that millions of elderly citizens and other millions of younger people are going to believe that the Government has promised to care for their medical needs. Those workers who must take home less pay as a result of the new medicare tax are going to expect the Government to keep its end of the bargain, and rightfully so. The elderly, who have believed the promises implied and explicit in the arguments of the proponents of medicare, will cancel their hospitalization policies immediately and, once those policies are canceled, they will never be reinstated.

I remind this committee of the unfortunate results of the public fanfare that accompanied the recent reduction in the income tax. I predict that the hardship that arose from public misunderstanding of that act will seem mild compared to the tragedy that will come about due to lack of understanding of this bill if it is passed. The proponents of this bill are allowing the American public to believe that all the medical problems of the elderly will be solved if only this bill is passed. It is not that they are actually lying to the people but they are allowing the people to lie to themselves and are making no effort to counter the misunderstandings that are so prevalent.

The result of this misunderstanding will be to force the Congress to reshape the bill to fit the public idea of what it is—to expand both the benefits and the number of persons covered.

At this point, it is well to remind ourselves that the Nation spends over $35 billion on medical care every year,[4] as of now, and that most of this $35 billion is spent by people who would rather spend it on something else, if they could.

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[3] Ironically, we now have the best care for the most people at the lowest cost and have been forced to defend it by proponents of a system which has proven its fallacies in every country adopting its principles. The fact that other medical systems may claim lower cost to the patient is well offset by the fact that in many cases the cheaper service is below our standards in quality. Also there are substantial waiting periods in every country with similar social medical systems wherein only emergency cases can get any timely service at the lower rates offered. Not only would the provisions of H.R. 6675 seriously hamper the efficiency and subsequent morale of the finest medical service in the world, its further steps toward inflation are particularly ominous at this juncture in the economic health of our Nation as viewed both at home and abroad.

[4] See Social Security Bulletin for October 1964, p. 10.

There is an alternative to the compulsory insurance approach to medicare for the needy. This alternative approach does not obligate us to a future of socialized medicine, nor does it complicate the already complicated social security program. It does not imply promises that are impossible to keep. It does not require an increased bureaucracy to administer it. It does fill the need for relief from the pressures of inflation on the medical care budgets of the elderly.

We refer to the bill that was introduced first in the 88th Congress as H.R. 21—the Bow bill, so-called for Congressman Frank Bow, its sponsor. Under this bill, the administration of insurance is left in the hands of those who are best qualified to administer it—the private and mutual health insurance plans. It is in no way connected with the social security program, so it does not threaten that structure as some proposals do. It requires no new form of taxation, being financed, as all other welfare measures are financed, from the general fund. It covers all who need it, and none who do not need it.[5] It is simple, which is more than can be said for the bill under consideration here.[6]

Most importantly, it does not establish an irrevocable principle, as the bill we are considering does. Again, we emphasize, H.R. 6675 is permanent, and no future Congress can do more than increase its benefits, but the Bow bill is in the nature of a welfare measure like the depressed areas bill, and is therefore flexible, rather than rigid.

Liberty Lobby, therefore, recommends that this committee not approve of H.R. 6675 but, instead, suggest that the Congress provide an immediate solution to the problem of health insurance for the elderly through a measure like H.R. 21, the logical alternative. Thank you.

Mr. Chairman, I would appreciate it if it were possible to enter into the record the text of the Bow bill referred to. I thank you.

Senator ANDERSON. I think it is a reasonable request.

Without objection it will be done.

How many votes did the Bow bill get in committee, do you recall?

Mr. HICKS. No, sir; I do not.

Senator ANDERSON. Very good.

Thank you.

Mr. HICKS. Thank you.

Senator ANDERSON. We will have to take a look at the Bow bill and see how long it runs but if we can't insert the full bill we will insert a synopsis of it.

Mr. HICKS. Six double spaced pages; that is it right there.

Senator ANDERSON. I think it is all right. It isn't a long bill.

Mr. HICKS. It is very short.

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[5] More than half of those over 65 in this country have voluntary health insurance, the preponderance of which has coverage devoted to the same area of health costs as this bill. Although doubtless there is thrift and self-denial implicit in many cases this would not seem to justify passing the cost of these voluntary programs onto younger householders. Forty-one percent of persons over 65 in this country had assets in 1960 in excess of $10,000 compared to only 27 percent of those under 65. Clearly H.R. 6675 in this case is taking from that segment that can ill afford it and giving it in over half of the cases to those who can afford it. Clearly this is as immoral as the Marxian concept of taking from the haves and giving to the have-nots. (For a thorough discussion on the economic assets of our population, by age groups, see "1960 Survey of Consumer Finances," Survey Research Center, University of Michigan.)

[6] The Bow bill (H.R. 21) is 10 pages long and provides better coverage at lower cost to the taxpaying public. H.R. 6675 is 206 pages and defies complete comprehension by the public.

Senator ANDERSON. It is one that provides for the payment of premiums to insurance companies and allows those to be fully deducted from income, is that it?

Mr. HICKS. Yes, sir; that is it.

Senator ANDERSON. It helps a man with an income of a $100,000 a year but it does very little for a man with a $1,000 a year.

Mr. HICKS. There is a limit on the amount of income that a person may earn. I mean he must earn less than that amount before he can apply for the deduction.

Senator ANDERSON. We will put it in the record.

Mr. HICKS. Yes.

(The bill referred to follows:)

[H.R. 21, 89th Cong., 1st sess.]

A BILL To provide for the medical and hospital care of the aged through a system of voluntary health insurance, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Insurance Benefits Act of 1963",

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress hereby finds that (1) many elderly Americans have resources inadequate to meet the expenses of major illness, (2) that more than one-half of all citizens who have reached the age of sixty-five have taken advantage of the growing opportunity to insure against such expenses, (3) that health and medical care insurance can be made available to all citizens regardless of previous medical history, (4) that health insurance coverage of all citizens who have reached age sixty-five is a desirable national objective, (5) that this coverage should be extended without Government interference on a voluntary rather than a compulsory basis, and (6) that it is in the public interest to provide Government assistance and encouragement to elderly Americans who seek the protection of medical care and hospitalization.

(b) The purpose of this Act is to make it possible for every citizen of the United States who has reached age sixty-five to obtain comprehensive medical care and hospitalization insurance of his choice, subject to minimum standards designed to protect against the costs of the customary illnesses of old age as well as major medical expenses, on a guaranteed renewable basis regardless of prior medical history, with direct Government assistance for all who are otherwise unable to obtain such protection, and with tax incentives for elderly citizens, their relatives or former employers who are able to provide such protection, utilizing the facilities of the voluntary health insurance carriers of the United States in a manner consistent with the dignity and independence of each individual and the historic ability of the American people to solve social problems through their own initiative and enterprise, making certain that the Government will not control the individual's free choice nor interfere in his selection of a physican or hospital.

SEC. 3. (a) Part IV of subchapter A of chapter 1 of the Internal Revenue Code 1954 (relating to credits against tax) is amended by redesignating section 38 as section 39, and by inserting after section 37 the following new section:

"SEC. 38. COSTS OF MEDICAL CARE FOR THE AGED.

"(a) DEFINITION OF QUALIFIED MEDICAL CARE INSURANCE PROGRAM FOR THE AGED.—As used in this section, the term 'qualified medical care insurance program for the aged' means a program, offered by one or more insurance carriers operating in accordance with State law, providing protection, without regard to any preexisting health condition, under guaranteed renewable insurance for individuals 65 years of age or over against the costs of medical care (as defined in section 213(e)) through a system of benefits including either—

"(1) a plan providing benefits which may not be less than:

"(A) hospital room and board charges equal to the hospital's customary charges for semiprivate accommodations, for confinements not to exceed 90 days in a calendar year;

"(B) $120 for hospital ancillary charges in any calendar year including any such charges in connection with surgery or emergency treatment on an outpatient basis;

"(C) $6 for convalescent hospital room and board charges per day of confinement and $186 for all days of confinement in any one calendar year, immediately following confinement in a general hospital;

"(D) surgical charges according to a fee schedule with a $300 maximum;

"(E) $5 per call for physicians' services, and $75 for all such services in any one calendar year; or

"(2) a plan providing payment at the rate of not less than 75 percent of the following covered medical expenses after a deductible and subject to a maximum as specified in (B) below:

"(A) covered medical expenses must include at least the following:

"(i) hospital room and board charges equal to the hospital's customary charges for semiprivate accommodations;

"(ii) hospital ancillary charges including any such charges in connection with surgery or emergency treatment on an outpatient basis;

"(iii) $6 for convalescent hospital room and board charges per day of confinement immediately following confinement in a general hospital and $540 for all days of confinement in any one calendar year;

"(iv) surgical charges according to a fee scheduled with a $300 maximum;

"(v) $5 per call for physicians' services, other than for surgery or postoperative care;

"(vi) $16 for professional private duty nursing charges per day and $480 for all days in any one calendar year;

"(vii) charges for drugs and medicines which require a doctor's prescription; diagnostic X-rays and other diagnostic and laboratory tests; X-ray, radium, and radioactive isotope treatment; blood or blood plasma not donated or replaced; anesthetics and oxygen; and rental of durable medical or surgical equipment such as hospital beds or wheelchairs;

"(B) payment of benefits for the foregoing charges may be subject to a deductible of not more than $200 in a calendar year and a lifetime maximum of not less than $10,000;

If a medical care insurance program which is otherwise qualified under the provisions of this section offers protection for individuals under age 65 as well as those 65 and over, such program shall be considered a 'qualified medical care insurance program for the aged' for purposes of this section but only with respect to beneficiaries who are 65 years of age or over.

"(b) DEFINITION OF CARRIER.—'Carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization which lawfully offers a health benefits plan.

"(c) ALLOWANCE OF CREDIT.—There shall be allowed to an individual, as a credit against the tax imposed by this subtitle for the taxable year, an amount equal to the aggregate of the premiums paid during the taxable year by such individual under one or more qualified medical care insurance programs for the aged (as defined in subsection (a)), to the extent that the aggregate of such premiums does not exceed $150 for any one person covered by such program or programs, plus

"(d) INDIVIDUALS ELIGIBLE FOR CREDIT.—The credit under subsection (c) shall be allowable to a taxpayer only if—

"(1) he is the beneficiary of the medical care insurance program involved and is 65 years of age or over, and his income does not exceed $4,000 or $8,000 in combined income with his spouse in his last taxable year, or he files a sworn statement that for the taxable year in which he applies for the credit his income will not exceed these limits, or

"(2) each beneficiary for whom the premiums were paid under such program is a person 65 years of age or over who bears any of the relationships to the taxpayer defined under section 152(a).

For purposes of this section, an individual shall be considered to be 65 years of age or over throughout any taxable year if he has attained such age by the close of such year.

"(e) COVERAGE CERTIFICATES.—Each insurance carrier offering a qualified medical care insurance program for the aged (as defined in subsection (a)) shall issue, to each individual who is covered under such program, a medical care coverage certificate setting forth the name of the insured, the amount of the premium, and a certification that the coverage meets the requirements of this Act. The credit provided by subsection (c) shall be allowed for any taxable year only if such certificate or a copy thereof is attached to the taxpayer's return for such year.

"(f) CREDIT IN CASE OF CERTAIN EMPLOYERS.—Under regulations prescribed by the Secretary or his delegate, if any employer provides protection against medical costs for its retired employees who are 65 years of age or over by purchasing coverage for such retired employees under one or more qualified medical care insurance programs for the aged, such employer shall be entitled to a credit against the tax imposed by this subtitle equal to the amount of the credit to which it would be entitled under subsection (c)(1) if it were an individual taxpayer and such retired employees were persons described in subsection (d)(2).

"(g) INDIVIDUALS NOT DERIVING FULL BENEFIT FROM CREDIT.—In the case of any individual—

"(1) who is 65 years of age or over,

"(2) whose tax under this subtitle for the taxable year will be less than $150 (as estimated in accordance with regulations of the Secretary or his delegate), and

"(3) who is not the beneficiary of a qualified medical care insurance program for the aged,

the Secretary shall upon application by such individual issue to him a medical care insurance premium certificate which may be used by him in purchasing coverage under such a program and will be redeemed for cash by the Secretary when presented by an insurance carrier who certifies that it was accepted in payment of the premiums on such a program. The amount for which any certificate will be redeemed under the preceding sentence shall be the amount of the premiums payable on the program for the year or $150, whichever is less reduced by the amount (if any) of the individual's tax for such year as estimated under clause (2) of such sentence and further adjusted (unless such an adjustment would be inequitable or impose undue hardship) to take account of any amounts by which benefits made available to such individual under this subsection in previous years were greater or less than they would have been if the estimate under such clause (2) for such years had been correct. No certificate under this subsection shall be issued to any individual for any taxable year unless he furnishes the Secretary with satisfactory proof of his compliance with clauses (1), (2), and (3) of the first sentence.

"(h) CREDIT NOT TO CAUSE REFUND OF TAX.—The credit allowed by this section shall not exceed the amount of the tax imposed by this chapter for the taxable year, reduced by the sum of the credits allowable under sections 33 (relating to foreign tax credit), 34 (relating to credit for dividends received by individuals), 35 (relating to partially tax-exempt interest), and 37 (relating to retirement income).

"(i) REGULATIONS.—The Secretary or his delegate shall prescribe such regulations (including regulations providing for the application of this section in the case of joint returns) as may be necessary or appropriate to carry out the provisions of this section."

(b) The table of sections for such part IV is amended by striking out

"Sec. 38. Overpayments of tax."

and inserting in lieu thereof

"Sec. 38. Costs of medical care for the aged.
"Sec. 39. Overpayments of tax."

SEC. 4. Section 213 of the Internal Revenue Code of 1954 (relating to deduction for medical, dental, etc., expenses) is amended by adding at the end thereof the following new subsection:

"(h) EXCLUSION OF AMOUNTS ALLOWED AS CREDIT.—Any expense allowed as a credit under section 38 shall not be treated as an expense paid for medical care for purposes of this section."

SEC. 5. The amendments made by this Act shall apply only with respect to taxable years ending after the date of the enactment of this Act.

Dr. John Knowles, director general of the Massachusetts General Hospital who was scheduled to testify today has submitted a written statement for the record in lieu of testifying. His statement will be placed in the record at this point.

(The statement referred to follows:)

STATEMENT BY DR. JOHN H. KNOWLES, GENERAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL

Gentlemen, I wish to plead for the interests of the patient. I am not here to plead the cause or discuss the worries of doctors, hospital administrators, or any other special group other than those whom all of us are ultimately interested in, i.e., our community of patients.

I would, therefore, respectfully like to call to your attention in H.R. 6675 to the exclusion of certain vital hospital services from section 18a; namely, the services of roentgenologists, pathologists, and anesthesiologists. These physicians are the very backbone of the teaching hospital and make possible the infinitely difficult diagnosis, the long delicate operation and the high standards of care. To fragment their services for what may be highly laudable socioeconomic reasons will produce a chaotic flood of small bills for the patients, a frustrating search for vouchers attesting to previous treatment by other physicians with a resultant reduction in current amicable relations, and lastly a noticeable change in the trusting attitudes presently existing in the medical world, a world that must revolve around the patient and his interests.

I know that this fragmentation of the services of the teaching hospital, the chaotic billing, and potential results of both have been considered by many brilliant minds here in Washington and I know too that the compromises so produced are considered to be the best possible answers. It is, however, my belief that the deliberative nature of the Senate will allow the further consideration necessary to eliminate those few aspects of this bill which inadvertently reduce our ability to give superlative services to the patient, whose interest is, of course, paramount in your study of H.R. 6675.

(The following was later received for the record:)

THE MASSACHUSETTS GENERAL HOSPITAL,
Boston, 5, 1965.

Hon. HARRY F. BYRD,
New Senate Office Building,
Washington, D.C.

DEAR SIR: I am writing to you with a sense of great urgency. It has come to my attention recently that the American Medical Association wishes to strike out provision for reimbursement to hospitals for the services of radiologists, pathologists, anesthesiologists, and physiatrists, as well as the financing of their representative departments.

May I respectfully inform you that this would be an absolute disaster for the best care of the aged sick of our country. Futhermore, a complete state of chaos could conceivably ensue for reasons too numerous to list here. In this connection I do hope that you will read the enclosed letter which my associate director and comptroller, Mr. Lawrence Martin, has written to me on this subject. It defines very lucidly what the separate billing for professional services would mean to the patient, to the doctor, and to the hospital.

I hope you will agree after careful consideration that the provisions suggested by the AMA as regards reimbursement to hospitals are totally undesirable. I do hope you will heed the recommendations of the American Hospital Association in this regard and not those of the AMA.

Thank you for your consideration of these problems.

Sincerely yours,

JOHN H. KNOWLES, M.D.,
General Director.

THE MASSACHUSETTS GENERAL HOSPITAL,
Boston, March 5, 1965.

DR. JOHN H. KNOWLES,
General Director,
Massachusetts General Hospital.

DEAR JOHN: As I recently promised you, I am writing this letter to put before you my thoughts concerning the effect to all concerned of separately billing for professional services of the radiologists. If the doctors' services are to be billed separately from the hospital charge, it will mean the following:

I. To the patient

A. The receipt of an additonal bill for the doctor's services.

B. It will provide the patient the opportunity to challenge a specific fee (for example, carotid arteriogram), since they do not realize or understand the professional involvement and responsibility in the radiological procedures.

C. There will be a radical change in insurance coverage, undoubtedly to the detriment of the patient since many people are only covered for hospitalization charges.

D. Misunderstanding and frustration will arise in the payment of these medical bills, since I know from experience the patient will send his professional fee bill payment to the hospital, and we, of course, will be unable to accept it.

II. To the doctor

A. The doctor will have the responsibility of submitting his own bills which will amount to some 200,000 procedures on 36,000 patients for the inpatients alone.

B. They will have the responsibility of collecting their own bills for which they are ill prepared.

C. There will be a substantial reduction in their own income due to—

(1) the inability of the elderly to pay uninsured medical bills. In our case this would amount to some 40 percent our patientload. If the doctors are included in the proposed legislation for the care of the elderly, the doctors will be paid 100 percent for these radiological procedures versus a questionable percentage if they are entirely uninsured for the radiological professional services;

(2) refusal by an additional segment of the elderly to pay because of misunderstanding that these heretofore covered services will no longer be covered. I think this is important because I have already heard conversations along these lines in connection with some of the facets of medical care which are not to be covered in the proposed legislation;

(3) the lack of adequate collection methods in the pursuit of small accounts. It is obvious that a more thorough collection effort can be made when a large hospital bill is at stake versus a $15 or $20 professional fee for X-ray services. If this becomes a matter for a collector, I know for a fact that we pay 25 percent as a collector's fee on the large accounts and anywhere from 33 percent to 50 percent as a collector's fee on the small accounts; and

(4) this will eliminate the radiologists from receiving the consideration now given to him by local charities which support to a certain extent the free care given to the medically indigent which in most cases includes charges for diagnosis and treatments.

D. Loss of fringe benefits:

(1) Life insurance (both Harvard Group Life and Massachusetts General Hospital group life insurance programs).

(2) Pension plan (both Harvard and Massachusetts General Hospital).

(3) Social security.

(4) Paid vacations.

(5) Continuation of pay while away on conventions, attending board examinations, and in general attending professional meetings around the country.

(6) Sick leave.

(7) Industrial accident.

E. Loss of direct association with the hospital:

(1) Reconsideration of appointments to committees within the hospital structure.

(2) Eventual loss of personal interest in the welfare of the hospital.

F. Reevaluation of the management of the department with respect to technicians, secretaries, equipment, and facilities.

III. To the hospital

A. The continual problem of explanation to the patient. It is obvious that the explanation of these separate bills will inevitably fall to the employees of the hospital, and in particular the accounting department.

B. Loss of close rapport with the radiologists who will if not immediately will gradually be lost as members of the hospital family.

C. Eventual dissatisfaction of the doctor with the decreased income which will lead to higher and higher professional fees. This will lead to a rigid government program of socialization of the doctors and the hospitals.

D. Gradual loss of allegiance to the hospital.

E. Reduction in the standard of patient care.

F. Possible reduction of quality in the teaching program.

IV. General comments

It is apparent from the foregoing material that this move would be an error to all parties concerned. It is apparent to me that the doctor under the proposed legislation would be no more socialized than he is at the present time. The Government program merely guarantees payment of full cost to the hospital, and if this cost contains the salaries of the radiologists, then he is paid in full. It in no way attempts to establish salary scales or payments for any services within the hospital. As a matter of fact, I personally feel that the radiologists would be more socialized if they were to submit their own bills and be covered under the Blue Shield program where their fees are essentially established by the Massachusetts Medical Society. At this hospital, as you full well know, the fees are established by the radiologists themselves. To me, this is an obvious step in the wrong direction.

I cannot help but feel that over a period of time there will be a gradual loss of this team concept which has kept such a high esprit de corps in the hospital family, with the resultant deterioration in our facilities and eventually in patient care.

If this comes to pass, the hospital and the hospital alone will set the fees for the hospital component of the radiology charge, and the doctors will lose the influential position they now have.

In closing, I cannot help but state that I feel this is a step backward for all parties concerned, and that the Radiological Society has elected a poor program upon which to settle their fundamental ideology on professional status.

Very truly yours,

T. E. MARTIN,
Associate Director and Comptroller.

Senator ANDERSON. The next witness is Dr. Jack Schreiber.

STATEMENT OF JACK SCHREIBER, M.D., CANFIELD, OHIO; ACCOMPANIED BY JOHN J. McDONOUGH, M.D., PRESIDENT, MAHONING COUNTY MEDICAL SOCIETY, YOUNGSTOWN, OHIO

Dr. SCHREIBER. Mr. Chairman, I am Dr. Jack Schreiber of Canfield, Ohio. With me is Dr. John McDonough, who is president of the Mahoning Medical Society of Youngstown, Ohio.

I appear here as a family physician practicing full time in a community of 3,500. I am here as a physician who is deeply concerned about the private practice of medicine and how the medicare bill would affect its future. I also appear here as a fellow citizen, even more concerned, and frankly worried about the same bill which could well change our very system of government. I speak entirely for myself; I represent no association, but I feel that I echo the sentiments of many Americans who are taking the time to think, and to ponder, and to wonder about the future course of our country.

I might say with reference to the witness who testified a little bit ago that I am proud to be a member of the AMA, as well as Dr. McDonough. It is not on trial here, but rather the American Medical Association is made up of 200,000 physicians and it is the wishes of

these people who dictate the policies of this fine organization but nevertheless I speak entirely for myself, and I should like to address my remarks not to the merits or the demerits of the American Medical Association but to the heart of the medicare debate; that is, shall the Federal Government assume the personal responsibility for the health care needs of a large segment of our population? Our elderly irrespective of their needs?

When our forefathers came to these shores 300 years ago, they came here for many reasons. One of the most compelling reasons was the right to manage their own personal and private lives—free of interference and control by the state or by the church. One of the reasons why so many followed and why they stayed and prospered, as no nation in history has prospered, was because this new idea of government worked. Thomas Jefferson put it this way. He said that freedom is a God-given right—not something granted by kings, or tyrants, or by government. Young America grew and became strong because its people were willing to pay the price for their newly won freedom. That price was, and still is, individual responsibility. Freedom isn't all free, you see. Someone has said that freedom is like a coin. It has the word "rights" written on one side, and the word "responsibilities" written on the other side. It does not have "rights" written on both sides.

America means individual freedom, and individual freedom requires individual responsibility to nourish and keep it alive. This philosophy of God-given freedom and personal responsibility has worked for three centuries, and worked successfully, and, what is more, it has also made it possible for this 7 percent of the world's population to come to enjoy over 50 percent of all the world's good things—including the finest system of medical care obtainable anywhere.

But all the while that Americans have been prospering and taking care of themselves and their own, they have not failed to look after those less fortunate. During the years since the uncertainties of Jamestown and Plymouth, we as a nation have established two ways of providing for the needy.

First, we said that it was proper and logical for government to assist those who could not, or would not, look after thehir own needs. At the same time, we said that this assistance should be on a local or State level. All of us, therefore, join together in paying our share of taxes to help those in need.

The second and perhaps the most important way in which we assist those in need, is through voluntary giving. This would be the church, community chest, voluntary health agencies, charitable and fraternal organizations. This great voluntary effort is the strong thread which runs through the fabric that is America, and which also is one of our most vital resources.

The single guiding light in both of these endeavors, be it tax supported or voluntary, is that funds are spent on those who need help. The medicare bill would change this fundamental philosophy, and this is the core of the debate. Shall we now use public money—taxes—to provide not just for the personal care of a few because of need—but for the first time in our history, shall we provide personal care for everybody, because he has had a 65th birthday?

May I suggest that we have no corollary in our national history or tradition either past or present.

May I refer to some of the measures in the Senate at the present time?

First of all, the law on poverty will not use tax dollars to benefit the well to do. The Appalachia program will not give Federal money to everybody who lives in West Virginia. The President's scholarship program is not designed to assist children of high-income parents. I am not aware of a single Federal program in existence today which uses public moneys to finance personal needs of the wealthy or self-supporting. Only medicare would change this basically American ethic.

Medicare, too, would drastically alter the Christian-Judaic principle of helping those who are in need. Is there a church group in this country, Protestant, Catholic, or Jewish, which uses benevolence or charity dollars to benefit the rich or those well able to care for themselves?

Aside from the expenditure of tax money for the nonneedy, medicare would also change another basic American concept. In this country we have believed that personal health is a private responsibility. We've also said that public health problems such as certain communicable diseases, water and air pollution, sanitation and the like, belong in the public sector, and therefore justly become the collective responsibility of all of us. However, one's own personal health is an extremely private matter, just as the provision for food, clothing, shelter, recreation, and other personal needs. These personal responsibilities, including health, become public only when family or charitable resources fail, and then only to the extent of local or State assistance. The medicare bill would shift this personal responsibility directly to the Federal Government, and I submit, sir, that this just is not in keeping with our time-honored and proven success story of self-government.

These are a few of the reasons why I am genuinely concerned about the medicare legislation. I am truly convinced that unless we examine and debate this issue carefully, we may well make the same tragic mistake made by so many other nations, in believing that the State should assume personal responsibilities of the individual. It is indeed ironic that we should even think of tampering with a successful system of government, and at a time when that very system has produced not failure—but a standard of living unparalleled in the history of all mankind.

The issue being debated here is not really one of medical care of the aged, for medical care is being given to the overwhelming majority of our older people—regardless of their ability to pay for that care, and, of course, we wish to make it better.

The issue is not just that of need, for while some are in need of more and better care, most are fully capable of taking care of themselves. The issue is not just that of cost, for the mere expenditure of enormous sum of money, $6 billion the first year, does not necessarily guarantee the same high quality of care now enjoyed under our free enterprise system.

The issue is not just that of eventual control of the doctor and his patient, for even under a system of Federal medicine, doctors will still care for their patients; but if the history of government medicine anywhere else in the world is any lesson, then this country has everything to lose and not one solid thing to gain through this experiment of medicare.

May I humbly suggest that the real issue of this debate is philosophical. It is neither figures nor data nor a series of charts. It is the

elementary question of how much government do we want in our personal and private lives? The tragedy of medicare is that so few Americans really understand its far-reaching implications. So few of our citizens realize that once adopted, this kind of social legislation is seldom, if ever, repealed. Indeed, very few Americans have any idea of the contemplated changes in our present form of government.

As a physician and a fellow citizen, I humbly and respectfully ask this committee to remove from H.R. 6675 those sections of the bill which would change the basic concepts of our Government by providing, at public expense, personal health care regardless of need. I earnestly pray that the final judgment of this committee and of the Senate of the United States will reflect the confidence and the trust placed in you by millions of Americans.

Thank you.

Senator ANDERSON. Thank you, Doctor.

Are there questions?

If not, thank you very much for being with us.

We will meet tomorrow morning again at 10 o'clock.

(Whereupon, at 12:15 p.m., the committee recessed, to reconvene at 10 a.m., Friday, May 7, 1965.)

SOCIAL SECURITY

FRIDAY, MAY 7, 1965

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

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, Senator Herman E. Talmadge presiding.

Present: Senators Long, Douglas, Gore, Talmadge, Ribicoff, Williams, Carlson, Curtis, and Dirksen.

Also present: Elizabeth B. Springer, chief clerk.

Senator TALMADGE. The committee will please come to order.

The Chair regrets to inform all witnesses that due to the great number that have requested to be heard, it has become necessary to impose a time limitation on the witnesses.

The first witness is Dr. Carl E. Becker, representing the American Nursing Home Association.

Dr. Becker, you are recognized for 15 minutes.

STATEMENT OF DR. CARL E. BECKER, MEMBER OF GOVERNING COUNCIL AND PAST REGIONAL VICE PRESIDENT OF AMERICAN NURSING HOME ASSOCIATION

Dr. BECKER. Mr. Chairman and members of the committee, I am Dr. Carl E. Becker, a member of the governing council and a former regional vice president of the American Nursing Home Association. I have been president of the Wisconsin Nursing Home Association since 1960.

I am an ordained clergyman of the American Lutheran Church and have been active in the social-health ministry since 1943. I am the administrator of the Lincoln Lutheran Home of Racine, Wis., which is a 177-bed facility directed by the American Lutheran Church of Minneapolis, Minn., and the Lutheran Church of America of New York. Altogether, the Lutheran churches own and administer slightly over 200 nursing homes in the United States. In the past few years we have spent over $40 million in the construction of new and modern homes. I am also on the board of directors of the Good Samaritan Society which operates approximately 120 nursing homes in our country.

The Lincoln Lutheran home, which I administer, is accredited by the National Council for Accreditation of Nursing Homes "as an intensive care facility," which is the highest class in the skilled nursing home category.

The Lincoln Home is a multiservice home having ambulatory, semiinfirm, infirm, and convalescent residents. It has its own med-

ical staff of over 100 physicians. We have a "meals on wheels" program serving the aged and convalescents, consisting of one hot meal a day in their own private residence at a total cost of 50 cents a day.

This fall we will implement a community day-care center and a controlled remotivation unit for seniles.

I am also the administrator for a 24-bed alcoholic treatment center which will be implemented this fall. This is a pilot institution, the first nursing home experimental treatment center for alcoholics in our country which will use a human ecology program.

I recite all these things, not out of personal satisfaction—although I do take pride in our progress—but to illustrate to this committee the modern concept of nursing homes, with the thought that it will better enable you to understand our problems. We in the nursing home field have made tremendous strides in the last 10 years toward improving the health care of the aged. We have changed the image of the nursing home from a converted house to a modern health center which offers everything that a modern hospital can except operating and delivery rooms, X-ray, and laboratory facilities, at one-half to one-third the cost of hospital costs.

True, there still are some poorly administered nursing homes in this country just as there are poorly and inefficiently run hospitals.

The American Nursing Home Association is an association of over 5,000 nursing homes and growing by leaps and bounds. Of these members, 10 to 15 percent are nonprofit homes like the Lutheran homes of which I spoke. In fact, we probably represent more nonprofit homes than the American Association of Homes for the Aged, which represents only nonprofit homes.

I. We propose that section 1832(a)(2)(B) and section 1832(a) be amended so that under the second layer of the House-passed bill a patient be allowed to convert up to 50 of his home health visits into 25 additional nursing-home days on the basis of 2 home health visits for 1 nursing-home day.

Under the first layer or basic plan (sec. 1812), there are 60 hospital days and 20 basic nursing-home days. However, a maximum of 40 unused hospital days can be converted on a one-for-two basis into 80 additional nursing-home days.

The average hospital stay for an elderly person is around 14 days. Normally, 20 hospital days in a spell of illness should be adequate. However, we can foresee cases of a major nature where a patient would use his full 60 days of hospitalization. In those cases, 20 nursing-home days would be totally inadequate. Under the second layer, an ability to convert part of his 100 home health care days might be advantageous to him. Accordingly, we propose that he be allowed to convert on a 2-for-1 basis a maximum of 50 home health visits for 25 nursing-home days. We do not believe that this would add much, if any, cost to the bill.

II. We would strike out the word "listing" in section 1863. This section allows the Secretary to consult with national accrediting or listing bodies. Since listing has nothing to do with the quality or nursing service or nursing-home standards, we do not believe that it has any place in the section of the bill which is primarily a standards section. In addition, the term is misleading. Some people are under the impression that listing is the same as accreditation.

III. We propose that section 1865 in regard to accreditation be amended to specifically recognize the National Council for the Accreditation of Nursing Homes.

We believe that where a national accreditation program has been undertaken by an independent body such as the National Council for the Accreditation of Nursing Homes, and is not unilateral, it should be recognized. The composition of the national council is similar to the Joint Commission on the Accreditation of Hospitals. The national council is composed of five outstanding physicians and four outstanding nursing-home administrators among whom are a former hospital administrator, an outstanding medical social worker, and a well-known registered nurse with many years of experience as a public health nurse and also as a private-duty nurse. The chairman of the national council, Dr. H. Close Hesseltine, is also a member of the Joint Commission on the Accreditation of Hospitals.

The joint commission is likewise composed of physicians and hospital administrators. The standards of the National council are equally as high in the nursing-home field as (if not higher than) those of the joint commission in the hospital field.

In addition, the members of the board of directors of the national council review each and every surveyor's report and staff recommendation to grant or deny accreditation of a facility. The joint commission does not review each recommendation of its surveyors and staff. This is left in large measure to the discretion of its staff. Attached to my written statement is a biography of the board members of the national council. Since the bill recognizes the joint commission in the hospital field, there is no reason other than oversight as to why the national council should be recognized in the nursing-home field.

IV. We would amend section 1867 under the title "Health Insurance Benefits Advisory Council" by striking out all words in the sentence on line 23 after the words "health activities" and add the following: "and at least one person each who is representative of the nonprofit nursing home, proprietary nursing home, and the general public."

The bill provides for an Advisory Council to the Secretary. Since it is to be composed of 16 members, it would seem that in addition to the hospital and medical field, that the nursing-home field should be represented. This is especially true since the Secretary will be as concerned with that field as he will be with the hospital and medical fields. It is believed that the use of the term "hospital, medical, and other health activities" was inadvertent. Of the 16 members among those fields for which representation should be specifically provided are those supplying services under the bill.

The bill affects most, other than the public, hospitals and nursing homes, proprietary and nonprofit, rehabilitation specialists, doctors, and nurses.

V. We strongly believe that the nursing-home provisions should take effect at the same time as the hospital provisions. Otherwise, during the 6 months' gap, you will have, as patients in hospitals, those who are convalescing cases in nursing homes at the time the hospital provisions take effect. This will greatly increase costs, among other things, and perhaps jeopardize the economic stability of some of our finest nursing homes.

Likewise, we believe that specific provision should be made in the bill, or the Secretary allowed to promulgate regulations, making special arrangements for convalescing patients who are in nursing homes at the time the law becomes effective. These people should not have to be moved to hospitals for 3 days in order to become eligible for medicare benefits under the first layer or basic plan.

Otherwise, on the effective date and shortly thereafter, there will be caravans of ambulances taking otherwise eligible recipients from skilled nursing homes to hospitals for 3 days. At the end of a 3-day period, the process will be repeated in their transfer back to the nursing home.

This problem did not become evident to us until after the bill had passed the House. Experience has shown that the transfer of elderly convalescing from their convalescing surroundings results in an increase in the mortality rate.

Certainly there is some method by which such unnecessary transfers can be avoided and overutilization of hospitals prevented. Some arrangement could be made whereby a certificate by a medical committee, who had reviewed the patient's record and made whatever diagnosis they deemed advisable, could certify that such patient would be legible for nursing-home care under the bill, despite the fact that he had not been admitted to a hospital for a 3-day period.

The association has been a leader in attempting to raise standards of professional nursing care in this country. With the American Medical Association, the American Dental Association, and the American Hospital Association, ANHA established the Joint Council on the Health Care of the Aging. Although this council is now sponsored by AMA and ANHA, 3-day institutes were held this year in Boston, Dallas, Denver, Minneapolis, and Hawaii which were attended by approximately 2,400 nursing-home administrators and others interested in the profession. These institutes have outstanding lecturers. They provide workshops to help nursing-home administrators keep up to date on the latest advances in the health-care field.

Our association, after 10 years of planning and conferences with AMA, AHA, and ADA, established with the aid of AMA the nonprofit, independent National Council for the Accreditation of Nursing Homes in August of 1963.

With the National Safety Council, we developed a safety manual for nursing homes. With the U.S. Public Health Service, we developed a uniform system of accounts for nursing homes.

On February 3, 1965, before the House Ways and Means Committee, we urged many amendments, some of which were accepted by that committee in one form or another.

We proposed that the definitions of an extended care facility in section 1861(j) be amended so that in addition to the present provisions such a facility also be required—

(1) To be fire resistant (or have an automatic sprinkler system) and have an automatic fire-detection alarm;

(2) To have in effect a disaster plan;

(3) To maintain a planned program of nursing care, including a plan for each individual patient, written nursing procedures, a patient-restoration program, and a continuing program of inservice training.

(4) To maintain a uniform system of accounts as developed by the Public Health Service in cooperation with ANHA under grant.

Specific amendments in regard to these matters are attached to the end of our proposed amendments as submitted to the committee. We still believe that the bill should be improved by requiring these additional standards.

Thank you, Mr. Chairman, and members of the committee.

Senator LONG (presiding). Thank you very much. You have made some very fine suggestions and I will endeavor to see that the committee considers these amendments when we go into executive session.

Any questions?

Senator Carlson?

Senator CARLSON. Doctor, I just want to state I sure appreciate your appearance before this committee this morning. I think the Lutheran Church is particularly entitled to much credit for the fine work they are doing in this field. We have some in Kansas, very fine homes. You have the Good Samaritan Homes which I notice you are a member of the board of directors and I think the statement you have submitted this morning should have and I trust and am confident it will have serious consideration of the committee when we write this bill.

The nursing home is becoming more and more a part of our national institution and service organizations, and I hope we can continue to improve it. You are entitled to much credit.

Thank you.

(App. A referred to follows:)

APPENDIX A

SUGGESTED ANHA AMENDMENTS TO MEDICARE TO BE PROPOSED BEFORE SENATE FINANCE COMMITTEE

I. (a) Amend section 1832(a)(2)(B) to read as follows:

"(B) Home health services up to 100 visits during a calendar year *(or fifty days home health visits and up to twenty-five days in an extended care facility)*;[1] and".

(b) Amend section 1832(a) by adding subsection (3) as follows:[2]

"*(3) The one-hundred days provided for by subsection (a)(2)(B) shall be decreased (but by not more than fifty days) by one-half the number by which the days for which the individual elects to receive extended care services during one year are less than one hundred. The individual may terminate the application of this subsection with respect to any day (and the remaining days in the year) by an election at such time and in such manner as may be prescribed by regulations. If the number of home health visits in a year in this subsection has been decreased pursuant to this subsection, a corresponding increase (on the basis of one day of extended care service for each two home health visits in excess of fifty plus, where the number of such visits of home health service is an odd number, one day of extended care service) shall be made in the number of days allowable for extended care services up to twenty-five days of such services.*"

Explanation: (a) and (b). It is believed that there will be hardship cases in which an individual will use up his 60 days of hospitalization under the first layer. He would then have only 20 days of nursing-home care.

Under the first and second layers combined, there could be 200 home health visits which such individual might use a portion of or none at all. Consequently, we suggest that an individual be allowed to convert the home health visits under the second layer into 25 additional nursing home days on a one-for-two basis. We do not believe that this would add any appreciable cost to the bill.

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[1] Italic indicates matter added to House-passed bill.
[2] Entire section new.

II. Amend section 1863 by striking out the words, "listing or" on line 7 between the word "National" and the words "accrediting bodies."

Explanation: We do not believe that mere listing bodies should be consulted in such serious matters as professional nursing-home care. Listing is not a guarantee of quality or high standards as is accreditation. Accordingly, we believe to leave "listing" in the bill will only serve to confuse the issue and make one believe something that is not true or valid.

III. Amend section 1865 under the heading "Effect of Accreditation" by striking out the present section and amending it to read as follows:

"SEC. 1865. An institution shall be deemed to meet the requirements of the numbered paragraphs (a) of section 1861(e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals, *and (b) of section 1861(j) (except paragraph (6)*[1] *thereof) if such institution is accredited as a skilled or intensive care nursing home by the National Council for the Accreditation of Nursing Homes.* If such Commission *or Council*, as a condition for accreditation of a hospital *or an extended care facility, as the case may be,* requires a utilization review plan or imposes any other requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission *or Council, as the case may be,* comply also with section 1861(e)(6). In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other *independent* accreditation body provides reasonable assurance that any or all of the conditions of section 1861(e), (j) or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

Explanation: We believe that where a national accreditation program has been undertaken by an independent body such as the National Council for the Accreditation of Nursing Homes, and is not unilateral it should be recognized. The composition of the national council is similar to the Joint Commission on the Accreditation of Hospitals. The national council is composed of five outstanding physicians and four outstanding nursing-home administrators among whom are a former hospital administrator, an outstanding medical social worker, and a well-known registered nurse with many years of experience as a public health nurse and also as a private-duty nurse. The chairman of the national council, Dr. H. Close Hesseltine, is also a member of the Joint Commission on the Accreditation of Hospitals.

The joint commission is likewise composed of physicians and hosptial administrators. The standards of the national council are equally as high in the nursing-home field as those of the joint commission are in the hospital field. Since the bill recognizes the joint commission in the hospital field, there is no reason other than oversight as to why the national council should not be recognized in the nursing-home field.

IV. Amend section 1867 under the title, "Health Insurance Benefits Advisory Council" by striking out all words in the sentence on line 23 after the words "health activities" and add the following: "and at least one person each who is representative of the *nonprofit nursing home, proprietary*[1] *nursing home* and the general public."

Explanation: The bill provides for an Advisory Council to the Secretary. Since it is to be composed of 16 members, it would seem that in addition to the hospital and medical field the nursing-home field should be represented. This is especially true since the Secretary will be as concerned with that field as he will be with the hospital and medical fields. It is believed that the use of the term "hospital, medical, and other health activities" was inadvertent.

V. NOTE.—Amendments should also be proposed (1) which will make the nursing-home provisions take effect at the same time as the hospital provisions and (2) which would make some special arrangements for convalescing patients who are in nursing homes at the time the law becomes effective so that these people do not have to be moved to a hospital for 3 days in order to be eligible for medicare benefits.

VI. Amend section 1861(j) by inserting the following four paragraphs after section 1861(j)(9) (p. 73, line 19) and renumbering section 1861(j)(10) to 1861(j)(14):

"(10) is a fire resistant building (or has an automatic sprinkler system) and has an automatic fire detection alarm;

"(11) has in effect a disaster plan;

"(12) *maintains a planned program of nursing care, including a plan for each individual patient, written nursing procedures, a patient restoration program and a continuing program of inservice training;*

"(13) *maintains a uniform system of accounts as developed by the U.S. Public Health Service in cooperation with the American Nursing Home Association.*"

Senator LONG. Thank you very much, sir.

All right, the next witness will be Dr. Clifford H. Keene of the Kaiser Foundation Health Plan.

STATEMENT OF DR. CLIFFORD H. KEENE, VICE PRESIDENT AND GENERAL MANAGER OF KAISER FOUNDATION HEALTH PLAN, INC.; ACCOMPANIED BY SCOTT FLEMING, LEGAL COUNSEL; ARTHUR WEISSMAN, MEDICAL ECONOMIST; AND LLOYD COTLER, OF WELMER, CUTLER & PICKERING, WASHINGTON, D.C.

Dr. KEENE. Mr. Chairman and members of the committee, I am Clifford H. Keene, vice president and general manager of Kaiser Foundation Health Plan. With me are Scott Fleming, our legal counsel; Arthur Weissman, our principal medical economist; and Lloyd Cutler, partner in the law firm of Wilmer, Cutler & Pickering which represents us here in Washington.

In cooperation with independent groups of physicians, the Kaiser Foundation Health Plan conducts the largest prepaid comprehensive group practice or "direct service" health care program in the United States. At present, our program provides most of the hospital and medical care services for over 1,200,000 persons—roughly 5 percent of the population of the Pacific Coast States and Hawaii—through 14 hospital-based medical centers and 29 outpatient clinics located in the metropolitan areas of San Francisco, Sacramento, and Los Angeles in California, Portland, Oreg., and Vancouver, Wash., and the island of Oahu in Hawaii.

We support the health care provisions of H.R. 6675 and believe they are a great stride forward. However, they can be further strengthened to give better health care and incentives for controlling costs—these are features which plans like ours stress. One way this can be done is to pattern the health care provisions after the highly successful Federal employees health benefits program so as to give the senior citizen a choice as to how he wishes to receive his medical care.

Another way is to leave no doubt that the bill authorizes payment for all covered services on the basis of capitation and other non-fee-for-service methods.

This will provide an incentive for effectively controlling cost. Also, some form of additional incentive for effectively controlling hospital use should also be considered. Our experience demonstrates the soundness of these recommendations.

There are different ways of bringing together finances and health resources to create prepaid medical care. The two basic concepts relate to the benefit which the subscriber receives from the prepayment organization. A direct service plan like ours, in itself provides health care services; other plans pay money toward the cost of services.

Examples of direct service plans include our program and the programs run by the Health Insurance Plan of Greater New York, the

Community Health Association of Detroit, the Group Health Cooperative of Puget Sound and similar plans in Minnesota, Missouri, Illinois, Ohio, and Washington, D.C. Examples of the other type of prepayment plan are the plans offered by Blue Cross and Blue Shield and the commercial insurance companies.

A direct service plan such as ours receives dues from its membership and assumes direct responsibility for providing services of hospitals and doctors, inpatient and outpatient, for a fixed payment per member per month. A direct service plan such as ours, organizes and maintains its own facilities, professional and supporting staff.

Our program, now serving more than 50,000 people aged 65 and over, has long recognized the difficult problem of financing health care services for aged persons. In connection with public hearings held in 1961 by the Ways and Means Committee of the House of Representatives, Mr. Edgar Kaiser, president of Kaiser Foundation Health Plan, Inc., filed a statement supporting the King-Anderson bill and endorsing its fundamental principles—that health care for our senior citizens should be supported by a very broad financing base, and that necessary health care services should be available to the aged without a means test. The legislation now before this committee is much broader in benefit structure than comparable measures considered in recent years. We favor these additions because the physician will have additional prepaid ways, other than by costly hospitalization, to study and treat his patients. But it is possible to improve the legislation even further.

One way this can be done is to recast the bill in the pattern of the Federal employees health benefits program in order that various plans for providing health benefits can be utilized. As the bill now stands, both the basic and supplementary programs are cast in a single mold under which the Social Security Administration would become virtually the sole insurer of health care services for our senior citizens. They would have no choice of prepaid medical coverage under our type of plan or any other voluntary health insurance plan. The bill provides insurance type benefits only, and part B is cast in the major medical indemnity form.

As some members of this committee may recall, it was the Senate which in 1959 rejected proposals for a single mold nationwide major medical insurance program for Federal employees and substituted the successful multiple choice program which exists today. This judgment of the Senate favoring diversity, flexibility and competition among significant alternative health plans has been strongly vindicated in actual experience.

Each type of health plan has its adherents and its critics. For example, take the deductibles and coinsurance features which loom so large in part B of the present bill. Some people believe deductibles and coinsurance are desirable methods of utilization control. Others claim that these features discourage preventive services and early detection of disease. Moreover, some opponents of the "major medical" approach contend that it tends to promote unnecessary and inappropriate utilization and inflation of health care costs.

Other approaches to voluntary health care coverage, including the Blue Cross-Blue Shield plans and the direct service plans, prefer to emphasize first dollar coverage and avoid or minimize deductibles and

coinsurance. These divergent viewpoints illustrate that serious differences of opinion do exist as to how best to organize the economics of medical care.

> No single approach toward prepaid health benefits has yet emerged as best for all.[1]

This remark was made by Mr. Andrew Ruddock, Director of the Bureau of Retirement and Insurance of the Civil Service Commission, with respect to the Federal employees health benefits program. This program is set up on a "multiple choice" basis. Every Federal employee has the choice of either a nationwide indemnity benefit program or a nationwide service benefit program, and he may choose group practice direct service plans like ours where they exist.

From the viewpoint of promoting sound public policy, the advantages of this approach are substantial. It will effectively implement the concept of significant choices which are fundamental in our society. It will preserve the opportunity for variation and experimentation on which continuing improvements in the organization of health care services depend. It will permit different kinds of health plans to continue covering their aged members, and it will permit direct service plans to continue doing this in a manner which stresses quality medical care under a system with built-in incentives for controlling costs.

As we understand the bill, it authorizes capitation and other non-fee-for-service methods of payment for all covered services. Such methods of payment are specified with respect to "reasonable costs" for institutional services under both parts A and B, and we understand that the "reasonable charges" for other services may be similarly handled on a per capita or other nonfee basis.

However, in order to preserve the cost control incentives of direct service plans it is important that no doubt be left on this score in either the language of the bill or the legislative record. We agree with the testimony of Mr. Nelson Cruikshank for the AFL-CIO when he said:

> * * * we believe it essential that this bill and the Secretary's administration of it clearly authorize and foster the continued existence and development of these plans, and especially their methods of compensating physicians on other than a fee-for-service basis. We believe this is authorized under the present bill, but we would welcome any technical improvements which would make this aspect more explicit. We also believe the record should make clear the intent of the Congress for the guidance of the administration in this regard.

The direct-service plans such as ours which operate on a per capita or other non-fee-for-service method of payment have built-in incentives for holding down costs and avoiding unnecessary or inappropriate utilization of services, particularly in the hosptial, and for stressing preventive care and early disease detection. Our members pay a fixed sum each month and the doctors and hosiptals serving these members receive an agreed amount per month without regard to the services actually performed. In this method of payment, there is a built-in incentive for economy of operation not present in the fee-for-service method of payment for medical care. This is so because under our method unnecessary treatment or unnecessary hospitalization does not increase income.

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[1] Paper presented by Mr. Ruddock before the joint session of the Medical Care Section of the American Public Health Association and Group Health Association of America, New York City, Oct. 7, 1964.

We believe that it is for these reasons that early experience under the Federal employees health benefits program indicates that direct-service plans such as ours use only 55 percent as much hospitalization as do other plans for persons 65 years of age or over.

Obviously, the bill must provide, as it does, for the fee-for-service approach, since that is the dominant pattern in this country, but it should be equally clear, as we believe it is, that alternative methods of payments are also authorized, in order that direct-service plans can continue to serve older citizens with effectiveness and economy, and we are submitting to the clerk an example of how we think the bill works.

Now, the bill contains provisions directed against excessive utilization. These could be strengthened by adding a financial incentive for health-care organizations which meet the health-care needs for their memberships while achieving significantly lower use of hospitals for a comparable population group. Such lower use would produce real savings under the program. Incentive payments for plans which hold down unnecessary hospital use would encourage these savings. It may be difficult to write this concept into the legislation, but we believe that at the very least the positive benefits which could be gained warrant either a careful study or an experimental program to explore the feasibility of the incentive concept.

Thus, the viewpoints we advocate are:

(*a*) The benefits of this legislation should be administered in a manner similar to the Federal employees health benefits program.

(*b*) In any event, it should be crystal clear that the bill authorizes alternatives to the fee-for-service method of payment in a form which will encourage economy of operation.

(*c*) Something should be done toward providing additional incentives to encourage the savings which can be achieved through effective utilization controls.

We offer the committee any assistance desired of us in implementing these proposals. Thank you for allowing me the opportunity to appear.

(The example referred to follows:)

EXAMPLE OF PAYMENT ON NONFEE BASIS FOR SERVICES COVERED IN H.R. 6675

A direct service health plan pays independent but cooperating hospitals and medical groups on a per capita, cost-reimbursement, or other basis not involving the payment of specified fees for particular physicians' services or per diem rates for hospitalization actually utilized.

The plan's cost structure is as follows:

Payments for part A services............................$*x* per member per month.
Payments for part B services............................$*x* per member per month.

Assume that the plan acts as an intermediary under both part A and part B of the bill with respect to medical and hospital services for persons 65 years of age or older who are enrolled in the plan. Assume also that the payments for services qualify in amount as "reasonable costs" and "reasonable charges" (as may be applicable) under H.R. 6675.

Assume further that an analysis on a statistical sample basis indicates that 75 percent of the hospital and other part A services provided through the plan would fall within the scope of medicare coverage—*i.e.*, assume that after adjusting applicable deductibles and limitations on hospital days, etc., it appears that 75 percent of the part A service provided through the plan would be paid for under H.R. 6675. This would produce an average cost for part A service for the total population covered by the plan of 0.75*x* per member per month. As-

sume that the experience of the plan shows that persons 65 years of age or over utilize 4 times as much part A service as the average for all persons covered by the total plan.

Under the foregoing assumptions, the reimbursement to the plan for part A services for medicare beneficiaries would become 4 times 0.75x per beneficiary per month.

A similar computation would be made with respect to part B services provided through the cooperating medical groups and other organizations. Assume in this regard that the statistical sample indicates that, of the $y per member paid by the plan for physician and such other services, 75 percent represents the portion (after allowance for deductibles and coinsurance) falling within the scope of part B of the medicare bill. Assume further the experience of the plan shows that the 65 years and over population utilizes 2.5 times the amount of part B services as is utilized by the average membership of the plan. Thus, 2.5 times 0.75y becomes the amount payable on account of part B services for medicare beneficiaries who are enrolled in the plan.

Senator LONG. Thank you.

Senator CARLSON. Dr. Keene, I want you to know that I appreciate very much the kind words and the commendation for the insurance program that was written for the Federal employees in 1959. It was my privilege to serve on the Senate Post Office and Civil Service Committee where it was written under the very able leadership and guidance of the distinguished chairman, the late Olin Johnston, and I am pleased to note that you feel it was in the interests of the Federal employees that we have a multiple choice program rather than a single program and I appreciate your kind words.

Senator LONG. Senator Douglas?

Senator DOUGLAS. Doctor, mention the plans which are similar to yours giving direct health care services as contrasted with Blue Cross, Blue Shield, and commercial insurance plans which pay money benefits.

Do you have an estimate of the total number of persons covered under the first set of plans as compared with the total number under the second set?

Dr. KEENE. The first one, our type of plan covers about 3 million, Senator Douglas.

Senator DOUGLAS. 3 million of which you have 1,200,000.

Dr. KEENE. Yes, sir.

Senator DOUGLAS. And the other plans?

Dr. KEENE. Somewhere in the neighborhood of 125 million.

Senator DOUGLAS. I notice you say your plan cuts down on hospital costs. I wonder if you would develop that theme a bit?

Dr. KEENE. For example, Senator, in the review of days of hospitalization per thousand members in our plan, the usual for the general average is about 600 days per thousand members per year. Other kinds of plans are substantially above this, up as high as 1,500 days per year.

Senator DOUGLAS. And the average is how much?

Dr. KEENE. Somewhere in the neighborhood of a thousand days a year.

Senator DOUGLAS. How do you account for this? Do they have an adverse selection of risks?

Dr. KEENE. No, sir; we believe that this is due to the fact that income to our hospitals is not related to the use of the hospitals. Our income is constant and fixed. There is no incentive, either to our hospital people or our physicians, to hospitalize people unnecessarily.

Senator DOUGLAS. Now are you saying in effect that when fees are charged on a per-day basis or per-visit basis that this leads to overprescription of hospital care and medical care?

Dr. KEENE. That could be one conclusion drawn, sir. But also our plan includes comprehensive outpatient benefits so that our diagnostic studies and many kinds of treatment, can be done in the outpatient departments which is relatively less expensive as compared with treatment within the hospital.

Senator DOUGLAS. You heard the very interesting testimony of Dr. Becker in which he advocated converting the benefits for home visits into nursing home care as well as converting unused the hospital care benefits into nursing home care.

Do you have an opinion on that?

Dr. KEENE. May I ask Mr. Weissman, our medical economist to handle that, sir?

Mr. WEISSMAN. Sir, we would appreciate the opportunity of studying it and sending a reply to you, to the committee, in writing.

However, there is one point that is a principle, and a principle we consider most important, and it is related to your first question; that it is vital that the physician have as many effective prepaid alternatives as possible so that the physician can prescribe appropriate care.

To the extent that we do not make available certain categories of services on a prepaid basis it tends to limit the physician's freedom to prescribe and to carry out his treatment program to the best advantage of the patient.

Senator DOUGLAS. The point is, What are the consequences of that general principle? The question, though, is whether convertibility of home visits into nursing home care, as well as hospital care into nursing home care, is advisable, in your opinion.

Mr. WEISSMAN. Senator Douglas, as I said I do want a chance to study the recommendation and our group would want to. However, if the physician does have a variety of alternatives such as nursing home care and home care, as well as hospital care, then the answer to your question, I believe, is that he can provide the appropriate care in accordance with his professional judgment.

Senator DOUGLAS. In other words, have it flexible across the board?

Mr. WEISSMAN. Exactly.

Senator DOUGLAS. As you know, the original King-Anderson bill provided that under the hospital care benefits there was to be coverage of the services of medical specialists, namely, X-ray people, pathologists, anesthetists and the like, but the House Ways and Means Committee eliminated coverage of these costs under the basic plan. Have you an opinion on that?

Mr. WEISSMAN. Senator, as far as our own program immediately is concerned, since we do incorporate all these categories of services, the item is of no immediate concern to our plan. However——

Senator DOUGLAS. Wait a minute. The House bill would throw such benefits out of the hospitalization plan. The present provision would provide that these charges could not be included under hospital services and would have to be handled on the basis of individual charges which, subject to the deductible feature, could be 80 percent covered under the supplementary plan for those who are under the supplementary plan.

Mr. WEISSMAN. Sir, this, however, I think, is important. We support the point of view of Mr. Celebrezze and the administration in recommending that they be reintroduced.

Senator DOUGLAS. That happens to be my point of view, too. I would like to have you look at this amendment and see if it is satisfactory to you. his would put back the original provision of King-Anderson, and include the services of these medical specialists under the basic plan where the hospitals include such costs in their charges. I wondered if you would look over that language and see if it is satisfactory to you.

Mr. WEISSMAN. We were especially impressed with the material introduced into the Congressional Record by Senator Douglas, with the detailed documentation from the several hospitals. The areas that we consider to be significant are, first, that this breaks away from the concept of fragmentation, and, second, it avoids a single mold concept of how you handle the specialty groups.

The third point which we consider to be of considerable significance, the question of public policy, however, is that the beneficiaries and undoubtedly the hospitals generally would be disadvantaged if the present form of the bill with reference to these services were incorporated.

Senator DOUGLAS. Thank you very much.

Senator LONG. Any further questions?

Thank you very much, sir.

I would like to make this announcement that Dr. Walter A. Noehren, of Sandy, Oreg., who was scheduled to testify today, notified the chairman that he would not be able to appear but his statement will be inserted in the record of the hearings.

(The statement referred to follows:)

STATEMENT BY DR. WALTER A. NOEHREN, M.D., SANDY, OREG.

Gentlemen: We have a compelling common interest—each of you and I—wherein it concerns the actual practice of medicine in each of your own and the sovereign States, you (the Member of Congress) are the only true writer of Federal law, and I (the individual doctor,) and the only true executor.

My concern is certainly not for the well-being of doctors, any more than is yours for the well-being of Senators. Our concern is rather for the enablement of well-being, the good health, the integrity, the "life, liberty, and the pursuit of happiness" of every individual citizen, in my town, in your State, in America, and in all the world. This is our mutual responsibility.

You may wonder why I have come so far for what appears to be a hopeless cause. It is because, gentlemen, since the times of Patrick Henry, Thomas Jefferson, and the others, then Lincoln, and now, bringing full and awesome power to bear upon it, President Johnson, America does not admit to any hopeless causes. "We are believers." "Every man must be free."

"There are only two certainties in this world" said Franklin, "death and taxation." These two limitations we will accept, none other. Of these two certainties, my job is concerned with health and (the difficult problems) of prevention of premature death; you are concerned with the equally difficult problems of taxation.

We both, at this minute, face a medicare bill: H.R. 6675, which has been written to the purpose to assure the availability to the best health care for all Americans, regardless of age or geography or economic status. We both know full well that H.R. 6675 will not accomplish this purpose, even though it represents the best efforts of good men who have worked long and hard to write it. We do not criticize them, but give them praise. The rapid evolution of H.R. 6675 from the original King-Anderson bill, its prompt passage by the House of Representatives,

and the impatience of the Senate and of President Johnson that your committee act promptly have now made it clear to all, beyond any question, that this Congress will pass extensive medicare legislation and that considerable sums of Federal funds will be devoted to problems of health care.

It is my opinion, and I can claim to be as knowledgeable as any other witness you will hear, that we now have an entirely new situation which demands that you quickly call in all the help you can find to write a new and truly comprehensive health care bill. Now is the time, not 1947 as I once hoped, to sit and reason together. We have come a long way since then, and we have come a long way in the past month. But that is the kind of a world we live in.

You are critical of my profession if we do not apply each new advance of medical science almost before it is proven. We in turn can be equally critical of you if you do not constantly adjust our Government to our new knowledge.

With all due respect to the administrators of our wonderful American hospitals and medical centers, our excellent insurance industry, our very productive and increasingly well-paid labor force, and the governmental staffs who concern themselves with health problems, I believe that you must give first consideration, in any legislation which concerns the practice of medicine, to the opinions of doctors. We are not easy to approach. One of the foremost objective observers of medical care has said, "but I really don't understand doctors." At this moment, however, perhaps for the first time, I am sure you will find all doctors sincerely interested and willing to communicate with you. We are not too sure that we understand legislators. Even Thomas Jefferson, expressed some doubts about our early Congress and wrote that it was as useless to argue with them as with the marble columns which surrounded them. He advised patience, to await a better time, that has come, let us not let it escape.

I do not believe that the AMA can or wishes to truly represent the entire medical profession, but it is a responsible, democratic organization. If you wish its true opinion now in this new circumstance, no part of this organization short of the entire house of delegates would be adequate, but you can have them here in Washington within a few days if you wish. The same would be true also of the American Hospital Association and other organizations which are involved. If the logistics of this concern you, think of how our military must move into less happy situations and you will not give it a second thought.

As to your part of it, we do not care where the money comes from and you have our confidence in this. But we do care how it is spent. As concern the use of a payroll tax I can say that the public does seem to accept this with good grace, even though it is a pay as you go system. The shoemaker in my town said the other day, "These taxes are terrible, and then there is that social security tax, but of course I may get some of that back if I live long enough." Whether you are being honest with the public to let them carry this understanding is for you to decide. Why labor wants to pay a disproportionate share of this tax is also difficult to understand, but they say they do.

We hear discontent over the fact that H.R. 6675 was written in closed session. It should not be necessary, as you now write a new law, that there be no open session. These would have to be very limited, however, timewise, and the whole process needs to be completed very rapidly.

What the doctors will do if you pass H.R. 6675 is difficult to predict. I can tell you that doctors at this moment are very depressed. I flew into Saskatchewan during the strike there, on the day the public marched on the capital. It was a dismal circumstance and the medical profession there has been damaged.

A distinguished architect has defined modern architecture as "power applied to purpose." We are happy that President Johnson is so willing to use the power of our Government to really pour it on. We invited him to do this in health care, but in such a way that our own power as doctors, will not be impaired but will be enhanced. Then we will begin to see his Great Society concept come true. In some areas it may be a little like war, where problems have an upper hand, but more and more it will become an understanding and eventually a peace in which every man will be free.

(Additional statement by Walter A. Noehren, M.D., May 7, 1965, Sandy, Oreg.)

Gentlemen, my name is Walter A. Noehren, M.D., of Sandy, Oreg. This is a supplement to my statement to the committee which I mailed in anticipation of my appearance as a witness.

I. Personal background in medical practice

I have been a "family doctor" for 25 years. I am a graduate of the University of Rochester Medical School.

A. Postgraduate professional training and experience:

(1) One year fellowship in pathology and research (Rochester, N.Y.).

(2) Two years rotating internship (Hartford Hospital, Connecticut).

(3) Two years residency training in internal medicine (Cooperstown, N.Y.).

(4). One year in public health, including line management experience as employee in industrial corporation (Dupont Co., Hanford, Wash.).

(5) Four years closed group prepayment practice (Kaiser Permanente, Vancouver, Wash.).

(6) Two years in community health center project (Troutdale, Oreg.).

(7) Fifteen years as independent "country doctor" (Sandy, Oreg.).

B. Special qualifications as a witness in medicare legislation:

(1) For quarter of a century have continuously studied and researched the problem of full medical care for all citizens.

(2) Have practiced medicine in the major forms of medical care administration, including—

(a) Medical school.

(b) Basic physiological research.

(c) Closed group practice.

(d) Closed group prepayment practice.

(e) Independent solo practice.

(f) Member of various prepayment health plans (including the Physicians' Association of Clackamas County, Oreg., an outstanding open panel doctor's service plan).

(3) Have published original articles on subject of "Medicare" in the following journals:

(a) Journal of Pediatrics.

(b) American Journal of Psychiatry.

(c) New England Journal of Medicine.

(d) Northwest Medicine.

II. Personal background in medicare

A. Practical research in medicare:

(1) Continuous intensive and comprehensive study of problems relating to medical care for all citizens.

(2) Originator of practical solution to national medicare needs.

B. Practical application of medicare project:

(1) Acceptance of project entitled "Medical Care for Everyman" by resolution of Clackamas County Medical Association.

(2) Unanimous approval of "Medical Care for Everyman" project by Oregon Medical Association.

(3) "Medical Care for Everyman" project formally presented to American Medical Association by delegates from Oregon Medical Association.

(4) Project "Medical Care for Everyman" partially incorporated in bills currently before Congress.

III. Recommendations

It is the recommendation of the witness that the Senate Finance Committee redraft the current health care bills to incorporate the best features of medicare, eldercare, and regional centers. (See references 1, 2, 3, 4, and 5.[1])

A. Redrafting now would give these results:

(1) Single standards of health care—the best—for all citizens.

(2) Would not interfere with the private market in medicare (including that all important inherent competitive adjustments of cost and utilization levels).

B. Redrafting would speed up the timetable for improving the Nation's health.

C. Redrafting would engender greater national support and enthusiasm for a comprehensive national health program.

(1) Most phsicians would endorse such a program.

(2) It would be consistent throughout with the code of ethics and policy of the American Medical Association.

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[1] Such attachments with the exception of Nos. 1 and 5 appear at end of supplemental statement. Attachments Nos. 1 and 5 made a part of committee files.

(3) Would follow President's stated purpose regarding health care legislation.

(4) Would be enthusiastically supported by retired persons and the workingman alike.

IV. Discussion

A. There is a logical reason why the redrafting of this bill has had to wait consideration by your committee—

(1) Because it has been necessary to demonstrate beyond any reasonable doubt—

(*a*) The determination of this Congress to pass health care legislation; and

(*b*) The determination of the medical profession to stand firm on principle.

B. Now, for the first time, with the arrival of H.R. 6675 in your committee, you have the opportunity to draft a truly comprehensive health care program in America. (Other nations, for the most part, because of premature and inaccurate legislation, lost this opportunity before they ever reached it.)

(1) The theoretical possibility of a comprehensive health care bill was reviewed in 1947. (See reference 1 attached.[3])

(*a*) At that time, this could have been accomplished only by forcing the American medical profession into an entirely new and different system of medical practice.

(*b*) It would have had to leave out of the picture all third-party and commercial insurance interests (including Blue Cross).

(2) Since then our doctors have had to adjust their medical practice to—

(*a*) Rising costs.

(*b*) Rapidly changing and expanding scientific knowledge.

(3) It is to the credit of our society that enough time has been allowed for adequate experimentation to develop, by slow democratic growth, sufficient knowledge to now design an effective comprehensive health care program. Special credit is due in this to—

(*a*) This committee, in particular your chairman, Hon. Harry F. Byrd;

(*b*) The Ways and Means Committee of the House of Representatives; in particular, Hon. Wilbur D. Mills, chairman; and

(*c*) The administrative advisers of our Federal Government, in particular, Mr. Wilbur J. Cohen.

(4) The American Medical Association has now endorsed, in very general terms, in its eldercare proposal, the necessary new policy regarding health care. I was personally present in Washington when this new AMA proposal was annnounced and noted that to most of you this seemed a last-minute superficial move. It was not. It was the logical result of long and careful study.

C. Financing Health Care:

(1) It is the responsibility of Congress to pass a bill providing a safe technique for full Federal enablement of personal health care throughout our States.

(2) The bill must—

(*a*) Fulfill the demands of our time.

(*b*) Be true to the fundamental principles of American Government.

(3) Financing must be by direct transfer payment to qualifying individual citizens so as not to interfere with responsible, personal and private medical practice.

4. Other methods of Federal financing, while opportune, will not be acceptable in the long run.

D. To what extent does the Federal or Central Government need to be involved?

(1) Since reasonable comprehensive health care is now generally considered to be a basic human right, it is the proper concern of the Federal Government to know that this is accomplished.

(2) It is essentially the responsibility of the local communities and States to accomplish this, however. Thus, any Federal enablement of care must be designed so as not to interfere with this responsibility, and to allow, at the

[3] Not printed. (See footnote 1.)

earliest possible time, the development of fulfillment of this responsibility by the locality or the State.

(3) At this time—1965—our communities and States are not succeeding adequately in fulfilling this responsibility. There is need to remedy all inequities in health care as rapidly as possible so that America can live up to its full concern for the health care of each and every citizen. For this reason, the medical profession and all others should welcome as much Federal enablement as Congress can give to this all-important problem as long as this is designed correctly. The witness recommends full Federal enablement of each citizen whose income is inadequate for his own purchase of care be extended now for the free-choice purchase of truly voluntary prepayment care.

(4) Special programs may receive enablement as a temporary expedient, as in the medical center proposal.

E. Why medical care legislation is needed now.

One fact is very clear: that in a competitive price and market production system (which private medical practice has always been and which real voluntary prepayment care is also) the producer simply cannot extend his product or his service to the nonpaying customer. In the past, doctors and hospitals, with community contributions, have tried to do this, and we still are doing so, but at this moment it is clearly impossible.

Also, in the past, doctors and hospitals have used the oldtime Robin Hood technique of overcharging the paying patient to make up for the nonpaying ones. This is no longer acceptable. (See reference 2 at end of supplemental statement.)

Thus, in a free society, individuals who are down on their luck, either chronically or momentarily, need to be sustained. They need minimal or modest sustenance for shelter, food, clothing and recreation, but they need full sustenance in health care.

(Reference No. 2)

[From the Medical Tribune, Mar 22, 1965]

BREAKTHROUGHS ARE EXPECTED IN THREE AREAS OF MEDICINE

Medical Tribune—Worldwide Report

ANN ARBOR, MICH.—Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare, predicted here that "1965 will be a year of significant breakthroughs in education, medicare, and in the financing of great medical complexes."

Mr. Cohen returned to his home campus for 3 days of lectures and seminars in which he covered a wide variety of social, economic, and health problems and prospects. He is officially on leave from his post as professor of public welfare administration at the University of Michigan School of Social Work.

Looking beyond the pending congressional approval of the Kerr-Mills bill, Mr. Cohen said: "Vast deficiencies in health care for the aged have overwhelmed consideration of similar existing deficiencies in children's care."

He noted that in recent years some 80 percent of welfare medical care has gone to the aged, and he indicated that national efforts will now be directed toward extending Kerr-Mills to cover any person under 21 who is medically indigent.

In those States that already have programs for the care of children, the Federal money to be made available would have to be used to expand and "fresh out" those services, he said, and not serve just as a different source of support for existing programs.

He also envisioned another amendment to Kerr-Mills in the near future. This one would eliminate those provisions that restrict mental health care to institutions. To relieve the mounting pressures on those institutions, Mr. Cohen stressed the need to extend Federal aid to alternative forms of care, notably home care and community-centered mental health centers.

"Successful achievements in these directions will cut the 600,000 patients now in mental institutions down to about 300,000," he said. "Such an amendment to Kerr-Mills would furnish the stimulus that could alter the whole character of the State mental health population."

In a seminar with social workers at the University of Michigan Hospital, Mr. Cohen made these points:

1. The American Medical Association scheme for eldercare "has no chance of getting through. They brought it on the scene too late. If it had come last year

when the issue was in doubt, they might have had a chance for success. But not now."

2. "HEW is taking a very conservative view of providing drugs under the health plans. We have learned that any drugs we will pay for, people will prescribe."

Hospital administrative problems

Questioned about the major hospital administrative problems he could forsee under medicare, he mentioned three.

"First is cost accounting, the problem of determining what is and what should be included under the hospital's costs. Should we, for example, make allowances for nurse education and the training of interns?

"The second problem will be to find the proper methods for handling charity patients under 65," Mr. Cohen said. "Today's self-supporting hospital transfers these costs to the paying patients. But once you have the Federal Government paying for those patients over 65, and then you add a percentage onto their bill in order to support the younger charity patient, you are actually evading the intention of the legislation." He suggested that one solution might be to make the States pay for all charity patients.

Third will be the hospital's administrative problem of becoming properly qualified to handle federally supported patients. "All hospitals will have to have a hospitalization review committee. In addition, it must be accredited by the Joint Commission on Hospital Accreditation or it must meet all the health and safety standards of accredited hospitals."

Mr. Cohen indicated that a hospital that could not gain accreditation because of its small size would be able to participate in the Federal program.

(Reference No. 3)

H.R. 6675	*Health Care for Every Man*
Diminishes the sovereignty of the individual citizen.	Enhances the sovereignty of the individual citizen.
Makes future commitments of great cost to the Federal Government.	Makes no commitments for the future.
Cannot be placed in effect soon.	Can be placed in effect almost immediately.
Does not allow full Federal enablement.	Will allow unlimited Federal enablement to immediately correct all deficiencies in present care if Congress so wishes, within a framework which will then become self-sustaining on local levels.
Will disturb seriously the economics of present private care of elder citizens able to pay their own way. (However, if Congress wishes to be generous to our affluent elder citizens, they can do so by transfer payments earmarked for health care. This then will not disturb the competitive production pattern.)	Will, in no way, disturb those areas of care which are now self-sustaining and which are producing the highest quality care in the world. Does not give any unearned benefits to the affluent elder citizen.
Leaves unsolved the problem of "charity" patients.	Eliminates what is now known as the "charity" patient, thus producing, in dramatic manner, the essence of a Great Society—"true charity."
Is contrary to the code of ethics and to the policies of the American Medical Association.	Is consistent with the code of ethics and the policies of the American Medical Association.
Will not relieve the President of the United States of worry over health care.	Will allow the President of the United States to relax and be true to his seeking of a Great Society as he faces the extremely difficult problems of a troubled world.
Will increase superficial political controversy over health care.	Will, to all practical purposes, remove health care from political debate.
Will not significantly add to the stabilization of our economy, and may possibly damage the correct evolution of a truly democratic social security system.	Will contribute significantly to stabilization of our economy, including full development of new employment in health care services.

Other considerations

Under any system of care, it is always the physician who must make all the important decisions in personal medical care. As stated in the report of the President's Commission on Heart Disease, Cancer, and Stroke, page 17: "The physician supply is beyond question the most critical single element in manpower for medical service. The physician calls the shots in every individual case, and the national toll of death and disability is only the sum of individual cases."

If this is so, why does our Government wish to pass any laws which the physicians of America truly believe to be incorrect? Why depress your doctors? Should they not, rather, if this is truly to be a Great Society, be inspired?

In respect to the proposal for regional centers as recommended by the Commission, this proposal should be included in your health care for every man bill and placed in effect immediately. The question has been raised, "Where will we find the doctors to staff these centers?" The answer is simple: If you do it right, the medical profession will develop as many doctors as are needed and as quickly as needed. It might be wise, to stimulate this, that these new centers be located not in relation to existing medical schools, but in areas where no medical school now exists, but where one could properly be developed, allowing the medical profession of each new area to develop cooperative modern democratic planning toward the end that these new schools would become, as soon as possible, private medical schools, self-sustaining, with teaching not only of new doctors and new paramedical personnel, but also producing a continuing educational program.

In respect to the current discussion of whether radiologists and anesthesiologists and pathologists should be employed or be in contract practice with hospitals or not, the answer is very clear. They should not. Every doctor, no matter what his discipline, should be a free agent as much as is possible, even if he might be employed on a salary basis. This principle is clearly demonstrated at the Mayo Clinic. If one is a patient there, his hospital bill is for his room, meals, and nursing services. His medical bill includes the services of the radiologist, anesthesiologist, and pathologist. The code of ethics of the medical profession is very clear in this matter. The fact that some doctors have not always lived up to this code does not make it any less logical.

(Reference No. 4)

MEDICAL CARE FOR EVERYMAN: A PROPOSAL[1]

Walter A. Noehren, M.D./Jack R. Hegrenes, Jr., ACSW, Sandy, Oreg.

This is a proposal which would involve the Federal Government and private insurance enterprise in a cooperative effort to make comprehensive prepayment medical care available to any American citizen unable to purchase it. It is a specific answer to the socioeconomic problems of contemporary medical care.

The proposal is simply to legislate the following: Each person whose income is inadequate for the purchase of his own care can, upon his voluntary request, receive assistance from the Federal Government for the purchase of comprehensive prepayment care.

The assistance would vary in amount from partial payment to total payment of the premium cost. Except for the lowest income group, each person would have to produce his own share of prepayment costs to qualify for assistance. (Today, a family with income of less than $4,000 per year would need help. No provisions would be necessary for those other persons—the great majority of our population—with income adequate for the purchase of their own prepayment care.)

Eligibility for assistance would be based solely on taxable income (an "income test," not a "means test").

The payment of money by the Government would be made in each instance to a prepayment plan as chosen by the individual applicant from those plans which would be approved and available in his locality. For this to be effective, good and comprehensive health insurance would have to be available on a competitive basis. In this respect, the American Medical Association Committee on Indigent Care has made the following statement: There should be a program that is based on the individual applicant's medical needs and his ability to pay for care without

[1] Intent of this proposal was presented to the AMA house of delegates at the 1961 clinical session at Denver in Resolution 16. The house referred it to the Council on Medical Service for consideration and report back at the annual session in Chicago, June 1962. The proposal was previously approved by the Clackamas County Medical Society in April 1961, and the Oregon State Medical Society in September 1961.

compromising those means essential for him to retain a self-supporting status after completion of treatment. This is it.

The declarations of need and the payments of money would be integrated in the existing structure of the Internal Revenue Service. The IRS is already set up with advanced, efficient techniques of performing income tests, and of dispersing funds (as in refund checks). The use of the IRS mechanism would accomplish precise distribution of assistance funds according to need, with precise discontinuance when need would be remedied. The use of the IRS computer system would allow accurate, up-to-the-minute data of medical care assistance costs.

Special areas of care could continue to receive special subsidy—from private sources, local government, State government, or Federal Government—to relieve prepayment mechanisms of unusual costs (e.g. open heart surgery, repair of congenital defects, etc.) until such time as it might become practical to include these under prepayment care. This would allow a large area for effective voluntary activity which is most desirable. Any increase in voluntary activity would reflect in reduced prepayment costs, with resulting reduced assistance program costs. As solutions to problems are achieved, as in polio at present, voluntary activity could be directed to other areas. Also, voluntary activity could continue to be used to help build and support hospitals in their tradition as charitable instituions.

This proposal is directed to the need that each individual person should be responsible for his own well being, and also for the well being of everyman.

It will be noted that this proposal does not limit itself to any age group, but applies to all persons equally. If a program is to be developed for one age group alone, the only logical justification for this would be to limit the experiment. In such case, one could argue which group would be best studied. However, we feel that this proposal could be applied now to the entire population with safety. We further believe that the need for a logical experiment of this sort is urgent.

Senator LONG. A representative of the International Association of Health Underwriters had made application to testify after the schedule of witnesses had been completely filled. He was advised by the chairman that his name would be placed on the waiting list to be scheduled in the event of a cancellation.

As promised by the chairman, the spokesman for the IAHU, Mr. Paul D. Hill, was immediately scheduled to fill the vacancy caused by the cancellation of Dr. Noehren.

However, the Chairman was advised that the spokesman for the association, Mr. Paul D. Hill, was unable to make the necessary transportation arrangements to come here from Chicago. He was notified at 3 o'clock yesterday and he will be unable to appear. If another vacancy should occur he will be scheduled again.

That gentleman, Dr. Hill, wrote members of his association and they, incensed that he was not scheduled to appear, sent irate wires and letters to us, and I would just like it known that he was offered the opportunity to testify, and he couldn't make arrangements to be here from Chicago which is of course, some distance away. I don't know how difficult it is, but so far as I am concerned I could have gotten here from Louisiana in the same period of time.

Senator DOUGLAS. An hour and forty-five minutes by plane but it may be difficult to get a plane.

Senator LONG. The next witness this morning is Dr. Wilbur of the Palo Alto Medical Clinic. Would you please proceed, sir?

STATEMENT OF DR. RICHARD S. WILBUR, PALO ALTO MEDICAL CLINIC, PALO ALTO, CALIF.

Dr. WILBUR. Thank you.

Mr. Chairman and members of the committee, my name is Richard S. Wilbur. I practice internal medicine as a partner in the Palo Alto Medical Clinic in Palo Alto, Calif.

Dr. Russell Lee has asked me to inform you that my views do not represent the views of all of the members of the clinic which is not a political organization and does not have any views on political matters, and this is entirely correct.

The sum of my statement is before you and I shall not read it verbatim since I assume you can read faster than I can read aloud.

I should like, however, to make the points which are present in this statement.

The first of these is that I am practicing in a city where I have practiced for 13 years and my father before me for 35 years, and he still does, and my grandfather before us. The reason I stress this is not our longevity or our patients' longevity but the fact that I feel in regard to a bill such as this rather different than one does in the average legal process where we have the adversary system and a man represents either the plaintiff or the defense.

I feel that I always represent my patint. He and I are in the battle together against disease and death and that this is a battle in which, despite temporary victories, in the end we will meet defeat.

Anything which you gentlemen can do to help me take better care of these people is of the greatest help to my personally and anything that you do to help me will in the end help them to live a better and a more healthy life.

Senator LONG. Doctor, you say in the end you will meet defeat, but I would say if I were able to live to be 120 I would just as soon cash in my chips at that point.

Dr. WILBUR. Senator, we hope someday to make you feel so well at 120 that you won't say that.

But being so, I feel that when we set up a health program for 20 million people we should set up the very best program we possibly can. There are certain things about part B which I would like to discuss.

I feel that the program should protect our patients against the possibility of catastrophe, something which will wipe them out financially.

This is health insurance, and as I have written here, health insurance and total health care are quite different things. Health insurance can be typified by the catastrophe, a heart attack, a stroke, the need for a major operation, and the fracture. Total health care includes colds, rashes, the small things that plague people, of which my older patients have many and for which I think they like to benefit by coming to see me.

But this is the type of utilization which the patient can control. The acuaries who have figured out the expense of this bill are able to predict for you quite correctly what the incidence of catastrophe will be for 20 million people over a year. They cannot predict for you what the utilization will be by people for lesser illnesses; that is whether they will or will not go to see a doctor when they have a cold. They have to come when they have a heart attack. They don't have to come for the more minor thing.

It has been the experience in every country which has set up total health care, and for those of us who have set up smaller plans, that when total health care is provided people take advantage of it and if one uses the example of Sweden, where I worked for 6 months, which has an 80–20 coinsurance factor, when you set up a program of total health care the ultilization will double.

There are not that many more catastrophies; this is utilization for small problems.

Again, I say the people are more healthy for coming in, but we must be sure the expense of providing this care does not become disproportionate.

I say in regard to the figures you have been given as to expense of this plan they will be too low because an actuary cannot figure the utilization by people for minor problems if these are covered.

I say in covering these minor problems we run the risk of raising the administrative costs. If a person had a $500 operation it costs us at the Palo Alto Clinic about $5 to fill out an insurance form and do all the other billing that go with it. We understand the insurance company, be it Government or private company or any other, spends about the same amount of money per form at its end.

For a $500 fee this isn't much of a problem. We are talking about 2 or 3 percent of the total. But for a $5 office visit once a month to fill out the insurance forms on both, the bill to the patient for $1 and to the Government for $4 becomes a prohibitive overhead expense. Now, overhead is a real problem for those of us in medicine.

We could spend the money on better nurses, better equipment. I think this is a reasonable thing for the patient or public, whoever is paying for it, to pay for, but to pay a doctor or the people who work with him for bookkeeeping I don't think really improves the health of the Nation.

For this reason, I would very much like the program set up to have an absolute minimum of administrative costs. I am not suggesting to you explicit ways of doing this except to say that it is in the coverage of the small problems that you get a disproportionate amount of this expense.

My feeling about the best way to solve this problem, and I have listed this here, is that you should be very certain to cover catastrophes that occur to people in this group. They must have this protection. I feel they would also benefit if they had an ability to purchase care for minor problems as well.

Like the previous speaker I happen to feel that prepaid capitation would probably be a more efficient system of taking care of small problems since it has a minimum of bookkeeping, but I would hate to see this put in on a large scale for 20 million people because we still have some problems involved in the utilization and expense, a problem the British are still struggling with 15 years after they set up the plan.

I feel it should cover catastrophes; I feel at least in the beginning you should eliminate what we might call the nickel and dime expenses as most insurance policies do, covering them only for the people who cannot afford even the $5 office visit, and there are some people in this group over 65 who cannot.

I feel in setting up this plan it would be most advantageous if your advisers were people who had been skilled in the field of providing health care on an individual basis, which is the usual basis for health care in this country, rather than, as is usually done, picking out a very distinguished professor who is a famous person but who hasn't had such experience.

I feel they would be useful advisers to you in writing part B, whether it would be along the line of the Federal employees bill, which is ex-

cellent, or any other line, I shan't tell you how to write laws because I have no experience in this, and I also would be pleased if the direction of this plan afterward were under the control of people skilled in health matters.

A health program for 20 million people will be a huge and complex matter, and I feel that even if you had to go to the extent of setting up a separate Secretary of Health that this would be very valuable.

Senator CURTIS. Mr. Chairman, may I interrupt right there?

Dr. WILBUR. Yes, sir.

Senator CURTIS. Would you define your term "individuals skilled in health matters"?

Dr. WILBUR. Yes, sir.

Senator CURTIS. You mean hospital administrators—do you mean physicians? Who do you mean?

Dr. WILBUR. I was speaking only to part B, Senator Curtis, which has to do with the physicians' care and certain other matters. I was thinking primarily in this context of the physicians and therefore the people skilled would be physicians who had cared for patients in the patient's home and who had been on call at night and did understand——

Senator CURTIS. The general practitioner.

Dr. WILBUR. That would be an example; yes, sir.

Senator CURTIS. He would be much better than the very fine specialist who is isolated and deals with a specific problem because he is dealing with people and a multiplicity of problems; isn't that right?

Dr. WILBUR. Yes; although many of us who are specialists working in a clinic actually do see all sorts of problems. Yes; someone like this. I am not saying this man should write the bill. I am saying he could give you advice as to how this bill would affect the relationship of the doctor and patient on what you might call the lowest level.

As I say, I feel this plan should be directed by some system which you, of course, would set up, where health people, people skilled in health, would be taking care of a health program.

I feel if you do this you will be doing the things which are of greatest benefit to my patients and that this, therefore, will make my life a great deal easier and we will all bless you for doing it.

Thank you.

(The prepared statement of Dr. Wilbur follows:)

STATEMENT BEFORE THE SENATE FINANCE COMMITTEE, U.S. SENATE, RE H.R. 6675, MEDICARE BILL OF 1965, BY RICHARD S. WILBUR, M.D.

Mr. Chairman and members of the committee, my name is Richard S. Wilbur. I practice internal medicine as a partner in the Palo Alto Medical Clinic in Palo Alto, Calif. This is the town where my father practices and in which my grandfather practiced before us. I am grateful for this opportunity to discuss with you some of the ways in which H.R. 6675 will affect the medical care of our patients who have been our friends and neighbors these many years. We have been caring for them for a long time and hope to continue to do so for some time to come. I would like to help them have the best possible arrangement for the payment of this future medical care. If enacted, H.R. 6675 will irrevocably set the pattern for the system of payment and thereby for the quality of this medical care in the future. Therefore, it should be the best possible program.

PROBLEM TO BE SOLVED BY H.R. 6675: HOW TO PAY FOR HEALTH PROTECTION

To assess any proposal, one should measure it against its objectives to see if this is the solution which best fits the problem. The problem, as I see it, is that

some of these friends, of all ages, are financially unable to protect themselves against a medical catastrophe by securing adequate health insurance. H.R. 6675 proposes to meet this problem by offering a program of complete health care to every one over the age of 65, subject to the provisions of a $50 yearly deductible and of 20 percent coinsurance. This should solve the problem, at least for the persons over 65, of protecting against medical catastrophe, but I believe that it, like so many solutions, will raise still other problems and I would like to talk about several which I think will arise from provisions of part B.

TOTAL HEALTH CARE IS MUCH MORE THAN HEALTH INSURANCE

The first new problem has to do with the fact that the proposed coverage goes well beyond protection against catastrophe, since total health care is much more than health insurance.

Insurance.—Insurance is protection against a medical catastrophe—stroke, heart attack, cancer, need for major surgery or serious injury. These are uncommon events in any one person's life, uncontrollable by the individual himself, although predictable in total incidence for a large population, such as the 20 million people over the age of 65. Because actuaries can predict the incidence of these disasters, they can also predict the approximate necessary utilization of health facilities and therefore the appropriate program expense. This permits accurate budgeting for large scale programs. Health insurance covers the unexpected great expenses which could impoverish a family, such as the $1,000 or $2,000 fee which Representative Mills quoted on the floor of the House (Congressional Record, House, Apr. 7, 1965, vol. III, No. 62, p. 6959).

Total health care.—Total health care not only includes the conditions included under insurance but goes far beyond it. It also includes all the common little occurrences which may or may not require medical attention; mild arthritis, constipation, colds, rashes, urinary irregularities, etc., as well as certain chronic conditions which do benefit from intermittent medical observation, such as swollen ankles, diabetes, or high blood pressure. These problems plague geriatrics patients who may benefit from medical treatment but who are neither greatly deprived without it or made destitute by paying for it. Utilization of this type of medical care is controllable by the patient to a great extent and the desire to secure this day to day type of care is greater than that shown by other age groups because retired persons have many more such problems and, as compared with workingmen or busy housewives with small children, more time available in which to seek this care. This type of care is best characterized by the $5 office visit.

TOTAL HEALTH CARE PROGRAMS LEAD TO INCREASED UTILIZATION OF MEDICAL CARE

1. An example of increased utilization in a program using 80/20 coinsurance principle is that of Sweden, which does not use the $50 deductible. Within 5 years of the installation of a total health care program in that country, health expenditures in the country had doubled. There was, of course, no such increase in the number of insurable medical catastrophes, but chiefly just an increased utilization for many minor problems.

2. Programs for older persons: The Palo Alto Medical Clinic has offered total medical care on a prepaid capitation basis to three retirement homes in our area. This has resulted in an increase in utilization among those people who were also our patients before the plan went into effect, from 6 visits per year per person to 13 visits per year. We think this has significantly improved their health care, certainly their death rate has been below that which had been actuarily predetermined for the group. Furthermore, the hospitalization rate has also been below that estimated for the group. However, it has made for an expensive plan.

From all the above, we may safely predict that a total health care program for the 20 million people over the age of 65 will result in a tremendous increase in the health facilities utilization by these people without any significant increase in incidence of serious diseases. An increase in utilization of medical care for the less serious illnesses and for prevention of more serious illnesses in their early stages is, as I indicated, associated with an improvement in general health and I, as a practicing doctor, believe that seeing a doctor is a good thing for a person to do and makes him healthier. However, it is an expen-

sive item in its cumulative effect and should be considered carefully before it is entered into in any prepayment program, as we at the Palo Alto Medical Clinic have found to our sorrow. This is not a new discovery. The California Physicians' Service had the same difficulty in 1939, when it attempted a broad scale plan of coverage and wound up paying its member doctors 80 percent less than an already low schedule fee. These experiences have made doctors, the world over, cautious of the estimated budgets for any total health care plans.

UNDESIRABLE EFFECTS OF INCREASED UTILIZATION UNDER A TOTAL HEALTH CARE PROGRAM

1. The total budget figures for the program will be invalidated by this actuarily unpredictable increase in utilization and the concommitant increase in expense.

2. Health care facilities, including personnel, will be strained, requiring still further expenditures for increasing these facilities and the number of personnel. This problem in regard to physician supply will be complicated by the provision in another section of H.R. 6675, which seeks to persuade physicians to retire at age 65, under social security. A disproportionate number of patients over age 65 are cared for by medical doctors in their same age group. Self-employed medical doctors still working at this age are almost all involved in the day to day care of the sick and will be sorely missed by the rest of us who will have to care for their patients. My father, who is 64, is currently seeing more patients today than any of the younger surgeons in our clinic and he will require more than one doctor to replace him if he retires at 65. The combination of increase in utilization and decrease in doctor personnel will cause some patients difficulty in obtaining necessary health care as quickly and conveniently as they would wish it.

DISPROPORTIONATE RISE IN ADMINISTRATIVE COSTS

The second problem presented by a program paying for all illnesses is that the administrative cost rises disproportionately to the cost of the actual medical care given.

Example.—It costs the 110-doctor Palo Alto Medical Clinic an average of $5 to fill out an insurance form. We understand that the insurance companies spend about an equal amount to process this same form at their end. There is an additional cost involved in mailing bills and in collecting from the patient for any portion of the charge not paid by insurance. For a $500 operation these costs are a small percentage of the whole. For a $5 office visit they are a prohibitive overhead expense.

Medical overhead.—At the Palo Alto Medical Clinic the cost of doing business has risen from 45 percent in 1950, to 55 percent of all fees collected now. Some of this increase is in services of direct value to the patient; increased parking space, comfortable chairs to wait in, better paid, more friendly receptionists to reassure distressed patients; better paid, more competent nurses; better paid and more reliable lab and X-ray technicians; better secretaries to type accurate records; air conditioning for comfort in the examining room; new and better medical equipment and even, sometimes, newer magazines in the waiting room. All of these items directly or indirectly are of benefit to the patient who seeks medical care, and are a justifiable health care expense. However, this is a second type of increase in medical overhead, which is that of the increased cost of collecting the payments. These costs have increased disproportionately over the years, and yet are not of any health value to the patient, nor of any value to the doctor. These have been occasioned by a multiplicity of government and private insurance forms, by the fact that it is uncommon in our area to pay cash for anything, and by the increased percentage of our patients who have some complicated arrangement for having their medical costs reimbursed. In our group practice we have therefore been experimenting with ways of cutting down on the bookkeeping type of administrative costs by setting up prepaid capitation plans for total health care. Persons paying a monthly premium receive all forms of care without additional charge or need for anyone to fill out a piece of paper. As you would expect, this has resulted in heavy utilization. As mentioned before, it is our belief that these plans have also resulted in an improved quality of medical care with a high ratio of actual health benefit to the patient, as against administrative costs. Whether people

are willing to pay the necessary high premiums for this improved care, has not yet been proven. We do regret that H.R. 6675 will effectively wipe out four promising experiments with patients over age 65, by forcing our group to convert them back to the older fee-for-service type of payment with the $50 deductible, and the 80/20 coinsurance feature for each service, and, therefore, a resultant increase in bookkeeping expense.

Under the total health care program provision of part B, the bulk of this increased utilization will be in the form of individual office visits about once a month or less often. The expected cost of billing the Government for 80 percent and the patient for 20 percent of the $5 office visit, with or without "certifying and recertifying" as to the need for the visit, will make the patient a financial burden, even though the fee paid is one which would ordinarily be adequate for this service as rendered to the usual patient who does not require this complicated system of doing business. The increased administrative expense to doctor, carrier, and Government, must in some way be passed on to the public as an increased cost of health care without, unfortunately, any commensurate increased benefit to the health of the public. This seems to me to be undesirable and unnecessary.

COMBINED EFFECT OF INCREASED ADMINISTRATIVE COSTS AND INCREASED UTILIZATION TOGETHER WILL LEAD TO A DEPLETED BENEFITS FUND

Because of the expected increase in both the number of demands for health care, and in the administrative expense per service as discussed already, I believe that the fund requirements will be much greater than those presently predicted. It has been our experience to date with welfare departments, at least in our local county and State government, that when the money runs short, they have met an understandable reluctance on the part of the legislators to raise the necessary taxes. This has then forced these welfare departments to make cutbacks in the benefits to the recipients. Unfortunately, the persons in charge of these programs, have usually been well trained in welfare but not in health matters and they have often made medically unsound decisions which have seriously interfered with the giving of proper medical care to our patients. For instance, allowed procedures under various VA and OAS programs have been severely and arbitrarily circumscribed from time to time. An example of this is the fact that in addition to being an internist, I am also a certified gastroenterologist, 1 of 2 among 1,200 M.D.'s in our county, and am referred patients by other doctors for the treatment of such diseases as jaundice and bleeding ulcers. I am considered competent by our local welfare department to treat my patients over the age of 65 for colds or to make house calls upon them when they have some minor problem. However, if they become seriously ill with jaundice or bleeding ulcers, they are taken from my care and sent 25 miles away to a county hospital to be cared for by an intern in training. I have never believed that this fragmentation of my patient with separation from his doctor, his family, and his friends has been a medically sound decision. These limitations on our provision of proper care for the OAS patients, plus the high bookkeeping costs attendant upon filling out the many forms associated with their visits, have made them relatively undesirable as patients, when compared with equally sick persons not under such programs. A doctor, given his choice, prefers to spend his time practicing medicine, not bookkeeping. Judging by their respective aptitudes for these two activities, most of them should stick strictly to medicine.

Ideally, it should always be the case that the doctor be glad that a patient chose him instead of another M.D. However, it is now the case in California that a doctor is better off if an OAS patient leaves him for another doctor. The first doctor is then left free to practice the best quality medicine for his remaining patients without the frustration of illogical, nonmedically determined limitations on his type of practice, compounded by the aggravation and expense of increased and often unnecessary bookkeeping. This is unfair to the OAS patients who are well aware of the fact that they, through no fault of their own, are now second-class patients. This should be corrected and I applaud title XIX of this bill as a long step in that direction. We must, however, be certain that part B of H.R. 6675 does not inadvertently convert 9 percent of the population into a similar group of medically second-class citizens, by loading their care with administrative expense, bookkeeping annoyances, and frustrating limitations on the best of care. We need to encourage doctors to take more care of our older citizens, not to discourage them from it by the complexities surrounding the delivery of such care.

SUGGESTIONS FOR SOLUTIONS TO THESE PROBLEMS

1. At least until we have gotten more experience with the amount of increased utilization and of expense, I would suggest that we restrict the program to those people who must have help now. This would seem to be the persons over 65, facing the possibility of medical catastrophe without adequate health insurance. If the bill were to provide wholly or in part the payment for protection against these catastrophes and were furthermore to provide a means whereby those who can afford to buy such adequate insurance themselves would be given the opportunity to purchase it at reasonable rates, with or without subsidy, then the fear of financial disaster would be removed from the homes of those over 65.

It might be felt that there is also a category of person who requires protection against more than serious illnesses alone, since for this fraction, even an office visit is too great an expense. For these persons, total health care could be provided, even in the knowledge that the cost would be increased disproportionately more than the improvement in health derived from this extension.

2. Invite as consultants to your staff in rewriting this bill, persons who represent the ordinary working doctor, who after all will perform most of the health care provided under the bill. In the past, it has been common practice to consult distinguished university professors who are better acquainted with the more complicated aspects of medical care than with the frustrations of everyday practice, or to consult public health doctors who have no experience with the giving of medical care on an individual basis.

3. If this plan for the health care of 20 million people is put into effect, it should seem logical to have it administered by a health-oriented agency. There does not seem to be any reason why education and welfare should be associated with this health agency. This could be a separate administrative agency, possibly a committee such as the Health Insurance Benefits Advisory Committee described in section 1867 of this bill, or even, as is done in most other countries, a separate Secretary of Health to cover the expanding problems and programs in this field.

SUMMARY

I have endeavored to show that in meeting the problem of protection from financial catastrophe caused by medical illness, part B of this bill has set up a system of total health care which will itself result in certain problems which should be preventable:

(1) Increased utilization of health facilities for relatively minor illnesses.

(2) High administrative costs for the handling of these less serious illnesses.

(3) Depletion of allocated funds subsequent to the increased utilization and increased administrative costs.

(4) Resultant need for higher taxes and/or premiums or for diminution of benefits.

I have suggested that solutions to these problems could be these:

(1) Entering the program more cautiously than is presently contemplated by protecting our patients only against the expensive part of health care, rather than all of it.

(2) Later expanding the program if there is a demonstrated need for more help in ways permitting experimentation and flexibility to take advantages of the rapid changes going on in the field of health care.

(3) Have the program's inception and continued direction guided by persons who have had experience in delivering health care to individual American citizens.

Senator LONG. Thank you so much.

I would like to depart from the usual procedure this morning to give the junior members of this committee an opportunity to participate more fully.

When I was a junior member of the committee, if I had a good question to ask it was usually asked before it ever got to me so I am going to start out with the most junior member of the committee on this occasion, and call upon the Senator from Illinois, the junior one, the young once, the newest member of the committee, to ask the first question.

Senator DIRKSEN. The longer I stay here, the less I have to say, after 30 years in the House and Senate.

Senator LONG, I will call the junior Senator from Connecticut.

Senator RIBICOFF. It is very thoughtful and considerate of you and I appreciate it.

I am curious about the statement you made. At the Palo Alto Clinic the overhead is 55 percent of the cost of services rendered?

Dr. WILBUR. Yes, sir; that is correct. My business administrator looked this over before I wrote it down. It is—has gone up as you noticed in the last year. I could detail why it has gone up.

Senator RIBICOFF. I am just curious. I read your whole statement. Of course that would not be the overhead of the average practitioner who practices medicine by himself, one who practices medicine very much as an individual doctor would.

Dr. WILBUR. This varies greatly with the specialties. An X-ray man who has to buy expensive equipment, and has to have lead-lined walls so he won't sterilize people in the next office, and has to buy X-ray film, will have an overhead much higher than that. A psychiatrist who only has to have a couch has a great deal lower overhead. There is a great deal of variation. It also depends on how well equipped your office is. We like to give our patients excellent service and we have good nurses and we use the syringe only once and then we throw it away. If you use it over and over again you run the risk of giving a person jaundice. These things are expensive items.

Senator RIBICOFF. Yet my understanding is that in a clinic such as yours the overall cost to the patient is usually less for the same type of service than that given by a specialist or special practitioner who practices by himself. Isn't that correct?

Dr. WILBUR. We like to think it is.

Senator RIBICOFF. That is my understanding. Do you have whether it is so? I don't know.

Dr. WILBUR. Our fees to our patients in our areas are, I would say, comparable to those of the other good doctors. They are lower than the highest and slightly above the lowest.

Senator RIBICOFF. This bookkeeping, do you look on this bill as raising some more complicated bookkeeping problems?

Dr. WILBUR. As I understand the provisions of certifying and recertifying as to the needs of patients coming to see me, this reminds me of the OAS program which, as you know, on each visit I have to write down why the patient came to see me. This takes a certain amount of my time to fill out this. It takes my secretary still more time to fill out various provisions of the form. As I understand the need for getting 80 percent from the Government and 20 percent from the patient at times, I do understand this is an indemnity plan, that I can get 100 percent from the patient, but I do feel for the small visits that there will be more bookkeeping; yes, sir.

Senator RIBICOFF. You didn't consult with Senator Long, did you, on his proposals for a catastrophic illness plan instead of this plan?

Dr. WILBUR. No, sir.

Senator RIBICOFF. Do you know he is advocating something like this?

Dr. WILBUR. No, sir. I would certainly be interested to read it.

Senator RIBICOFF. You realize you have an advocate for your bill,

Senator LONG. I have two or three advocates. [Laughter.]

Senator RIBICOFF. Thank you very much.

Dr. WILBUR. Thank you.

Senator LONG. Any further questions?

Senator TALMADGE. Doctor, as I understand the thrust of your statement, you contend that the bill should be limited to catastrophic illnesses rather than day-to-day and ordinary routine and minor illness, in that correct?

Dr. WILBUR. I believe at least until we have had more experience with it that would be the best thing; yes, sir.

Senator TALMADGE. Wouldn't the $50 deductible feature virtually do that?

Dr. WILBUR. I don't speak for the whole country and I come from a very high level, high cost of living part of the country. That $50 would be reached fairly early in my part of the country. I am well aware in other parts of the country the fees are significantly lower, as the whole cost of living is, and it would take much longer to get to the $50. In my part of the country, no. A high percentage would reach that earlier.

Senator TALMADGE. No further questions.

Senator LONG. Any further questions?

Senator DOUGLAS. It so happens that in 1950 I advocated confining health insurance to catastrophic illnesses as a substitute for the Wagner-Murray-Dingell bill. I must say it was opposed by all elements in the community, by the American Medical Association because it went too far, and by the advocates of the Wagner-Murray-Dingell bill because it didn't go far enough. While I think that on the insurance side this is the proper method, nevertheless, what about the treatment end?

I notice you say that as a result of minor ailments being treated by your clinic that the death rate and the morbidity rate have fallen markedly. That is true, is it not?

Dr. WILBUR. Yes, sir.

Senator DOUGLAS. The question comes then whether that isn't worth the extra cost.

Dr. WILBUR. Senator, I think it is, as a matter of fact, I have nothing in the world, as a doctor, against lots of money being spent on health care. I think it is a wonderful place to spend money but I do think you should be forewarned that the estimates of how much it will cost you are, to my belief, much too low because of the cost of caring for these lesser illnesses, and also that I feel that, as I understand, this the administrative costs will rise disproportionate to the actual health benefit to the patient.

Senator DOUGLAS. Do you have any practical suggestions?

Dr. WILBUR. Well, I have some but I wouldn't want to spot—amend the bill. Yes, sir; I would like, as the previous speaker would, to go ahead with our capitation plans which we do have at the clinic, where we get a lump sum and we do no bookkeeping. This has resulted in an expensive plan——

Senator DOUGLAS. How would the American Medical Association regard that?

Dr. WILBUR. Well, I can't speak for the whole American Medical Association.

Senator DOUGLAS. Are they not bitterly opposed to any capitation system or any prepaid plan? Isn't that historically the fact?

Dr. WILBUR. You mean a Government-sponsored?

Senator DOUGLAS. No, any prepayment plan or any capitation system?

Dr. WILBUR. Again, as I say, I can't speak for the whole AMA. We at least in California have such systems, as you have heard, and they are accepted. The president of your county society——

Senator DOUGLAS. You read the Journal of the American Medical Association?

Dr. WILBUR. Yes, sir.

Senator DOUGLAS. Don't you know they have gone on record against such plans?

Dr. WILBUR. If so, I guess I missed that issue recently. I wouldn't dispute you at all.

Senator DOUGLAS. I would suggest that an impartial committee be set up to scrutinize the resolutions of the American Medical Association to see what their attitude has been. I wat 'ı this fairly closely and if my memory serves me they were very mucl. opposed to prepayment plans and even more opposed to capitation plans.

Dr. WILBUR. As Dr. Keene said, I would like to see a variety of plans available because I still believe in experimentation.

I don't think we have the best system yet. I would like to see you set up competing plans and then have this impartial committee say this one gives better health care per dollar than does that, and therefore, this is the way we should do it.

Senator DOUGLAS. What are your charges for people over the age of 65, per year or per month?

Dr. WILBUR. Under this capitation system?

Senator DOUGLAS. Yes.

Dr. WILBUR. $15 a month.

Senator DOUGLAS. $15 a month?

Dr. WILBUR. Yes, sir.

Senator DOUGLAS. Or $180 a year.

The provision under the supplementary benefits plan is $3 a month for the insured person and $3 a month for the Government or a total of $72 a year. You think the $72 would be too low?

Dr. WILBUR. Yes, sir.

Of course that has a $50 deductible in it which we don't have.

Senator DOUGLAS. Yes; that is right.

Dr. WILBUR. And has the 80–20 coinsurance. We are covering everything.

Senator DOUGLAS. You don't have a deductible?

Dr. WILBUR. No, sir; we don't have a deductible.

Senator DOUGLAS. So that your plan is not catastrophic illness but an all-out system?

Dr. WILBUR. It is total care.

Senator DOUGLAS. Yes, total.

Dr. WILBUR. The difference in this is there is no bookkeeping for the doctor involved.

Senator DOUGLAS. I see.

And no limitation, therefore?

Dr. WILBUR. On utilization, none at all, and as I indicated we have had tremendous utilization in this plan. We are not sure we can afford it even at $15 a month.

Again, Palo Alto is a very expensive place to live.

Senator DOUGLAS. So I have heard. [Laughter.]

Senator LONG. Senator Carlson?

Senator CARLSON. Doctor, I just want to say this, it is encouraging to have someone come in before the committee at least mention or stress the possible extra costs that will be involved when we enact this legislation. Your statement has been very helpful to me, and I think we should give some consideration to it as we go through this bill.

Dr. WILBUR. Thank you, sir.

Senator LONG. Senator Curtis?

Senator CURTIS. Am I accurate in describing one of the ideas that you presented as we should direct our attention to that illness or injury that the patient just couldn't carry alone?

Dr. WILBUR. Yes.

Senator CURTIS. Rather than take care of some things which perhaps he could carry but which would be very expensive administration-wise for the Government to handle.

Dr. WILBUR. Absolutely, sir, yes.

Senator CURTIS. A minor matter might call for as many Government forms, as much bookkeeping and as much time expended, as making the necessary records for something which was really extremely serious, in fact, in the neighborhood of catastrophic, is that right?

Dr. WILBUR. That is the way I see it, the $5-visit and the $500 operation are just the same on the form and the amount of bookkeeping. Yes, sir.

Senator CURTIS. That is all.

Senator LONG. Thank you very much, Doctor.

Dr. WILBUR. Thank you, sir.

Senator LONG. The next witness will be Mrs. Shirley Powell Marlow speaking for the Princess Anne Council of Republican Women.

STATEMENT OF SHIRLEY POWELL MARLOW, PRINCESS ANNE COUNCIL OF REPUBLICAN WOMEN

Mrs. MARLOW. Good morning, Mr. Chairman and members of the committee.

I hope you will permit me to give my oral presentation in story form, otherwise, I am afraid you wouldn't have the faintest idea of how I got involved in medicare.

My best friends and I drove home in silence. Outside it was a gloriously sunny winter afternoon, but inside the car we sat in a kind of frozen silence. Each woman completely absorbed in her own thoughts. Each stared blankly at the road ahead. Finally, one said, "I can't believe it. I just can't believe that we are just months away from the beginning of socialized medicine. Somehow it seems impossible that this is about to happen to us—to our country. But how do you stop it? How do you go about fighting such a big, overwhelming force?

"Well, they say that truth will make you free. Maybe that's the answer."

Yes, maybe that could be the answer. It had been the answer for us that morning. We had been asked to attend a lecture on medicare—and since my nice family doctor was to be the speaker and we all trusted and respected him—sure, I'd go and listen. And we learned so much, but we were left very puzzled. Why was medicare being pushed so hard? Who was behind it? Who was going to reap the profit? Surely not just the old people. This didn't begin to solve their problems. The younger people would be paying for it all their lives—many of them would never reach the age of 65 to collect anything. Well, if it wasn't adequate, and the people didn't understand it—and those who did didn't want it, then why was it being forced down your throat like so much castor oil?

Was it a campaign promise that someone felt had to be kept? Why? Who were the people and why did they want it passed so badly? What was the hurry behind it all?

Worse yet, you're such a novice you don't know where to start, but since it is now your problem, then logically start with yourself.

So I phoned my doctor. "If I call in my friends and neighbors for a coffee break, will you come over and explain the pitfalls within medicare?" He said he would. That one "coffee" in February grew and grew and grew into discussions all over our Tidewater area. PTA groups, civic leagues, garden clubs, both political parties, church groups and fraternal and business clubs invited speakers. The newspapers, television, and radio stations arranged special news stories and asked doctors and laymen to discuss all phases of medicare.

At the very start, I wanted to know what the biggest obstacle was in our path. Early one evening, another good friend kept my 5 youngsters—along with her 5 little ones, and I set out on a typical street, in a typical housing development—where I knew no one, and I went door-to-door to 20 houses and discussed medicare for 5 to 20 minutes with each family. Nineteen out of the 20 could not discuss any phase of medicare. They simply did not know anything about the subject. One man did know something.

This gentleman told me he was 74. He said he favored the passage of medicare. I asked him why? He said he didn't have to know why, that he relied on the judgment of the Machinist Journal (or Guide), which he described as a labor newspaper. I offered him some literature, which he refused. He said he never read any newspaper or magazine other than his labor paper. He said what the union prescribed was good enough for him. I learned a good deal from my own private survey. There were 19 cases of total ignorance concerning medicare and one person in favor of the bill—who, by his own admission, subjected his mind and will completely to the control of his labor affiliation. Suddenly, one part of the puzzle started to fit.

Senators, before you cast your vote for or against this bill, I strongly recommend that you conduct your own private survey, too. Take a weekend off. Go back home. Pick out a street—preferably one where you are not known. Take 10 houses. Find out what these

people do and don't know about medicare. You'll be very, very surprised at the answers you'll receive.

In your home State there are many situations that are just as true as they are in my beloved Virginia. In Norfolk and Portsmouth all of our large hospitals are now operating at 95 to 100 percent capacity; often it goes over 100 percent capacity. I have this substantiated in a newspaper story.

When you offer this alleged "free" hospital care in 1966, where are you going to put this tremendous increase? Who will decide then which patients will be admitted and which will be turned away? Will it not resolve itself to some degree as to which elderly persons have someone with "connections"—perhaps, political "pull" who can arrange to get grandma into the crowded hospital because "after all, remember, we worked pretty hard for the party during that last election." Don't you honestly think that doctors, nurses, and hospital administrators have enough headaches now without getting politics into the act?

You will find out something else, too. Did you know that medicare has already become a pretty cruel hoax? Many, many elderly people were so confused by the last national election that they thought medicare was the absolute cureall to old age. They thought it was going to be "free" and it would cover all sorts of medical needs, and they would be treated in the local hospitals right in their own hometown. They have been so sadly misinformed and misled that many patients have told our doctors here that they have already dropped their hospitalization policies.

Let's look directly at another cruel fact. This bill implies that everyone over 65 is either sick, destitute, or irresponsible. Look at the people 65 and over who are still productive, who still enjoy working, who still love being needed within their family circle. Look around this room. All those 65 and over—are you sick, destitute, and irresponsible? No; these people have planned their lives for retirement for old-age illnesses. Why cover them twice? Look at the large percentage who don't need this "free" coverage in the first place.

At this point, I must represent my many friends who are Navy or military wives. Since January 1, 1957, they have been paying social security. Should this bill pass, they will have to pay the increased tax, too. And they emphatically want to know why? Right now they are entitled to medical attention—all the medical attention they want or need. Upon retirement, they are still entitled to medical care, as part of their fringe benefits. So why do they have to be taxed twice? These service families have been promised a pay increase, but what long-range good will it accomplish, when it will have to go toward the increased social security tax? Why take it from one pocket and put it in another?

As long as we have freedom of choice, Navy, military, and civilian families will still pick and choose their own doctors and hospitals. Plenty of our civilian doctors have service families for patients in Tidewater. Socialized medicine in England has not been the answer there, either. Private practice has started to flourish outside of the national health program.

I personally attended somewhere between 40 and 50 of these medicare coffees, and never once did these citizens come to a full realization

of the far-reaching consequences of medicare but what they, in turn, tried to write Congressmen, Senators, and editors and ask them to vote against passage.

Now, gentlemen, we come to my strongest objection to medicare. This bill is trying to shift what is basically our moral obligation to care for our own relatives into the hands of the Federal Government. I am unalterably opposed to this.

We are instructed in the Ten Commandments to "Honor thy mother and thy father." These are ancient laws that have endured through thousands of years, and now more than at any time before in the comparatively short span of our history as a nation we feel the need to return to these fundamental teachings. We need so deeply and desperately to strengthen our family bonds—to help our parents, our older people, our friends. This is the responsibility of my generation to aid an older generation. By accepting my responsibility, I teach my children by my example to be concerned with the needs of their generation.

You may say that's fine for you, Mrs. Marlow, but what about those children who will not accept the challenge? Are these people to go wanting or drain the financial status of their children by a long or terminal illness? No; that is a condition to be corrected, too, but corrected locally, within each State. The medical conditions within 1 State cannot be the same for all 50 States, nor should it ever be the same for all 50.

We are strong and progressive because of our individuality. As for those who shirk their family obligations, we have no right to shift our personal obligations to the shoulders of the Federal Government, just because some do not care for their elderly. Rather, we should adopt an attitude with this congressional session of greater determination to strengthen the American home. There is where your answer lies to so many, many problems. Look deeper into the lives of our Nation's families, and you will see the problem very clearly.

You cannot shift or sort personal need into an IBM machine or stamp it on a social security card, and with a clear conscience say, "Here, machine, here's grandpa; he's 65 now—he's your responsibility now."

No, thank you. When I am old, I don't want to be sent half way across the State to die in a spotlessly clean, sanitary, Government-approved hospital surrounded by unfamiliar faces and muffled voices. No; just let me be in that disorganized, noisy, half-furnished wonderful home in Virginia that I left to come talk with you Senators today.

Thank you. God bless your decisions.

Senator LONG. Mrs. Marlow, Senator Byrd requested me to tell you he is sorry he was not here to hear your testimony today, but he is going to read your statement, and knowing the chairman, I am sure he will agree with you.

Senator CURTIS. Mrs. Marlow, I want to thank you for your statement, and I certainly agree with you that the minute we make individual responsibility of less importance in our national life our country will suffer. We have a fine medical system in this country, do we not?

Mrs. MARLOW. I am glad to say we have the finest there is in the world.

Senator CURTIS. We are not an emerging nation which needs a Government medical program to give us a fine system of health care, are we?

Mrs. MARLOW. No; we never had one of these "coffees" except where we had a doctor present because we felt there were so many questions come up as pertaining to our local welfare problems that we always wanted a doctor down there to answer the questions, and believe me, I don't think really, and I grant a great deal of knowledge and respect to all of you here this morning but I don't think a question could possibly be raised in this room that was not raised in all those 50 "coffees" that I attended.

Senator CURTIS. Over what period of time did they run?

Mrs. MARLOW. We started about the middle of February.

Senator CURTIS. This year?

Mrs. MARLOW. Yes.

Senator CURTIS. Coming back to my question, we do not need a program here to put the Government into the business to improve the system of medicine.

I just totally reject that. Whatever problem we have from the standpoint of Government is that there are some elderly people who, because of their own resources or lack of family or otherwise, are unable to avail themselves of the medical system we have, and there the problem ends, isn't that right?

Mrs. MARLOW. That is right. We have talked to some of them——

Senator CURTIS. No need has been demonstrated at all for a Government health program for that segment of our population that can take care of themselves, has there?

Mrs. MARLOW. I have some more literature here on how that has been, that particular phase of it has been, overexaggerated, I will leave it with you to examine.

Actually, it is a very small percentage. It has been exaggerated out of all proportion. We have so many that—I will read this to you, this is from, I have no ties with the AMA. I sought their help, they did not come looking for my services, and they ran a little story about what we had done in our area and that is why I have this AMA newsletter from February 22, 1965, and I quote in one of their question and answer pages:

How many people now have health insurance?

The answer:

More than 78 percent of all people in the Nation and over 60 percent of the elderly.

Senator CURTIS. Yes. They have some health insurance.

Mrs. MARLOW. Yes.

Senator CURTIS. While admittedly it is not adequate in many instances, considerable progress has been made in the last 10 years, hasn't it?

Mrs. MARLOW. Yes; and frankly I feel since this has all been brought to the forefront that you scared the daylights out of the insurance companies and they are bending over backwards to increase their programs because this could mean the end to so many insurance plans. It could mean the end for so many husbands' jobs who are employed in the insurance field.

Senator CURTIS. I do not know to what extent you have studied the language of this bill, but——

Mrs. MARLOW. I have only gotten through about page 60 but I have questions I would like to raise on all 60 pages.

Senator CURTIS. You are probably 60 pages ahead of a great many of the proponents.

Mrs. MARLOW. I never saw the bill until about 3 days ago. Something that does distress me a great deal——

Senator CURTIS. The part dealing with physicians and surgeons?

Mrs. MARLOW. I don't believe I have given this consideration in the first 60.

Senator CURTIS. The Government is the insurer. They say, we are going to provide all of this list of benefits, doctors' calls, various places and so on, and the participants will pay in $3, the general treasury will pay in $3 a month, and then the Government agrees not to raise that $3 for about 18 months.

That puts the Government of the United States into the insurance business, doesn't it?

Mrs. MARLOW. Yes, sir.

Senator CURTIS. And it also means that the Government subsidizes half of the premium, isn't that right, because the participant puts in $3 and the General Treasury puts in $3. And how that could be advocated to apply to people who may not be retired, have unlimited resources, and may be enjoying the highest income of their lives is beyond me.

Mrs. MARLOW. Well, it is basically if you earn $6,000 a year you pay the same taxes as some earning $600,000 a year which is not quite fair and those who are of the age to reap the benefits immediately will do so.

Those of my generation, and those younger than myself, will have to pay for this for a considerably long time and frankly as hard as I have ever fought medicare I doubt if I will ever reach the age of 65 to collect it. There are some very pertinent things in here that I am concerned with.

Senator CURTIS. There are some philosophical questions involved here and I have a feeling if this bill is driven through, and we give these free benefits to people who are, and I realize it is not all of them, but to people who are far better able to pay for them than the person doing the paying, that there may be a reason why that is being advocated.

Mrs. MARLOW. I believe I found a great reason on page 51, I believe it is. I have been asking myself and several of the ladies that, from the beginning have been asking ourselves, why, why, why is this thing being pushed so hard when everybody that we know is so opposed to it and we have sent hundreds, literally hundreds of thousands of letters into Washington in opposition to this, we don't know where to send them since I am a Republican and since the day after the last election, and I sent them to Senator Dirksen, and I believe his office has these letters on file.

Senator CURTIS. What I am getting at is this. If this Congress provides free hospital and medical treatment for an individual 65 who is retiring, who is not burdened with buying a home, paying for life insurance, educating children, and so on, and who has some

means and is rather taking it easy, maybe vacationing it in a little boat summer and winter; if it is generally known in my community that he is getting free hospital and medical attention at the taxpayer's expense, then it is going to be most difficult for the Congress to resist extending this program to all ages.

Isn't that right?

Mrs. MARLOW. I read in the papers somewhat—and I wish someone would inform me, because I haven't come to it in the first 60 pages in our evening paper—about 3 or 4 weeks ago they carried a story of the bill as it was coming out of the House of Representatives and I believe at that time—at that point they said that dependent children had been attached to this bill. Is that correct, not just 65 and over?

Senator CURTIS. That is in another section. It relates to this. This is directly——

Mrs. MARLOW. Oh, a foot in the door has already started to march.

Senator CURTIS. Yes. I won't take any more time but I want to thank you.

Mrs. MARLOW. To whom should I refer all of these questions that I have on each page as I go through the bill?

Senator CURTIS. I don't know. [Laughter.] If this bill was understood it wouldn't have gotten to first base.

Mrs. MARLOW. Thank you.

Senator LONG. Senator Dirksen?

Thank you very much.

Dr. Malcolm Watts, of the American Society of Internal Medicine

STATEMENT OF DR. MALCOLM S. M. WATTS, REPRESENTING THE AMERICAN SOCIETY OF INTERNAL MEDICINE; ACCOMPANIED BY DR. JAMES J. FEFFER AND DR. JOSEPH WALLACE

Dr. WATTS. Mr. Chairman, I am Dr. Malcolm S. M. Watts of San Francisco. I am the immediate past president of the American Society of Internal Medicine. On my right is Dr. Joseph Wallace, chairman of our legislation committee, and my left is Dr. James Feffer, chairman of our medical services committee.

I am a practicing internist. I represent more than 8,000 physician members of the American Society of Internal Medicine. This organization is devoted solely to the problems of maintaining and improving the quality of medical services to patients in the modern social, economic, and political context. Our "Airs and Purposes" have been sent to you as background material in order that you may be more familiar with our organization.

INTRODUCTION—THE INTERNIST AND H.R. 6675

As internists we are especially concerned with persons in the over-65 age group. A great many of them are our patients. We treat their diabetes, strokes, cancer, and heart conditions. Most of their requirements for medical care are for the kind of nonsurgical medical services which are characteristic of internal medicine.

For these reasons, the American Society of Internal Medicine has a particular interest in H.R. 6675. Our comments and suggestions

accept the premise that Federal funds will be used to provide medical care for almost all persons over 65, whether they are in financial need or not. Our concern as physicians, is that the bill be workable, and that it encourage rather than restrict high quality patient care. Our concern as taxpayers, is that it not be wasteful and that the costs of administrative overhead not be excessive. I am sure that those concerns are shared with everyone in this room.

Our organization has studied H.R. 6675 carefully. It quite clearly invests in the Secretary of Health, Education, and Welfare wide discretion in its implementation. The Secretary is given the final responsibility and the final authority with respect to the care and services to be provided. However, he is required to seek advice from advisory groups, which he himself will appoint under the provisions of the bill (secs. 1867, 1868). Much will, therefore, depend upon the manner in which the present and future Secretaries choose to administer the program.

Our comments on H.R. 6675 and our recommendations are offered with the hope that, if adopted, they will improve the quality of care available to the elderly under this bill.

COMMENTS AND RECOMMENDATIONS

We applaud the prohibition against any Federal interference "with the practice of medicine or the manner in which medical services are provided" (sec. 1801) and endorse "free choice by patient guaranteed" (sec. 1802). These are wise and important provisions. We support the use of deductibles (in pts. A and B) of coinsurance (in pt. B) and of physician-sponsored local review committees. Properly motivated, these are workable and proven devices which discourage overuse and other abuses.

(1) Part A

With respect to part A ("Hospital Insurance Benefits for the Aged") we are aware of the arguments for and against the inclusion of diagnostic services as a hospital benefit. We are also aware of the arguments for and against separating the technical—that is nonprofessional—and the professional aspects of these services into parts A and B, respectively.

We support the intent of the authors of the bill who evidently envisioned part A as a hospital service program, with all professional services to be provided through part B. We believe that the high quality services of physician anesthetists, pathologists, radiologists, and physiatrists are professional services which truly belong in part B. We therefore recommend that all diagnostic services ordinarily supervised by physicians be transferred from part A to part B.

Beyond this, we believe the restriction of coverage for diagnostic services for ambulatory patients to hospital controlled facilities is unwise. This will surely result in unnecessary travel costs, time lost, and much inconvenience to many elderly patients and to their relatives and friends who in many instances will have to assist them in getting back and forth from the doctor's offices and the hospitals where the diagnostic tests are performed. We, therefore, recommend that benefits for diagnostic services should be extended to cover ambulatory

patients in nonhospital facilities such as physicians' offices and laboratories.

(2) Part B

With respect to part B we are aware that the attention of the Finance Committee has been called to the many administrative problems involved in the allocation of payments for professional services. We are concerned with the vagueness in this section of the bill. Its administration would appear to require rather careful and precise regulation and control of professional services by the Secretary of Health, Education, and Welfare.

However, if he were to contract with one or more health insurance carriers, they could then deliver these benefits within the mainstream of medical care. It appears to the American Society of Internal Medicine that the Federal employees' health benefit plan has resolved most of the difficulties which may be foreseen. This has been accomplished to the general satisfaction of patient, physician, insurance carrier and Federal Government.

We therefore recommend that part B be replaced by a provision for a program comparable to the Federal employees' health benefit plan.

(3) Catastrophic illness

As internists we often see the economic ravage which a prolonged illness can bring to an afflicted elderly patient and his family. We believe the absence of any provision for truly catastrophic illness is a major omission in this otherwise comprehensive bill. This is the great fear of the elderly. This is what much of the public expects of medicare. This is a cost which most taxpayers are willing and glad to share.

We, therefore, recommend that the benefits of part A, and hopefully also of part B, be extended to include truly catastrophic illness for the perhaps 2 to 4 percent of beneficiaries who will really need it.

(4) Accreditation of health care plans

The American Society of Internal Medicine thoroughly endorses the recognition in the bill of the voluntary acceditation process as a means of assessing quality. Our organization is on record as officially advocating the development of voluntary accreditation for health care plans. Accreditation would then be evidence that the benefits are of high quality and the cost not excessive.

When this is accomplished it should ease the burden of the administrators of many Federal health care programs, and should also stimulate the voluntary effort in this field.

(5) A medicare board or commission

Finally, I wish to address myself to the very real fear of Federal regulation and control of medical care. It is shared by many physicians, and much of the American public. We all know that he who pays the piper calls the tune. We all know that serious illness becomes a very personal matter. Whether or not the care is "free" somehow takes second place in these trying circumstances, and the thought of impersonal Federal regulation of medical services in such circumstances is, at the least, disquieting.

The American Society of Internal Medicine believes that the public interest would best be served if the administration of the medicare pro-

gram were carried out by a governmental board or commission which would be as independent as possible.

Such a board might be constituted much as is suggested for the Health Insurance Benefits Advisory Council in the present bill. There should be members to represent the social security system, the Department of Health, Education, and Welfare and the insurance carriers, as well as "persons who are outstanding in fields related to hospital, medical, and other health activities and at least one person who is representative of the general public." (Sec. 1867.)

The members of this board or commission would be appointed by the President for terms to be prescribed in the law. If this were done, responsibility for the medicare program would then rest more closely with the representatives of those who must make it work on a day to day basis. Administered in this way, the program could become a truly cooperative effort of Government, the healing professions and the huge and dynamic health care industry in the United States.

The American Society of Internal Medicine expresses its grateful appreciation of this opportunity to present its views on H.R. 6675 to the Finance Committee of the U.S. Senate.

Senator LONG. Thank you very much, sir.

Senator Douglas?

Senator DOUGLAS. Doctor, if the amendments which you favor would be adopted, would you favor the passage of the bill?

Dr. WATTS. I personally am opposed to the bill. I believe the bill is going to be passed. I thought my most valuable contribution to the Senate Finance Committee would be to offer suggestions for its improvement.

Senator DOUGLAS. But even if those amendments were to prevail, if you were a Member of the Senate you would vote against the passage of the bill?

Dr. WATTS. So far I have not given any consideration to what I would do if I were a Member of the Senate.

Senator DOUGLAS. You say that you are opposed to the bill.

Now, if we were to adopt these suggestions would you favor rejection of the bill even as amended.

Dr. WATTS. I think under the present circumstances, if the bill were amended as I have suggested, I think I would favor its passage.

Senator DOUGLAS. Favor its passage. But if it were not amended would you favor the bill or oppose the bill?

Dr. WATTS. I would oppose the bill.

Senator DOUGLAS. Oppose the bill.

Dr. WATTS. As I say, I haven't really considered my role as a Senator.

Senator DOUGLAS. It may come up, you know, you are a member of the public and public opinion is a very powerful force.

Would you insist on all the amendments which you suggest in order to get your support for the bill, or are there some amendments which you regard as more vital than others?

Dr. WATTS. I would like to see the whole bill replaced by a program that would parallel the Federal employees health benefit program. I think if parts A and B were both replaced by this, I think, many of these problems would be resolved.

Secondly, I would——

Senator DOUGLAS. You favor a voluntary plan as opposed to a compulsory plan in part A?

Dr. WATTS. I was not addressing myself to the method of financing, I was addressing myself to the method of providing medical services.

Senator DOUGLAS. Are you opposed to an all-inclusive plan for hospital and nursing home care or would you make this voluntary upon choice of the individual?

Dr. WATTS. In general, I am in favor of voluntary rather than compulsory mechanisms.

Senator DOUGLAS. Do you think the young folks would come into the plan then? The prospect of illness in old age is very far away from young people.

Dr. WATTS. I imagine, I will say that with a compulsory program more of the young folks will come in.

Senator DOUGLAS. All of them will come in. But will many of them come in under a voluntary plan?

Dr. WATTS. I don't believe I can answer that, Senator.

Senator DOUGLAS. At the age of 25 do the average man and woman consider the fact that when they reach 65 they may be ill, or do they have more immediate concerns such as courtship and other items of expense which weigh more heavily upon their minds?

Dr. WATTS. Well, I can remember when I was 25 and I didn't spend a great deal of time either about what I was going to do when I was 65.

Senator DOUGLAS. I think that is a very honest answer. I think this is the last thing that is in young people's minds.

At the age of 30, by which time the young folks, most of the young folks, have married, is the foremost problem what happens to them after 65 or is it one of furnishing or getting a home?

Dr. WATTS. I think as one goes on through life one tends to become more conservative, and I think one also tends to give more thought to the future, and toward the end of one's life this gets to be quite a problem.

Senator DOUGLAS. The obvious of that statement is that in the early ages people don't consider what happens to them after the age of 65.

Senator LONG. I can't recall just precisely what it was but wasn't the Gore plan we passed last year a voluntary plan—with $7 all you get in medicare—wasn't that the idea or was that the Ribicoff plan?

Senator GORE. The Ribicoff amendment was the alternative plan. My amendment provided a $7 increase in cash benefits in addition to hospital insurance benefits.

Senator DOUGLAS. The difficulty, Doctor, is that under a voluntary plan it is not until people get along to quite an advanced age that they begin to think of the risks of illness after 65. By that time the number of years during which they can make contributions is relatively limited and, therefore, the protection which they can build up is relatively limited. The great advantage of an all-in system is that you have your actuarial tables and you know that a given percentage, plus or minus a margin of error, will need medical attention and hospital attention after the age of 65. In this respect, the actuarial tables, representing the collective experience of the race, are more accurate than

individual judgments which postpone consideration of these issues until it is almost too late.

That is really the case.

I know you are a very honest and sincere man but I think these considerations are sometimes not thought of.

Dr. WATTS. If I may speak, Mr. Chairman, I did not intend to address myself in this paper to the method of financing of this program. I did intend to address myself to the method by which the medical and hospital services involved the patient.

Senator DOUGLAS. I wanted to find out about your judgment in this matter to which obviously you have given a good deal of thought.

Dr. WATTS. Thank you, sir.

Senator LONG. Senator Curtis?

Senator CURTIS. Doctor, you have made a good statement here and I will not ask you to answer this because you should not be called upon to referee an argument that I might have with my distinguished friend from Illinois.

It is my own feeling that our young citizens 25 and 30 years of age are just as much concerned about the future 40 years from now as the present generation of politicians are concerned about what the people will have to face 35 or 40 years from now.

One of the big reasons why the proponents of this bill have to have the people 20 years of age and 30 years of age and 40 years of age and so on into this program is that they are the ones who are going to have to pay for it. We are going to start right off with giving almost 20 million people free hospital and medical benefits without any payment whatever, and these young people are going to be called upon to give that to the people who are well able to provide for themselves as well as those people who need it. So, I am not overly impressed about this solicitude of what is going to happen to a young man who is 25 now when he is 65, because the real urgency to get him in now is to make him pay and pay and pay for 40 years or more.

That is all, Mr. Chairman.

Senator LONG. Any further questions?

Thank you very much, Doctor.

Dr. WATTS. Thank you.

Senator LONG. That will conclude today's hearings and we will recess until 10 o'clock Monday.

(The following were later received for the record:)

(Supplemental report submitted by Department of Health, Education, and Welfare advocating additional clarifying, technical, and minor substantative amendments to H.R. 6675.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., May 17, 1965.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In testimony before your committee on April 29 and 30, 1965, on H.R. 6675, a bill to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, Secretary Celebrezze indicated we would have some clarifying and technical changes in the bill to bring to your attention at a later time.

Enclosed are copies of three groups of these changes together with explanations thereof, where appropriate. The list labeled "Correction of Minor Drafting or Typographical Errors" is self-explanatory and, therefore, is not accompanied by explanations.

The group labeled "Correction of Technical Defects" consists of changes necessitated by defects in various provisions of the bill which we discovered when we were able to accord the bill further and more careful study in the light particularly of those provisions which were added to our original proposal by the House. It also includes clarifications of what we believe was the intent of some of the provisions.

A third group is labeled "Minor or Technical Amendments." This group includes a number of amendments to existing law which involve only minor policy considerations and no controversial issues and which are necessary for the elimination of troublesome administrative problems or irritations caused by the requirements of the existing law. It also includes several improvements of relatively minor significance in various provisions of the bill.

We would be pleased to discuss any of these changes with you or your committee or committee staff.

In view of the fact that the committee has not yet completed public hearings on the bill there may be other suggested changes which will be brought to our attention. If there are any other changes which appear necessary or desirable, we will get in touch with you immediately after the close of the public hearings.

We have not completed our review of all of the amendments offered by Members of the Senate which have been referred to your committee. As requested by you, we will submit reports on these amendments in accordance with the usual procedure.

Sincerely,

WILBUR J. COHEN, *Acting Secretary.*

CORRECTION OF MINOR DRAFTING OR TYPOGRAPHICAL ERRORS

On page 39, line 5, strike out "because he needed".

On page 66, line 15, page 68, lines 14 and 21, page 69, line 18, page 70, line 2, and page 91, line 25, strike out "on the" and insert "on".

On page 67, line 15, strike out "the extent" and insert "such extent".

On page 102, line 6, insert "or other person" after "provider of services".

On page 103, line 9, strike out "under title II of such Act" and insert in lieu thereof "under such title II or such Railroad Retirement Act of 1937".

On page 103, line 13, strike out "1834" and insert "1841".

On page 111, lines 14 and 17, strike out "(1)" and "(2)" and insert "(A)" and "(B)", respectively.

On page 112, line 14, strike out "such Act" and insert in lieu thereof "this Act".

On page 146, before the period in line 5, insert ", and in the parenthetical phrase appearing in paragraph (2) thereof".

On page 174, line 24, insert "monthly" before "benefit".

On page 186, line 6, strike out "paragraphs" and insert "subparagraph".

On page 277, line 19, strike out "or (b)".

On page 287, line 26, page 288, line 23, and page 289, line 16, after "expenditures for" insert "premiums under part B of title XVIII for individuals who are recipients of money payments under such plan and other".

CORRECTION OF TECHNICAL DEFECTS

HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCES

(Exclusively or Almost Exclusively)

Beginning date of enrollment period and coverage period.

Combine inpatient hospital services under part A and inpatient psychiatric hospital services under part B for purposes of the limitation of inpatient hospital services to 60 days during a spell of illness.

Combine physicians' services and medical and other health services and include services incidental to physicians' services.

Option to receive payment on basis of cost instead of charges for prepayment organizations.

Advancing the time of appropriation of funds for payments to supplementary health insurance trust fund for contingency reserve.
Allow payment of amount appropriated for noninsured at the beginning of the fiscal year.
Provide standards for independent laboratories performing dianostic tests under the supplementary health insurance program.
"Physician" limited to doctors of medicine or osteopathy.
Inclusion of combinations of drugs or biologicals in the definition thereof.
Provide that an employing agency of certifying or disbursing officer would be excused from liability when such officer is excused.
Deletion of specification of only some of the services included as diagnostic tests under "medical and other health services."
Individual not to be considered discharged from an extended care facility if admitted to same or any other such facility within 14 days.
Advance filing of applications for hospital insurance benefits by noninsured.
Improvement of provisions on administration of benefits undersupplementary health insurance program.

OASDI (EXCLUSIVELY OR ALMOST EXCLUSIVELY)

Clarifying changes in provision relating to the adoption of a child by an old-age insurance beneficiary.
Addition to provision relating to the change in the definition of disability to provide for continuation of life of applications of dependents of new disability insurance beneficiaries.
Qualification of divorced wife for widow's benefits.
Provision to avoid an increase in the family maximum for some families solely because of entitlement of a child attending school.
Repeal of a recomputation provision no longer needed.
Additional point for conversion of a disability insurance benefit to an old-age insurance benefit.
Provide alternate rules for determining which benefit is payable to an individual simultaneously entitled to a disability insurance benefit and an old-age insurance benefit.

PUBLIC ASSISTANCE

Elimination of separate requirements in relation to tuberculous patients.
Federal participation in cost of training professional medical personnel.
Authorization of protective payments for the blind and disabled under titles X and XIV of the Social Security Act.
Time limitation for giving State notice of hearing on public assistance issues and scope of judicial review.
Social security payments to be disregarded by the State in determining need.
Medical care and services substituted for medical assistance; comparability not required for services in tuberculosis or mental institutions.

Beginning date of enrollment period and coverage period

On page 43, lines 2 and 3, strike out "the first day of the second month which begins after".

On page 43, strike out lines 21 through 25 and insert in lieu thereof:

"(2) (A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 in or before the month in which he first satisfies paragraphs (1) and (2) of section 1836, the first day of such month, or

"(B) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 after such month, the first day of the third month following the month in which he so enrolls, or

"(C) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls."

Explanation of amendment

The proposed change on page 43, lines 2 and 3, would facilitate administration of the supplementary health insurance program by advancing to the date of enactment the time during which a person eligible to enroll may enroll. This change would provide at least one additional month during which applications could be taken. The proposed insert in lieu of lines 21 through 25 of page 43 would permit

supplementary health insurance to become effective in the month the individual attains age 65 if he enrolls in that months, or any of the three prior months, and is otherwise eligible.

Combine inpatient hospital services under part A and inpatient psychiatric hospital services under part B for purposes of the limitation of inpatient hospital services to 60 days during a spell of illness

On page 11, line 6, insert "or inpatient psychiatric hospital services" after "such services".

On page 12, line 18, before the comma at the end of the line, insert "of this section and subsection (a) (1) of section 1834".

On page 36, line 19, insert "or inpatient hospital services" after "such services".

On page 37, line 14, insert "of this section and subsections (b) and (c) of section 1812" before the comma.

Explanation of amendment

As presently drafted, the bill is not clear that days of inpatient hospital services and days of inpatient psychiatric hospital services should be added for purposes of the limitation of 60 days of coverage during a spell of illness. The proposed changes would make this clear and would prevent any incentives to transfer from a general hospital to a psychiatric hospital, or vice versa, in order to get coverage of more than 60 days of care in a spell of illness.

Combine physicians' services and medical and other health services and include services incidental to physicians' services

On page 33, strike out lines 18 through 21 and insert in lieu thereof: "for medical and other health services, except those described in paragraph (2) (C); and".

On page 34, line 5, insert ", other than physicians' services," after "health services".

On page 82, strike out line 14 and insert in lieu thereof:

"care services, or home health services):

"(1) physicians' services;

"(2) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills, and hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

On page 82, lines 10, 18, 20, and 22, and page 83, lines 1, 5, and 8, redesignate paragraphs (1), (2), (3), (4), (5), (6), and (7) as paragraphs (3), (4), (5), (6), (7), (8), and (9), respectively.

Explanation of amendment

The charges by a physician for services furnished in the home or office usually take into account items, supplies, equipment and services of aides, etc., which are customarily considered incident to the physician's personal services. The proposed change would make clear that payment could be made for such items, supplies, etc., regardless of whether the physician performs his personal services in a hospital, a clinic or in his office, and regardless of whether the bills for the services and the incidental items, supplies, etc., are rendered by the physician, by a hospital, etc., or by both.

Option to receive payment on basis of cost instead of charges for prepayment organizations

On page 84, line 22, strike out "and" and insert in lieu thereof: "except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such service if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b); and".

Explanation of amendment

The present bill provides for payment of the reasonable charges for physicians' services. However, under prepaid group practice plans, covered medical services are provided directly by the physicians associated with the plan to a member without charge other than the membership fee that the patient has paid to the plan. As an alternative to paying such a plan 80 percent of reasonable charges for covered services, the proposed change would permit payment of 80 percent of the reasonable cost of providing the covered services.

Advancing the time of appropriation of funds for payments to supplementary health insurance trust fund for contingency reserve

On page 62, lines 13 and 14, strike out "during the fiscal year ending June 30, 1966".

On page 62, line 16, strike out "the next fiscal year" and insert in lieu thereof "the fiscal year ending June 30, 1966".

Explanation of amendment

The changes would amend a provision in the bill which deals with the reserve contingency advance for supplementary insurance. The changes are needed to provide greater flexibility as to the time of appropriation by authorizing it to be made at the beginning of the fiscal year 1966, at any time during such fiscal year, or shortly thereafter.

Allow payment of amount appropriated for noninsured at the beginning of the fiscal year

On page 109, line 25, insert "for any fiscal year" before the comma.

On page 110, line 1, insert "or to be made during such fiscal year" after "payments made".

On page 110, line 7, insert "or expected to result" before "therefrom".

On pave 110, line 10, insert "at the end of such fiscal year" after "the same position".

Explanation of amendment

The changes would amend a provision in the bill which deals with payments from the general fund of the Treasury for noninsured persons eligible under the transitional insured status provision. The proposed changes would allow payment of the full amount appropriated for a fiscal year at the beginning of the fiscal year as well as during such year.

Provide standards for independent laboratories performing diagnostic tests under the supplementary health insurance program

On page 83, between lines 11 and 12, insert the following new sentence: "No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (1) unless such laboratory—

"(A) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (i) is licensed pursuant to such law, or (ii) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

"(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary."

On page 90, line 12, before the period insert ", or whether a laboratory meets the requirements of subparagraphs (A) and (B) of section 1861(s)".

Explanation of amendment

Public health authorities have expressed concern about the effects of payment under the supplementary insurance program for diagnosite tests which are not performed in a hospital or in the attending physician's office. In recent years there has been a rapid growth of so-called freestanding laboratories specializing in volume testing and mail order operations. Investigation by State health authorities has produced evidence of unsanitary conditions, errors in tests, faulty records, and subcontracting of work on specimens. Some States have established requirements that these laboratories must meet in order to operate. The proposed change would support State efforts in this direction and would assure

that the laboratories meet the same standards essential to the health and safety of beneficiaries as hospital laboratories.

"Physician" limited to doctors of medicine or osteopathy

On page 82, lines 5 and 6, strike out "an individual" and insert in lieu thereof "a doctor of medicine or osteopathy".

Explanation of amendment

The change is needed to make it clear that the term "physician" includes doctors of medicine and doctors of osteopathy but not other practitioners who, under the laws of some States, may be licensed to practice medicine and surgery.

Inclusion of combinations of drugs or biologicals in the definition thereof

On page 83, line 15, insert "(1)" after "only" and "(or approved for inclusion)" after "included".

On page 83, line 19, strike out "as are approved" and insert in lieu thereof "(2) combinations of drugs or biologicals if the principal ingredient or ingredients of the combinations meet the conditions specified in clause (1), or (3) such drugs or biologicals as are approved,".

On page 83, line 22, before the period insert ", for use in such hospital".

Explanation of amendment

Some of the drugs frequently administered in hospitals are combination drugs. While the principal ingredient of the combination drugs may be listed in the formularies specified in the bill, the other ingredients, of secondary importance, may not. The proposed changes would permit such drugs to be covered under part A if provided as a part of covered inpatient hospital services or extended care facility services.

Provide that an employing agency of certifying or disbursing officer would be excused from liability when such officer is excused

On page 26, between lines 7 and 8, insert the following new paragraph:

"(3) No agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2)."

On page 57, after line 25, insert the following new paragraph:

"(3) No carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2)."

Explanation of amendment

The changes are needed in order to provide agencies and organizations authorized to make payments under part A and carriers authorized to make payments under part B with the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers.

Deletion of specification of only some of the services included as diagnostic tests under "medical and other health services"

On page 82, strike out lines 15, 16, and 17 and insert in lieu thereof the following:

"(1) diagnostic X-ray and laboratory tests, and other diagnostic tests;

Explanation of amendment

The proposed change would simply and clarify the provision covering diagnostic and laboratory tests under part B by deleting the mention of some but not all of the tests for which payments could be made.

Individual not to be considered discharged from an extended care facility if admitted to same or any other such facility within 14 days

On page 71, lines 24 and 25, strike out "if readmitted thereto within 14 days after discharge therefrom" and insert in lieu thereof "if, within 14 days after discharge therefrom, he is admitted to such facility or any other extended care facility".

Explanation of amendment

The bill now provides that an individual discharged from an extended care facility will be deemed not to have been discharged if he is readmitted to the

same facility within 14 days. In some cases, a bed may not be available when he needs to return. The proposed change is needed to permit the person to go to some other participating facility.

Advance filing of applications for hospital insurance benefits by noninsured

On page 109, line 1, insert "more than 3 months" after "filed by an individual".

Explanation of amendment

The change on page 109, line 1, is needed because without this change an uninsured person, who is made eligible for hospital insurance benefits under part A, and who attains age 65 in September 1966, for example, could enroll under the supplementary insurance plan in June 1966 but would have to be told to come back again in September 1966 to file another application for hospital insurance under the basic plan, since no advance filing by such an individual is provided for under the bill. The change would permit applications for part A coverage by such individuals also to be made in advance and thus would facilitate administration.

Improvement of provisions on administration of benefits under supplementary health insurance program

On page 53, strike out lines 14 through 19 and insert in lieu thereof the following:

"SEC. 1842. (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance by other organizations); and, with respect to any of the following functions which involve payments for physicians' services, the Secretary shall to the extent possible enter into such contracts:".

Explanation of amendment

Under the present bill, organizations nominated by providers of services (hospitals, extended care facilities, and home health agencies) could be used by the Secretary to reimburse these institutions and agencies on a reasonable cost basis for services covered under part A, and carriers would be used to make payments for services covered under part B, including payments to providers of services on a cost basis and for doctors' bills on a reasonable charge basis. In addition, the bill specifies that, except as otherwise provided under the bill, the Secretary may perform any of his functions directly or by contract.

The proposed changes would permit a distribution of part B functions among carriers, organizations with which part A agreements are in effect, and contractors performing services in behalf of the Secretary in a way that is most efficient and convenient for hospitals and beneficiaries. These changes would eliminate the need for organizations selected to pay doctors' bills on a charge basis to acquire experience in paying hospitals on a cost basis. As under present language, it would still be required that, to the extent possible, doctors would be paid through carriers. Under the proposed changes, nominated organizations having experience with cost reimbursement could determine the amounts of payments and make such payments whether under part A or part B. In the absence of a suitable nominated organization, the Secretary could contract out all or part of this service or handle the function directly. Also, the proposed changes would permit the Secretary to use carriers under section 1842 to make payments only for services that are paid for on a charge basis unless the carrier is also an organization which is capable of handling payments for services on a cost basis.

Clarifying changes in provision relating to the adoption of a child by an old-age insurance beneficiary

On page 261, line 8, after "such individual" insert "adopted after such individual became entitled to such disability insurance benefits".

On page 261, line 21, before the comma insert "(or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65)".

On page 262, strike out lines 1 and 2 and insert in lieu thereof "paragraph (0)) who adopts a child after such individual becomes entitled to such benefits, clause (i) of paragraph (1) (C) shall not apply to such child unless such".

Explanation of amendment

The change on page 261, line 8, and the changes on page 262, lines 1 and 2, amend a provision in the bill which imposes new eligibility requirements upon children who are adopted after the worker becomes entitled to old-age insurance benefits or disability insurance benefits. The changes are needed to limit the application of the new requirements to cases in which the child is adopted after the worker becomes entitled to the benefits.

The change on page 261, line 21, is needed because under H.R. 6675 a period of disability terminates when the worker becomes 65. Without this change there would be cases where a child who met all of the requirements could not become entitled to benefits because the period of disability which existed up to age 65 would not exist at the time of the adoption.

Addition to provision relating to the change in the definition of disability to provide for continuation of life of applications of dependents of new disability insurance beneficiaries

On page 182, line 21, after the period insert the following new sentence: "The provisions of the preceding sentence shall also be applicable in the case of applications for monthly insurance benefits under title II of the Social Security Act based on the wages and self-employment income of an applicant with respect to whose application for disability insurance benefits under section 223 of such Act subparagraph (B) (i) or (ii) of the preceding sentence is applicable."

Explanation of amendment

The addition on page 182, line 21, amends a provision in the bill which permits an application for disability insurance benefits filed prior to the month of enactment to be effective for benefits under the new law if the applicant did not die prior to such month and notice of the final decision on such previous application has not been given. Since the provision is applicable only to applications for disability insurance benefits and periods of disability, the addition is needed to include applications by dependents filed on the earnings record of a disabled worker. Without this addition, there would be cases in which benefits would be payable to a worker based on a previously filed application but not to his wife and children for some months because they do not have effective applications under the new law, even though they may all have filed on the same date.

Qualification of divorced wife for widow's benefits

Page 209, line 3, insert before the comma: "who was not entitled to wife's insurance benefits on the basis of the wages and self-employment income of such individual for the month preceding the month in which he died".

Explanation of amendment

This change would clarify the provision to assure that in every case a woman age 62 or over who is entitled to wife's benefits as a divorced wife can become entitled to widow's benefits as a surviving divorced wife. If the change were not made a woman who qualified for wife's benefits and whose wife's benefits did not terminate when she later became divorced (after having been married for 20 years) would have to meet the special support requirements added by section 308 to qualify for widow's benefits. Her wife's benefits would terminate with the death of her former husband and as a result she could not get widow's benefits unless she could show that at the time her husband became entitled to benefits (while she was married to him) or at the time he died she was receiving from him at least half of her support or substantial contributions toward her support or there was a court order for such contributions.

Provision to avoid an increase in the family maximum for some families solely because of entitlement of a child attending school

On age 167, lines 8 and 15, after "person" insert "(other than a person who would not be entitled to such benefits for such month without the application of the amendments made by section 306 of the Social Security Amendments of 1965)".

Explanation of Amendment

The change on page 167, lines 3 and 15, is needed because without this change a child who applies for benefits under the provisions of section 306 of the bill in the month of enactment could, in cases where the family maximum is applicable, get more in benefits than would be payable if he delayed his application until a later month. This problem arose when the new provisions for a child age 18 or over (sec. 306 of the bill) were made retroactive to January 1965. There was no intent to increase the family maximum applicable in case of families entitled to benefits for the month of enactment or any prior month by including the benefit of a child over 18 who becomes entitled to a benefit for any such month by reason of the new provisions under an application filed in the month of enactment of the bill. A premium should not be put on filing in a particular month. Section 302(a)(2) should apply in the month of enactment, as it does now, for other people on the rolls, but the benefit of a child entitled as a result of section 306 of the bill should be excluded from "the sum of the benefits" which is increased under the bill and applies as the new family maximum.

Example

A widow and one child are on the benefit rolls in January 1965. Their benefits are based on a present law PIA of $102. (The family maximum of $228.80 does not apply with only two people on the rolls). In January they were paid $76.50 each. In June 1965, H.R. 6675 is enacted and a child, age 20, applies for benefits in that month. As the bill is now written, their benefits would be as follows: New PIA, $109.20; family maximum, $228.80.

A lump-sum check for retroactive benefits would be paid to the 20-year-old child (assuming he was entitled as of January 1965.)[1] The amount would be $379 (family maximum, $228.80, minus $153 (two times $76.50), equals $75.80 per month—for 5 months (January to May) totals $379). For June, this child is entitled without the application of section 202(j)(1) and the benefits for the family for June and future months would be:

	Original under present law	Adjusted	Increased 107 percent
Widow	$76.50	$76.30	$81.70
Child	76.50	76.30	81.70
Do	76.50	76.30	81.70
Total		228.90	245.10

If the older child had waited until July to apply for benefits, the family's regular monthly benefits would be as follows:

	Original benefit	Adjusted benefit
Widow	$81.90	$76.30
Child	81.90	76.30
Do	81.90	76.30
Total		228.90

Repeal of a recomputation provision no longer needed

On page 176, between lines 9 and 10, insert the following new paragraph:

"(7) Effective January 2, 1966, subparagraph (B) of section 102(f)(2) of the Social Security Amendments of 1954 is repealed."

Explanation of amendment

The change on page 176, between lines 9 and 10, repeals an old provision in the 1954 amendments (102(f)(2)(B)) for a dropout recomputation based

[1] Residual payment to family maximum for retroactive months. (Sec. 202(j)(1) and sec. 203(a)(2), as amended.)

on the acquisition of six quarters of coverage after June 1953. It was intended that this provision be repealed when the reference in section 215(b)(5) of present law was deleted by section 302(a)(3) of the bill, but through oversight the repeal provision was omitted. It would be rare for a person (who would now be over age 75) who has not qualified for a dropout recomputation over the past years to finally acquire his sixth quarter of coverage after 1965 and qualify under this provision.

Additional point for conversion of a disability insurance benefit to an old-age insurance benefit

On page 181, between lines 17 and 18, insert the following new subsection:

"(e) So much of section 215(a)(4) of such Act as precedes 'the amount in column IV' is amended to read as follows:

'(4) In the case of an individual who was entitled to a disability insurance benefit for the month before the month in which he died, became entitled to old-age insurance benefits, or attained age 65,'.

On page 181, line 18, strike out "(e)" and insert thereof "(f)".

On page 183, between lines 20 and 21, insert the following new paragraph:

"(5) The amendment made by subsection (e) shall apply in the case of the primary insurance amounts of individuals who attain age 65 after the enactment of this Act."

On page 188, strike out lines 7 and 8 and insert in lieu thereof:

"(k) Section 215(a)(4) of such Act is amended by striking out 'such dis-".

Explanation of amendment

The new paragraph (e) inserted between lines 17 and 18 on page 181 to change section 215(a)(4) of the act is needed because of the new definition of disability that would be provided by section 303 of the bill. Without the change in section 215, there would be no way to convert the benefit of a woman who meets the new definition immediately upon enactment of the bill. The change is essential in subparagraph (A) of section 215(a)(4); since a similar change in subparagraph (B) is appropriate and would make the two subparagraphs the same, they are combined into one paragraph.

The change on page 181, line 18, is a conforming change.

The change on page 183, between lines 20 and 21, provides the effective date for the change on page 181.

The change on page 188, lines 7 and 8, is needed in order to eliminate a reference to "clause (B)" which, as explained above in connection with the change on page 181, has been eliminated.

Example

A woman reaches age 62 in January 1965 and applies for an OAIB (old-age insurance benefit). Nine years are used in the computation of the PIA (primary insurance amount on which the OAIB is based).

H.R. 6675 is enacted in June 1965. She meets the new definition of disability (sec. 303 of the bill), files for DIB (disability insurance benefits) in July 1965, and her disability is established as of June 1963. Her waiting period begins January 1964, when she is deemed to be age 62. Her DIB computation can be based on 7 years (out of the period 1951–63, inclusive) with earnings in the disability period excluded, or on 8 years out of the period 1951–64 inclusive. Her DIB is based on the 8-year computation using 1964 since this is better for her.

She attains age 65 in January 1968—ending her period of disability. Under section 215(a)(4), her DIB is converted to an OAIB when she "became entitled to an OAIB." Since she was previously entitled to an OAIB, her PIA for this benefit must be based on (*a*) the 9 years used originally or (*b*) the 7-year computation (out of the period 1951–63). Either of these periods gives a lower PIA than the 8-year computation on which her DIB is based. There is no way under present law to use the 8 years—converting the DIB to an OAIB. If a third computation point—attainment of age 65—were provided, this problem would not occur. Hence, the change on page 181.

Provide alternate rules for determining which benefit is payable to an individual simultaneously entitled to a disability insurance benefit and an old-age insurance benefit

On page 184, lines 4 and 5, strike out "such disability insurance benefit for such month" and insert in lieu thereof "the larger of such benefits for such month,

except that, if such individual so elects, he shall instead be entitled to only the smaller of such benefits for such month".

Explanation of amendment

The change on page 184 is needed because in some disability freeze cases—especially in the case of blind people who become entitled to the disability freeze but continue to work and earn substantial amounts—the reduced old-age insurance benefit is larger than the disability insurance benefit, and in such a case the disability beneficiary can become entitled, under present law, to the old-age insurance benefit before he reaches age 65. The difference in the benefit amount in such cases occurs because (1) earnings in a period of disability are excluded in the disability insurance benefit computation and (2) earnings in the period of disability can be included in the old-age insurance benefit computation. Blind people have been advised to apply for the disability freeze and have been assured that this would guarantee that their benefit would be the largest they could qualify for under any provision of the law.

The portion of this change which would permit a beneficiary to elect the smaller benefit is needed in order to continue a present practice. Some people getting disability insurance benefits apply for the lower old-age insurance benefit after they reach age 62, if they have substantial earnings, because they would rather have a smaller benefit and have the retirement test apply than be annoyed by periodic investigations of their disability status and the uncertainty of knowing what benefits they can count on getting. There seems to be no good reason why a worker who is eligible for both should not be allowed to choose between a disability insurance benefit and an old-age insurance benefit.

Elimination of separate requirements in relation to tuberculous patients

On page 132, line 22, page 137, line 23, page 154, line 8, page 156, lines 11 and 12, page 158, line 24, and page 161, line 9, strike out "tuberculosis or".

On page 133, lines 1 and 2, page 154, lines 11 and 12, and page 159, lines 3 and 4, strike out "or tuberculosis (as the case may be)".

Explanation of amendment

As a part of the amendment adopted by the Senate last year and incorporated in H.R. 6675 the restrictions were relaxed on Federal matching of expenditures for aged persons in institutions for mental diseases or tuberculosis and for persons in other hospitals following a diagnosis of tuberculosis or psychosis. Most of the safeguards designed to insure improved care were made applicable to both groups. Subsequent study indicates that the number of aged, tuberculous patients is so small that with present methods of treatment special safeguards were not necessary for this group.

The amendment would accordingly leave the safeguards fully applicable to the mentally ill but would simply eliminate restrictions on the treatment of tuberculosis in general hospitals or of the aged persons with tuberculosis who are in specialized institutions. These patients would then be in the same situation exactly as anyone in a hospital for any other illness.

Federal participation in cost of training professional medical personnel

On page 137, line 11, after "compensation", insert "or training".

Explanation of amendment

In developing H.R. 6675, the Ways and Means Committee concluded that, since the program was primarily one of medical assistance, provisions for social services and training like those in the other public assistance titles of the Social Security Act were unnecessary and inappropriate. Such provisions accordingly were not included in the bill. As a result, the bill omits authorization for training of health personnel to work in the medical assistance program. However, authorization for this training does not exist in the other public assistance titles.

The amendment would correct this defect by including authorization for Federal participation in the cost of training along with the separate provision for participating in the compensation of professional medical personnel and staff directly supporting them. In this context it would be clear that the training authority is intended to apply only to health personnel.

Authorization of protective payments for the blind and disabled under titles X and XIV of the Social Security Act

On page 274, between lines 9 and 10, insert the following:

"(c) Section 1006 of the Social Security Act (as amended by section 221 of this Act) is amended by adding at the end thereof the following new sentence: 'Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1002 includes provision for—

'(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

'(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the blind to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

'(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

'(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judical appointment of a guardian or other legal representatives, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

'(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made.'

"(d) Section 1405 of the Social Security Act (as amended by sec. 221 of this act) is amended by adding at the end thereof the following new sentence: "Such term also includes payments which are not included within the meaning of such term under the preceding sentence, but which would be so included except that they are made on behalf of such a needy individual to another individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such needy individual, but only with respect to a State whose State plan approved under section 1402 includes provision for—

"(1) determination by the State agency that such needy individual has, by reason of his physical or mental condition, such inability to manage funds that making payments to him would be contrary to his welfare and, therefore, it is necessary to provide such assistance through payments described in this sentence;

"(2) making such payments only in cases in which such payments will, under the rules otherwise applicable under the State plan for determining need and the amount of aid to the permanently and totally disabled to be paid (and in conjunction with other income and resources), meet all the need of the individuals with respect to whom such payments are made;

"(3) undertaking and continuing special efforts to protect the welfare of such individual and to improve, to the extent possible, his capacity for self-care and to manage funds;

"(4) periodic review by such State agency of the determination under paragraph (1) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that such action will best serve the interests of such needy individual; and

"(5) opportunity for a fair hearing before the State agency on the determination referred to in paragraph (1) for any individual with respect to whom it is made."

On page 274, line 10, strike out "(c)" and insert in lieu thereof "(e)".

On page 274, line 12, insert ", X, XIV," after "title I".

Explanation of amendment

Originally the Social Security Act authorized only money payments to public assistance recipients. Such payments could also be made to a legal guardian where one exists. Since 1950 the act has also authorized payments for medical care on behalf of public assistance recipients. In 1958 a Senate amendment was enacted which authorized not only legal guardians but legal representatives to receive money payments. As part of the Public Welfare Amendments of 1962 the Congress authorized protective payments to be made under safeguards to another individual concerned with the welfare of a recipient who, because of physical or mental incapacity, was unable to handle money. The 1962 amendments limited this provision to recipients of aid to families with dependent children.

H.R. 6675 would extend protective payment provisions and apply safeguards surrounding them to aged persons receiving assistance under title I of the Social Security Act and to the aged, blind and disabled persons receiving assistance under title XVI. The proposed amendment to the bill would include the same provisions in the separate programs of aid to the blind and aid to the permanently and totally disabled administered under titles X and XIV of the act, thereby making all the public assistance titles the same in this respect.

Time limitation for giving State notice of hearing on public assistance issues and scope of judicial review

On page 276, line 2, strike out "Upon" and insert in lieu thereof "Within 30 days after".

On page 276, line 15, strike out "notice" and insert in lieu thereof "it has been notified".

On page 276, lines 24 and 25, and page 277, lines 6 and 7, strike out "unless substantially contrary to the weight of the evidence" and insert in lieu thereof "if supported by substantial evidence".

Explanation of amendment

The judicial review provision included in the House-passed bill sets time limits on virtually all steps of the process by which a State may appeal to court. In one instance, however, no time limit is set. This is the period between the Secretary's receipt of the State's request for hearing and the sending of a notice setting the time and place of such hearing to the State. The amendment would set a 30-day time limit that may elapse at this point.

The judicial review provision also uses "unless substantially contrary to the weight of the evidence" as the standard for determining whether the administrative findings of fact are conclusive. Virtually all of our grant-in-aid statutes, as well as the Administrative Procedure Act, use the more commonly accepted phrase which the amendment here recommended would substitute.

Social security payments to be disregarded by the State in determining need

On page 281, strike out lines 12 through 14, and insert the following:

"Act, any amount paid to any individual under title II of such Act (or under the Railroad Retirement Act of 1937 by reason of section 326(a) of this Act), for any one or more months which occur after December 1964 and before the third month following the month in which this Act is enacted, to the extent that such payment is".

Explanation of amendment

Section 406 of the bill would authorize the States to disregard, in determining the need for aid or assistance under the Federal-State public assistance programs, any payment for months prior to the month it is received which is attributable to the OASDI benefit increase or the newly authorized benefits for children age 18 to 22 attending school. The amendment on page 281 would make it clear that this section is intended only to take care of cases where the payments for prior months are due to the provision in the bill making the benefit increase and these new children's benefits retroactive to January 1, 1965. As drafted, this section of the bill is not clearly confined to such payments, as it unquestionably was intended to be. The revision would make it clear that this section applies only to payments covering a period of 1 or more months before the month in which the payment is made, and which occur after December 1964 and before the third month following the month in which the bill is enacted.

The Social Security Administration indicates that if the bill is enacted during the first 15 days of a month the first regular monthly check reflecting the

benefit increase (or including the regular payment for children over 18) will most likely be the check for the second month following the month of enactment. This check would be mailed to the beneficiaries for receipt on the third day of the next month, i.e., the third month following the month of enactment. The lump-sum check covering retroactive payment of the benefit increase (or retroactive benefits for children over 18) would be mailed during the second month following the month of enactment and would cover the increase through the month following the month of enactment.

If enactment is delayed until after the 15th of a month, the first regular check would be the one for the third month after enactment (mailed in the fourth month) and the lump-sum retroactive check would be mailed in the third month after the month of enactment (to include payments through the second month). The proposed revision would cover such retroactive checks.

The Ways and Means Committee, while clearly not intending to cover retroactive payments which are not related to the provision of the bill making the benefit increase and the benefits for children over 18 retroactive to January 1, 1965, did intend to cover all payments which were so related, including payments covering this 1- or 2-month period after enactment; otherwise the States would be required to make a distinction between the portion of the retroactive check which covers months after the month of enactment and the portion thereof which covers months up through the month of enactment.

Medical care and services substituted for medical assistance; comparability not required for services in tuberculosis or mental institutions

On page 127, line 15, after "provide that" insert "(except as to care and services described in paragraph (14) of section 1905(a))".

On page 127, line 23, page 128, line 1, and page 128, lines 8 and 15, strike out "assistance" and insert " care and services" (and on page 128, line 1, strike out "is" and insert "are" and on page 128, line 7, after "provide" insert "(except as to care and services described in paragraph (14) of section 1905 (a))".

On page 142, lines 21 and 24, after "services" insert "(other than services in an institution for tuberculosis or mental diseases)".

On page 143, line 17, strike out "and" at the end of the line.

On page 143, between lines 17 and 18, insert the following new paragraph:

"(14) inpatient hospital services and skilled nursing home services in an institution for tuberculosis or mental diseases; and"

On page 143, line 18, strike out "(14)" and insert in lieu thereof "(15)".

Explanation of amendment

Amendments beginning on page 127 and down through page 143 should be considered as a group.

The new title XIX defines "medical assistance" as payment for care and services furnished to specified classes of individuals—persons age 65 or older, dependent children, etc. Some of the requirements in the bill for an approved State plan; e.g., the comparability of the care and services provided for various groups of individuals, use the term "medical assistance" when some or all of the persons involved are not those included in the definition. This group of amendments would, for this reason, change the term "medical assistance" in those instances to "medical care and services."

Among the requirements for approval of State plans under the new title XIX is one for comparability of services among various groups of recipients (mentioned above) and another requiring provision of inpatient hospital services, physician services, and several other specified types of services by July 1, 1967. This group of amendments would also make it clear that such requirements do not apply in the case of services in institutions for tuberculosis or mental diseases; Federal financial participation is authorized only with respect to those age 65 or older and, therefore, applying this requirement to such services would not be appropriate at this time.

The amendments would exclude from "inpatient hospital services" and "skilled nursing home services" (which are part of the definition of medical assistance) services provided in tuberculosis or mental institutions and would list separately such services provided in institutions for tuberculosis or mental diseases. This change would help make clear that it is optional, rather than mandatory, for a State to include such services for aged individuals under its plan.

MINOR OR TECHNICAL AMENDMENTS

HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE (EXCLUSIVELY OR ALMOST EXCLUSIVELY)

Provide for coordination of coverage of diagnostic services under part A and part B.
Change of designation of supplementary program.
Provide for the deduction from CSC annuities of premiums under the supplementary health insurance benefits program.
Overpayments and underpayments (included under OASDI group).

OASDI (EXCLUSIVELY OR ALMOST EXCLUSIVELY)

Permit the validation of coverage of certain ministers who reported their earnings for social security purposes for years after 1954 even though they had not filed waiver certificates effective for those years.
Provision to authorize procedures whereby the surviving payee of a combined social security benefit check could be paid the amount of the check issued for the month in which the other payee died, on the condition that any resulting overpayment would be recovered.
Provision to authorize the Federal courts to prescribe the fees that attorneys may charge their clients for representing them in court cases arising under the social security program.
Overpayments and underpayments (also applicable to hospital insurance and supplementary medical insurance).
Validation of certain erroneously reported wages of some employees of nonprofit organizations who have filed waiver certificates for OASDI coverage.
Extend the life of applications for social security benefits and determinations of disability to the date of the final decision thereon by the Secretary.

PUBLIC ASSISTANCE

Extension of time for State to comply with new requirements relating to provision of medical assistance
Description of standards and procedures a State will use to assure high-quality medical care
Income disregarded under one public assistance title to be disregarded also under other public assistance titles

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Provide for coordination of coverage of diagnostic services under part A and part B

On page 13, strike out lines 5 through 11 and insert in lieu thereof "deductible".

On page 19, line 20, before the period insert "; except that, in the case of outpatient hospital diagnostic services, such amount shall be equal to 80 percent of such cost".

On page 85, line 12, before the period insert ", and except that the amount of any deductible imposed under section 1813(a)(2) with respect to outpatient hospital diagnostic services furnished in any year shall be regarded as an incurred expense under this part for such year".

On page 93, line 16, before the period insert "or, in the case of outpatient hospital diagnostic services, for which payment may be made under part A".

Explanation of amendment

Under the House-passed bill, for persons insured under both the basic and supplementary plan, there would be differences in the extent to which the patient's expenses for outpatient services are reimbursed depending on whether the services are rendered in an outpatient section of a hospital or in a physician's office. The $50 deductible and coinsurance provision under the supplementary plan in some cases create a financial incentive for a beneficiary to obtain diagnostic services in the outpatient department of a hospital, in which event the services would be subject only to a $20 deductible; in other cases the incentive would be in the opposite direction.

The changes proposed would minimize differences in reimbursement under part A and part B by providing for payment of 80 percent, rather than 100 percent, of the cost (above the deductible) of outpatient hospital diagnostic services cov-

ered under part A, and by counting the outpatient deductible under part A as an incurred expense under part B. The changes would also minimize the problems that beneficiaries would otherwise face in deciding whether to have diagnostic services performed in a hospital or a physician's office.

Change of designation of supplementary program

Change all references in the bill from "supplementary health insurance" to "supplementary medical insurance".

Explanation of amendment

Changing "supplementary health insurance" to "supplementary medical insurance" wherever it appears in the bill would make more clear the distinction between the compulsory hospital insurance program and the voluntary health insurance program and promote better understanding among beneficiaries about the coverages under each program.

Provide for the deduction from CSC annuities of premiums under the supplementary health insurance benefits program

On page 48, between lines 15 and 16, insert the following new subsection:

"(e)(1) In the case of an individual receiving an annuity under the Civil Service Retirement Act, or other Act administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

"(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other act administered by the Civil Service Commission, to the Federal Supplementary Health Insurance Benefits Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small."

On page 48, lines 16 and 23, strike out "(e)" and insert in lieu thereof "(f)".

On page 48, line 22, strike out "(f)" and insert in lieu thereof "(g)".

On page 49, line 1, strike out "(g)" and insert "(h)".

On page 53, between lines 12 and 13, insert the following new subsection:

"(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Civil Service Commission in making deductions pursuant to section 1840(e). During each fiscal year, or after the close of such fiscal year, the Civil Service Commission shall certify to the Secretary the amount of the costs it incurred in making such deductions and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee."

Explanation of amendment

The amendment would facilitate the collection of premiums under the supplementary health insurance benefits plan. There are several hundred thousand civil service annuitants (and their spouses) who are 65 years or older and who are not insured under the social security or railroad retirement systems. As the bill is now drafted, individual premium collection machinery would have to apply to such individuals. It would be much simpler and more economical if the premiums were deducted automatically from the annuities of civil service annuitants and their spouses each month just as social security and railroad retirement beneficiaries would have the premiums deducted from their monthly cash benefits.

The effect of the recommended change is that if a civil service annuitant enrolled under the supplementary health insurance benefits plan his premium amount would be withheld from the monthly installment of his annuity. If the spouse of a civil service annuitant enrolled under the supplementary plan, the premium would be withheld from her husband's annuity if he agreed to it. There is provision for reimbursing the Civil Service Commission for the amounts it would cost them to make the necessary withholdings.

Permit the validation of coverage of certain ministers who reported their earnings for social security purposes for years after 1954 even though they had not filed waiver certificates effective for those years

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications, the new sec. 329, relating to overpayments and underpayments, and the new sec. 330, relating to payments to two or more individuals of the same family), insert the following new section:

"VALIDATING CERTIFICATES FILED BY MINISTERS

"SEC. 331. (a) Section 1402(e) of the Internal Revenue Code of 1954 (relating to certificates to waive tax on self-employment income in the case of ministers, members of religious orders, and Christian Science practitioners) is amended by striking out paragraphs (5) and (6) and inserting in lieu thereof the following:

"'(5) OPTIONAL PROVISION FOR CERTAIN CERTIFICATES FILED ON OR BEFORE APRIL 15, 1967.—Notwithstanding any other provision of this section, in any case where an individual has derived earnings in any taxable year ending after 1954 from the performance of service described in subsection (c)(4), or in subsection (c)(5) insofar as it related to the performance of service by an individual in the exercise of his profession as a Christian Science practitioner, and has reported such earnings as self-employment income on a return filed on or before the due date prescribed for filing such return (including any extension thereof)—

"'(A) a certificate filed by such individual on or before April 15, 1965, which (but for this subparagraph) is ineffective for the first taxable year ending after 1954 for which such a return was filed shall be effective for such first taxable year and for all succeeding taxable years, provided a supplemental certificate is filed by such individual (or a fiduciary acting for such individual or his estate, or his survivor within the meaning of section 205(c)(1)(C) of the Social Security Act) after the date of enactment of this paragraph and on or before April 15, 1967, and

"'(B) a certificate filed after the date of enactment of this paragraph and on or before April 15, 1967, by a survivor (within the meaning of section 205(c)(1)(C) of the Social Security Act) of such an individual who died on or before April 15, 1965, may be effective, at the election of the person filing such a certificate, for the first taxable year ending after 1954 for which such a return was filed and for all succeeding years,

but only if—

"'(i) the tax under section 1401 in respect to all such individual's self-employment income (except for underpayments of tax attributable to errors made in good faith), for each such year described in subparagraphs (A) and (B), is paid on or before April 15, 1967, and

"'(ii) in any case where refund has been made of any such tax which (but for this paragraph) is an overpayment, the amount refunded (including any interest paid under section 6611) is repaid on or before April 15, 1967.

The provisions of section 6401 shall not apply to any payment or repayment described in this paragraph.'

"(b) In the case of a certificate or supplemental certificate filed pursuant to section 1402(e)(5) of the Internal Revenue Code—

"(1) for purposes of computing interest, the due date for the payment of the tax under section 1401 of such Code which is due for any taxable year solely by reason of the filing of a certificate which is effective under such section 1402(e)(5) shall be April 15, 1967;

"(2) for purposes of section 6501 of such Code, the statutory period for the assessment of any tax for any taxable year for which tax is due solely by

reason of the filing of such certificate shall not expire before April 16, 1970; and

"(3) for purposes of section 6651 of such Code (relating to addition to tax for failure to file tax return), the amount of tax required to be shown on the return shall not include tax under section 1401 of such Code which is due for any taxable year solely by reason of the filing of a certificate which is effective under section 1402(e) (5).

"(c) Notwithstanding any provision of section 205(c)(5)(F) of the Social Security Act, the Secretary of Health, Education, and Welfare may conform, before April 16, 1970, his records to tax returns or statements of earnings which constitute self-employment income solely by reason of the filing of a certificate which is effective under section 1402(e) (5) of such Code.

"(d) The amendments made by this section shall be applicable (except as otherwise specifically provided therein) only to certificates with respect to which supplemental certificates are filed pursuant to section 1402(e)(5)(A) of such Code after the date of the enactment of this Act, and to certificates filed pursuant to section 1402(e)(5)(B) after such date; except that no monthly benefits under title II of the Social Security Act for the month in which this Act is enacted or any prior month shall be payable or increased by reason of such amendments, and no lump-sum death payment under such title shall be payable or increased by reason of such amendments in the case of any individual who died prior to the date of the enactment of this Act. The provisions of section 1402 (e)(5) and (6) of the Internal Revenue Code of 1954 which were in effect before the date of enactment of this Act shall be applicable with respect to any certificate filed pursuant thereto before such date if a supplemental certificate is not filed with respect to such certificate as provided in this section."

Explanation of amendment

Under present law, ministers who have been in practice for at least 2 years had until April 15, 1965, to file certificates electing social security coverage. In some cases ministers have reported their earnings for social security purposes and paid the social security tax for several years without ever filing the required waiver certificate. The absence of a waiver certificate is not discovered until the death or retirement of a minister, and benefits are either reduced or denied altogether as a result of the failure of the minister to file the certificate.

The statute of limitations does permit some ministers who have been reporting their earnings for social security purposes for several years without filing the required waiver certificate to retain some social security credits. Generally, self-employment income credited to an individual's earnings record for a taxable year may be removed only within 3 years, 3 months, and 15 days following the end of that taxable year. Thus, a minister who has been reporting his earnings erroneously since 1955, for example, and whose situation came to our attention after April 15, 1965, will still be able to retain his social security credits for the years 1955 through 1961. However, the amount of benefits payable would most likely be considerably less than if credit for years after 1961 were permitted to be used in the computation of benefits. (Such a situation exists in the case of the late Rev. Donald Aksel Olsen whose widow and minor children are receiving greatly reduced social security benefits as a result of Reverend Olsen's failure to file a waiver certificate. A private bill for the relief of his widow and minor children passed the House of Representatives in 1964.)

To assure prompt discovery of the absence of a waiver, where ministers' tax returns are filed in the future, the Social Security Administration has recently instituted a system whereby self-employment tax returns filed by ministers are checked against our files to see if each minister who reports his earnings for social security purposes has filed a valid waiver. If the minister has not filed a waiver, and is eligible to do so, we will contact him and secure the waiver.

Under the proposed amendment, a minister who filed a waiver certificate by April 15, 1965 (the expiration date of the present filing deadline) which was not effective for the first year after 1954 for which he reported his earnings for social security purposes would be permitted to file by April 15, 1967, a supplemental waiver certificate making his original waiver certificate effective with the first year after 1954 for which he filed social security returns.

In addition, the survivors of a minister who died on or before April 15, 1965, and who had filed social security returns without having filed a waiver, would be permitted to file a waiver on the minister's behalf by April 15, 1967, which

would be effective with the first year after 1954 for which the minister filed social security returns.

The proposal provides that all social security taxes due for each year for which a supplemental waiver filed by a minister, or a waiver filed by a survivor must be paid, or if previously refunded, repaid, by April 15, 1907, without interest. Benefits would be payable or increased beginning with the month after enactment.

The Bureau of the Budget has expressed interest in validating legislation of this type. There has also been White House interest expressed on behalf of the widow of a minister who filed social security returns without ever filing a waiver certificate.

The cost of this proposal would be negligible.

(NOTE.—The proposed amendment is very similar to the ministers' validating provisions in the 1960 amendments.)

Provision to authorize procedures whereby the surviving payee of a combined social security benefit check could be paid the amount of the check issued for the month in which the other payee died, on the condition that any resulting overpayment would be recovered

On page 266, between lines 22 and 23 (but after the new sec. 328, relating to applications, and the new sec. 329, relating to overpayments and underpayments), insert the following new section:

"PAYMENTS TO TWO OR MORE INDIVIDUALS OF THE SAME FAMILY

"SEC. 330. Section 205(n) of the Social Security Act is amended to read as follows:

"'(n) The Secretary may, in his discretion, certify to the Managing Trustee any two or more individuals of the same family for join payment of the total benefits payable to such individuals for any month, and if one of such individuals dies before a check representing such joint payment is negotiated, payment of the amount of such unnegotiated check to the surviving individual or individuals may be authorized in accordance with regulations of the Secretary of the Treasury; except that appropriate adjustment or recovery shall be made under section 204(a) with respect to so much of the amount of such check as exceeds the amount to which such surviving individual or individuals are entitled under this title for such month.'"

Explanation of amendment

Present procedures require that when one payee of a combined social security benefit check dies, the check issued for the month in which death occurs shall be returned to the Treasury Department for cancellation, and that another check shall be issued to the surviving beneficiary in payment of the particular benefit to which that beneficiary is entitled for the month. The delay involved in this procedure frequently results in hardship for the survivor. This hardship might be avoided if procedures were worked out whereby the surviving beneficiary could be authorized to cash the combined check, on the condition that any resulting overpayment would be recovered. Since the Social Security Act does not contain any authority for making overpayments—and the combined check for the month of death will (unlike checks for previous months) represent an overpayment—legislative authority is needed for making such temporary overpayments.

The proposal would authorize the Secretary to make a temporary overpayment so as to permit the surviving spouse to cash the combined check for the month in which the other spouse died. The overpayment resulting from the cashing of the combined check would be recovered through the adjustment procedures now in the law. Specific procedures for cashing the check and for recovery of the overpayment would be spelled out in regulations of the Secretary of the Treasury.

There would be no cost to the program as a result of this change.

Provision to authorize the Federal courts to prescribe the fees that attorneys may charge their clients for representing them in court cases arising under the social security program

On page 266, between lines 22 and 23, insert the following new section:

"DETERMINATION OF ATTORNEYS' FEES IN COURT PROCEEDINGS UNDER TITLE II

"SEC. ——. The heading of section 206 of the Social Security Act is amended to read "REPRESENTATION OF CLAIMANTS". Such section is further amended

by inserting "(a)" after "SEC. 206." and by adding at the end of such section the following new subsection:

"'(b) (1) Whenever a court renders a judgment favorable to a claimant, who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past due benefits to which the claimant is entitled by reason of such judgment, and the Secretary may, notwithstanding the provisions of section 205(i), certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

"'(2) Any attorney who charges, demands, receives, or collects, for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.'"

Explanation of amendment

This amendment is designed to alleviate two problems that have arisen with respect to representation of claimants by attorneys. The first relates to the need to encourage effective legal representation of claimants. Under the provisions of section 205(i) of the Social Security Act, accrued amounts of benefits that are due to a claimant as a result of a court decision are to be paid directly to him. Under section 207, assignment of benefits is prohibited. Attorneys have complained that such awards are sometimes made to the claimant without the attorney's knowledge and that some claimants on occasion have not notified the attorney of the receipt of the money, nor have they paid his fee.

Another problem that has arisen is that attorneys have on occasion charged what appeared to be inordinately large fees for representing claimants in Federal district court actions arising under the social security program. Usually, these inordinately large fees result from a contingent fee arrangement under which the attorney is entitled to a percentage (frequently one-third to one-half of the accrued benefits). Since litigation necessarily involves a considerable lapse of time, in many cases large amounts of accrued benefits, and consequently large legal fees, may be payable if the claimant wins his case.

The amendment would provide that whenever a court renders a judgment favorable to a claimant, it would have express authority to allow as part of its judgment a reasonable fee (not in excess of 25 percent of accrued benefits) for services rendered in connection with the claim. Any violation would be made subject to the same penalties as are provided in section 206 of the law for charging more than the maximum fees prescribed in regulations (20 CFR 404.975) for services rendered in proceedings before the Secretary. In addition, as a specific exception to section 205(i), the Secretary would be permitted to certify the amount of the court-approved fee to the attorney out of the amount of accrued benefits. As a result, claimants would be insured more effective legal representation and also would be protected from being charged exorbitant fees.

Overpayments and underpayments

On page 102, strike out everything beginning with line 9 and down to and including line 9 on page 103 and insert in lieu thereof the following:

"(b) Where the Secretary finds that—

"(1) more than the correct amount of payment has been made under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

"(2) any payment has been made under section 1814(e) or 1835(c) to a provider of services or other person for items or services furnished an individual,

proper adjustment or recovery shall be made with respect to the amount in excess of the correct amount, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by (A) decreasing any payment under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, to which such individual is entitled, or (B) requiring such individual or his estate to refund the amount in excess of the correct amount, or (C) decreasing any payment under title II of this Act or under the Railroad Retirement

Act of 1937, as the case may be, payable to the estate of such individual or to any other person on the basis of the wages and self-employment income (or compensation) which were the basis of the payments to such individual, or (D) by applying any combination of the foregoing."

On page 103, lines 10 and 16, after "adjustment" insert "or recovery".

On page 103, strike out everything beginning with line 18 to and including line 24 and insert in lieu thereof the following:

"(c) There shall be no adjustment as provided in subsection (b) of payments (including payments under section 1814(e) and 1835(c)) to, or recovery as provided in such subsection by the United States from, any person who is without fault if such adjustment or recovery would defeat the purposes of title II of this Act or of the Railroad Retirement Act of 1937, as the case may be, or would be against equity and good conscience."

On page 266, between lines 22 and 23 (but after the new section 328, relating to applications), insert the following new section:

"OVERPAYMENTS AND UNDERPAYMENTS

"SEC. 329. (a) Section 204(a) of the Social Security Act is amended to read as follows:

" 'SEC. 204. (a) Whenever the Secretary finds that more or less than the correct amount of payment has been made to any person under this title, proper adjustment or recovery shall be made, under regulations prescribed by the Secretary, as follows:

" '(1) With respect to payment to a person of more than the correct amount, the Secretary shall decrease any payment under this title to which such overpaid person is entitled, or shall require such overpaid person or his estate to refund the amount in excess of the correct amount, or shall decrease any payment under this title payable to his estate or to any other person on the basis of the wages and self-employment income which were the basis of the payments to such overpaid person, or shall apply any combination of the foregoing.

" '(2) With respect to payment to a person of less than the correct amount, the Secretary shall make payment of the balance of the amount due such underpaid person, or, if such person dies before payments are completed or before negotiating one or more checks representing correct payments, disposition of the amount due shall be made under regulations prescribed by the Secretary in such order of priority as he determines will best carry out the purposes of this title.'

"(b) Section 204(b) of such Act is amended to read as follows:

" '(b) In any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this title or would be against equity and good conscience.' "

Explanation of amendment

Overpayments

Under section 1870 of the Social Security Act, as added by H.R. 6675, the Secretary is authorized to recover a health benefit overpayment made to or on behalf of a person (who will be referred to, for convenience, as the "overpaid person") by withholding the cash social security or railroad retirement benefits payable to him or, if he should die, by withholding such benefits payable to others getting benefits on the same earnings record. This provision parallels the provision in present law relating to the recovery of cash benefit overpayments. Neither the provision in H.R. 6675 nor the provision in present law specifically authorizes recovery through withholding benefits payable to another person getting benefits on the same earnings record where the overpaid person is still alive.

An administrative procedure has been developed, and has been used for about 20 years, under which an incorrect payment made to one beneficiary who becomes ineligible for benefits is recovered from benefits subsequently payable to another beneficiary in those cases where the latter was living with the overpaid person at the time the overpayment was made (and presumably, therefore, shared in the overpayment) and is living with the overpaid person at the time the action is taken to recover the overpayment. Since there is no specific legal authority for present practice, it cannot be followed if the beneficiary whose benefits are being withheld objects. If the person objects after his benefits have been withheld, any benefits withheld must be repaid.

The General Accounting Office, in a report to the Congress dated July 25, 1961, recommended that the Secretary of Health, Education, and Welfare seek legis-

lative authority to recover overpayments to a living person by withholding benefits of other people getting benefits on the same earnings record. Under the proposal, the Secretary would have authority, in any case where there had been an overpayment of either health benefits or cash benefits, to recover the overpayment by withholding the cash social security benefits (and, in the case of an overpayment of health benefits, cash railroad retirement benefits) of the overpaid person or of other people who are getting benefits on the same earnings record, whether or not the overpaid person is alive.

Under section 1870 of the Social Security Act, as added by H.R. 6675, and also under present law, a beneficiary who is liable for repayment of an overpayment made to or on behalf of another person is denied the opportunity for waiver of adjustment or recovery if the overpaid person was at fault, even though he himself is without fault and otherwise meets all conditions for waiver. The first part of this proposal, which would authorize the Secretary to recover an overpayment with respect to one person (regardless of whether he is dead or alive) by withholding benefits of another who is getting benefits on the same earnings record as the overpaid person, would result in more instances than under present law where people who are liable for repayment of overpayments made to or on behalf of others would have no opportunity to have recovery waived.

Under the proposal, any beneficiary who is liable for repayment of an overpayment, whether the overpayment was made to him or to another person, would be able to qualify for waiver of adjustment or recovery if he is without fault and if adjustment or recovery would defeat the purpose of title II or the Railroad Retirement Act, or would be against equity and good conscience.

Underpayments

A provision of present law enacted in 1939 provides that where "an error has been made" resulting in an underpayment to a beneficiary who has subsequently died, the underpayment is to be paid by increasing the subsequent benefits of others getting benefits on the same earnings record as the deceased. Since the law did not (and does not now) contain any provision for the disposition of underpayments in death cases where there are no subsequent benefits payable, policies were developed in conjunction with the General Accounting Office and regulations were issued to define procedures for settling such underpayments. In the absence of complete and specific statutory authority for the settlement of underpayments, these administrative procedures have beeen challenged in several court cases. A 1949 case forced the Social Security Administration and the General Accounting Office to make a distinction between cases where a check had been properly issued but had not been cashed by the beneficiary before his death, on the ground that no "error" had been made, and cases where, though the payment was due, no check had yet been issued.

In a case decided last year, *Guarino* v. *Celebrezze*, the court held that, even in cases where a check has not been issued, in the absence of an actual error the provisions in present law for settling underpayments do not govern. The court stated that nonpayment is not an "error." Since most underpayments do not involve mistakes, it would seem to be necessary, in the absence of a change in the law, to further revise the procedures for settling underpayments. Moreover, it appears from court opinions that the question will have to be resolved by providing for payment to the estate rather than to subsequent beneficiaries in more instances than under present procedures. The procedure for paying the estate is much more complex and cumbersome than the procedure for merely adding the amount of the underpayment to subsequent benefits payable on the same earnings record.

In order to simplify the procedures for settling underpayments and to make it possible to handle underpayments without the threat of adverse court decisions, this proposal would provide specific statutory authority for the Social Security Administration to settle underpayments.

There would be no additional cost to the program as a result of these changes.

Validation of certain erroneously reported wages of some employees of nonprofit organizations who have filed waiver certificates for OASDI coverage

On page 235, between lines 7 and 8, insert the following new subsection:

"(d) If—

"(1) an individual performed service with respect to which remuneration was paid before the date of enactment of this Act by an organization

which, before such date, filed a waiver certificate pursuant to section 3121 (k)(1) of the Internal Revenue Code,

"(2) such service is excluded from employment under title II of the Social Security Act but would not be excluded therefrom if the requirements of such section 3121 (k)(1) had been met with respect to such service,

"(3) such service was performed during the period such certificate was in effect, and

"(4) such individual was listed pursuant to such section 3121(k)(1) at any time during such period and before the date of enactment of this Act as an employee who concurred in the filing of such certificate or such individual filed a request for coverage pursuant to section 105(b) of the Social Security Amendments of 1960, as in effect prior to the enactment of this Act (but such listing or request was not effective with respect to the service described above),

then, subject to the conditions stated in subparagraphs (B), (C), (D), and (E) of paragraph (1), and paragraph (4), of section 105(b) of the Social Security Amendments of 1960, as amended by this section, the remuneration of such individual which was paid with respect to such excluded service shall be deemed to constitute remuneration for employment for purposes of such title II."

Explanation of amendment

Employees of nonprofit organizations can be covered under the social security system only if the organization files a waiver certificate in accordance with section 3121(k) of the Internal Revenue Code. If such a cretificate is filed, then all current employees who sign a list at that time (it may be amended to include additional names for a period of 2 years thereafter), or who are employed after the filing of the certificate, are covered for social security purposes.

From time to time in the past organizations which have failed to meet all the requirements of section 3121(k) of the Internal Revenue Code with respect to some or all of their employees, but which have paid the taxes due with respect to the remuneration of the employees not fully covered as a result of the failure, have been given an opportunity to rectify their omissions or other errors prospectively or retroactively, or both, through the enactment of special provisions of law. (The present bill includes one such provision, although, hopefully, the enactment of the bill, which also includes a provision permitting the waiver certificate filed under sec. 3121(k) of the Internal Revenue Code to be made retroactive (at the option of the organization) for up to 5 years, should all but completely eliminate the need for such special provisions in the future.)

Though the Social Security Amendments of 1960 permitted many organizations to rectify their past errors under section 3121(k), we have learned of at least one case—and there may well be others—where the organization made further errors in attempting to provide social security coverage for its employees through the use of the provisions of the amendments. As a result of thee errors, the attempt to gain coverage for such employees was ineffective for part of the period of their employment. Their services both before and after this noncoverage period were effectively covered for social security purposes. The change here recommended in the bill would enable this organization, and any others in similar circumstances, to rectify this further, unintentional, error on their part and remove this gap in the coverage of some of their employees.

Extend the life of applications for social security benefits and determinations of disability to the date of the final decision thereon by the Secretary

On page 266, between lines 22 and 23, insert the following new section:

"APPLICATIONS FOR BENEFITS

"SEC. 328. (a) Section 202(j)(2) of the Social Security Act is amended to read as follows:

"'(2) An application for any monthly benefit under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.'

"(b) Section 216(i)(2) of such Act (as amended by subsection (b)(1) of section 303) is amended by striking out subparagraph (E) and inserting in lieu thereof the following:

"'(E) An application for a disability determination filed before the first day on which the applicant satisfies the requirements for a period of disability under this subsection shall be deemed a valid application only if the applicant satisfies the requirements for a period of disability before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.'

"(c) The first sentence of section 223(b) of such Act is amended to read as follows:

"'An application for disability insurance benefits filed before the first month in which the applicant satisfies the requirements for such benefits (as prescribed in subsection (a)(1) shall be deemed a valid application only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application. If upon final decision by the Secretary, or decision upon judicial review thereof, such applicant is found to satisfy such requirements, the application shall be deemed to have been filed in such first month.'

"(d) The amendments made by this section shall apply with respect to (1) applications filed on or after the date of enactment of this Act (2) applications as to which the Secretary has not made a final decision before the date of enactment of this Act, and (3) if a civil action with respect to final decision by the Secretary has been commenced under section 205(g) of the Social Security Act before the date of enactment of this Act, applications as to which there has been no final judicial decision before the date of enactment of this Act."

Explanation of amendment

Under present law, the prospective life of an application for monthly social security benefits is limited to 3 months from the date of filing except in the case of an application for disability benefits where the application must be filed within 3 months of the beginning of the waiting period. In effect, an applicant who does not meet the requirements for eligibility on the date of application has 3 months in which to meet them before his application expires.

A problem arises under present law when an application is disallowed and much later, during some stage of the appeals process, it is determined that the applicant first became eligible—for example, met the disability requirements or attained retirement age—after the period for which his application is effective has expired. The need for filing a new application may be discovered so late (an application may be effective retroactively for no more than 12 months) that no entitlement can be established for the first months of eligibility. In such a case, if the claimant has died without filing a new application, no entitlement for any months can be established and a loss of all benefits is incurred.

Such cases appear inequitable; yet, without the proposed change, the only complete remedy is to take repeated applications to prevent loss of benefits in cases which are in process for a considerable period to obtain needed evidence or because of reconsideration and appeals.

There would be no cost to the program as a result of this change.

Extension of time for State to comply with new requirements relating to provision of medical assistance

On page 58, line 22, page 59, line 20, page 60, line 14, page 120, line 6, page 135, line 24, page 282, line 19, and page 296, line 21 strike out "July 1, 1967" and insert in lieu thereof "January 1, 1968".

On page 59, line 23, strike out "July 1967" and insert in lieu thereof "January 1968".

On page 145, line 4, strike out "June 30, 1967" and insert in lieu thereof "December 31, 1967".

Explanation of amendment

H.R. 6675 gives States until July 1, 1967, to have in effect a plan under title XIX—medical assistance—if they are to continue to make, with Federal participation, vendor payments for medical care. It also imposes on that date certain minimum requirements as to persons included in the plan and services that must be provided under it. Many States will need action by their legislatures to effect these changes.

It has been pointed out that many 1965 legislative sessions are drawing to a close and that 1967 will be the first opportunity that some States will have to consider needed legislation. Such States are faced with a difficult if not impossible situation to get legislation enacted and a State plan developed and in operation by July 1, 1967. The proposed amendment would accordingly give States another 6 months to comply with the new requirements by advancing the relevant dates from July 1, 1967, to January 1, 1968.

Description of standards and procedures a State will use to assure high-quality medical care

On page 134, line 11, strike out "and".

On page 134, line 20, strike out the period and insert in lieu thereof "; and", and between lines 20 and 21 insert the following new paragraph:

"(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical care and services provided to recipients of medical assistance are of high quality."

Explanation of amendment

Title XIX includes a number of requirements that States establish standards and enter into cooperative arrangements between State agencies in the operation of their medical assistance plans. Utilization of professional medical personnel in the administration of a plan is also required. In order to insure consistency and to set forth clearly the various elements which a State will use to assure a high quality of medical care under its plan, the proposed amendment would require that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. The amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new title XIX, requiring States to have an authority or authorities responsible for establishing and maintaining standards for private or public institutions in which recipients may receive care or services.

Income disregarded under one public assistance title to be disregarded also under other public assistance titles

On page 145, strike out lines 8 through 16 and insert in lieu thereof the following paragraph:

(2) Section 1109 of such Act is amended to read: "Any amount which is disregarded (or set aside for future needs) in determining eligibility of and amount of the aid or assistance for any individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX shall not be taken into consideration in determining the eligibility of and amount of aid or assistance for any other individual under a State plan approved under any other of such titles.".

Explanation of amendment

Existing law (sec. 1109) requires that when income is exempted in determining the need of a blind person under title X of the Social Security Act that the income which has been exempted for the blind individual not be taken into account in determining the need of another individual, such as a spouse or dependent, who is applying for assistance under one of the other public assistance titles. H.R. 6675 extends this principle to the new title XIX—medical assistance. The proposed amendment would make the principle applicable to all public assistance programs. This is desirable since a number of earnings exemptions are now required or authorized under the various public assistance titles.

(REPORT OF THE TREASURY DEPARTMENT ON H.R. 6675)

TREASURY DEPARTMENT,
Washington, D.C., May 17, 1965.

Hon. HARRY F. BYRD,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to the resquest for the views of the Treasury Department on H.R. 6675, entitled a bill to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes.

The major provisions of this bill are being reported on by the Department of Health, Education, and Welfare, and with regard to them the Treasury Department is in accord with that Department. Beyond these provisions, however, are two sections of the bill which are of special concern to the Treasury Department.

AMENDMENTS OF MEDICAL EXPENSE DEDUCTION

Section 106 of the bill would make five principal changes in the portion of the present Internal Revenue Code which provides income tax deductions for medical expenses. In brief, the nature of these changes and the views of the Treasury Department on them are as follows:

(1) The usual 3 and 1 percent minimum limitations on the medical expense deduction would be made applicable to persons aged 65 and over.

The Treasury Department supports this amendment.

(2) A portion of medical insurance premiums would become deductible without regard to the normal minimum limitations.

For several reasons, the Treasury Department strongly opposes this amendment.

(3) Present law would be clarified to indicate that premiums paid for accident and health insurance are deductible only to the extent that they represent charges for medical coverage.

The Treasury Department supports this amendment.

(4) Current deductions would be permitted for certain medical insurance prepayments by persons under 65.

The Treasury Department opposes this amendment.

(5) The special maximum limitations prescribed by present law for disabled taxpayers and spouses aged 65 and over would be made available in all cases of disability, without reference to the age of the taxpayer or his spouse.

The Treasury Department recommends that this amendment be expanded to eliminate completely the present maximum limitations on the medical deduction. However, to prevent abuse of the new, more liberal rule, the Department proposes that deductions not be allowed for costs of facilities, devices, and services customarily used primarily for nonmedical purposes.

A memorandum is enclosed which explains the specific character of these amendments and the considerations which support the Treasury Department views on them. A draft of the additional amendment which the Department recommends is also enclosed.

SOCIAL SECURITY COVERAGE OF TIPS

A second provision of the bill which is of special concern to the Treasury Department is section 318. That section would treat tips received by employees from customers as wages for social security and income tax withholding purposes. Under present law, only regular wages of waiters, waitresses, and other employees whose earnings are principally from tips may be counted toward social security benefits. Since the wages of these employees are usually relatively low, they can qualify only for very limited benefits for themselves and their dependents. Also, the advantages of the pay-as-you-go income tax system are largely foreclosed to them. To deal with both of these problems, the Treasury Department and the Department of Health, Education, and Welfare, after considerable study developed the measure now contained in section 318 of the bill. The Treasury Department strongly supports this measure. A memorandum is enclosed explaining in greater detail the operation of the section and the reasons for its enactment.

The Bureau of the Budget has advised the Treasury Department that there is no objection from the standpoint of the administration's program to the presentation of this report.

Sincerely yours,

STANLEY S. SURREY,
Assistant Secretary.

TREASURY DEPARTMENT VIEWS ON H.R. 6675 (89TH CONG.) SECTION 106

AMENDMENTS OF INCOME TAX DEDUCTION FOR MEDICAL EXPENSES

Accompanying the major provisions of H.R. 6675 are several revisions of the portion of the present Internal Revenue Code which provides income tax deductions for medical expenses. The amendments, contained in section 106 of the House bill, would make five principal changes in the existing statute. The general effect of these changes and the Treasury Department's position is as follows:

(1) The usual 3 and 1 percent minimum limitations on the medical expense deduction would be made applicable to persons aged 65 and over.

The Treasury Department supports this amendment.

(2) A portion of medical insurance premiums would become deductible without regard to the normal minimum limitations.

For several reasons, the Treasury Department strongly opposes this amendment.

(3) Present law would be clarified to indicate that premiums paid for accident and health insurance are deductible only to the extent that they represent charges for medical coverage.

The Treasury Department supports this amendment.

(4) Current deductions would be permitted for certain medical insurance prepayments by persons under 65.

The Treasury Department opposes this amendment.

(5) The special maximum limitations prescribed by present law for disabled taxpayers and spouses aged 65 and over would be made available in all cases of disability, without reference to the age of the taxpayer or his spouse.

The Treasury Department recommends that this amendment be expanded to eliminate completely the present maximum limitations on the medical deduction. However, to prevent abuse of the new, more liberal rule, the Department proposes that deductions not be allowed for costs of facilities, devices, and services customarily used primarily for nonmedical purposes.

The nature of the House amendments, the views of the Treasury Department on them, and the additional amendment which the Treasury Department proposes are explained in greater detail in the following paragraphs.

1. Restoration of percentage limitations upon medical expense deductions for persons who have attained the age of 65

The general rule of present law is that medical expenses are deductible for Federal income tax purposes only to the extent that the total of such expenses, during a given tax year, exceeds 3 percent of the taxpayer's adjusted gross income. The general rule also is that amounts paid for medicine and drugs can be taken into account, in computing the deductible portion of the year's medical expenses, only to the extent that they total more than 1 percent of adjusted gross income. Exceptions are made to both of these rules, however, for people aged 65 and over. If either the taxpayer or his spouse has reached 65 by the end of the tax year in question, expenses for the medical care of both are entirely deductible, without regard to the usual 3 and 1 percent floors. Similarly, if a dependent father or mother of the taxpayer or his spouse has attained 65, the full amount of the medical expenses which the taxpayer pays for that dependent are deductible, whether or not the taxpayer himself or his spouse are yet 65.

Section 106 of the House bill would eliminate these special exceptions to the ordinary medical expense rules for persons who have reached 65. The effect of the amendment would, thus, be to make the normal 3 and 1 percent floors on deductibility applicable without regard to the age of the taxpayer, his spouse, or a dependent for whom a medical expenditure is made.

The considerations underlying the measure are sound. The original intent of the medical expense floors was to limit the deduction to extraordinary expenditures. The floors were also related to income: the higher the income, the higher the floor on deductibility of expenses. The special exceptions to the floors for those aged 65 and over were introduced into the tax law at a time when the Federal Government had no general health insurance program designed to

alleviate the burdens which medical costs impose upon older people. Recognizing the hardships generated for those 65 and over by increasing medical needs, Congress sought to mitigate the difficulty indirectly—through the tax law—by granting larger medical expense deductions to the members of this group than are available to taxpayers in general. By its nature this indirect tax subsidy has, at best, provided only a partial and imperfect method of dealing with the basic problem. Since the tax benefits which it confers decrease as the level of adjusted gross income diminishes and the tax rate declines, the provision inevitably affords greatest assistance to those who need it least and, conversely, least assistance to those who need it most.

The present bill, on the other hand, attacks the fundamental problem in this area directly; it establishes programs carefully fashioned to enable even the low-income groups of the aged to meet their medical needs. With the advent of this direct and comprehensive Federal attack upon the problem, the need for the special tax provisions disappears.

Two other considerations support reinstatement of the 3- and 1-percent floors for those 65 and over. First, the voluntary health insurance program provided for in the House bill will require annual payments from General Treasury funds. According to our estimates, for the first full year of the operation of the program, the necessary payments will be at least $560 million.[1] The additional $170 million of tax revenue developed by restoration of uniform 3- and 1-percent floors for medical deductions would, in part, offset these payments. Since the impact of the 3- and 1-percent floors increases as the level of adjusted gross income rises, such a method of recouping the Government's expenditures would be linked closely to taxpayer ability to pay. In this way, funds which the Government now assigns to the indirect and inappropriate medical assistance device contained in the tax statute could be rechanneled to the support of the direct, carefully developed, appropriately structured medical program provided by the House bill, and could thereby provide medical assistance for those who need it most.

Secondly, removal of the special medical deduction rules for those 65 and over will result in considerable simplification of the tax law in this area. The incorporation of these special rules in the present statute has compelled use of an additional two-page reporting form solely for the computation of the medical expense deduction. Restoration of uniform floors would make possible the elimination of this form.

Upon these grounds, the Treasury Department supports the portion of section 106 of the House bill which would make the general 3- and 1-percent limitations upon medical expense deductions operative without reference to the age of the taxpayer, his spouse, or his dependents.

2. *Partial deductibility of medical insurance premiums without regard to 3-percent floor.*

Under present law premiums paid for medical and hospital insurance are subject to the general 3-percent floor upon medical deductions. Like other medical expenses, they are, thus, ordinarily deductible only to the extent that the taxpayer's total medical expenses for the year exceed 3 percent of his adjusted gross income. Section 106 of the House bill would alter this rule; it would permit deduction of one-half the premiums which the taxpayer pays for medical insurance covering himself, his spouse, and his dependents (but not more than an annual total of $250) without regard to the normal 3-percent floor.

The Treasury Department strongly opposes this amendment. The Department is of the view that the tax law ought not to be used as a mechanism to encourage the acquisition of medical insurance. If the Internal Revenue Code is to be pressed into service for this end, one can argue with equal force that it ought to provide incentives for taxpayers to procure other kinds of insurance. Existing tax law, for example, makes no effort to encourage taxpayers to buy automobile or fire and casualty insurance: it accords no deductions for the premiums on such insurance, and none for losses compensated by insurance, but does allow deductions for uncompensated losses. Like medical insurance, other forms of insurance are socially desirable; and it is difficult to contend that the tax statute affords any more suitable vehicle for the promotion of medical insurance than it provides for the advancement of other types of insurance. Yet the revenue losses consequent upon such use of the tax law would be exceed-

[1] The estimates indicate Government contributions ranging from $560 million (if there is 80-percent enrollment in the program), to $665 million (if there is 95-percent enrollment).

ingly large—so great, perhaps, as to require an upward revision of tax rates. Adoption of the proposed amendment would, hence, constitute a dangerous and very undesirable precedent.

The amendment would, also, represent a fundamental departure from the long-established policy of the medical expense deduction. The objective of the deduction has always been to minimize the financial stress in a period in which a taxpayer must bear the burden of extraordinary medical expenditures. The target of this tax benefit is a sort of crisis situation, a period in which medical costs consume an abnormally large proportion of the taxpayer's income. The benefit was not originated for—indeed, it was specifically designed to exclude—situations in which normal, regular, and moderate medical disbursements are attended by a flow of income adequate to meet them. By making medical insurance premiums a single, special exception to the general 3-percent floor, the amendment would specifically extend the medical deduction to payments which are small, do not bear a disproportionate relationship to the taxpayer's income, and do not, therefore, impose financial hardship upon him. In doing so, it would broaden the medical deduction beyond the area to which it has thus far always been confined—that of real taxpayer need.

An additional and self-sufficient reason exists for rejecting the proposed amendment. The provision would cause a very significant loss of revenue. Our estimates indicate that an annual reduction of approximately $88 million would take place. If adopted, this revision of the statute would, in other words, wipe out more than half the revenue which would otherwise be produced by the extension of the 3 and 1 percent floors to taxpayers of all ages.

Since, then, the proposal would constitute a broad and most undesirable precedent, would distort the fundamental intent of the medical expense deduction, and would produce a substantial loss in revenue, the Treasury Department strongly recommends that this portion of section 106 of the House bill be rejected.

3. Limitation of deductibility of insurance premiums to amounts paid for medical coverage

The section of existing law which governs medical expense deductions specifies that amounts paid for "accident and health insurance" shall be deemed payments for medical care. Several courts have construed this provision to permit complete deduction of premiums paid for policies which provide insurance coverage for items other than the expenses of medical care of the taxpayer, his spouse, and his dependents. E.g., *Heard* v. *Commissioner*, 269 F. 2d 911 (C.A. 3d 1959); *Donald G. Kilgore*, 38 T.C. 340 (1962); *Pretzman* v. *Commissioner*, 1963-1 U.S.T.C. 9413 (S.D. Ohio 1963). These decisions, for example, allow deductions for premiums paid on policies which indemnify taxpayers against accidental loss of life, sight, or limb, or which insure them against loss of income during periods of disability. Similarly, they allow taxpayers to deduct the consideration which they pay for riders which waive premiums on life insurance contracts during periods of disability. Under the approach of these courts, such results obtain even if the insurance contract in issue includes no provision for reimbursement of the costs of the taxpayer's medical care.

Section 106 of the House bill would revise the present statute to make it plain that medical expense deductions are permitted for insurance premium payments only if, and to the extent that, the insurance policy affords actual medical care coverage. Where proceeds are payable under the contract for items other than medical care expense, this amendment would restrict the deduction to the portion of the premium which the contract states separately as the charge for medical expense coverage.

The proposed amendment represents a simple and definite method of achieving an altogether proper result. The rule recognized by the described judicial decisions grants medical expense deductions for payments which bear no relationship to medical care. By doing so, it extends the medical deduction beyond the reason for which it was established. The amendment makes clear the restriction of the deduction to items which have a necessary relationship to the provision of medical care for the taxpayer, his spouse, and his dependents. Desirable in any event, this clarifying provision would become especially important if the Congress should decide to retain the portion of the House bill which permits partial deductions for insurance premiums without reference to the 3-percent floor.

For these reasons, the Treasury Department recommends approval of this portion of the House bill. The revenue effect of the measure would be negligible.

4. Current deductibility of premiums for certain future medical insurance

A fourth change in the medical expense statute would provide current deductibility for premiums paid by a taxpayer under the age of 65 for insurance covering the costs of medical care for himself, his spouse, or a dependent after the taxpayer attains 65. The provision would apply only where, under the insurance contract, premiums are payable (on a level payment basis) for at least 10 years or until the taxpayer reaches 65; it would not apply in any case in which the premiums are payable over a period of less than 5 years.

According to the information available to the Treasury Department, this amendment would have little practical effect. At present, only approximately 1 percent of the companies which write health insurance offer policies of the type to which the proposal would apply. At least one major insurance carrier attempted in the past to sell such insurance, but found little market for it (for reasons which do not appear to relate to the tax status of the premiums), and has since discontinued offering it. Thus, because the amendment would complicate the law without having significant practical import, the Treasury Department recommends its deletion from the bill.

5. Increase of maximum limitations in certain cases of disability

Existing law places maximum limitations upon the total amount of the medical expense deduction which a taxpayer can be allowed in any 1 year. Generally, the ceiling is fixed by multiplying $5,000 by the number of the taxpayer's exemptions (other than those for blindness or age), subject to upper limits of $10,000 (for a single taxpayer), and $20,000 (for one who is married). Where the taxpayer or his spouse or both have attained 65 and are disabled, however, upper limits of $20,000 and $40,000 become applicable under a special set of rules.

The House bill's final revision of the medical deduction statute would remove all reference to attainment of the age of 65 in the rules governing the $20,000 and $40,000 limitations. Under this proposal, as a consequence, these rules would apply to all disabled taxpayers and spouses without regard to their ages. Revenue reduction under the measure would be negligible.

The Treasury Department favors the principle of this amendment, but is of the opinion that the present proposal does not carry it sufficiently far. In the Department's view, all existing maximum limitations on the medical deduction ought to be removed. The limitations add substantially to the complexity of the statute. More significantly, they can create genuine hardship. Grave illness confronts some taxpayers with exceedingly large medical costs. Multiple injury or illness in a single family can have the same consequence. The necessity of providing continuing institutional care for one or more dependents can constitute an extraordinary financial burden. In such situations, the maximum limitations may operate to deny the medical deduction to precisely those who need it most.

To prevent abuse, however, elimination of the maximum limitations should be attended by one safeguard. Under existing law, taxpayers have frequently been able to sustain claims of medical deductions for expenditures for facilities, devices, and services which are of types customarily employed primarily for nonmedical purposes. In certain cases taxpayers have, for example, been able to deduct part or all of the costs of installing swimming pools in their yards or air-conditioning systems in their homes. Because most persons normally use the facilities or services in this class for nonmedical purposes, and because even the taxpayer who claims a medical deduction will ordinarily derive substantial nonmedical benefits from his expenditure, the task of determining the deductibility of a given expense frequently becomes a complex, arduous, and uncertain one. The intricate and inherently factual character of the issues has proved to be an invitation to controversy and litigation. Yet, since taxpayer expenditures for nonmedical facilities and services are commonly quite large items, repeal of the maximum limitations on annual deductions could well accentuate present problems in this area.

For these reasons, the Treasury Department recommends that all existing maximum limitations on the medical expense deduction be removed, but that, correlatively, a provision be added to the present statute's definition of the term "medical care," specifying that the phrase does not comprehend facilities, devices, and services customarily utilized primarily for purposes other than medical care. The latter provision would foreclose deduction of the costs of a swimming pool or an air-conditioning system, since those items are used by most persons pri-

marily for nonmedical purposes. It would not, however, prevent deductions for the cost of an inclinator for a cardiac patient, or prosthetic devices for a person subject to partial paralysis, because such equipment is normally devoted primarily to medical uses.

Such an amendment would eliminate both the hardship which the present maximum limitations sometimes cause and the complexity which they introduce into the tax law. It would, also, resolve an issue which has given rise to considerable administrative difficulties. The revenue effect of the measure would be negligible.

6. Effective date

The medical care programs established under the principal provisions of H.R. 6675 become operative, generally, on July 1, 1966. To postpone the effect of the medical deduction amendments until those programs have begun and to avoid the reporting complexities which would result from a midyear revision of the income tax statute, section 106 of the House bill has been made applicable to tax years beginning after December 31, 1966.

COVERAGE OF TIPS

Description of coverage of tips in H.R. 6675

Beginning in 1966, employees who in the course of work with any one employer receive at least $20 in cash tips in a month would be required to report their tips in writing to the employer. This report would have to be made at least by the 10th day of the month following the month in which the tips were received. More frequent reports could be required by employers and the bill would authorize employers to gear these tip reports to their payroll schedules. The employer would add the amount of reported tips to the employee's wages. He would withhold from the wages the employee's share of the social security tax and the appropriate amount of income tax due on the combined amount of tips and wages. The employer's liability for his share of the social security tax on tips would be limited to those that are reported on time and even as to these he would be responsible for his tax only to the extent that he had enough unpaid wages due the employee or funds turned over by the employee to cover the employee share of the tax.

The bill would require employees to turn over funds to the employer to cover the employee share of the social security tax whenever the appropriate amount of tax could not be withheld because of insufficient unpaid wages. This is a most unlikely situation however. See discussion on page 4 regarding adequacy of wages to cover both social security tax and income tax withholdings. In any case in which an employee failed to report tips or failed to make additional funds available if needed, the employee would be required to pay both the employer's and employee's share of the social security tax. With regard to the withholding of income tax, an employee would not be required to turn funds over to his employer to make sure the full amount of tax due is collected from month to month as in the case of the social security tax. The employer, however, would withhold throughout the year whatever he could from wages. The employee would, of course, be responsible to pay the full amount of income tax either in quarterly installments or with his return at the end of the year to the extent that withholding did not cover his full liability.

Background

The Congress has considered various proposals to cover tips under social security since 1950. In that year, during the 81st Congress, a bill (H.R. 6000) which later became the Social Security Amendments of 1950 came before the Committee on Finance with a provision which would have treated tips received in the course of employment as remuneration paid to the recipient by his employer. The bill would have required employees to report in writing to their employer by the 10th day after the end of a quarter all tips received during the quarter. The committee stated in its report on the bill that it believed such a change in the law would introduce administrative complications and it did not accept the proposal (S. Rept. 1669, 81st Cong., 2d sess, p. 17).

Since 1950, many proposals on tips have been introduced in both Houses and many of these, at some time or other, have been before one or the other or both of the tax committees. The Treasury Department and the Department of Health, Education, and Welfare have examined and studied carefully all of these proposals. Studies of various other suggestions and alternatives for extending social

security and income tax coverage to tips have also been made. In 1958 the Committee on Ways and Means gave serious consideration to a proposal based on a system of reporting by employees similar to that it had approved in 1950. The committee, however, was unable to satisfy itself that the plan would be workable on a national scale and it requested the two Departments to further study the problem (H. Rept. 2288, 85th Cong., 2d sess., p. 7). In 1960 the Departments recommended a proposal which combined a system of reporting of actual tips with a formula for estimating tips when the actual amount was not known to the employer. This plan was also rejected because the committee could not arrive at a formula that it considered equitable when applied to all regions of the country. The extensive discussions of the formula approach in committee convinced this Department and the Department of Health, Education, and Welfare that the only acceptable solution to the problem would be one which used as a base for the tax and benefits computations the actual amount of tips received by an employee and that it had become essential to devise a workable system to accomplish this.

At about this time, employee groups had become interested in getting tips covered under social security because, as the result of tip drives by the Internal Revenue Service, more and more employees were beginning to report their tips for income tax. Employers, as a matter of self-interest, had always urged that tips should be recognized as earnings from self-employment and taxed at the self-employment rate. Tips, however, are in reality remuneration for services rendered in an employment relationship and thus cannot legally be regarded as self-employment income. Moreover, it is common knowledge that in setting wages of employees who customarily receive tips employers take account of the tips. This is apparent from the terms of bargaining agreements covering nontip as well as tip employees. Tips, accordingly, are part of the wage pattern in certain industries and they should be treated as wages for all purposes. (See discussion below of minimum wage laws.) It would also be unfair to tax tips at the self-employment rate, which is 1½ times the employee rate of tax on wages, if tips are in fact wages.

It has sometimes been suggested that, since tips are paid directly to employees, and employers have no interest in knowing how much is received in tips, employees should report the tips directly to the Internal Revenue Service and pay the employee share of the tax due on the tips with this report. The Service would then bill the employer for his share of the tax on the basis of the employee report. Although this system appears simple it has no advantage for anyone. Employees would be burdened with keeping records for 3-month periods, filing quarterly reports and computing their own tax liability. The Internal Revenue Service would be burdened with many more wage reports to process and would have to collect the employer tax 1 year or more after the tips were claimed to have been received. Finally, employers would be at a disadvantage in contesting their liabilities in view of this time lag. Employee groups originally suggested a plan of this type, but they have since realized its shortcomings for all concerned and are no longer urging it.

The proposal in H.R. 6675 is realistic

In developing the proposal which is now in H.R. 6675, the Department of Health, Education, and Welfare and the Treasury inquired concerning the operations, especially the pay and bookkeeping practices, of businesses where tipping is customary. All the various objections made by employers against the adoption of a system of reporting of tips by employees such as the one in H.R. 6675 have also been considered carefully. Many modifications were made in the original recommendation as the result of these employer comments and studies. The proposal as it now stands makes no unnecessary or unreasonable demand on employers. The system of reporting required under H.R. 6675 is as simple and efficient as it can be in view of the nature of tips and the objectives of the proposal, which are: more comprehensive social security coverage of over a million workers and their dependents and better reporting and easier payment of income tax liability on tips.

Tip reports can be geared into the payroll

Employers will have a great deal of freedom in determining the frequency and the manner in which employees report their tips. The only requirement is that at least one report be filed for each month by the 10th day of the following month. Also, within any quarter withholdings for social security and income taxes may be made at a predetermined and constant rate for each pay period,

provided that before the end of the quarter the amounts withheld be adjusted to reflect the taxes due on the actual amounts of tips reported during the quarter. This will allow large employers whose payrolls are prepared with the aid of business machines to gear the tip reports into their payrolls. The addition of tips to wages will require some additional recordkeeping, but since employers are already withholding and reporting to the Internal Revenue Service social security and income taxes on wages, the basic records are already in existence and the procedures are well established. The additional work required should be manageable.

Wages are adequate to cover withholding for tips

An argument which employers frequently assert against the tip proposal in H.R. 6675 is that wages of tip employees are generally so low that in most cases there will not be enough to cover the social security and income taxes that should be withheld. The facts have been examined carefully and there would appear to be no real basis to this argument. Surveys of hotels and eating and drinking places conducted in 1961 and 1963 by the Bureau of Labor Statistics (Bulletins Nos. 1328, 1329, 1400, and 1406) show that, although regular wages of tip employees in these industries are relatively low, in the great majority of cases the wages would be more than adequate to cover the social security and income taxes which would have to be withheld under the terms of the bill.

The allegation that wages paid to tip employees will generally not be sufficient to cover the full amount of taxes that would have to be withheld is based on an overestimation of the amounts of social security and income taxes that are collected on wages. The current combined rate of withholding is approximately 18 percent (3⅝ percent for social security and 14 percent for income tax); next year it would be exactly 18 percent under the new rates proposed in the bill. At the current rate, a weekly wage of only $15 would be sufficient to pay the taxes on $15 in wages plus $75 in tips, or total weekly earnings of $90. A weekly wage of $15 would represent an average hourly wage of 37½ cents (only 9.3 percent of all waiters and waitresses in the United States received in 1963 an average hourly wage under 40 cents) for a 40-hour workweek (84 percent of restaurant workers in the United States work 40 hours or more per week). Weekly tips of $75 represent earnings at the rate of $1.50 per hour during a 48-hour week or $1.87 per hour during a 40-hour week. In the 1961 Bureau of Labor Statistics survey of eating and drinking places, the only survey with tip data, only 40 percent of waiters and waitresses in large metropolitan areas surveyed were reported to earn $1.25 and over an hour in tips. Because the survey was primarily interested in the lower paid workers, tabulations were not made beyond $1.25. These illustrations are submitted to show that even at the lowest end of the pay scale enough wages would ordinarily be available to an employer from which to withhold the social security and income taxes due on tips. A more typical example would have an employee earning a weekly wage of $32 (on the basis of 81 cents per hour, the average wage of waiters and waitresses in the 1963 survey). Such a wage would approximately cover the taxes on combined earnings in wages and tips of $200 a week.

Employers know approximately what employees earn in tips

It has also been claimed that employees want no part of a plan of social security coverage which will require them to disclose the amount of their tips to the employer because, it is reasoned, if employers knew how much tips employees receive they would want to reduce the already low regular salary paid to employees. This argument assumes that employers are ignorant of the amounts received by their employees. This may have been true years ago, but today tipping habits are fairly uniform and well known. Moreover, more and more tips are being paid through employers by users of credit cards so that employers have a fairly accurate knowledge of the sums received by their employees. Another recent development which has contributed to the general knowledge concerning tips has been the publicity attending trials of taxpayers charged with understating their tip income. In these cases, various formulas have been applied by the Commissioner of Internal Revenue to determine the amount of unreported tips and determinations fixing tips at levels between 10 and 15 percent of the price of meals served have generally been upheld by the courts.

Tips and the minimum wage laws

Employers have argued that the coverage of tips under social security would be unfair to them so long as they are prevented, under certain State laws, from

taking tips into account in determining whether a minimum wage is paid. At present, there is no uniformity among the States on the treatment of tips under the State minimum wage laws. Of the 36 States having minimum wage laws, 14 now prohibit the counting of tips. At the last session of the Congress a bill (H.R. 9824) was introduced in the House which reflected the administration's views that tips should be counted toward the minimum wage where they are accounted for by an employee to the employer. It is believed that the adoption of Federal legislation including tips under social security would be influential on the States to also modify their laws to permit the counting of tips for minimum wage purposes. In any event, after tips are covered under social security employers will be in a better position to demand the amendment of State minimum wage laws to take tips into account. This argument was influential in the final decisions made this year by the Ways and Means Committee.

The "tax receipt" argument

The inclusion of a provision in H.R. 6675 requiring the withholding of income tax on tips reported to the employer has caused employers to comment that because of the low wages paid to these employees no cash wages will be left after all the taxes are withheld and instead of wages employees will receive, in their pay envelope, only a receipt showing the taxes withheld. The implication in this argument is that employees think of wages only in terms of take-home pay and if no cash wages remain after taxes are collected the employers will be pressed for an increase in wages. This is largely an educational problem which employers and employees must face. It is not at all certain that employees will be unhappy to have their income tax on tips collected on the pay-as-you-go withholding system. It seems almost incontrovertible that employers will find that the majority of their employees would consider the proposed arrangement very helpful. Certainly the current furor over slight amounts of underwithholding for 1964 and the growing consensus for graduated withholding indicate that taxpayers prefer paying taxes on a pay-as-you-go basis. Another answer to this objection of employers is that, as was pointed out earlier, although wages of tipped employees are relatively low, they are not so low that all cash wages of workers will be needed to cover the taxes to be withheld. On the contrary, these cases will be the exception rather than the rule.

Withholding is the only humane way of collecting income tax on tips

The chief argument in favor of withholding of income tax on tips is that this is the only humane way to collect the income tax from the low-bracket taxpayers. It is expected that once tips are covered for social security there will be better reporting of tips for income tax. In view of this, it seems only fair to afford employees who receive most of their earnings from tips the opportunity available to other employees to pay their income tax currently by having the tax due on the tips withheld from regular wages. Without withholding, tip employees will be forced into paying their tax in quarterly installments. This method of payment is usually reserved for more sophiscated taxpayers—professionals or the wealthy who receive large amounts of income in dividends or interest. For the low-income taxpayer the filing of estimates of income and making quarterly payments would be a hardship which could subject them to penalties. Many of them would find it difficult to budget in order to meet the quarterly payments which can be substantial.

Since tips are an integral part of the compensation of persons engaged in certain occupations, it is reasonable that this form of compensation should be treated as wages and that employers, who take account of tips in setting the wages of these employees, should also be required to assume the burden of withholding on tips. This burden would only be one of bookkeeping since employers would never be required to advance their own funds for the payment of employee tax liability. Their obligation to withhold would always be limited to the cash wages or other funds of the employee under their control. Withholding of income tax on tips will make the payment of taxes much easier on employees. It will increase the revenue collections and at the same time reduce the number of costly administrative and legal collection procedures that are now required to enforce the payment of income taxes on tips.

Underreporting of tip income

Tips are one of the few sources of income which under our self-assessment system continue to escape effective taxation. Enforcement activities of the Internal Revenue Service have been only moderately productive in this area.

After many years of continuous efforts to educate tip recipients to their obligation to report and pay taxes on their tips, the Service is convinced that the only recipients reporting tips with any degree of regularity and accuracy are those who, in prior years, have had their returns examined, had substantial deficiencies assessed against them, and know that their returns continue to be examined.

Field offices of the Service were contacted recently for information regarding tip enforcement activity. Reports were received from offices covering the North Central, Southern, and Southwestern States, the only regions conducting special tip drives in recent years. In one large northern city in 1964 group examinations of employees of 5 restaurants and 2 hotels revealed that of 154 employees who would normally be expected to receive tips practically no one had reported any tips. Following this examination, 40 percent of these taxpayers agreed to deficiencies averaging $460. The other cases involved deficiencies averaging $600. These cases have not yet been settled. At the same time and in the same city, 62 beauticians working in department stores agreed to deficiencies averaging $200 on account of tips received over 2- or 3-year periods. Some 33 others had been assessed deficiencies averaging $400 over similar periods.

In a large city in the South, 552 returns of waiters and waitresses were examined in 1960 and 1961 resulting in deficiencies being assessed in the total sum of $132,222. This represents an average deficiency per return of approximately $240. In the same period, 316 returns of beauticians at downtown shops and department stores were examined and deficiencies were assessed in the amount of $45,234, for an average deficiency per return of about $140. In a city of the Southwest, examinations were made in 1962 of 420 returns of the tip employees at 2 hotels (waiters, waitresses, bellhops, et al.). More than 50 percent of these returns showed no tip income whatever. As a result of this examination, deficiencies averaging $200 per return were assessed against these employees for a total deficiency of $83,614.

TREASURY DRAFT NO. 1

Medical expense deduction—Removal of maximum limitations and elimination of deduction for certain nonmedical facilities, devices, and services

(Page and line reference are to the H.R. 6675 print referred to the Committee on Finance.)

On page 116, following line 7, insert the following:

"The term 'medical care' does not include amounts paid for facilities, devices, and services customarily used primarily for purposes other than those specified in subparagraph (A)."

On page 117, strike out lines 12 through 22 and insert in lieu thereof:

"(d) Section 213 of such Code (relating to medical, dental, etc., expenses) is further amended—

"(1) by striking out subsection (c) of such section, and

"(2) by striking out paragraphs (1), (2), and (4) of subsection (g) of such section."

(On p. 308 Senator Anderson indicated, during the questioning of Dr. Russell B. Carson, National Association of Blue Shield Plans, that he would submit further questions to Dr. Carson. The 14 written questions by Senator Anderson and the replies by Dr. Carson follow:)

RESPONSES TO QUESTIONS POSED BY SENATOR CLINTON P. ANDERSON, IN LETTER, MAY 7, 1965, TO RUSSELL B. CARSON, M.D., CHAIRMAN OF THE BOARD, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

INTRODUCTORY COMMENT

The National Association of Blue Shield Plans recognizes that the problem of prepaying or insuring payment for necessary medical care for the elderly is a national problem, and we approach the problem in the firm expectation that we can speak for our member plans throughout the United States in proposing a national solution.

Question 1.—If Blue Shield were to underwrite a health insurance plan for some or all of the 19 million aged, the funds involved would be enormous. They would run into hundreds of millions of dollars of Government funds. Do you think such funds with their potential effect on the economy should be turned over to you to invest?

Comment.—It is true that the premium income under this program can accumulate into sizable sums each month. However, the major portions of these funds would immediately be used to pay for the health services received by the aged individuals and to defray the cost of administering the program. In effect, these funds would constitute a revolving fund. The Ways and Means Committee pointed out in its report (p. 61) that this program is to be maintained on a "current cost" financing basis.

Any funds in excess of current operating needs plus incurred but unpaid claim liability would be invested under Government supervision, presumably in Government securities, and as in the Federal employee program, the proceeds of such investments (interest) would be returned to the program in terms of reduced subscription charges or extended benefits and would not accrue to the benefit of Blue Shield.

We might point out that H.R. 6675 would establish a very large contingency fund at the outset. Although this fund would be retained by the U.S. Treasury to be used by the program only if necessary, there is little reason to expect that it would become necessary. Even under the most severe circumstances, it would be several months before this fund would be needed.

Question 2.—The Federal Government does not purchase insurance against fire, theft, and liability through private organizations; it self-insures because it has the resources to take the risk better than any private organization and it doesn't make sense then for the Government to pay a private insurer a risk charge. Why should the Government pay Blue Shield a risk charge for underwriting health insurance in this program for the aged?

Comment.—We do not believe one can equate a health insurance program for all citizens over the age of 65 with fire, theft, and liability insurance associated with the operations of the Federal Government. Insurance against such risks as fire, theft, and liability—representing cash liabilities—is not comparable to medical care insurance which involves complex interpersonal relationships and professional problems requiring a special degree of sophistication if the program is to be satisfactory to all concerned.

In the case of part B of H.R. 6675, the Government is proposing to share the entire cost of the program equally with the people who will voluntarily participate in it. If the Government, therefore, undertook to self-insure this program, it would not be assuming the total risk, but would be sharing the risk and the cost equally with the citizens involved. H.R. 6675 specifically calls for a voluntary program with the Government merely making a contribution. If this is a voluntary program, there is all the more reason to utilize the voluntary system, and to utilize it to the fullest possible extent.

The voluntary insurance industry has the resources necessary to undertake this risk and Congress should take full advantage of these resources in carrying out the purposes of this legislation. For more than a quarter century, Blue Shield plans have been meeting the risks of a constantly expanding program of medical care prepayment, now covering more than 56 million people, and they have never been forced to apply for public assistance in meeting their obligations.

Question 3.—If a private organization underwrote the health costs of the aged, it would use large safety factors in the premiums the Government would pay and would always keep their risk safe. Isn't it true then that whatever arrangements are made between the Government and the insurer, the insurer would be taking little or no risk especially since the Government would not stand by and let Blue Shield take a loss of the size that might bankrupt it and end the program?

Comment.—Our suggestion that the Government engage the services of Blue Shield as a carrier is motivated by a desire to render a useful service, not in any degree by a wish to take on a new "safe risk." Nor are we motivated by any idea of making a profit at the expense of Government or of the aged population. Nor, again, do we have any desire to monopolize the market for this particular group. On the other hand, Blue Shield has little interest in being used merely as a conduit of funds between the Government and the aged patient or his doctor. If the Government uses Blue Shield in this program, it should do so principally because Blue Shield is able to make a medical care prepayment program work to the

satisfaction of both patients and physicians. Blue Shield has developed over the past 25 years relationships and patterns of function as an organization solely devoted to helping prepay their medical expenses.

In your third question it is implied that if Blue Shield underwrites this program, it would require large safety factors in the premiums. We would respectfully refer you once again to our experience with the Federal employee program. A contract was negotiated between the Government and Blue Shield including a realistic premium rate—a rate that was acknowledged to be actuarially sound by the Government's own actuaries and has proven to be sound over the years since.

The Ways and Means Committee report on H.R. 6675 (p. 46) emphasized the manner in which contracts with carriers would be supervised by the Secretary of HEW.

Question 4.—If Blue Shield had the role you suggest, it would decide what benefits the aged should have. Why do you think the Congress should let Blue Shield decide what the provisions should be any more than it should let the insurance industry decide what social security should do or why any other large Government program legislation should be made the responsibility of a private party?

Comment.—We agree that neither Blue Shield nor any other carrier should arbitrarily decide the scope of benefits. On the contrary, Blue Shield is suggesting that the aged patient himself should have a degree of choice, not only as to whether he participates in the program, but also as to the benefits and the manner in which benefits would be delivered. The Blue Shield proposal set forth in our testimony embraces all of the medical benefits prescribed in H.R. 6675. The significant difference is that the deductible and coinsurance factors would not apply to those medical services which are likely to be most expensive; mainly those associated with a hospitalized spell of illness. However, with respect to those medical expenses which are likely to be less onerous as to cost (they being set forth on p. 16, lines 9 through 15 of our prepared statement) Blue Shield would apply a $100 annual deductible and 20 percent copayment on the part of the patient. (We attach hereto an exhibit setting forth the precise differences between the benefit pattern prescribed in H.R. 6675 and that proposed by Blue Shield.)

Health benefits are not comparable to social security benefits. The latter are dollar amounts, geared to the individual's earnings. The need for medical services bears no relationship to the amount the individual has earned. Furthermore, medical practice is changing and evolving as new and better techniques are developed and as new and better apparatus is invented. In our judgment, it would be unwise to freeze into statutory language the specific benefits to which an individual may or may not be entitled.

Question 5.—On page 7 of your testimony, you stated three questions on how to apply a deductible. On page 15, you proposed covering some 10 kinds of services with an annual deductible of $100 and 20 percent copayment. Why wouldn't the Government use the same methods you use to deal with the same problems in the Federal employees plan, for example?

Comment.—Blue Shield does contemplate using the same system for administering deductibles and coinsurance (where they apply) as it has been using under the Federal employees plan, simplifying the procedures for this particular group where possible.

Referring to the questions raised on page 7 of our testimony concerning the application of deductibles, we would point out that under the alternative pattern proposed by Blue Shield, we would expect to take advantage of our service agreements with participating physicians which enable us to deal directly with the physician and to relieve the patient of the necessity of advancing payment on his bill or of attempting to determine, during the course of an illness, how much is owed, to whom, and what his rights and privileges are under the program. These considerations are most important to the patient's welfare during a serious illness or disability involving hospitalization.

Your question 5 would seem to imply that you feel that the Government is in a position immediately to duplicate the administrative staffs which Blue Shield plans have developed over the years to administer complex programs involving delicate interpersonal relationships. We submit that the success of the Federal employee plan is in large measure due to the fact that the Government has seen fit to utilize established private mechanisms to the fullest extent, and under constant surveillance, thus assuring the utmost protection of the public interest. Similarly it has been shown in the medicare program for de-

pendents of uniformed servicemen that this program has benefited from being superimposed on already existent privately operated systems, thereby gaining in economy, efficiency, and satisfaction to the services.

We believe that Congress should understand the vital importance of building a bridge of cooperation and understanding between the Government and the medical profession by making maximum use of the prepayment mechanism with which the physicians are accustomed to working in the provision of prepaid medical care.

Question 6.—In your testimony you said, in effect, that Federal employees were given a choice of health benefit plans under the 1959 Federal Employees Health Benefit Act and that the aged should now be given the same kind of option. Federal employee legislation excluded employees who had already retired and the 1960 program covering them provided that the already retired employees would be covered under a single nationwide plan. The Civil Service Commissioner said "Our experience with retired employees, with whom all contacts are by mail rather than by face-to-face counseling, indicates that the exercise of a choice is not an easy decision for annuitants to make particularly those of advanced age * * *." Do you have evidence Civil Service was making an erroneous statement?

Comments.—Blue Shield participated in the discussions surrounding coverage for retired employees who were excluded from the 1959 Federal Employees Health Benefits Act. It is true that the Civil Service Commission decided that those retired persons should not be asked to exercise a choice of two nationwide programs. However, these persons were permitted to retain the coverage they had previously had if they so desired. After having made the offer to these persons, the Civil Service Commission reported that 128,375 took advantage of the nationwide program, but this represented only slightly more than half of those eligible. The remainder, 106,815, retained the program they already had, and of these, 65,405 retained Blue Cross-Blue Shield. Thus, these retired people did actually exercise a choice as to whether to retain their existing coverage or take the Government's program.

We should like to call your attention to another example. Early this year, the State of Rhode Island implemented a very comprehensive MAA program. Twenty thousand persons already covered by Blue Cross-Blue Shield enrolled and were accepted under the State program. However, 11,800 of these chose not to cancel their Blue Cross-Blue Shield membership and elected to continue paying the premiums even though the State program was provided to them at no cost whatsoever. It was only after a concerted effort on the part of Blue Cross-Blue Shield, including a guarantee to these persons that Blue Cross and Blue Shield would hold their membership in reserve and permit them to be reinstated without requiring waiting periods of any type, that the State was able to get these persons finally to cancel their Blue Cross-Blue Shield coverage.

It should be pointed out that the Government is about to establish a policy that will determine its relationship with some 20 million people and with an increasing number of people in the future. All of these people up to now have exercised the privilege of free choice among major patterns of health insurance available to the general population. The two examples cited above tend to show that, if offered a single plan by the Government, many of the elderly people will prefer to retain, at additional cost to themselves, the coverage to which they have been accustomed.

Question 7.—You said that older people should be allowed to keep the Blue Shield coverage that they had while young and with which they are familiar. Is it not true that Blue Shield study No. 2 indicates that only about 5 percent of the total Blue Shield membership has physicians' coverage involving home and office visits? Isn't it true that only three of the Blue Shield plans for senior citizens cover physicians' services in home and office? Now, to emulate the supplementary plan of H.R. 6675 you propose such coverage because such coverage is better even though unfamiliar. Could you comment?

Comment.—More than 10 million Blue Shield members are enrolled under supplemental programs which do provide coverage for home and office visits on either a schedule or copayment basis. However, it is true that only about 5 percent of the total Blue Shield membership has physicians' coverage for home and office visits as part of basic coverage. Also, only three of the Blue Shield programs that are specifically designed for initial enrollment of senior citizens cover physician services in home and office as a basic contract.

Nearly all Blue Shield subscribers have covereage for surgical services rendered during home or office visits and a majority also have coverage for specified anesthesia, radiology, and diagnostic services on an out-of-hospital basis.

It should also be pointed out that the great majority of the approximately 5 million Blue Shield members over age 65 obtained their covereage at an earlier age and have continued the pattern of coverage originally purchased. These patterns tend to be broader than the scope of coverage made available under special senior citizens' offerings. Experience has shown that most people prefer to budget for casual nonemergency services. By applying a "corridor" deductible of $100 to such services as these, the Blue Shield pattern would bring Government funds into play only when such services have become a major item of expense. The "corridor" deductible also would tend to inhibit unnecessary use of these services, some of which are at least partly elective in nature.

Question 8.—You said Blue Shield subscribers are used to service benefits which meet the full cost of covered services. Is it not true that your study No. 2 shows 29 percent of your members covered by pure indemnity plans had incomes which exceeded the sometimes very low income limits in the plans and, therefore, had only indemnity protection?

Comment.—The dominant feature of Blue Shield's offering to the American people is the paid-in-full (service benefit) concept. However, it is true that a minority of Blue Shield subscribers are members of plans which do not have a service benefit commitment from their local physicians. It is also true that a minority of subscribers in service benefit plans have incomes in excess of the income limit covering the local service benefit commitment. To this extent, such subscribers may be said to have indemnity protection. However, even in "indemnity plan areas" the Blue Shield schedules generally reflect the prevailing charges in the community. Therefore, an increasing percentage of claims are satisfied in full by the Blue Shield payment. As you know, there is a growing tendency among physicians throughout the country to stabilize their fee schedules and to accept the same fee for similar service from all patients regardless of income.

With respect to the proposed plan for the elderly population, it is reasonable to expect that Blue Shield plans throughout the country will be able to provide services on a paid-in-full basis for 80 to 85 percent of the aged patients.

Question 9.—You made a major point that the deductibles you use are "corridor" deductibles. Isn't it a fact that this merely means that when you cover home or office visits of doctors, which is not often, you use deductibles?

Comment.—Yes. This is desirable in order to concentrate the benefit dollar on the more costly illnesses. As indicated previously, the purpose of the deductible essentially is to require the less urgent and less important charges to accumulate to a sizable sum before we begin to provide benefits for such services.

For controlling utilization of basic medical services, Blue Shield has found that physician agreements, predetermined schedules, and various types of utilization review committees provide the necessary elements of control. However, we believe that deductibles and coinsurance provisions are helpful in controlling utilization of certain extended services which are generally less costly and frequently elective in nature. For this reason, Blue Shield supports the proposal that the patient share the costs of these extended services.

Question 10.—Is it not also true that 12 plans for the aged apply a deductible to in-hospital medical coverage? The deductible is in terms of days, not dollars, but may that not mean that there is no protection to the patient on the amount he might have to pay in the unproteced period?

Comment.—The great majority of persons over 65 now covered by Blue Shield are enrolled in plans which have no service limitations on in-hospital medical care, and we do not propose to put such limitations on those electing to subscribe to the proposed Blue Shield program under H.R. 6675. It is true that the special senior citizen programs designed by 12 plans for initial enrollment of elderly persons do apply a service deductible for in-hospital medical coverage and there is not contractual protection to the patient on the amount he might have to pay in the unprotected period. However, these plans for the most part were offered in combination with hospital benefit programs and various devices have been used to keep the premium as low as possible.

It should also be pointed out, in respect to this question, that our plans are making increasing use of the growing number of local grievance mechanisms established by the medical profession in order to protect the public from charges considered unwarranted or excessive.

Question 11.—You may be proud of your service coverage of 70 percent of your members but is this "service" coverage full coverage in any real sense when 80 percent have no coverage of in-hospital medical care but only surgical coverage;

56 percent have no coverage on intensive in-hospital care; 30 percent have no coverage of medical care of mental illness; 45 percent have no coverage of medical care for a secondary illness while the patient is in a hospital for another reason; 58 percent have no coverage of medical consultation; and at least 75 percent have no coverage of home or office care? Aren't such total omissions from coverage as hard on the patient's pocketbook as a $50 deductible?

Comment.—Your question 11 contains what appears to be a mistatement, that "30 percent have no coverage of in-hospital medical care, but only surgical coverage." As of December 31, 1962, 90 percent of all Blue Shield members had coverage for in-hospital medical care, and there has been a considerable improvement since that time.

The other figures cited as to the scope of coverage for medical services are consistent with our study findings. However, we would again point out that these figures relate to basic coverage only.

All these benefits would be provided under our proposed scope of benefits for the elderly under H.R. 6675.

Question 12.—I understand a plan can be a Blue Shield member only so long as it is approved by the medical society that established it. Furthermore, the corporate membership of all the New York plans studied by Dr. Trussell, and I presume other plans as well, is almost 100 percent physicians. Finally, of the boards of directors of the plans, the heavy majority are physicians. Is there not some question whether the Blue Shield can wholeheartedly, without conflict of interest, represent the consumer and the public rather than doctors in setting fees to be paid and so forth?

Comment.—At present, nearly one-third of the trustees serving on local Blue Shield governing boards are representatives of the general public. The tendency has been for the proportion of public representative to increase and thereby decrease that of physicians. Even in the case of the several plans which do not have members of the general public serving as members of their boards of directors, these plans do have public advisory committees as part of their organizational structures.

Most Blue Shield plans work under the constant and intimate supervision of State insurance departments and often undergo public hearings when rate adjustments are proposed.

There are valid reasons for a strong representation, if not a majority, of the medical profession on the board of a Blue Shield plan. Blue Shield asks the practicing physician to make a unique commitment to the plan and its subscribers, and physicians rightly wish to have a voice in the direction of an organization which affects them as substantially as Blue Shield does. This commitment includes not only an agreement to accept the Blue Shield scheduled fee as full payment under prescribed circumstances, but also an agreement to accept a prorated fee in the event that the plan is unable to pay full schedule at any time.

There is always the necessity for a fine balance of judgment between consumer and the public on one hand, and the interest of the doctors on the other, in determining fair compensation for physicians' services.

Perhaps the best evidence of the fact that Blue Shield does serve the public interest is its growth within 25 years to a membership of more than 56 million persons who have enrolled entirely on a voluntary basis. This membership is incomparably greater than that of any other single underwriter of medical benefits in the voluntary health insurance field.

Question 13.—Studies of Blue Shield plans show great variation in benefits offered; costs of administration, functions performed in regard to obtaining cooperation and service basis of reimbursement, review of utilization, and services to subscribers. Considering this variability, how can anyone know how Blue Shield will operate if it participates under the program?

Comment.—While we feel that the phraseology of your question 13 tends to exaggerate the degree of variation in benefits offered, cost of administration, etc., among Blue Shield plans, much of this variation is attributable to the local orientation and the continuing local autonomy of the plans with respect to local problems and needs. Blue Shield believes that the public interest can best be served under the voluntary system and by the utmost practical responsiveness to local conditions and needs. During the years, however, Blue Shield plans have demonstrated their ability to expand the communities which they serve and to work together to meet national problems. This has been most impressively demonstrated in the Federal employee health benefit program.

In order to meet such nationwide undertakings effectively, Blue Shield plans have strengthened their national association by delegating to it prime responsibility for negotiations with national employers and national labor groups. This service by the national association has enabled these larger employers to deal with a single organization and thereby avoid the perplexities involved in dealing separately with several plans.

At present, a high proportion of our enrollment is through national employers and national labor groups, or with organizations having covered employees in more than one plan area.

Question 14.—What suggestions do you have on how to assure that if Blue Shield participates it will operate in the public interest?

Comment.—If Blue Shield participates in the supplementary program under H.R. 6675, it would expect to do so through a pattern of benefits with which our plans, our participating physicians, the State insurance departments and subscribers are familiar—a pattern of benefits that would not do violence to our own concept of what constitutes a good prepaid medical care program—a pattern of benefits that would not injure or possibly destroy the relationships and mutual commitments between the plans and the physicians which have enabled us to provide a service benefit type of coverage. We would wish to participate under arrangements that would enable us to bring our full resources to bear on a successful and satisfactory administrative job.

If Blue Shield is to participate on this basis, there could be no question that it would participate in the public interest. As Mr. Nelson Cruikshank of the AFL-CIO pointed out in his testimony before the Senate Finance Committee, "This new system will operate in a goldfish bowl. Not only the medical profession, but the public and the Government will be aware of any abuses that may occur." Mr. Cruikshank pointed out that the "principle of disclosure" will operate in this program. "This principle," he said, "has been effective in other areas in assisting nongovernmental groups in their efforts at self-discipline."

Blue Shield agrees with this statement, and we feel that any carrier participating in this program must and will do so in the public interest.

COMPARISON OF BENEFIT STRUCTURES

H.R. 6675 PATTERN	PROPOSED BLUE SHIELD PATTERN
Any and all these services subject to calendar year deductible of $50 and 20 percent copayment:	No deductibles, no copayment:
Surgical care	Surgical care
Emergency first aid	Emergency first aid
Hospital visits	Hospital visits
Anesthesia service	Anesthesia service
Radiation therapy service	Radiation therapy service
Diagnostic X-ray (in hospital)	Diagnostic X-ray (in hospital)
Diagnostic lab (in hospital)	Diagnostic lab (in hospital)
Physiatry (in hospital)	Physiatry (in hospital)
Diagnostic X-ray (out of hospital)	$100 calendar year deductible and 20 percent apply only to these services:
Diagnostic lab (out of hospital)	Diagnostic X-ray (out of hospital)
Home visits and office calls	Diagnostic lab (out of hospital)
Home health services	Home visits and office calls
Consultation	Home health services
Rental of durable equipment	Consultation
Prosthetic devices	Rental of durable equipment
Braces, artificial legs, etc.	Prosthetic devices
Ambulance service	Braces, artificial legs, etc.
Psychiatric hospital care	Ambulance service
Outpatient psychiatric care (50 percent copayment)	Psychiatric hospital care
	Outpatient psychiatric care (50 percent copayment)

A feature of the proposed Blue Shield pattern is the absence of any deductible applied to the basic surgical-medical services that usually are associated with hospitalized care.

In the great majority of hospitalized cases this makes it possible for the patient to receive full physician care at no cost to him. These, of course, are the sickness incidents that are usually more expensive, and certainly less predictable. These

also are the kinds of medical costs that most persons prefer to protect themselves against through the purchase of insurance or prepayment.

Deductibles and coinsurance do play an important role in the Blue Shield program, but Blue Shield applies them principally to physician care and other medical expenses outside the hospital. Most of these services are less expensive and are spread over a longer period of time, so that the average person can more easily budget for them without relying upon an insurance or prepayment program. It is only after this special group of expenses have accumulated to a sizable sum—such as the $100 that Blue Shield proposes as a "corridor" deductible—that insurance benefits become available.

In the opinion of our actuary, either of these two patterns will result in about the same overall total cost. In support of this contention, it should be noted that the rates that apply to these patterns in the Federal employees' program are now virtually the same. The major difference, therefore, is not cost; the difference is in the number of people who will benefit and in the way those benefits will apply.

In comparing benefits and costs of the pattern of medical and related services prescribed presently in H.R. 6675 with that proposed by Blue Shield, a basic fact should be kept in mind. We refer to the finding of the Department of HEW as reported by Mr. Robert Ball and recorded in the executive hearings before the Committee on Ways and Means in February 1965 that among patients over 65 who are required to be hospitalized in the course of the year, the average annual cost of medical care was $1,223, while for those not hospitalized the cost was only $233. However, the latter group is much larger.

In recognition of this fact, the emphasis of the Blue Shield program is on maximum protection of the hospitalized patient. Thus, under the proposed Blue Shield plan, most hospitalized patients would receive full physician care at no cost; while those under the H.R. 6675 pattern would invariably have to pay a portion of their care. For example, if the physicians' charges total $100, the patient would have to pay $60; if the total was $500, the patient would pay $140; if the total physicians' charges were $1,000, the patient would pay $240.

While the deductible specified in the Blue Shield pattern is $100 against a deductible of only $50 prescribed in the pattern presently in H.R. 6675, it must be remembered that the $100 Blue Shield deductible would apply almost entirely to out-of-hospital services; some of them elective in nature; most of them relatively inexpensive as compared to operative procedures in the hospital. On the other hand, the $50 deductible in the present H.R. 6675 program would apply immediately to the basic costs of medical care in the hospital (and would be added to the hospital deductible.) Once satisfied, this total deductible would have no deterrent effect whatever with respect to the less imperative and less essential services rendered or available to the patient outside of hospital.

(Whereupon, at 11:45 a.m., the committee recessed to reconvene at 10 a.m., Monday, May 10, 1965.)